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Alternative Financing Strategies for Universal Health Coverage

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Many countries have identified Universal Health Coverage (UHC) as the goal for their health systems, and health financing reforms are at the core of strategies to move in this direction. While there is no one “best” financing strategy that applies in every context, this chapter synthesizes both theory and practice into principles that can be used to guide country progress with their financing reforms, while also highlighting pitfalls to avoid on the path to UHC. It begins with the conceptual underpinnings of both UHC and health financing policy, arguing that the emergence of UHC after the Second World War had profound implications for public policy on health coverage, particularly with regard to the role of general government revenues and the weakening of contributory-based entitlement. This is followed by a synthesis of lessons with a particular focus on low- and middle-income countries (LMICs), including the importance of increasing reliance on compulsory revenue sources raised through diverse mechanisms, reducing

fragmentation in pooling arrangements and addressing inefficiencies through strategic purchasing and effective provider payment methods (PPMs). We then address a key challenge facing LMICs — extending effective access and financial protection to the informal sector who comprise the majority of the population.

Keywords: Universal Health Coverage; Health Financing.

Introduction/Overview of Chapter

Background

Universal Health Coverage (UHC) has gained great attention among policymakers and academics since the publication of the World Health Organization's (WHO) World Health Report in 2010 (WHO, 2010a). Health system reform plans from Indonesia to Mexico to Nigeria to Thailand have used UHC as a justification, often grounding this in constitutional or legal guarantees that have long gone unfulfilled. However, the specific health financing approaches used or proposed as part of these plans vary greatly across countries. While this is consistent with the idea that there is no blueprint strategy that applies to all countries, it is a concern where the label of "UHC" is applied but the proposed strategy is not consistent with the concept of UHC or fails to incorporate core lessons from experience. For purposes of this chapter, we use a definition of financing for UHC derived from the World Health Report (WHO, 2010, p. 6):

"Financing systems need to be specifically designed to:

- Provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective;
- Ensure that the use of these services does not expose the user to financial hardship."

Taken literally, these conditions cannot be fully achieved anywhere. Even where all people are protected from financial risk, there is always some gap between the need for and use of services, and quality often varies. To transform UHC from a mere aspiration to a practical concept requires identifying the specific goals embedded within the definition and orienting policy toward *progress* on these goals. Hence, we reframe the goal as *moving toward UHC*, meaning taking actions to reduce the gap between the need for and use of services, improve quality and improve financial protection. Further, UHC implies that these goals be assessed at the level of the entire system or population rather than within specific financing schemes (Kutzin, 2013).

The agenda of health system reform to progress toward UHC extends beyond health financing. For example, while health financing actions directly affect financial protection, so do actions to improve the availability and price of medicines.

Similarly, many parts of the system (service delivery, human resources, medicines, technologies, financing) influence equity in service use relative to need. And financing is typically only a complementary instrument for influencing quality — reforms in service delivery, human resources/medical education, medicines, technology and information play the leading role. The focus of this chapter is on financing reforms, but key linkages between financing and other aspects of the system, particularly service delivery, will be noted as relevant throughout the chapter.

Key messages

It is not relevant to define a single, “best” model of health financing for UHC because systems are dynamic and path-dependent.¹ Thus, the best option for a country in a given circumstance may not be relevant for another country. The issue is not what specific strategy is best in an abstract sense, but rather, given where a country is today, what are promising directions to take to enable progress on the UHC goals. That being said, however, there are important lessons learned from both theory and practice that provide useful principles to guide progress and avoid well-known pitfalls in health financing policy. These lessons are reflected throughout the chapter, but we note them here in brief:

- Countries should seek to move toward predominant reliance on compulsory funding sources (general tax revenues, earmarked payroll taxes, or a combination), as voluntary mechanisms suffer from serious shortcomings. Indeed, no country has attained universal population coverage based on a system organized around voluntary prepayment. Moving toward compulsory sources is a major challenge for fiscally constrained countries that are typified by large shares of the population who are not in regular salaried employment. We address this context head-on in the chapter, with particular attention to policy options for countries in such contexts.
- Countries that have made significant progress toward UHC have had the benefit of a strong political commitment to UHC, reflected in the prioritization of health in their national budgets. All potential government revenue sources for the health sector have potential consequences for other sectors in the broader economy, however. The efficiency and equity impacts of alternative tax instruments (e.g., income tax, corporate tax, value-added tax) are highly context-specific and arise from the combined impact of all tax measures. In turn, their implications for

¹ In this context, “path dependent” means that each country already has its health financing arrangements that have developed and changed over a period of years. When embarking on a new reform agenda, such as one explicitly oriented to UHC, these arrangements provide the unique “starting point” for the reforms, with decisions on what to do next contingent, at least in part, on what is already in place.

social welfare need to be considered in concert with the level and distribution of benefits made available through the spending they finance.

- There is a general trend toward greater diversification of revenue sources, including a diminishing role for payroll tax funding. This is a practical consequence of the “ideology” of UHC. With the move toward UHC, entitlement to health coverage is being delinked from employment, and from direct contributions more generally. On the practical side, wage-linked contributions cannot generate a sufficient revenue base, both in high-income countries (because of aging populations and macroeconomic concerns regarding increasing wage-based taxation) and also in low- and middle-income countries (LMICs) (because of low participation rates in formal sector employment).
- Whatever the level of prepaid funds, countries should seek to maximize the redistributive capacity of these funds by reducing or eliminating fragmentation in pooling arrangements to the extent possible.
- Countries cannot simply spend their way to UHC; the way the funds flow through the system and whether spending can be matched to priority programs, populations, and services also matters. Attention to addressing inefficiencies is essential to sustain progress, with purchasing/provider payment the central instrument in the health financing armamentarium to achieve this purpose.
- Effective reform requires policy coherence, meaning a focus on alignment of policy measures across the financing system as well as alignment with the rest of the health system. A narrow focus on single-instrument “magic bullets” (such as social health insurance, user fee introduction or elimination, results-based financing (RBF), diagnosis-related groups (DRGs), insurance competition, etc.) will be inadequate and may do more harm than good.

Overview of chapter

Following this introduction, the next section provides a deeper exploration of the underlying concepts of UHC and health financing policy, as well as the implications of UHC for public policies on health coverage. This is followed by a synthesis of lessons learned and core challenges based on global experience with health financing for UHC. The following section contains a systematic exploration of financing options for UHC in the context of high labor force informality, distinguishing alternatives broadly by the basis for entitlement (contributory vs. non-contributory) and defining specific choices within these categories based on empirical experience. The chapter concludes with a derivation of adaptable principles to guide financing reforms, pitfalls to avoid, and core public policy questions that need to be addressed.

Core Concepts and the Implications of UHC for Health Financing Policy

Health financing policy and UHC: Conceptual approach

Health financing policy and related reforms are best understood in terms of specific functions and policies, rather than by historical labels (e.g., Beveridge, Bismarck) that are largely linked to the main source of funds (Kutzin, 2001). Regardless of the labels attached to them, health financing arrangements in all countries include:

- Revenue raising — Sources of funds, contribution methods used, and mechanisms for their collection.
- Pooling — Arrangements for the accumulation of prepaid funds on behalf of a population within the system.
- Purchasing — Transfer of funds to providers on behalf of a population, incorporating both provider payment mechanisms and the organizational/institutional structure of purchasers.
- Benefit design and rationing policies — Entitlements and obligations of the population with regard to health services, including measures such as patient cost sharing (user fees/copayments), service exclusions and waiting lists, which countries use to ration access.
- Stewardship of the financing system — Government's role in orchestrating the financing arrangements, including governance of health financing agencies, regulation of markets and information provision.

The WHO definition of UHC noted above embodies three specific goals: Equity in service use, sufficient quality, and financial protection. The aim of financing (and other system) reforms is thus to move systems toward these goals² by considering the ways that reforms can *influence* progress. Based on the health financing functions, this has led (Kutzin, 2013) to the specification of intermediate objectives of financing for UHC:

- Equity in the distribution of health system resources.
- Efficiency in system organization, service delivery, and administrative arrangements.
- Transparency and accountability of the system to the population.

²While it is not the purpose of this chapter to justify UHC as a goal, we note that this specification is consistent within a wider framework on health systems performance in which financial protection is an overall goal of health systems, and equity in use and quality are intermediate objectives with regard to the goals of improving health (overall level and equity in health) and responsiveness (WHO, 2000; 2007; Murray and Frenk, 2000).

A detailed functional analysis of a country's health financing system is needed to provide a sound basis for understanding how it is organized and how it functions, which in turn can support a diagnosis of the ways in which it may be contributing to under-performance relative to the UHC goals and intermediate objectives. This requires not only exploring the organization of each "sub-function" but also their alignment/misalignment with each other as well as across a range of different financing schemes that might exist in a given country.

Foundations for public policy on health coverage: From Bismarck to UHC

UHC is not a new concept. In many ways, it emerged after the Second World War, underpinned in many countries by a broad value consensus such as *social cohesion* in European countries (Figueras *et al.*, 2012) and *human security* in Japan (Reich *et al.*, 2011). A *right to health* or health care is reflected in the text of the WHO Constitution (WHO, 1948) and the Universal Declaration of Human Rights (United Nations, 1948). It is also reflected in many national constitutions, for example, the constitutions of South Africa (1996) and Mexico (2013) declare that everyone has the right to access to health care services.

The advent of UHC has marked a change in the underlying rationale for public policy on health service coverage. Prior to this, beginning in 1883 with Bismarck in Germany, followed by several other European countries and Japan over the next 40 years, the motivation was different. These countries sought to support industrial development through a healthier workforce with a concern to mitigate growing political pressures from labor unions (Saltman and Dubois, 2004; Ikegami *et al.*, 2011). The coverage policies introduced — health insurance for workers in the formal sector of the economy funded by mandatory contributions of employers and employees — were consistent with these underlying motivations. It meant, however, that large shares of the population, particularly those working in agriculture or otherwise outside of the formal/industrial economy, did not have any explicit form of entitlement.

