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The Challenge of Financing. The Fundamentals of an Equitable Health Financing System

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This paper is part of the "Global Health Inequities: Bridging the Gap" project

Introduction

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Health systems face great challenges identifying needs, raising resources and spending fairly. They need to be adequate, sustainable, efficient, define a clear set of entitlements and above all be acceptable. Equity is an increasing priority, but the history of financing health systems shows this can be elusive. As Universal Health Coverage (UHC) takes centre stage, people who need care find significant obstacles in accessing quality services.

A recent report from the Rockefeller Foundation, Save the Children, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) identifies emerging policy lessons for equity in low- and middle-income countries (Brearley 2013):

- Mandatory, progressive prepayment mechanisms including revenues from taxation and the elimination of out-of-pocket spending.
- Risk and resource pools consolidated to help redistribution.
- A universal benefit package designed to meet the needs of the poorest.
- Enabling factors, notably political leadership and mechanisms for accountability.

This paper explores these themes by asking basic questions to raise issues for debate at the seminar 'Bridging a Global Health Social Contract for the 21st century.'

1. How much does it cost?
2. Who should pay?
3. What should we buy?

1. How Much?

$5·3 trillion was spent on health care across the globe in 2010; 90% in high- and high-middle income countries (Mattke 2011). In low-middle and low-income countries, 94% came from domestic sources, 6% from external sources. Domestic funding is the predominant source of funding even in low-income countries – contributing on average 72% of total health expenditures. Development assistance for health (DAH) accounts for more than 50% of total health expenditure in only four countries; however, in another 21 it exceeds 25% (Moon & Omole 2013).

The last 10 years have seen a threefold increase in spending from both domestic and external sources. However marked variation is seen between countries at similar levels of income, whether grouped as high-, middle- or low-income. A recent report focusing on countries in the WHO European Region showed that while some had been able to maintain their health spending during the current economic crisis, others had seen their health budgets cut; in Latvia, for example, government spending on health prevention and promotion activities fell by 89% between 2008 and 2010.

The situation is more acute in countries home to the 'bottom billion'. On the one hand, the global financial crisis affected their economic growth much less than rich countries. On the other, their low starting level of national income has limited their ability to increase health spending to levels necessary to assure universal coverage with even a basic set of needed health services, or to ensure financial risk protection for the population. In 2010 low-income countries spent only $32 per capita on health, including public and private spending and that received from external sources. But it is estimated that $60 per capita is required to supply a basic package of care (Elovainio & Evans 2013).

2. Who Should Pay?

2.1 Domestic Funding

An analysis of 46 vulnerable countries, shows only six would be able to reach the level of per capita spending needed to ensure a basic package from their own domestic sources by 2015, assuming current projections of economic growth. Increased, predictable flows of external funding for health are still needed (Elovainio & Evans 2013). That said, scope remains for raising more resources domestically. Many low- and middle-income countries have already taken steps to do this, and their diverse experiences demonstrate it is possible to do this.

2.1.1 Raising Domestic Funds

In five of the 46 countries, out-of-pocket payments (OOPs) represent less than 20% of total health expenditure (THE), and in five countries they represent more than 75% of THE. Thus, while countries can raise more revenue for health, they need to do it increasingly through mandatory prepayment mechanisms.

One option is to increase the priority that governments give to health when allocating government revenues. Countries differ markedly in the share of general government expenditure (GGE) going to health: in 25 of the 46 vulnerable countries, health receives less than 10% and in 10 countries it is even below 5%. The 2001 Abuja Declaration, adopted by the African Union heads of state, agreed a goal of 15%.

Countries also have scope to raise more revenue. Some strategies relate to tax reforms. Sierra Leone introduced a single goods and services tax (GST), which led to an increase in the share of government revenues relative to GDP, from 11.7% in 2010 to 14.9% in 2011. Tobacco and alcohol taxes and levies also exist in most countries. In the Philippines, such taxes aim at providing public funding for the current administration's universal health coverage program (Elovainio & Evans 2013).

