The critical role of health financing in progressing universal health coverage

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Universal health coverage has been defined as the ability of all people who need health services to receive them without incurring financial hardship, thereby achieving equity in access. Universal health coverage consists of two interrelated components:

- Coverage with quality health services, including promotion, prevention, treatment, rehabilitation and palliation; and
- Coverage with financial protection, for everyone.

The former captures the aspiration that all people should obtain the good quality health services they need, while the latter aims to ensure that they do not suffer financial hardship linked to paying for these services.

For all countries, moving towards UHC is a process of progressive realization on several fronts: the range of available services; health services of sufficient quality to achieve the desired outcomes; the proportion of costs of those services covered; and the proportion of the population covered with specific focus on equity.

Progressing towards the goal of UHC requires countries to advance in terms of health system inputs, outputs and coverage.
of good quality services in all population groups while ensuring solidarity through financial protection against catastrophic OOP health payments. It is necessary to pool resources and to eliminate direct payments at the point of service in order to provide quality services equitably.

UHC is much desired and progress in its implementation will result in improving health outcomes and tackling poverty, by increasing access to, and coverage of, quality health services, and by reducing the suffering associated with payment for health services. Health financing is central to providing the different components of health systems needed to make progress in UHC. However, there are several constraints militating against the financial resources for health that are essential to implementation of UHC in the African Region.4,5 This article describes those constraints and potential measures to circumvent those challenges.

Constraints in implementation of universal health coverage

Insufficient financial resources

The high-level Taskforce on Innovative International Financing for Health Systems6 estimated that in 2009 a low-income country needed to spend on average US$ 44 per capita, and US$ 60 as a target for 2015, to strengthen its health system and to provide an essential package of health services. In 2012 the data show that 26 countries were on or above US$44 per capita while 19 were below that amount (Figure 1).

Unexpectedly, there is no positive correlation between health expenditure and health indicators — r²=0.17 for the maternal mortality rate (MMR) and 0.018 for the under-five mortality rate (U5MR). In addition, the countries with an average expenditure on health of more than US$ 60 per capita do not have improved health indicators; probably due to inefficiency in the utilization of the available resources including the prioritization of high-impact interventions. For example, Mauritania, Côte d’Ivoire and Sierra Leone are spending US$ 50–100 per capita on health, but their MMRs are 300, 700 and 1,100 per 100,000 live births, respectively. Algeria, Botswana and South Africa have low rates of MMR, <200 deaths per 100,000 live births, but they are spending respectively US$ 250, 380 and 650 per capita. This situation is similar for the U5MR (Figure 2). Spending in investment and supply will not show outcome impact (reduction of mortality and morbidity), but investing in primary health care and high-impact interventions may show a quick outcome impact.

Apart from per capita expenditure, governments can also allocate more money for health from domestic sources. In this regard, the 2001 Abuja Declaration urges African Union states to allocate “at least 15%” of national budgets to the health sector”. Despite this landmark decision, only six countries had implemented this by 2012 (Liberia, Rwanda, Swaziland, Zambia, Malawi and Togo). Considering both the Abuja and high-level Task Force targets, only Liberia, Rwanda Swaziland and Zambia have met both (Table 1).

Heavy reliance on out-of-pocket health expenditure

The public health facilities rely heavily on funds obtained through prepayment schemes and OOP spending of patients as a source of health-care financing to meet operational costs. Evidence shows that when OOP payments are below 20% as a proportion of THE, the incidence of financial catastrophe caused by OOP health expenses is negligible. However, this was not the case for 35 countries (79%) of the 47 countries in the African Region in 2012 where OOP expenditure was more than 20% of THE. Indeed, in 21 (45%) countries, the OOP was more than 40% of THE, which presumes that households are exposed to impoverishment caused by catastrophic health expenditure (Figure 3).
The incidence and intensity of catastrophic health expenditure and impoverishment due to health payments are shown in Figure 4. A recent survey on financial protection in seven African countries showed that the incidence of catastrophic health expenditure ranged from 6.8% in Mauritania to 0.4% in Seychelles. Impoverishment due to health payments was highest (2.7%) in Kenya and lowest (0.15%) in South Africa.\textsuperscript{7–12} It is very clear that the burden of OOP payments is high in the African Region, and households are becoming poor and many more are being trapped in poverty due to health-care payments. African Members States should urgently consider alternative health financing mechanisms that offer financial risk protection to the population. Such approaches, as clearly stated in the WHO 2010 report, should encourage risk pooling and income cross-subsidization.\textsuperscript{1}

Some African countries are doing relatively well in the implementation of the WHO 2010 recommendations and five of the best practices documented\textsuperscript{13} are described in Table 2.