The shift from "workers" to "people" as those entitled to coverage after the Second World War had important implications for health financing policy.³ In particular, it meant that there had to be a shift away from a purely contributory

³ In fact, some countries moved in this direction earlier. In Hungary in 1920 and the USSR in 1937, health services were made available to the entire population, financed either wholly from general tax revenues or a combination of these with social insurance contributions. New Zealand took similar measures between 1939 and 1941 to extend service coverage to its entire population (Abel-Smith, 1987).

funding mechanism and basis for entitlement. More specifically, the use of revenues from general public budgets were needed to provide all or nearly all of the funds, as is the case in the British NHS established in 1946 (Abel-Smith, 1987), or to supplement compulsory health insurance contributions to ensure coverage for the poor and others outside of the formal sector of the economy, as in Japan, which achieved universal population affiliation with its health insurance system in 1951 (Ikegami *et al.*, 2011).

Much of the advice provided to LMICs in the 1980s and 1990s on health financing encouraged them to initiate compulsory health insurance for formal sector workers. Such recommendations (e.g., Akin *et al.*, 1987; Griffin and Shaw, 1995) were implicitly based on (or at least consistent with) the pre-war rationale for public policy on health coverage, combined with a politically hopeful (or naïve) expectation that such coverage programs would be fully self-funding and thus enable public subsidies for health services to be captured by the poor. Unfortunately, this approach tended to concentrate even greater shares of public subsidies on the formal sector population. In 1992 in Thailand, for example, public spending per person covered was 916 baht in the civil servants scheme, 480 baht in the scheme for private sector workers, and only 214 baht in the scheme for low-income persons (Hsiao, 1993).

Such recommendations were also consistent with the view that the way coverage had expanded in currently high-income countries, starting with the formal sector and then gradually expanding, was “the way,” and that LMICs should proceed down this path. In retrospect, this approach not only neglected the change in the underlying public policy rationale motivating action on health coverage, it also failed to account for another contextual shift: the development and diffusion of medical technology. In 1900 in Europe, governments were simply not faced with life-or-death choices as to which population groups would have preferred access to the latest medications. But by the 1990s if not before, the health Minister of every country in the world, including LMICs, had to confront this. By initiating explicit coverage with the formal sector, LMIC governments provided privileged access to such technologies to a relatively small part of their populations that were both economically advantaged and well organized. As a result, those initially covered pushed for more subsidies and benefits, not for the extension of the same entitlements to the rest of the population. This different medical context meant that the political response to following the historical (pre-war) pattern of European health coverage expansion in the post-war setting of today’s LMICs exacerbated rather than compensated for underlying social inequalities with regard to health and health service use (Savedoff, 2004; Kutzin, 1997; González-Rossetti, 2002). Such approaches tended to segment health financing and often service delivery systems by social class and have

proven very resistant to change, as evidenced by the inability of countries such as Mexico (Knaul *et al.*, 2012) and Thailand (Prakongsai *et al.*, 2009) to unify their systems. But at least in these two countries, if not others as well, such explicit inequalities proved politically unsustainable, stimulating UHC-oriented reform agendas that began to delink entitlement from contribution (and labor force status) and rely predominantly on general government budget revenues as the main source of funds for coverage expansion.

Health Financing for UHC: Lessons Learned and Core Challenges

An adaptable approach to health financing policy

In addition to the specification of goals and intermediate objectives, as well as the functional approach to understanding health financing arrangements in any country, policy analyses and recommendations need to be guided by an approach to applying these concepts. For this, three factors need to be considered that, broadly, address the following questions:

- (1) Where are we going?
- (2) From where are we starting?
- (3) How far and how fast can we go?

The first issue is to orient the direction of reforms to specific policy objectives. For these, countries can be guided by the broad UHC goals and intermediate objectives, tailoring these to their specific circumstances (for example, how do problems of equity in service use, inefficiency, or transparency manifest themselves in the country?). The second question is grounded in a fundamental policy reality: the starting point for any reform is the system that currently exists in the country. Understanding this requires a detailed functional analysis of the country's health financing arrangements. Combining these first two questions can lead to conclusions (or plausible hypotheses) with regard to how the current organization and operation of health financing in the country is contributing to performance shortcomings with regard to the UHC goals and intermediate objectives. In addition to these analyses, the third question speaks to the context — the factors largely outside the control of health policymakers — that have implications for both what can be implemented and what can be attained in terms of progress towards UHC. While many of these are country-specific, two critical contextual factors are relevant in all countries: The country's fiscal capacity (in particular, its ability to generate tax revenues) and the structure of its public administration (Kutzin, 2008).

This approach leads to the conclusion that the question of whether or not there is a “best model” for health financing is not particularly relevant. Even though the UHC goals and intermediate objectives are broadly shared, the starting point and context for health financing is unique to each country. In addition, the specific ways that performance problems manifest themselves also vary across countries. The “right reforms” for any country to move towards UHC depend critically on these factors. This recognition led the authors of the World Health Report to write that “Health financing strategy needs to be home-grown — pushing in the direction of universal coverage out of the existing terrain.” (WHO, 2010, pp. 90–91). However, this conclusion does not mean that every country is on its own, with little of value to be gleaned from experience elsewhere. In fact, there are important lessons from experience that can help one country avoid the mistakes of others, and that can provide principles to guide the policies and actions that aim to reform and align health financing sub-functions to support progress toward UHC (Kutzin, 2012).

Lessons from experience: Revenue raising, pooling, purchasing and benefits

- *Compulsion, subsidization, and adverse selection*

All countries that are recognized to have made substantial progress toward UHC — where the entire population is able to use publicly guaranteed services with high degrees of financial protection — rely predominantly on compulsory funding sources. While not a perfect reflection of this, Figure 1 shows the general pattern, which is that where governments spend more on health, people have less need to pay out-of-pocket at the time of use. It is well known that high levels of out-of-pocket payment are associated with higher risk of catastrophic and impoverishing health payments, and that the need to pay at the point of use exacerbates inequalities in service use.

Similarly, relatively few countries rely on voluntary prepayment to provide significant resources for their health systems. Figure 2 shows that in only five countries in 2012, voluntary health insurance (VHI)⁴ accounted for more than 20% of total health spending. Among high-income countries other than the USA, VHI plays a negligible role with the exceptions being where it provides an explicitly complementary function (covering patient cost sharing in the statutory system, as in France and Slovenia) or where it offers supplemental benefits beyond those in

⁴VHI means that the decision to become insured is not mandated by government but is a choice made by an individual or an entity on behalf of that individual (e.g., an employer). VHI can be managed by private commercial companies, NGOs, “communities,” and even governments.

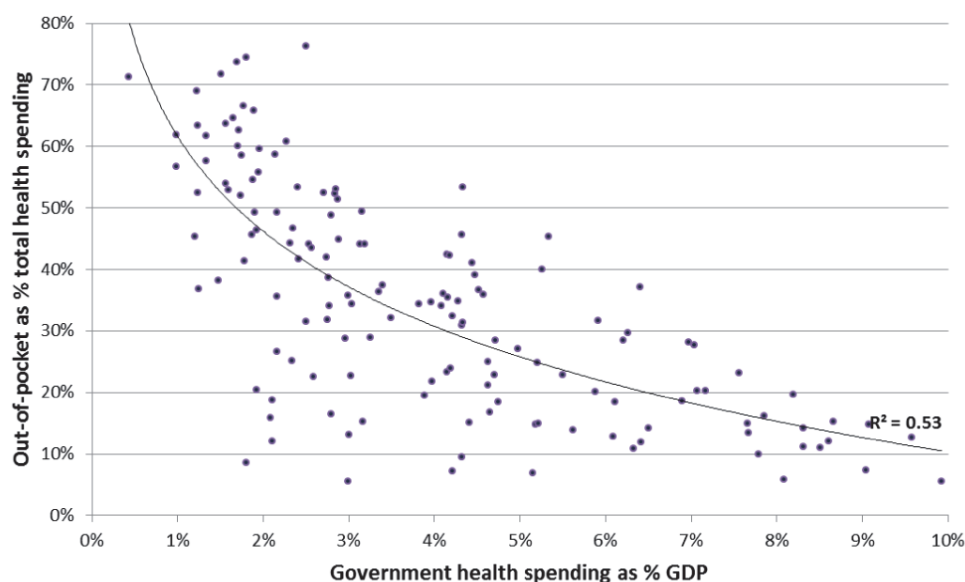


Figure 1. Relation between levels of government and out-of-pocket health spending, 2012

Source: WHO (2014). Excludes countries with population less than 600,000. Also excludes 10 countries where external funds accounted for more than 40% of estimated total health spending.

the main compulsory system (such as covering private “amenity beds” in hospitals in Ireland and Germany) (Mossialos and Thomson, 2004).

The minimal role for voluntary prepayment is not an accident; it reflects both theory and experience with regard to the shortcomings of voluntary approaches. All forms of VHI suffer from *adverse selection* (Cutler and Zeckhauser, 1998). Individuals who know they have worse health status are more likely to enroll, and so over time this makes health insurance more expensive than the average actuarial cost of a premium across the entire population. Insurers respond by raising premiums, driving more people out of the market. Ultimately, those who need the coverage most are least able to afford it. This runs counter to the objective of pooling, which is to maximize the redistributive capacity of prepaid funds from the healthy to the sick.