Several low- and middle-income countries have increased government revenue promoting tax compliance and collection efficiency (e.g. South Africa, Kenya). Capital flight from low-income countries may be as high $1trillion per year (Kar 2008). Hence, domestic government revenue could dramatically increase through improved global governance on tax competition and tax havens, and increasing transparency, especially on payments related to natural resource extraction (UNSDN 2013).

2.2 External Funding

Aid increased rapidly between 2000 and 2010 (from $76 billion to $124 billion). DAH rose even faster (from $11 billion to $28 billion, including non-governmental assistance). Governments remain by far the largest source of DAH, accounting for 70% of the total. But private sources of funding (including foundations, NGOs and corporations) have grown in importance, increasing from 8% of total DAH in 1990 to 15% in 2010, with the largest single contributor being the Bill & Melinda Gates Foundation (IHME 2012). Critiques of DAH have followed, including amounts falling short of commitments; volatility; conditionality and displacement of domestic resources; priorities diverging between donors and countries; and costs imposed from fragmentation (Ooms 2010, Harman 2012).

2.2.1 Raising External Funds

The plateau of DAH over the last 2 years suggests we are not facing the end of aid as we know it. Alternative external financing mechanisms may at least support current levels. Proposals include new taxes, e.g. on financial transactions or innovative financial mechanisms; ways of reforming the institutions through which aid is channelled; and new proposals that go beyond the current system, including international law to codify mutual obligations and new institutions such as a Global Social Protection Fund.

An international levy on financial transactions (such as trade in equities or currencies) may raise between $5 and $400 billion per year, depending on the tax rate, the taxed item, and those countries that implement it. For instance, the recent European Enhanced Cooperation Arrangement between 11 countries, if adopted, may raise $45 billion (Lopez 2013). However, it is unlikely health will be the primary beneficiary.

Other proposals involve managing financial flows (as opposed to raising more money), including building on the GAVI Alliance's International Finance Facility for Immunization, which front-loads investments by using long-term pledges from donor governments to sell 'vaccine bonds' in capital markets; or the Global Fund to Fight AIDS, Tuberculosis and Malaria's (GFATM, or Global Fund) Debt2Health initiative, which redirects funds for debt repayment by recipient countries to domestic health investments (Moon & Omole 2013). More ambitious is a Global Social Protection Fund to enable long-term resource transfers to poorer countries or populations, based on an expansion of the notion of social protection beyond the nation-state (Ooms et al., 2010).

2.3 Searching for Equity

Pooling resources to protect people from the financial consequences of ill health is central to ensuring equity. In financing, equity means equal health care expenditure for equal need, and equal access to health care for equal need. Pragmatically, in low-income countries it refers to equal use of basic services and goods. But it is also dependent on equity in other factors that determine access, such as information, infrastructure, and service quality. And any reform needs to consider the side effects on vested interests and assess the winners and losers.

Although few governments would actively oppose calls for equity, hostile debates can emerge when establishing equity in health outcomes.

Even rich countries with a strong social welfare tradition have struggled to reduce health inequalities in both care and outcome terms. Funds allocated on the basis of need often do not counteract the disadvantages associated with parental wealth, nutritional status, gender and location have had varying effects.

In emerging economies, there have been marked differences in their respective patterns of economic growth and access to health care. Equity within these countries will affect the global picture markedly given their population size and the presence of most of the world's poor. While statistically speaking the global health agenda is their domestic agenda, increasingly they have investment and development ties in low-income countries. How should we assess the global commitment of large emerging economies that are facing insurmountable health challenges at home?

In poorer countries, the structure of the economy, with a large share of the population outside salaried employment, makes it difficult to enforce either income taxes or payroll taxes on most citizens. Thus, increasing the size of the compulsory prepaid pool of funds requires transfers from general revenues (sourced predominantly from consumption taxes (e.g. value added tax) in most low-and middle-income contexts), and the relative need for this grows in proportion to the size of the so-called "informal sector" of the population (Kutzin 2012).

