Commonwealth Foundation

CHPA
Commonwealth Health Professions Alliance

# POLICY BRIEF

# Funding models to finance Universal Health Coverage

**About this policy brief:** Civil society organisations across the Commonwealth, supported by the Commonwealth Foundation, host an annual policy forum addressing the theme of the annual Commonwealth Health Ministers' Meeting (CHMM) which is held each year in Geneva on the eve of the World Health Assembly. Through the forum, stakeholders come together to discuss, debate, and develop a consensus position or set of positions and recommendations with a declaration for action on the policy issues under discussion. These positions or requests for action are then presented by civil society to Commonwealth Health Ministers at their meeting.

The 2017 Commonwealth Civil Society Policy Forum will address the following issues:

- Funding models to finance universal health coverage;
- The politics of wellbeing;
- Women's voices on structural violence in health care.

Three policy briefs have been developed on these issues. The briefs have been shared with civil society across the Commonwealth through an online survey to gain input into and consensus on the proposed recommendations and action to be presented to Commonwealth Health Ministers.

## Introduction

There is a great deal of research and opinion available in the literature about potential ways to finance Universal Health Coverage (UHC) and the challenges for governments in doing so. This policy brief is not intended to replicate, summarise, or take a position on any particular research finding or opinion but to share the findings of a study commissioned by the Commonwealth Health Professions Alliance in 2016 and conducted by the Institute for Health Policy in Sri Lanka. The findings suggest that, in addition to the two widely recognised models for financing UHC, the Bismarck and the Beveridge models explained briefly below, some countries have achieved UHC at a relatively low expenditure of GDP, using a mixed funding model. The policy brief outlines some of the features of this model and recommends that the Commonwealth play a major role in researching the features of all financial models used by Commonwealth countries that have achieved UHC, with a view to sharing those experiences and lessons learned.

## Defining UHC

The World Health Organisation (WHO) defines universal health coverage as "all people receiving the health services they need, including health initiatives designed to promote better health (such as anti-tobacco policies), prevent illness (such as vaccinations), and to provide treatment, rehabilitation, and palliative care (such as end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship".[1] The WHO goes on to note that a significant number of countries, at all levels of development, are embracing the goal of UHC as the right thing to do for their citizens. UHC, the WHO says, is a powerful social equalizer and contributes to social cohesion and stability. Supporting the right to health and ending extreme poverty can both be pursued through UHC.[2] The WHO also notes that UHC is a critical component of the new Sustainable Development Goals (SDGs) which include a specific health goal: "Ensure healthy lives and promote wellbeing for all at all ages". Within this health goal, there is a specific target for UHC: "Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[3],[4]

## What are the issues?

UHC requires countries to ensure that all people have equitable access to needed quality health care services without experiencing financial risk, such as excessive out of pocket expenses. There is a lack of consensus, however, as the best way to finance UHC, but as Jamison et al note, a universal health system that provides core essential services to all is a key priority regardless of how it is financed.[5] The 2010 World Health Report, puts forward a number of messages central to achieving UHC:

- Raising sufficient resources for health,
- Removing financial risk and barriers to access
- Promoting efficiency and eliminating waste, and
- Addressing inequalities in coverage.[6]

There is consensus in the literature that achieving UHC requires a predominant reliance on compulsory or public funding for health services and is central to ensuring access to health services, whilst also protecting individuals and families from potentially unaffordable out of pocket expenses. Whilst private financing plays a role in all health systems, the WHO states that evidence clearly shows that it is public financing which drives improvements in health system performance on UHC.[7],[8] No country has attained UHC by