Writing in the aftermath of the failed effort in the USA to pass legislation to create universal insurance coverage in the mid-1990s, Victor Fuchs wrote that:

“No nation achieves universal coverage without subsidization and compulsion. Both elements are essential. Subsidies without compulsion will not work; indeed, they could make matters worse since the healthy flee from the subsidized common pool, only to return when they expect to use a great deal of care. Compulsion without

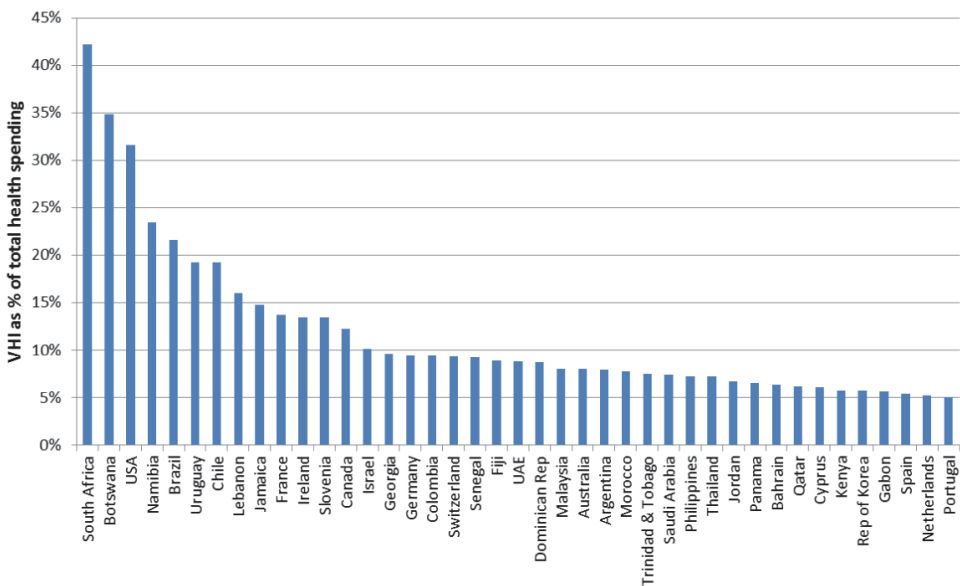


Figure 2. Countries in which VHI accounted for more than 5% of total health spending, 2012

Source: WHO (2014). Excludes countries with population less than 600,000.

subsidies would be a cruel hoax for the millions of poor and sick who cannot afford health insurance.” (Fuchs, 1996, pp. 188–189).

This phenomenon has been observed around the world, independent of a country’s level of income, or whether the ownership of the insurance is commercial, not-for-profit, “community,” government, or where, for example, people outside of formal employment are allowed to voluntarily prepay into a national social health insurance (SHI) scheme (Bitran, 2014; Baeza and Packard, 2006). It is simply the nature of a VHI market.

The lesson is both simple and clear: moving toward fulfillment of the “Fuchs conditions” (compulsion and subsidization) in health financing is a guiding principle for health financing policy oriented toward UHC. It is also the fundamental reason why many fiscally constrained LMICs face such difficulties in making progress. Current fiscal challenges, however, should not lead countries or analysts to believe in magic, however, such as expecting that because a VHI program is owned by a not-for-profit entity such as a local community, it will achieve high rates of coverage. Both theory and evidence (see, for example, Acharya *et al.*, 2012) are consistent on this reality. Thus, moving towards UHC in many countries must include strategies to increase the share of total health spending coming from compulsory (i.e., taxes, whether direct or indirect) sources.

- *Delinking entitlement from contribution and the critical role of general budget revenues*

While it is commonly assumed that in countries where entitlement to health coverage has been linked to employment, wage-based contributions (payroll taxes) many of these countries combine these with general budget funding, and several have increased reliance on the latter in recent years (Busse *et al.*, 2004; Sheiman *et al.*, 2010). As noted previously, this has been driven in part by the shift toward UHC as the underlying rationale for public policy on health coverage, with entitlement for each person in society rather than only for those in the labor force, and in part by the practical realities of different tax instruments in each country. Broadly, high-income countries are facing the demographic challenge of aging populations, with a shrinking share of working-age adults to provide a base for employment-linked contributions. In lower-income countries, the small share of employment in the formal sector from which payroll taxes feasibly can be collected does not provide a sufficient revenue base. Hence, moving toward predominant reliance on compulsory sources requires a focus on general budget revenues in most countries.

In France, for example, until the end of the 1990s, funding for the statutory health system depended almost exclusively on payroll contributions from employers (63%) and employees (32%). Since 1998, most of the employee payroll contribution has been substituted by an earmarked tax, the General Social Contribution (CSG), which is levied not only on wage income but also income from financial assets and investments, pensions, unemployment benefits, disability benefits and gambling. The CSG is now one of the main sources of funding for the insurance system (37%). In addition, specific taxes on tobacco and alcohol consumption and on the pharmaceutical industry complement the revenue base. However, while this change has widened the revenue base for health coverage, it has not increased the actual amount of revenue collected (Chevreul *et al.*, 2010).

In Japan, universal coverage is 49% financed by social insurance contributions, 37% by general taxes (25% national, 12% local), and 14% by out-of-pocket contributions (Ikegami and Maeda, 2014). In Ghana, although government sources only contribute about 53% of total health spending, the sources are diversified and mostly from general revenue. In addition to supply-side subsidies from general budget funding, Ghana's National Health Insurance Scheme is funded by an earmarked portion of the value-added tax (VAT) (more than 75% of the revenues of the scheme), social security contributions (18%), as well as grants, investment income, and premiums paid by non-exempt individuals such as self-employed and informal sector workers (NHIA, 2012). Similarly, the financing reforms in Mexico and Thailand introduced during the 2000s were entirely funded from general budget revenues, with entitlement made available to all individuals who were not

already affiliated with one of the contributory social security schemes for formal sector workers (Prakongsai *et al.*, 2009; Knaul *et al.*, 2012). A review of reforms in 9 LMICs also pointed to the increased reliance on general tax revenues to fund coverage expansions (Lagomarsino *et al.*, 2012).

Priority for health in the government budget using the (context-specific) right mix of sources

Figure 1 showed that the dependence of systems on out-of-pocket spending (OOPS) falls as the level of public spending on health (as a share of GDP) increases. More specifically, where public spending on health is less than 4% (or even 5%) of GDP, very few countries depend on OOPS for less than 20% of total health spending, a threshold below which the risk of catastrophic spending is generally small.⁵ In an accounting sense, public spending on health is a product of two factors, as shown in this simple equation:

$$\frac{\text{GGHE}}{\text{GDP}} = \frac{\text{GGE}}{\text{GDP}} * \frac{\text{GGHE}}{\text{GGE}}$$

GGHE = general government health expenditure

GGE = general government expenditure

GDP = gross domestic product

Put another way, in any year, the level of public spending on health is the product of a country's fiscal capacity (proxied by GGE/GDP) and the priority it gives to health in public resource allocation (GGHE/GGE).⁶ So to move in the direction of greater reliance on compulsory sources of funds for the health system, both fiscal context and government priorities matter. And in fact, most countries that have made significant progress toward UHC have had both the benefit of strong macroeconomic conditions and commitment to priority for health in the budget. That being said, macroeconomic conditions are outside the scope of influence of the health sector, and even the government may have limited scope to substantially increase overall tax revenues in the short run. Policy priorities are

⁵A cross-country analysis has suggested that once OOPS are reduced to below 15% of total health spending in a country, very few households experience catastrophic expenditures, as measured using a threshold of 40% of non-subsistence household consumption (Xu *et al.*, 2003). Hence, a 20% OOPS share of total health spending is a more generous threshold (though more realistic for most countries) for increased risk of catastrophic costs.

⁶In the calculation of GGHE and GGE, compulsory social insurance contributions (and expenditures from these) are included as part of government, in line with public finance logic that recognizes such contributions as a form of direct taxation.

less subject to these contextual factors and indeed vary greatly across countries. In 2012, for example, the average share of public spending devoted to health was 11.5%, but ranged from 1.5% in the lowest (Myanmar) to 28% in the highest (Costa Rica). Within this range were low-income countries that have very high priority to health (e.g., Rwanda, Liberia and Malawi allocated more than 17% of public spending to health) and some high-income countries with the reverse (e.g., Qatar and Cyprus devoted less than 7%) (WHO, 2014).⁷

A review of experience with reforms for UHC in 11 countries (Maeda *et al.*, 2014) found that the priority for health in the government budget has been maintained or increased in those countries that have made progress expanding coverage. The scope for increasing the share of the total budget allocated to health will be limited in part by the share of the budget that is actually discretionary, or not already accounted for by earmarks, other legislated expenditures, and debt payments. Civil servant wage spending in particular has been treated as a non-discretionary expenditure, often crowding out government spending in other priority areas. Public debt and debt servicing (interest payments) are also major constraints. Debt relief initiatives, such as the Highly Indebted Poor Countries (HIPC) Initiative of the IMF and World Bank, which reduce the volume of debt payments a government makes and thus reduce nondiscretionary expenditures, provide an important opportunity to create room for more health spending.

To secure priority for health in the budget, some countries have dedicated a specific tax or a share of government revenue to be earmarked for health, such as Ghana's earmarked of the revenue from the VAT to fund the National Health Insurance Scheme or the earmarking of taxes on alcohol and/or tobacco consumption ("sin taxes"). Increasing budget allocations have been achieved in some countries without specific financial commitments (e.g., earmarks), however, and earmarking and budget targets do not always ensure overall health funding is protected (Maeda *et al.*, 2014). Earmarked payroll taxes are considered to introduce inefficiencies in the economy by distorting labor market decisions, and other earmarking is considered to impose constraints on fiscal policy, which reduce flexibility and possibly allocative efficiency (Tandon and Cashin, 2010). In practice, the effectiveness of earmarking taxes or revenue for health appears to be mixed in terms of increasing overall funding or improving its stability. In some countries, the earmarked allocations for health have been offset by reductions in other parts of the health budget (Sheiman *et al.*, 2010). On the other hand, the extent to which earmarking for health creates inefficiencies in budget allocations has not been studied. One study of 11 countries committed to UHC found that only three (Brazil, France, and Ghana) have some form of explicit budget earmarks.