### Inefficiency in management of health systems

Implementation of prepayment mechanisms will not have much positive impact if not executed simultaneously.
Figure 3. Out-of-pocket expenditure as percentage of THE, 2012

Figure 4. Distribution of households facing catastrophic health expenditure payments and impoverishment due to capacity to pay in seven countries of Africa

Governance and accountability

African leaders are taking the decision to implement UHC. Some countries in the African Region are already implementing strategies to improve access to and coverage of health services (Botswana, Gabon, Ghana and Rwanda) while many others (Benin, Burundi, Congo, Côte d’Ivoire, Democratic Republic of the Congo, Kenya, Malawi, Mali, Mauritius, Namibia, Nigeria, Senegal, Seychelles, Sierra Leone, Togo, Uganda and United Republic of Tanzania) have made commitments to take measures towards achieving UHC.

However, implementation of UHC requires putting in place a clear policy and plan with a monitoring and evaluation (M&E) framework to guide the implementation and to measure progress. It also calls for government stewardship to coordinate the different stakeholders. Although mobilizing sufficient financial resources and obtaining long-term commitments are obviously crucial requirements, design details, the formulation process, and implementation plans also need careful consideration.
Harnessing stakeholder contributions in health financing

The health arena in the African Region contains many actors, dispersed efforts and unclear results in relation to impact on priority health problems. Most health systems in the African Region are pluralistic; services are delivered by public and non-state providers, including private for-profit and private not-for-profit actors. Communities also play a role in mobilizing resources for health and service delivery. In addition, improving health outcomes requires the effort of more than the health sector alone. Harnessing the contribution of the multiplicity of actors remains a challenge due to lack of implementation of appropriate frameworks and instruments. Roles and mandates of the different stakeholders are not explicitly spelt out. In addition, the capacity of government officials in negotiation, comprehensive planning and monitoring needs to be strengthened.

Research including monitoring and evaluation

Monitoring and operational research systems are still weak, making it hard to evaluate achievement, identify gaps and implement appropriate solutions to make progress. Although several countries have undertaken national health accounts (NHA) to inform policy making and guide priority setting when developing national health strategies and operational plans, it is not yet institutionalized in several countries. As countries move forward, they will need to track their own progress and make adjustments to their strategies and plans on health financing as necessary. Some progress has been made in the Region in recent years – 33 countries participated in orientation and capacity-building workshops for the revised System of Health Accounts (SHA) in 2011. As a result 60% of those countries are using (or preparing to use) SHA, which is the global standard for tracking resources, adopted by various UN agencies such as UNAIDS and UNFPA, as well as by the Global Fund for AIDS, Tuberculosis and Malaria. This means that they are producing health accounts with disease expenditures including expenditures on women’s, children’s and adolescents’ health. They are also in the process of institutionalizing SHA so that accounts are produced annually for expenditure of the previous year, with results published on time for budget development and policy planning.

Table 2. Best practice in the implementation of UHC: What works in the African Region

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<th>Country</th>
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<tr>
<td>Ghana</td>
<td>Ghana has been implementing health financing reforms since 2004 in order to increase population coverage and ensure a fair and more cost-effective system. A range of pooled mechanisms were introduced to reduce direct OOP payments and increase the range of services provided in the benefit package. The Ghana National Health Insurance Scheme (GHIS) is one of the most comprehensive schemes to be established in sub-Saharan Africa. Under the scheme, exemptions for the poor were included initially. Indeed, relatively poor districts and disadvantaged population groups have higher NHIS coverage. The key design principles are “equity” in access to a defined benefit package irrespective of the capacity to pay and “risk equalization” where the financial risk of illness is equally shared among all.</td>
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<td>Rwanda</td>
<td>Rwanda has enacted a law regarding the creation, organization, operation and management of a national health insurance scheme. The law stipulates that, “Any person residing in Rwanda shall be bound to health insurance, any foreigner entering the country shall also be bound to health insurance within a time limit not exceeding fifteen days.” The scheme now covers about 92% of the population and includes medical consumables, services, capital projects, logistics and equipment for service providers. In addition, a strategy to identify destitute people in order to determine national health insurance scheme contribution subsidies and exemptions has been devised, and the government and development partners pay for groups that have been identified as part of poverty alleviation activities.</td>
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<td>Gabon</td>
<td>Gabon initiated reforms in 2007 in its health financing system to achieve UHC. The reform culminated in the establishment of the National Health and Social Insurance Fund, which receives money through special taxes paid by mobile telephone and money transfer companies, and social contributions by wage earners, independent workers, employers and state subventions. The authorities adopted an incremental approach to membership, starting in 2008 with the poorest, state employees in 2010 and private sector workers in 2013. The Caisse Nationale d’Assurance Maladie et de Securité Sociale (CNAMGS) resources for health have multiplied by four in three years, from about 10 billion CFA francs in 2008 to more than 37 billion CFA francs in 2011. The pooling of funds has facilitated access to health services for various categories of the population such as the formal and informal sector, and both rich and poor.</td>
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<td>Burundi</td>
<td>Burundi, faced with challenges of underfunding, implementation of user-fee schemes with subsequent impoverishment, low utilization of services that were of poor quality, and poor health indicators, the government introduced fee exemptions for pregnant women and children under five in 2006. Although this led to a marked increase in health service utilization, the persistent underfunding for health by the government further compromised the quality of health services, with disgruntled health workers and subsequently reduced utilization rates. Official user fees were replaced by under-the-table payments. Piloting of results-based financing (RBF), a health financing strategy that focuses funding to outputs, was introduced in 2008. The health facilities in the pilots received performance bonuses for both the quantity and quality of services delivered, and quantity indicators related to a basic health package, which included services that were exempted from the fee scheme. The pilots produced positive results with an average increase of 50–60% for each indicator compared with the period before the introduction of RBF. This initiative was scaled up to more provinces and a national RBF scheme was launched.</td>
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<td>Botswana</td>
<td>Botswana is one of the few countries in the Region to make a significant government investment in health. The current health financing system provides a high level of financial risk protection for its population compared with other countries in the Region. Botswana uses a tax-based system to cover the population for a wide range of services, and has one of the Region’s lowest levels of OOP spending on health at only 8% of GNP. Government expenditure on health, at US$384 per capita, is also considerably higher than the average (US$147 per capita) for other countries in the Region.</td>
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To date, 11 countries are producing or have already produced at least two consecutive SHA 2011 health accounts reports with disease expenditures. Another 10 countries are in the process of producing their first SHA 2011 with disease expenditures, including expenditure on women’s, children’s and adolescents’ health (Figure 6).