1. World Health Organisation (2015). ***Tracking universal health coverage: first global monitoring report.*** p.8. Available at: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf [Accessed 16 May 2017].
2. World Health Organisation (2015). ***Tracking universal health coverage: first global monitoring report.*** p.4.
3. World Health Organisation (2015). ***Tracking universal health coverage: first global monitoring report.*** p.4.
4. United Nations (2015). Sustainable Development Goals: goal 3. Available at: *http://www.un.org/sustainabledevelopment/health/#7e9fb9b0ec8c8e6e6* [Accessed 16 May 2017]
5. Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, Bustreo F, Evans D, Feachem RG, Frenk J, Ghosh G, Goldie SJ, Guo Y, Gupta S, Horton R, Kruk ME, Mahmoud A, Mohohlo LK, Ncube M, Pablos-Mendez A, Reddy KS, Saxenian H, Soucat A, Ulltveit-Moe KH, Yamey G. (2013) *Global health 2035: a world converging within a generation*. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24309475 [Accessed 16 May 2017]
6. World Health Organization (2010). *Health systems financing: the path to universal health coverage in the World Health Report*. Available from: http://www.who.int/whr/2010/en/ [Accessed 16 May 2017]
7. Jowett, J. and Kutzin, J. *Raising (2015) Revenues for health in support of UHC: strategic issues for policy makers. WHO Health Financing Policy Brief No.1*. p.2. Available at: http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf [Accessed 16 May 2017]
8. Jowett M, Brunal MP, Flores G, Cylus J, World Health Organisation

relying on voluntary contributions to insurance schemes regardless of whether they are run by non-government, commercial or government entities.[9]

Kutzin maintains that compulsion, with subsidisation for the poor, is a necessary condition for universality and goes on to say that while public funding can come from general government revenues or compulsory social health insurance contributions (e.g. income and payroll taxes), the allocation of general government revenues is essential, especially for poorer countries where large segments of the population may not be in salaried employment and are not subject to the collection of income or payroll taxes. This position is reinforced by the WHO, commenting that there will be a proportion of the population too poor to contribute through income taxes or insurance premiums and will need subsidisation from pooled funds, generally government revenue.[10]

The answer to the question "how much public spending is enough", Kutzin notes, is not straightforward and there is no single or simple answer, as the extent to which funds are pooled, and the way in which pooled funds are spent, are equally important in determining health system performance.[11]

A number of health expenditure targets exist but there is no agreed formula. These include targets based on absolute spending amounts and those based on spending relative to a denominator such as GDP or total government spending. There are wide variations between targets: for example, the Abuja Declaration of 2001 recommended that governments allocate 15% of their budget to the health sector. The 2010 WHO World Health Report comments that "those countries whose entire populations have access to a set of services usually have relatively high levels of pooled funds in the order of 5-6% of gross GDP".[12] The Commonwealth Medical Association 2016 Colombo Declaration called for countries to invest a minimum of 6% of GDP for health, prioritising investment in the most cost effective approaches, including public health and primary health care, and sustainable financing for health systems.[13]

Many countries however have achieved a high degree of UHC with less than 6% of GDP (Sri Lanka 3.5%; Malaysia 4.2%; and Jamaica 5.4%).[14] Conversely many Commonwealth countries already spend much more than 6% GDP without achieving UHC. To add to the confusion, targets and estimates are not always explicit in stating whether they are referring to public expenditure on health as a percentage of GDP or total spending on health as a percentage of GDP.[15] The numbers differ depending on which denominator is used and consequently, many benchmarks or spending estimates offer little in terms of useful guidance to countries. Worse still, these estimates may divert policy focus away from improving the way existing money is spent and hide wide variations in performance.[16] Although there is no agreed formula, it is clear that many households forgo care or face financial risk from out of pocket expenses or payment at time of service in those countries that rely predominantly on private sources of health care. It is also apparent that even at low levels of public spending, countries can make significant steps towards UHC.