⁷The calculations exclude countries with population less than 600,000 people.

Other countries that have made significant progress toward UHC have done so without such earmarks, but have consistently kept their budgetary allocation to health relatively high (Maeda *et al.*, 2014). In Japan, for example, the Ministry of Finance and the Ministry of Health, Labor and Welfare negotiate to set the fiscal subsidy each year, and the fee schedule and payment systems are adjusted every two years to meet the changing fiscal envelope (Ikegami and Maeda, 2014). In Vietnam, there is no specific earmark, but legislation does specify that health expenditure must increase as a share of the total government budget. In Thailand, the lack of a specific earmarked revenue source for its “Universal Coverage Scheme” was not an impediment to scaling up public funding to ensure the entire population was covered (Maeda *et al.*, 2014).

All of the potential government revenue sources for the health sector involve some trade-offs for the broader economy. Evidence from high-income countries shows that property taxes are least distorting and damaging for growth, followed by consumption taxes, the personal income tax, and the corporate income tax (IMF, 2011). Taxation of capital income has a potentially strong impact on investment. Similar evidence is not available for lower-income countries, however, and the efficiency impact of different types of taxes is likely to be highly context-specific depending on composition of the economic activity and the strength of the institutions. The equity impact of taxes also may not be obvious, since the impact of a tax cannot be determined in isolation. “A regressive tax may be the only way to finance strongly progressive public expenditure (IMF, 2011).” On the other hand, the merit of the spending that is financed by new or increased taxes may not justify a disproportionate burden on lower income groups or distortions in the economy they create.

For the health sector, additional criteria that matter for assessing revenue options are whether sources of funds are in alignment with the other health financing functions of pooling and purchasing, and whether the sources provide a stable and predictable revenue base. For example, several LMICs have opted to introduce earmarked payroll taxes as a source of new revenue for the health sector because they could be collected in off-budget funds and avoid the restrictions in the public budget systems that limit the effectiveness of pooling and purchasing (Kutzin *et al.*, 2010b). What matters is the combined impact of all tax measures as well as the magnitude and distribution of the benefits from the spending they finance.

- *Enhance redistributive capacity of prepaid funds*

While increasing the overall share of spending from compulsory sources is important for progress towards UHC, the way these prepaid funds are organized

also matters, and changes in these *pooling arrangements* have been at the core of financing reforms for UHC in many countries. A given level of funding organized into fewer pools has more redistributive capacity than the same level of funding organized into more pools. Even in settings where the scope for increasing tax revenues for health is greatly constrained, by reducing fragmentation in pooling (i.e., barriers to redistribution arising from the organization of fund pools) it is possible to increase redistributive capacity (WHO, 2010b).

In addition to the structure of pooling arrangements, the *composition* of funding pools also matters. Simply put, in order to enhance redistribution from the healthy to the sick, pools must be comprised of both healthy and sick people. So for example, to the extent that poorer people have greater health service needs, schemes that only serve the poor (as in the US Medicaid program, for example) will have limited scope for redistribution within the pool and hence will require a larger budget per capita than would a similarly sized pool serving a more diverse risk mix.

Fragmentation is pervasive and takes many forms. One of the most common manifestations found in LMICs is the existence of separate pools for separate population groups linked to employment status. This is the pattern found in many Latin American countries in which there is a contributory (though often subsidized) SHI scheme for the population working in the formal sector, and a budget-funded public system for the rest of the population (Londoño and Frenk, 1997; Frenk, 1995). As described previously, this situation is a consequence of the approach of starting explicit coverage programs for the relatively well-off, best-organized part of the population. The consequence is typically both inequities as the formal sector captures a disproportionate share of subsidies and services, as well as inefficiency arising from the duplication of functional responsibilities (including sometimes separate service delivery arrangements) for health financing in the same geographic area.

But there are many other forms of fragmentation. The ex-USSR countries inherited systems of integrated financing and delivery that were administratively decentralized — each level of government budgeted and operated its own system, and once budgets were allocated there was no scope for redistribution across these boundaries. This also had severe efficiency consequences because the system was organized by level of government rather than geography, so within the capital city of any region there were financing and delivery arrangements for the city and the provincial (oblast) levels of the system (Kutzin *et al.*, 2010a). More generally, fiscal decentralization is a common source of fragmentation, particularly where revenue raising-responsibility is delegated to lower levels of government.

Fragmentation between public and voluntary/private pooling is a major source of inequity in South Africa, which is the country with the world's highest

share of total health spending coming from VHI (see Figure 2), more than 42% in 2012. Yet this level of spending serves only about 16% of the population, resulting in huge inequalities between the relatively well off and the rest of the population (Health Economics Unit, 2010). There are also other problematic forms of fragmentation, such as multiple small-scale insurance funds, competing insurers in a compulsory insurance market without adequate risk equalization mechanisms to serve as a virtual pool among them, geographically overlapping but non-competing statutory insurance funds, and many others.

There is no blueprint for a policy response, but experience demonstrates that countries can take action to enhance redistributive capacity by either reducing fragmentation or mitigating its consequences. For example, in Thailand and Mexico, where there were existing SHI schemes covering the formal sector, it was not possible to create a single unified national scheme. Their governments compensated by creating budget-funded, non-contributory schemes for the rest (majority) of the population and gradually increasing its level of subsidy so that funding levels were nearly equalized (Prakongsai *et al.*, 2009; Knaul *et al.*, 2012). In Ghana, the legislation that established the National Health Insurance Scheme included strong incentives for small-scale (village level) schemes to aggregate into one district-level mutual health insurance scheme and linked each of these to the national scheme (Agyepong and Adjei, 2008; WHO, 2013a). Rwanda's system similarly combines top-down funding flows from general tax and external sources with some bottom-up contributions from the population, and there are funding flows that enable redistribution across schemes within a district, across districts, and up to the national level (Makaka, 2012). In Kyrgyzstan and Moldova, the response to the fragmented budgetary system inherited from the USSR was to create a "single payer" National Health Insurance Fund, sourced from (mainly) general tax revenues supplemented with payroll tax. A unified national pool covers both formal and informal sector populations in both countries (Kutzin *et al.*, 2009). And even in the United States under the Patient Protection and Affordable Care Act (ACA),⁸ the state of Arkansas agreed to accept Medicaid

⁸The ACA was adopted in 2010 and has numerous features aimed at reducing the number of American citizens who do not have public or private insurance. The main features of the ACA are summarized in Kaiser Family Foundation (2013). In a global context, what is important to note is that the reform aims to address core problems in pooling in the US health system, particularly coverage shortfalls in the private health insurance market for individuals and small groups, and uneven coverage by the publicly-funded insurance program for the poor, Medicaid. In each state, the reform has established an insurance market "exchange" to help individuals choose among insurance plans that meet standards defined in the ACA. Insurers are not allowed to exclude persons with pre-existing conditions, and all individuals are required to become insured or face a federal tax penalty. There are also income-related subsidies available to support the purchase of insurance on the exchanges. Premiums on the exchange are community-rated rather than individually-rated, and the

expansion but largely eliminated as a separate pool, instead enabling beneficiaries to buy coverage on the state health insurance exchange in the same manner as other residents who do not have employment-based coverage. This approach, if implemented as planned, would end the segregation of much of the state's poor population into the Medicaid pool and instead merge them with non-poor persons, thus increasing the ability of the system to redistribute in relation to the health service needs of the population (Allison, 2014).

Overall, by moving to both increase the relative size of compulsory prepaid pools, increase the diversity of the health risks covered in these pools, and reduce fragmentation in the overall structure of pooling, these reforms have enabled increases in the redistributive capacity of their health financing systems.

• *Strategic purchasing for efficiency and results*

While mobilizing sufficient public resources and organizing pooling to maximize redistributive capacity are essential for achieving equitable and affordable health care access for all, it is of equal importance that collected resources be efficiently used in order to maximize and sustain the provision of benefits for the population. Strategic use of the purchasing function is the key health financing instrument for this purpose.

Historically in many LMICs, the government directly funds government-run/owned health facilities by paying for their *inputs* such as personnel, medicines, supplies and equipment through line-item budgets, often reflecting bureaucratic inertia. Little attention is given to how financial incentives or other mechanisms might be used to motivate providers to improve quality or efficiency, as their accountability is for inputs, not for delivering specific outputs or outcomes. In contrast, strategic purchasing involves proactive and explicit selection of predefined outputs and outcomes based on some combination of demand and population need, linking payment to information provided on the delivery of

exchange creates a pool among those who obtain coverage through this route. This is meant to reduce the problems associated with the very small pools that existed in the individual and small business market. The ACA also expanded Medicaid coverage by increasing eligibility to all persons with incomes below 133% of the Federal poverty line. In the US federal system, Medicaid is run and partially funded by the states, but under the ACA, states which accepted the Medicaid expansion would have this 100% funded by the central government for the first 3 years (2014–2016), with this share gradually declining to 90% by 2020 and thereafter. Apart from the Arkansas plan, Medicaid remains a separate pool. This is an important difference from other high-income countries with mandatory contributory health insurance arrangements, such as Germany, Japan, the Netherlands, and Switzerland. Those countries also subsidize lower income persons from general budget revenues to ensure that everyone is covered, but none of those countries have a separate health insurance pool for the poor.

these pre-defined products and, where choices of providers exist, selecting the most qualified and efficient to purchase from. In doing so, the purchaser seeks to improve efficient allocation of resources and effective service delivery in order to maximize population health and reduce financial risk (Figueras *et al.*, 2005). Critical factors that influence the effectiveness of purchasing as a policy instrument include: (1) PPMs and (2) organizational structure of purchasers.