Indeed it has been argued that equity in itself is required for efficient outcomes. A recent analysis reveals the deaths of 1.8 million children under-five and 100,000 mothers could be averted each year by eliminating within-country wealth inequities in coverage of essential maternal and child health interventions in 47 of the 75 Countdown to 2015 countries. This may reduce maternal and child mortality by one-third and one-fifth respectively (Brearley 2013).

Equity is also central the post-2015 agenda. The World Bank and WHO are proposing two targets relating to UHC — one to end impoverishment from health expenditures and another to achieve 80% coverage in the poorest 40% of the population of two composite measures for MDGs 4, 5 & 6 and non-communicable diseases. But inequities, particularly within fragile states, may expose ambitions of equitable financing. A 'bottom billion'-focused aid system may arise as the number of emerging economies increases. Given the larger role of non-state actors in where governance is weak, information sharing and coordination between actors is vital if inequities in access are to be addressed, if only partially.

In emerging economies, outcomes such as halving the death-rate gap between the richest and the poorest, between the best-performing and worst-performing region, and between, say, ethnic minorities and the national average may be appropriate. Such equity targets could be calibrated on a country-by-country basis in the light of data available, and informed by national dialogue and the perspectives of civil-society groups working with the poor (Watkins 2013).

3. What Should We Buy?

3.1 Searching for Efficiency & Accountability

Without the availability of good quality services, financial risk protection will not be sufficient. At both the macro and micro level it is necessary to make sure that funds are allocated those services which translate into beneficial effects for health. And although a basic package can be defined, where, how and who delivers it can vary wildly.

Access and quality of services are in turn dependent on infrastructure, human resources, medicines, good data and good governance. Strategic purchasing is a useful instrument to optimize the use of available resources based on evidence of population needs and provider performance. However, high-income countries have diminishing returns on health spending. A potent mix of high-cost diagnostics, expensive surgery and new drugs add cost pressures, with mixed, often slight benefits for patients. In low-income settings, drug and vaccine prices can vary 90%. Using off-patent drugs and applying regional mechanisms for financing and procurement can reduce costs. Governments have an important role to play here in the efficient production, distribution and pricing of medicines.

Private-sector expertise may bring improvements in quality and delivery. Public–private partnerships may also encourage investment, protect innovation and support prompt access to new medicines. Governments need to assess what patented drugs they need beyond a basic package. Public health emergencies may require compulsory licenses where alternative interventions are not available and wholesale prices are extreme (Chand 2012).

Despite such complexities, coherent reform is possible. Thailand has been cited as an example where supply-side investments (building and upgrading infrastructure, introducing effective workforce policies) accompanied demand-side investments (monies channelled through the different pooling mechanisms) (Chatham House 2013).

Conclusion

The rationale for an equitable health financing system is based in both human rights and economic arguments. Each year, direct payments for health services exclude 1.3 billion people from gaining access to health services and push 100 million people into poverty. Only when the percentage of out-of-pocket payments falls to 15–20% does the risk of poverty become negligible.

However, other determinants have a complementary role in enabling access, financial risk protection and defining outcomes. In building a global health social contract fit for this century, we must consider the risks that may undermine access to food, water, education and jobs. A key uncertainty is the global economy. Further deleveraging may precipitate a depression with a significant effect on both domestic and external health financing.

Population growth, urbanization, trade and development are in turn driving trends in consumption, physical inactivity and pollution. This means that the crude number of non-communicable diseases is set to rise. If UHC is to be sustainable, it will have to move beyond health care, to a broader, yet complex governance agenda that seeks to do no harm and knows when nutrition or jobs need to take centre stage.

It is best to invest now while costs are low. Community-based care offers improved coverage, sustainability and cost-effectiveness. Countries such as Brazil, China, Colombia, Ghana, Kyrgyzstan, Rwanda, Sri Lanka and Thailand have made great strides in coverage. We must be realistic, but given the marked variation already in place between countries, we have reason to be ambitious (Chand 2012).

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