To show how UHC is making progress, in addition to the NHA mentioned above, the use of the framework of monitoring progress towards UHC at country and global levels, elaborated and published jointly by WHO and the World Bank, will be useful in measuring progress at country and regional level. Baseline studies using this framework to assess capacity to successfully apply the framework for monitoring progress towards UHC have already been conducted for Ethiopia, Ghana, Kenya, South Africa and the United Republic of Tanzania. Botswana, Côte d’Ivoire, Lesotho, Namibia, Uganda, Seychelles and Swaziland are in the process of producing their baseline assessments on progress towards UHC using the same framework.14,15
Key requirements for strengthening health financing to improve UHC

- **Support for assessing the current situation in relation to health financing and UHC:** financial and technical support to country teams analysing the current state of UHC, how the health financing system currently operates, and technical options for change that would enable progress towards UHC.

- **Facilitate inclusive policy dialogue for health financing strategy development:** Development or revision of countries’ policies and strategies for health financing systems will ideally involve multistakeholders – all ministries involved in the provision or financing of health services (including the ministries of finance, labour and social affairs), subnational governments, civil society, private sector etc. Existing platforms should be used wherever they operate well – for example, active donor groups often exist at country level (sometimes separately for health financing issues) and could be used as the facilitation mechanism; regional partnerships such as Harmonization for Health in Africa (HHA) could facilitate these exchanges in some countries; while global partnerships such as Providing for Health (P4H) would be able to encourage these country dialogues in other settings. In addition, WHO will facilitate dialogue and interaction with the national health planning process where this is occurring.

- **Scale-up policy advice to countries:** This should occur during the evaluation of health financing options, and then in the provision of technical support during the rollout of plans and strategies, and the monitoring and feedback stages. Again, existing partnerships would be used where they work well and have the expertise in health financing for UHC.

- **Facilitate innovation and learning-by-doing at country level:** It is important that countries are able to innovate, monitor and evaluate as they move forward so that they can modify their own strategies rapidly when necessary. Other countries could also benefit from sharing experiences. Innovation with learning-by-doing is required in almost all of the specific health financing reforms that might be instituted – linked to raising more money, reducing financial barriers and increasing financial risk protection, and improving efficiency and equity. External partners as well as governments would need to provide sufficient finance to rollout innovations, but also to fund recipient-country nationals or institutions to undertake independent reviews of achievements. They would also need to provide technical inputs on design and implementation of this type of “research” in some settings.

- **Provide support to countries seeking to improve transparency and accountability:** It is important to assess the way health funds are raised and used. This would require among other things strengthening the country’s ability to: a) track financial resources allocated to and spent on health, including government, non-government and external resources (institutionalized in the NHAs); b) identify how resources are used and who benefits from them; and c) identify areas in which more “value for money” could be obtained by improving efficiency and equity.

**Conclusion**

UHC is obviously an ambitious endeavour but making progress on it will be of immense benefit, particularly to the African Region as it will be associated with improved access to health services, financial protection to all citizens of a particular country and improved health outcomes. The development of robust health financing policies, strategies and sustainable financing mechanisms are central to the implementation of the key components of UHC. These strategies will require that the various sectors and stakeholders within and outside the health sector play their roles. Countries need to take responsibility, ownership and lead the processes involved. WHO will convene the necessary forums and provide the technical support to facilitate the acceleration of the processes needed for UHC.

**References**


6. Taskforce on Innovative International Financing for Health Systems. More money for health, and more money for the money; to achieve the health MDGs, to save the lives of millions of women and children, and to help babies in low-income settings have a safer start to life. London 2009.