A PPM is the mechanism through which funds are transferred from the purchaser to the provider of health services, and each PPM embodies specific incentives which influence provider's behavior in treatment decisions, and thus quality and efficiency of service provision. In designing payment systems, key considerations include: (1) Whether payment is made prospectively or retrospectively; (2) the unit of payment; and (3) the level of payment. Together, they determine the amount of risk borne by the providers versus the purchaser. Any provision of service involves some level of uncertainty in costs. The more risk is borne by the provider, the greater incentive there will be for the provider to reduce costs — especially if the provider is able to retain savings, but it can also create incentives for reducing necessary care and thus compromise quality. In general, the more prospective a PPM and the more aggregate the unit of payment is, the greater risk is borne by the provider (Ellis and McGuire, 1990; Ellis and Miller, 2008; Roberts *et al.*, 2002, Chapter 9).

International experience with PPMs suggests some generalizable lessons. For example, fee-for-service (FFS) reimbursement of activities reported by provider is inflationary. When FFS is combined with expansion of service coverage, it can lead to rapid health expenditure growth and threaten the sustainability of financing. China's recent expansion of health insurance coverage coupled with FFS speaks to this point. Despite the increase in population covered by China's SHI and in the rates of insurance reimbursement, the financial burden on households has not reduced and in some cases, increased, because health expenditure has grown at an even faster rate under FFS (Meng *et al.*, 2012; Wagstaff and Lindelow, 2008). In countries where services are underprovided, FFS can be used in the initial phase to incentivize providers to provide more services, and many countries (e.g., Ghana, Indonesia) have initiated payment reforms with this mechanism as a way to get buy-in from providers and boost utilization (Maeda *et al.*, 2014). However, efforts should be made from the earliest stages to plan for a transition to methods that operate within an overall budget cap, in order to avoid entrenched provider behavior in over-provision. These include prospective payment methods such as capitation and global budgets, or methods such as case-based payment (typically based on DRGs) as a basis for determining the size of hospital budgets or as a reimbursement mechanism that is combined with volume caps or adjustment factors that limit overall expenditure growth beyond a pre-determined limit.

At the other extreme, input-based payment tends to incentivize providers to increase inputs according to the actual basis for budgeting (e.g., beds or staff), but provides no incentives to improve efficiency or quality, or to respond to patients' needs. The global trend shows that more countries are moving away from pure FFS or input-based PPM, towards more aggregated and output based PPM such as global budget, capitation and case-based payment, in particular, the DRGs payment system (Langenbrunner *et al.*, 2005; Charlesworth *et al.*, 2012). Each has its pros and cons, and no single PPM is perfect. In short, PPMs that have the highest incentives for cost savings and efficiency improvement also have the greatest risk of selecting against more severe patients and under-providing in terms of quality and quantity.

There are important interactions between how PPMs are designed and the incentives they provide to facilitate integrated delivery, rather than further fragmenting service delivery, which is the dominant situation in most LMICs. For example, under a capitation payment system, providers are paid a fixed amount per person registered with the provider, or reside in a catchment area for a given period of time, usually a year. Depending on the scope of services included in the capitation payment rate, the incentives embodied in a capitation payment method vary. If only outpatient services are included in the capitation rate, providers have incentives to refer patients to inpatient facilities. Whereas if the capitation rate includes a population-based scope of services, providers have incentives to treat patients at the lowest cost settings, invest in prevention and coordinate care with other providers. Similarly, if global budgets are paid for each facility separately, each facility has incentives to refer out the sickest patients, which could lead to poor care coordination, risk selection and more expensive care.

As a result, governments are progressively moving towards blended or mixed payment regimes that capitalize on the benefits of various schemes. For instance, pay-for-performance (P4P), often used interchangeably with terms such as "performance-based funding" (PBF), "paying for results," or RBF, has dominated the literature on strategic purchasing as increasingly decision-makers seek to refine traditional PPMs. P4P programs link payment of individual providers or institutions to predefined outcome or output/activities that have established evidence of being cost-effective in improving health outcomes (Peabody *et al.*, 2011; Sutton *et al.*, 2012; Witter *et al.*, 2012; Yip *et al.*, 2014). Typically, P4P elements are combined with traditional payment methods such as capitation or global budget and give health care providers a bonus payment rewarding them for meeting or exceeding agreed-upon performance targets. Should providers fail to meet those targets or underperform, payment could also be held back. The most commonly chosen performance targets are output or process indicators that are easily measurable, verifiable and where well-established evidence enables them to be linked

to good outcomes. Examples include the Quality and Outcomes Framework (QOF) in the UK for primary health care services and a number of maternal and child health focused programs in LMICs (Basinga *et al.*, 2011; Morgan *et al.*, 2011; Cashin *et al.*, 2014).

The organizational structure of purchasing is closely linked with that of pooling, and has implications for the incentive environment facing providers and hence the effectiveness of purchasing as an instrument. Fragmentation in pooling necessarily implies fragmentation in purchasing, limiting the effectiveness of each individual purchaser. As providers are faced with multiple purchasing arrangements, the leverage each purchaser on the provider is reduced to the share of revenue or population it represents for a provider. As seen in the US, fragmentation in purchasing also leads to problems of cost shifting, that is, when a purchaser exerts cost control on the provider, the provider shifts its cost over to the other purchasers with more generous contractual terms. This poses potential barriers to controlling overall health system costs (Wu, 2010; Frakt, 2011; Robinson, 2011).

Effective purchasing is dependent on having an effective purchaser. The primary responsibility of the purchaser is to purchase on behalf of the people or enrolled population. Because of asymmetry of information in the health care sector, individuals do not possess the knowledge and information to be an effective purchaser. An entity should therefore have explicit responsibility for purchasing. More specifically, this entity should be empowered to make evidence-based decisions on (1) what services to purchase, (2) which providers to purchase from and (3) how to purchase. Such entities can take a variety of organizational forms and ownership — for example, government health ministries, local health authorities, public autonomous agencies, private health insurers (whether commercial or not-for-profit) or non-governmental organizations (NGOs). In some countries in which governments do not have the capability to take on this role within their core line ministries or government departments (either due to lack of relevant skills, the rigidity of public finance systems that do not allow movement away from rigid line-item budgets, or a combination), they have either established public autonomous agencies (e.g., Moldova's National Health Insurance Company, Ghana's National Health Insurance Agency) or have contracted out the purchasing function to NGOs or private insurance companies (e.g., India's RSBY government-sponsored health insurance scheme for persons below the poverty line). In either case, it is essential to strengthen government capacity to ensure that purchasing practices are aligned with policy priorities, either to manage the contracts with external purchasers or to take on this role within some form of public agency.

The mere establishment or contracting of an agency to take on this role does not guarantee that purchasing will be strategic. Many such organizations focus

largely on financial concerns only — balancing their books and reducing cost outlays — and pay little attention to quality of care. This was a concern in the early years of India’s RSBY program, for example. Conversely, Thailand established the National Health Security Office (NHSO), a quasi-public organization, as the purchaser, with a board chaired by the Minister of Public Health and comprised of key stakeholders including members of local government, civic society groups, professional bodies and technical experts. The board is responsible for setting the benefits provided by the Universal Coverage Scheme, making the policy rules and guidelines that govern the NHSO, and determining providers’ reimbursement mechanism. In this way, it has the capacity to ensure that the NHSO aligns with government objectives. More generally, the lesson is that the incentives and accountabilities of purchasing agencies need to be aligned with public policy objectives as part of the process of moving toward more strategic purchasing in the health system as a key instrument for sustaining progress toward UHC.

Alternative Approaches to Financing for UHC
in the Context of High Informality

Why labor force informality is a core challenge

As noted above, it is necessary to meet the Fuchs conditions (compulsion and subsidization) for a financing system to make rapid progress toward UHC. More broadly, we summarize attributes of the various health financing functions and policies that are important for making and sustaining progress towards UHC in Table 1.

Table 1. Directions for reform in health financing functions and policies

Health financing element	Desirable attributes/directions for reform
Revenue sources and contribution mechanisms	Moving toward predominant reliance on compulsory sources of funds (i.e., various forms of direct and indirect taxation) — the enabling factor to meet the Fuchs conditions
Pooling	Reducing barriers to redistribution, increasing diversity of health risks within pools
Purchasing	Establishing and strengthening incentives for efficiency and quality in purchasing mechanisms
Benefits and rationing measures	Promoting use of cost-effective services and limiting out-of-pocket burden, especially for the poor, in the design of policies on benefits and rationing (and their alignment with purchasing)
Stewardship of financing	Unified, coherent, goal-driven, and evidence-informed governance arrangements in the financing system

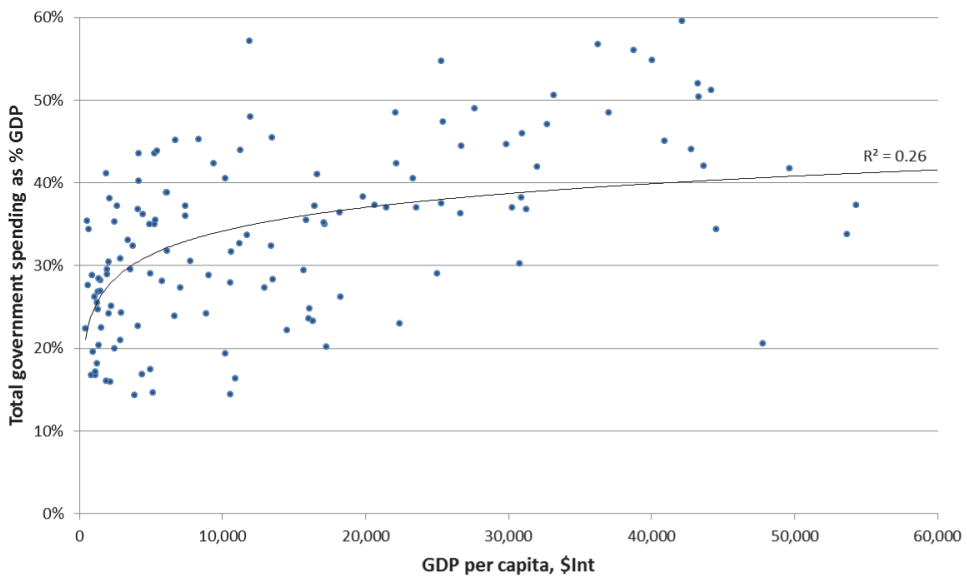


Figure 3. Relation between country income and overall public spending, 2012

Source: WHO (2014). Excludes countries with population less than 600,000.

From a health financing perspective, the extent of informality reflects the size of the population that is not in receipt of predictable salaries or wages. As such, this is a population that is difficult to tax, and this challenge is greater in LMICs because they tend to have larger shares of the population in the informal economy than high-income countries (ILO, 2014). Lower tax revenues mean lower capacity for public spending, including on health. The link between GDP per capita, the extent of informality, and public spending is supported by the data in Figure 3. Several authors (Schieber and Maeda, 1997; Gottret and Schieber, 2006; Kutzin and Jakab, 2010) have also pointed to this as one of the main reasons why LMICs are more dependent on non-government (mainly out-of-pocket) funding sources. And indeed, the data are consistent with this interpretation, as reflected in Table 2. Overall, governments in richer countries spend more not only in total but as a share of their economies, and this translates into less dependence on household spending. The situation is reversed for low-income countries, which suffer the greatest burden of OOPS. While this broad pattern emerges from the data, it is also not strictly deterministic. There is considerable variation around the trend shown in Figure 3, revealing both countries with similar income levels but very different fiscal capacity, as well as countries with different income levels but similar fiscal levels. For any specific country, therefore, the extent of both informality and implications for the mix and level of public revenues needs to be understood.

Table 2. Fiscal capacity and dependence on OOPS by country income group, 2012

Country income group	Total government spending as a % of GDP	Out-of-pocket as a % of total health spending
High	41	21
Middle	33	37
Low	25	43

Source: WHO (2014). Excludes countries with population less than 600,000.

While informality is a major challenge for meeting the Fuchs conditions, the implications for the other desirable features of health financing (Table 1) are not inherently problematic. However, many policy decisions countries already made have actually caused problems related to informality. With regard to pooling, for example, the exclusion of persons outside the formal sector from explicit forms of coverage, or the establishment of entirely separate schemes for the poor have created fragmentation along labor market or income dimensions. As a consequence of having established separate pools in this way, the reform process in many countries has also created differences in purchasing mechanisms along these dimensions. For example, where SHI schemes have been established for formal sector employees, one consequence has been the concentration of scarce skills for health service purchasing on behalf of a relatively small and privileged part of the population (Kutzin, 1997). And similarly, formal sector SHI schemes have tended to have an explicit, funded entitlement, while the rest of the population often suffers from vague and poorly funded entitlements that are difficult to enforce at the point of service. This was the case, historically, in Mexico and Thailand, where the informal sector population was disadvantaged by lower levels of public funding per capita than formal sector workers (Prakongsai *et al.*, 2009; Knaul *et al.*, 2012).

Thus, from a health financing policy perspective, the “problem of informality” is mainly an issue of fiscal capacity, with informality constraining the ability of countries to generate enough public revenues, particularly from direct taxation, to ensure that most funding for health comes from public sources. In looking to policy responses in any country, it is important to separate the clear issue of the fiscal implications of informality from past policy choices that can be addressed through a reform agenda. Indeed, inequalities that were caused by past policy choices (again, most obviously the decision to initiate explicit coverage programs for the formal sector, as in Mexico and Thailand, or historically inherited patterns of inequality, as in South Africa) have been key political drivers of the UHC reform agenda over the past decade.

Health financing reform options to move toward UHC in a context of high informality

Here we apply the functional approach to establish a categorization of options that countries have used in their health financing strategies aimed at progressing toward UHC. As with all such frameworks, there is some over-simplification, and it remains important to understand the nuances in each particular case rather than fall into the trap of thinking in terms of overall models of financing. Keeping this in mind, the two broad categories of options are defined in terms of the *basis for entitlement*, and in particular, whether this is *contributory* or *non-contributory*.⁹ According to the System of Health Accounts (OECD *et al.*, 2011), one of the key criteria for distinguishing between types of financing schemes is whether, under a particular scheme, entitlement to benefit derives from a specific contribution made by or on behalf of an individual (contributory-based entitlement), or whether entitlement derives from some other factor, such as citizenship, residence, poverty status, etc. (non-contributory entitlement). This is a useful distinction from a policy perspective and not merely for accounting purposes. Within these two broad categories, we identify a set of options that different countries have applied.¹⁰ These are summarized in Table 3, and are reviewed in more detail in the remainder of this section.

- *Non-contributory options*

A1. Universal, budget-funded, population-based systems

This approach is used in several high-income countries, such as the United Kingdom, Spain, and the Nordic countries. In these countries, entitlement is not linked to any specific contribution or labor force status, and they have also been fairly successful at promoting equity in financial access and financial protection for their populations. Many LMICs have, historically, tried to do the same, but most have fallen short for a variety of reasons. A universal, fully budget-funded system requires substantial public revenues, and for many LMICs in which adequate funds were not forthcoming, there have been mismatches between what was publicly promised (e.g., free service in government facilities) and what was

⁹It is worth emphasizing that having a non-contributory basis for entitlement does not imply that beneficiaries do not financially contribute. Indeed, in countries that rely predominantly on indirect taxation for public revenues, anyone who purchases a product subject to tax is contributing. The distinction here — and countries vary in the choices they make with regard to this — is whether or not entitlement to health benefits actually derives from a specific contribution made for that purpose.

¹⁰Some countries also use a mix of contributory and non-contributory approaches.

Table 3. Categorization of financing reform options to move towards UHC despite high informality

Non-contributory-based entitlement options	Contributory-based entitlement options
A1. Universal, budget-funded, population-based systems	B1. Compulsory SHI for the formal sector, and a largely unsubsidized informal sector who must prepay directly for their coverage (often combined with non-contributory funded coverage for the poor or otherwise vulnerable)
A2. Budget-funded program for all persons not already covered by an explicit social security mechanism	
A3. Entitlement for some population groups to a range of services	B2. Compulsory SHI for the formal sector, fully funded coverage for the poor, and heavily subsidized coverage for the informal “middle”
A4. Universal population guarantees for a set of specifically defined services	

realized in practice (e.g., shortages of key inputs, informal payments). In some countries, this approach was connected to non-strategic “passive” PPMs reflected in historical, input-based supply-side budgeting practices,¹¹ although this is by no means inherent (as reflected in the experience of the UK and many of the other countries noted here).

An exception to this pattern has been Sri Lanka, although it differs from the high-income examples because the budget-funded public system coexists with high levels of OOPS. However, because there is good physical access to free government outpatient and inpatient health facilities combined with a private outpatient service sector that offers greater amenities, the use of public facilities is strongly pro-poor while private use is pro-rich, and hence the OOPS is heavily concentrated among the rich for ambulatory services and medicines. As a result, it has achieved good indicators of both service coverage and financial protection, despite having a low overall level of public spending on health (less than 2% of GDP) and relying on passive budgeting of government health facilities (Rannan-Eliya and Sikurajapathy, 2008).

¹¹ *Passive provider payment* is the opposite of strategic or active purchasing. *Input-based historical supply-side budgeting* refers to when the budget for a year is effectively based on the previous year’s budget, plus/minus a%, and typically justified according to inputs such as the number of beds or staff.

A2. Budget-funded, explicit coverage program for persons not covered by existing social security health insurance schemes for the formal sector

This is the approach reflected by the reforms in Mexico and Thailand. In Mexico, the *Seguro Popular* (Popular Health Insurance) is open to anyone not enrolled in the social security system. While initially planned with a beneficiary contribution, this has been largely dropped because it was found to be both administratively costly and a barrier to affiliation. While called “insurance,” it is mainly a revision to the inter-governmental resource allocation formula in Mexico’s federal system. Under the *Seguro Popular*, transfers from central to state governments for health are driven by the enrollment of the non-salaried population in the program, with the overall level of the transfers greatly increased as well. The program also included legislation to ensure beneficiaries have access to a comprehensive package of essential services, as well as to an explicit set of costly, specialized interventions. For these latter services, a “Fund for Protection against Catastrophic Health Expenditures” was established, which essentially functions as a centralized purchasing/contracting agency. Overall, the government’s commitment to redress past inequalities through this program was reflected in a much higher rate of growth in the Ministry of Health’s budget (which included the *Seguro Popular*) than in the existing social security schemes, such that public spending per beneficiary in the social security schemes was 2.1 times that of the rest of the population in 2000 but fell to only 1.2 times by 2010 (Knaul *et al.*, 2012).

Thailand’s approach to coverage was similar, although reform there did not have to address the challenge of operating within a federal budget system. The Universal Coverage Scheme (UCS) began with the plan to include a small contribution, but then dropped this, similar to the *Seguro Popular*. It combined several previous coverage programs — one for the low-income population, a subsidized VHI program, and a scheme for the elderly — into one and merged the funding for this with previous supply-side budgets. A new pooling and purchasing entity was established as an independent public agency with a representative board — the NHSO. In the UCS, the NHSO enters into contracts with providers and pays using closed-end mechanisms (capitation and DRGs within an overall budget cap). Since its introduction in 2002, coverage has grown rapidly, and impressive results in financial protection and access to services have been documented (Prakongsai *et al.*, 2009; Evans *et al.*, 2011). And similar to Mexico, the government’s commitment to the UCS has greatly narrowed the gap in public funding per capita with the existing social security scheme for private sector workers (though a budget-funded scheme for civil servants remains funded at much higher levels).

This approach has much to commend it. Unable to merge with existing, entrenched schemes for the formal sector, but with the political support to mitigate the inequitable consequences of this, they each established a parallel scheme, funded entirely from general budget revenues, but with explicit commitments to deliver on benefits for the population. By opening coverage to everyone not enrolled in social security, the schemes avoided costs and complications related to targeting, and they also created pools with more socioeconomic diversity than would have been the case with a targeted scheme for the poor.

The real challenge for countries considering moving in this direction, as with the broader universal non-contributory approach, is fiscal capacity and the ability to manage expenditure growth. Mexico and Thailand had both the fiscal capacity and the political commitment to raise public spending for this purpose. In Thailand, for example, health represented about 10% of total public spending in 2002, the year the UCS was introduced. It rose quickly to over 14% in 2007 and has stayed in the 14–15% range ever since. Despite its relatively low fiscal capacity, this share has enabled it to ensure that public spending on health remains at around 3% of GDP (WHO, 2014). This level of spending is quite low by international standards in terms of achieving low dependence on OOPS (see Figure 1), but combined with the strong attention to efficiency and cost control reflected in the PPMs used, it has been enough to sustain progress. Other countries considering this approach need to incorporate a realistic sense of what can be provided from general budget revenues as well as learning from the approaches used to get the most from pooling and purchasing arrangements.

A risk of going with this approach is that it can reinforce fragmentation. In both the Thai and Mexican cases, the reforms were a response to an already fragmented system, and at least in the Thai case, the aim was to merge with the schemes for civil servants and private sector workers (but they have been unable to do so). As noted above, the starting point matters, so this option needs to be considered carefully as one way to compensate for fragmentation that may already exist, while ensuring that it does not introduce fragmentation into a system that does not have this particular manifestation of the problem.

A3. Entitlement for some population groups to a range of services, funded from general revenues

This approach may be relevant for highly constrained fiscal contexts, and includes measures such as exemptions from user fees/copayments or budget-funded insurance coverage for the poor. While targeting brings costs and complexity, these can be mitigated if the health sector takes advantage of existing mechanisms (e.g., for food or cash assistance) rather than creating its own.

Within this broad option are examples that involve an explicit split between purchase and provision for the covered services or population groups, and other approaches that do not. The beneficiaries of Cambodia's Health Equity Funds (HEFs), for example, are identified through a proxy means test¹² implemented by the Ministry of Planning. These identified poor persons qualify for free services in government health facilities. The HEFs receive donor and government budget revenues and use these to pay the user fees in these facilities on behalf of their beneficiaries. In other words, the HEFs support means-tested user fee exemptions with a purchasing mechanism to enable the promise of free services to be realized, and indeed, positive effects on both equity in service use and financial protection for the poor have been documented, although the targeting mechanism was not perfect (Annear *et al.*, 2013).

This approach contrasts with the generally poor performance of simple exemptions from user fees for certain categories of the population (McPake *et al.*, 2011), which is another variant of this option. Without the link to an explicit purchasing mechanism, it tends to result in an unfunded mandate, relying entirely on decisions made by health workers at the point of service. This highlights the importance of alignment of different elements of financing policy — in this case the alignment of purchasing methods with defined benefits, and both of these with service delivery arrangements — in order to ensure that the desired results are achieved. It also suggests implementation prerequisites, namely the existence of some type of targeting mechanism that pre-identifies those who are entitled, and the administrative capacity to link the results of this targeting to beneficiary identification at the level of the purchaser and the provider (and the beneficiary as well).

These prerequisites are reflected in another variant of this approach, targeted subsidies for health insurance coverage, as in the RSBY and several state-budget-funded insurance programs in India. In these schemes, all persons who have a card showing that they are below the poverty line are entitled to join, and the schemes pay for hospital services up to an annual financial limit per person. As in Cambodia, entitlement depends on the results of a proxy means test implemented by government for other purposes (e.g., food subsidies) but used to determine beneficiary status for health coverage. There are important variants within India, however. Under RSBY, those entitled to join still have to pay a (very) small annual registration fee. Conversely in the scheme sponsored by the state government of

¹²The aim of means testing is to identify and distinguish those families or individuals that have the capacity to pay something for health services from those which are too poor and cannot. However, it is difficult and costly to implement an administrative mechanism for this purpose, and hence some countries including Cambodia rely on "proxies" that are relatively easy to identify and are well-correlated with household income. For more on this, see Qingyue *et al.* (2010).

Andhra Pradesh, those who qualify (under a more generous definition of the poverty line that includes about 80% of the population) are automatically enrolled (La Forgia and Nagpal, 2012).

While the implementation details vary considerably within the bounds of this approach, several features emerge as important. In contrast to the Mexican and Thai examples, it relies on targeting, which is both costly and subject to errors of inclusion and exclusion. But it is the incremental rather than the absolute costs that matter, and in India and Cambodia, for example, the health reform simply uses the results of existing targeting mechanisms implemented by government. It is hard to imagine circumstances in which it would be advisable for the health sector to undertake its own, parallel program of means testing. Still, the results of the means tests have to be linked to the health system at both the purchaser and provider levels (and updated periodically), and this does impose additional costs. So for fiscally-constrained countries considering this approach as compared to the untargeted option, these incremental administrative costs have to be taken into account to ensure it is worth going this route.

A4. Universal population guarantees for specific services

In a sense, this approach involves targeting specific services rather than population groups as the means for coverage expansion. Examples would be untargeted free care initiatives such as the blanket elimination of user fees for maternal and child health services, as in several African countries in recent years (Meessen *et al.*, 2011). It also includes approaches used in very different contexts. In Moldova, for example, about 20% of the population was uninsured under the national health insurance program, despite various efforts made over the years. In 2009, the government passed legislation that extended primary care coverage to all persons irrespective of their insurance status (Shishkin and Jowett, 2012). Similarly in Chile, the reform known as Universal Access with Explicit Guarantees (AUGE is the Spanish acronym) defined a set of specific treatments (initially 56, then 69, and then 80) guaranteed¹³ to all citizens regardless of their insurance affiliation, funded by a 1% increase in the VAT (Bitran, 2013).

What has made these initiatives different from simple declarations of free or guaranteed services has been the connection of these promises to provider accountability for delivery, and to a funding source, often supported by a specific

¹³In fact, the “guarantees” under the AUGE program include not only the right to these specific services but also guarantees with regard to quality (definition and adherence to treatment protocols for these services), maximum waiting times, and limits to patient cost-sharing for these services (Bitran, 2013).

provider payment mechanism that links the funding to the promised entitlement. Perhaps most notable among these developments has been the link between selective user fee removal and RBF. The link between the defined entitlement and the payment mechanism is similar to the Cambodian HEF approach described above, with the key difference being that the HEF is targeted according to population characteristics (poverty status) but not according to the type of service. Conversely in Burundi, for example, implementation of a Presidential decision to eliminate user fees for maternal and child health services involved replacing the lost fee revenue with an RBF mechanism to give providers an incentive to treat pregnant women and children while simultaneously eliminating the demand-side financial barrier of the fees (WHO, 2013b).

As shown here, expanding specific services for everyone (or for all in defined groups such as pregnant women and children) is an approach that has been applied in countries of various income levels. It can be coordinated with any other financing scheme that may exist in a country, or it may be implemented independently. As with many of the other reforms described, effective implementation requires combining the expanded entitlement with a funding mechanism and especially a PPM targeted to the expanded services. It is notable because this option is a means to expand coverage that does not involve enrollment in an “insurance scheme”. Further, because entitlement is related to the specific populations who are potential beneficiaries of the incentivized services on a non-contributory basis, employment status is irrelevant to coverage. While avoiding the costs and complexity associated with a contributory approach, it does require strong capacities for service purchasing and a willingness to set explicit priorities.

- *Contributory options*

B1. Unsubsidized coverage for the non-poor informal sector

This is perhaps the option that is considered most frequently by LMIC governments seeking to expand coverage. It involves some effort to differentiate within the informal sector between those who are poor and thus unable to contribute, and those who are not poor but are not captured by the country’s tax system. Thus, implementation of this approach requires that government has the administrative capacity to implement some type of targeting mechanism, as well as the fiscal capacity and willingness to fund coverage for the poor. Persons in the informal sector who are not deemed to be poor may be either required or asked to prepay for their health coverage, though in countries with limited tax collection capacity, such contributions tend to be de facto voluntary.

In theory, this approach offers several advantages, as it would be equitable relative to the ability of people to contribute. In practice however, it does not work

(despite its popularity). Most fundamentally, the non-poor informal sector tend to remain uncovered if they do not benefit from substantial subsidies (Acharya *et al.*, 2012). This is the core problem of adverse selection in VHI markets described above, and it applies regardless of whether the insurance is managed by a commercial company, a “community”, or the government. Beyond the problem of these markets, there are other barriers to participation. One may be the desire of some persons in the informal sector to avoid paying income tax, and related to this, fear that if they register for health insurance they will be more easily “captured” by the tax system. Another may arise in single-pool contexts that bundle together the health insurance contribution with other elements of social security, thereby raising the price of enrollment (Baeza and Packard, 2006). For this combination of reasons, this approach tends to result in a “missing middle” problem in terms of population coverage: The “top” covered by formal social security health insurance, the “bottom” covered from targeted budget funds, but the middle (non-poor informal sector) remains at potentially great financial risk for health care costs.

B2. Heavily subsidized coverage for the informal sector population

This approach aims to balance recognition of the limits of contributory-based entitlement with the retention of that aspect of “personal responsibility” for providing for one’s coverage, as well as a concern with the fiscal implications of going for a fully non-contributory approach. Even in high-income countries with contributory systems, there is an explicit role for budget subsidies to both fully subsidize for those deemed unable to do so, and partially subsidize those outside of regular salaried employment. They recognize that this is the only way to attain 100% population coverage in their context. In Japan for example, 25% of the revenues of the health insurance system come from general budget transfers (Ikegami *et al.*, 2011). In Hungary, such transfers account for about 60% of health insurance fund revenues (Szigeti *et al.*, 2012).

In most LMICs that provide some subsidies (or lower contribution rates) for the non-poor informal sector, success with this approach has proven more challenging. As with the first option, there tends to be low participation. Retention is also a problem; there is a high dropout rate the year after acute health events. With this approach, it remains an administrative challenge to determine the boundary between who should be fully subsidized and who only partially subsidized. Two countries, however, have had much greater success (90% or more) in contributory population affiliation to their health insurance programs — China’s New Cooperative Medical Scheme (NCMS) and Rwanda’s Community Based Health Insurance (CBHI). Their experiences have several implementation features in common that are likely to have contributed to this and may be relevant elsewhere (Hou *et al.*, 2012; Yip *et al.*, 2012; Musango *et al.*, 2013). Beyond this,

at least in the Rwandan case, these reforms have been linked to important gains in financial access, financial protection, and increased use of priority services (Sekabaraga *et al.*, 2011).

The first common element has been the magnitude of the subsidies, which enables the expected cost of the “premium” to the population to be much less than the perceived value of the benefit. The magnitude of this “contribution–entitlement gap” (Baeza and Packard, 2006) is a key factor in stimulating demand. In both countries, budget subsidies flow to both the supply side (e.g., direct salary payments) and the demand side (or perhaps more accurately, the “purchaser” side, i.e., subsidies flowing to the insurance fund), while the benefit package for the subsidized population is the same as that of everyone else. Contributions are not based on an actuarial calculation but rather on what is deemed to be affordable for the population taking into account the government’s ability to afford the subsidies.

In China’s NCMS, there is an explicit link between public and private contributions that may be particularly interesting for countries in which part of the challenge is concern from finance ministries that they do not know where the money given to the health sector is going. In this program, when an individual makes his/her prepayment for coverage, it triggers a contribution from local and central governments that is four times (on average) the amount of the individual’s prepayment.¹⁴ Thus, it is very explicit that the finance authorities are “buying health insurance” for the population, and moreover, that with their subsidy policy, they are leveraging prepayment from the population. From the individual’s perspective, their relatively small contribution leverages a large contribution from the state on their behalf. So this funding model provides an excellent example of complementarity between public and private funding sources.

In Rwanda, the subsidy policy is slightly less explicit, but significant. It relies to a greater extent than China on supply-side subsidies for salaries and some other costs of the health system. The government also fully subsidizes the contributions for about 25% of population that are deemed to be unable to contribute (based on each community’s own assessment). For the rest, there are two contribution rates linked to income (Republic of Rwanda, 2010; Musango *et al.*, 2013). The supply-side subsidies and the full subsidies for the poor mean that these contribution rates are in fact not set on a full actuarial basis but instead create an affordable mechanism to bring more household prepayment into the common pool.

The second common element is the role played by local government officials as active intermediaries in the enrollment process. Both countries use a

¹⁴ And for those individuals deemed to be extremely poor, the Ministry of Civil Affairs pays the entire contribution on their behalf.

well-organized system of incentives or targets for local officials to enroll eligible populations into the coverage program. In China, leaders of local governments (usually the deputy mayor in charge of health) were given explicit enrollment targets to reach, and together with a set of other performance targets, they form the basis of local government leaders' promotion. They, in turn, instruct NCMS office staff to find the most effective ways to enroll people, including going door-to-door, taking advantage of other collective activity, for example, immunization days, driving around vans with slogans on the benefits of NCMS. In Rwanda, part of each district mayor's pay depends on getting their population enrolled in the local Community-Based Health Insurance scheme. Behind these policies is a political reality that is less easily replicated; both countries have very strong central governments with an ability to instruct, guide or otherwise organize local government actions. The extent to which these two countries' abilities to achieve high enrollment are dependent on this government structure has not been systematically studied, and thus it is premature to draw strong conclusions. Applied research is needed to explore how some aspects of the approaches used by these two countries — particularly the role and magnitude of subsidies and the engagement of local government as active intermediaries — are applied in different political contexts.

Conclusions

UHC is more than an aspirational goal: It embodies widely shared health policy objectives on which all countries seek to make progress — equity in service use, quality and financial protection. The emergence of UHC after World War II marked a change in the underlying rationale for public policy on health coverage, from a focus on workers and labor productivity, to a right (often constitutional) of citizenship. This shift had important implications for health financing policy, as it meant that entitlement to benefits could no longer be solely based on a specific contribution made for that purpose. If 100% of the population is to have a funded entitlement, then some of the funding must come from general budget revenues to ensure that those unable (due to their incomes) or unwilling (due to adverse selection) are included. However, much of the health financing advice coming to LMICs since the 1980s was implicitly based on copying the historical patterns of development that began around the start of the 20th century, specifically the contributory approaches focused initially on the formal sector workforce. As the shortcomings of this approach — particularly the exacerbation of inequalities — relative to UHC have become more widely recognized, and especially as several countries have taken alternative pathways and have documented successes, it has become clear that alternatives to those historical models are needed.

The search for a “best model” of health financing is not a relevant undertaking because the “right next steps” for any country depend critically on the starting point: Their existing arrangements for health financing and the wider health system, specific aspects of context such as fiscal capacity and the structure of public administration, and a range of other factors that require a tailored, country-specific policy response. This reality does not mean, however, that there is little to be gained from international experience. Much is known about what works and what does not, and this knowledge should not be ignored. In this chapter we have identified lessons from both theory and practice that can be crystallized as a set of principles — not specific reforms — that offer promising directions for progress as well as guarding against pitfalls to avoid.

By looking at financing reforms from a functional perspective, and informing our analysis with both country experience and some of the core foundations of health economics (particularly the economics of VHI markets), we have identified desirable directions for change (Table 1), building on the essential features identified by Fuchs (compulsion and subsidization). The context of low formal workforce participation found in most LMICs poses a particular challenge for meeting the “Fuchs conditions” because of the difficulty of generating revenues from direct taxes. And going the route that many are taking, expecting that a large percentage of persons in the informal sector can be made to contribute most of the premium for their coverage, is a pitfall that flies in the face of both theory and evidence. Thus, taking into account both the need to meet the Fuchs conditions with the fiscal context associated with high informality, leads to the conclusion that for most LMICs, financing reforms to move towards UHC will require greater reliance on general revenues sourced from indirect taxes. An additional important lesson from the reform experience highlighted here and elsewhere (Kutzin *et al.*, 2010b) is that, irrespective of whether new revenues are generated or needed, *changing how existing budget revenues are used* is key to successful reform.

The reform experiences of Thailand, Mexico, Burundi, Rwanda, China, Cambodia, Kyrgyzstan, and other countries illustrate the importance of changing how existing budget revenues are used — whether the reform involved changes in the level, flow and flexibility of budget funds alone, or whether it involved a combination new revenues and changes in the use of budget funds. While, of course, more funding can enable greater progress toward UHC goals, what has marked relatively successful reform experiences is an increase in the flexibility in the use of these revenues, in particular allowing for strategic purchasing techniques to be applied to revenues from the public budget.

The importance of changing how general budget revenues can be used to transform health systems points to a key public policy question: How has it been possible to do this, given that most public financial management (PFM)

systems are quite rigid when it comes to the planning and use of revenues that come out of the annual budget process? There seem to be two broad approaches, and further analysis of these is central to the “financing for UHC” reform agenda in the future. One option is to modify the existing PFM systems to accommodate this flexibility, such that within routine processes it will be allowed to match some budget revenues to either specific populations or specific services (rather than buildings and inputs) and make payments to the providers accordingly. The other, which may be more frequent, involves “going around” the core PFM system by channeling general revenues to new purchasing entities (as with the Thai NHSO, Kyrgyz or Moldovan national health insurance funds, or Cambodian HEFs, for example). Regardless of the approach chosen, there is clearly a need for more intensive engagement with a country’s finance and budget authorities to reach understanding on the need for flexibility in the use of funds in the health sector, and combining this with an approach to demonstrate new and better ways that health authorities can be held accountable for the use of public funds.

There are also important policy questions related to pooling. Both theory and evidence suggest that countries should seek to avoid creating separate pools for different population groups, such as the poor, formal sector and informal sector. In order to maximize the redistributive capacity of prepaid funds, countries should seek to both reduce barriers (fragmentation) between pools and to increase diversity of health risks within pools. The challenge is how to do this in the context of path-dependent structural arrangements for pooling that exist in many health systems. This is another example of why searching for a “best” might be irrelevant. Instead, what would be potentially useful for decision-making is to understand how different countries have been able to enhance pooling within the constraints of their historical arrangements, political economy, and system of public administration.

Another set of important policy questions for which further applied research is needed relates to the need to align different aspects of health financing (such as purchasing and benefits) as well as the alignment with service delivery. While alignment makes sense, it is not always the case that all aspects of reform can or should proceed simultaneously. Sequencing matters, but there has not been much knowledge generated from reform experience on this issue. It would appear obvious, for example, that a country should not proceed with a purchasing reform or new benefit package if the service delivery arrangements are not in place. But how to put them in place is an issue, especially if financial mechanisms are part of the means of doing so. Related to this is another key issue: Thinking through the appropriate mix of supply-side funding vs. the types of “purchaser-side” funding

flows that have been a part of many of the reforms described in this chapter. The case for supply-side budgeting would seem to involve the scaling-up agenda: Investment in new capacity to extend service coverage. But again, there has been inadequate analysis of country experience with regard to the supply-side and purchaser-side flows. And if the evidence leads, as it likely would, to something other than an “all or nothing” conclusion, it will be essential to synthesize the types of factors that call for greater focus on one type of funding flow than another, and also to consider how to combine these in a coherent way. Countries are certainly using both approaches now, but policy makers need guidance on how these can be better aligned.

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