## UHC funding models

The two most commonly reported UHC financing systems are:[17]

- Social health insurance (or the Bismarck Model): Insurance contributions from government, employers and individuals are used to finance a public insurance scheme

(2016) *Spending targets for health: no magic number.* Available at: http://www.who.int/health_financing/documents/no-magic-number/en/ [Accessed 16 May 2017]

9. Kutzin, J., World Health Organisation (2012). *Anything goes on the path to universal health coverage?* Available at: http://www.who.int/bulletin/volumes/90/11/12-113654/en/ [Accessed 16 May 2017]
10. World Health Organization (2010). *Health systems financing: the path to universal health coverage in the World Health Report*. p.14. Available at: http://www.who.int/whr/2010/en/ [Accessed 16 May 2017]
11. Kutzin, J., World Health Organisation (2012) *Anything goes on the path to universal health coverage?*
12. World Health Organization (2010). *Health systems financing: the path to universal health coverage.* p.15.
13. Commonwealth Medical Association (2016). *The Colombo Declaration*. Available at: https://www.thecommonwealth-healthhub.net/colombo-declaration-plan-collaborative-action/ [Accessed 16 May 2017]
14. The World Bank (2017). *Health expenditure % GDP.* Available at: http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.TOTL.ZS&country [Accessed 16 May 2017]
15. Jowett M, Brunal MP, Flores G, Cylus J, World Health Organization (2016). *Spending targets for health: no magic number.* Available at: http://www.who.int/health_financing/documents/no-magic-number/en/ [Accessed 16 May 2017]
16. Jowett M, Brunal MP, Flores G, Cylus J, World Health Organization (2016). *Spending targets for health: no magic number.*
17. Rannan-Eliya, R., Amarasinghe, S. and Nilamudeen A. (2016). *Universal health coverage: the potential contribution of hybrid funding strategies.* Available at: http://www.chpa.co [Accessed 16 May 2017]

that pays for services, usually by private providers (examples include Germany, Japan and Korea). Kutzin notes however that countries that have initiated financing reforms with a health insurance scheme solely for particular groups such as the formal workforce, are focusing attention and resources on already advantaged and well organized groups, which tends to exacerbate rather than redress inequalities.[18] Government contributions are still required for those who are not covered by the social health insurance or who cannot afford to pay

- Tax-funded systems (or the Beveridge Model): General revenue taxation is used to pay for the bulk of all health care services delivered predominantly, although not exclusively, through a public sector delivery system (examples include United Kingdom, Sweden and New Zealand). In this model, most, but not all hospitals and clinics are owned by the government: some doctors are government employees however there are also private doctors who collect their fees from the government and private hospitals and clinics.

These models, or their variations, face challenges however even in high income countries requiring at least 3% of GDP and often more. In developing countries this may be difficult to achieve because of the limited capacity of low-income countries to raise taxation funding or social insurance contributions to implement either Beveridge or Bismarck approaches to achieve UHC. Less researched is a mixed model of public and private health care provision which appears to achieve UHC at a surprisingly low proportion of GDP.[19] This model combines public provision of a universal package of health services for all, both rich and poor, with private health care provision meeting consumer demand for 'add on' services as outlined below. This mixed public/private health care model appears to have developed 'spontaneously' post-independence in a number of Commonwealth countries: examples include: Jamaica and many of its English-speaking Caribbean neighbours, Sri Lanka, Malaysia, Hong Kong, Ireland and Australia. Sri Lanka and Malaysia have achieved a high degree of UHC with public spending of 2.0% and 2.3% of GDP respectively and have health indicators comparable or better than some high income countries.[20]

In all cases of the mixed models reviewed, governments focused on maximizing universal or equitable access to a universal package of services for both rich and poor, and reducing exposure to financial risk, whilst minimizing government spending. These systems have the following characteristics:

1. Government financing comprises the majority of the funding for health and is exclusively tax-based, with no adoption of social health insurance mechanisms.
2. The publicly funded package includes substantial funding for hospitals and inpatient treatment.
3. The publicly funded package of services is genuinely available to the poor regardless of geographic location through a widely dispersed delivery network.
4. Private financing of health care provision is allowed to meet consumer demand for additional 'add on' services such as doctor of choice, reduced waiting times, and enhanced amenities such as private rooms and choice of food. Limited public funding benefits the poor more than the rich, not by means testing, but by differences in consumer quality.

Richer patients desire (and can pay for) greater doctor choice, shorter waiting times, and better amenities in their hospitals and clinics. In these mixed models, governments have generally had less focus on these consumer aspects of care but instead focused on maintaining quality core clinical components of care available to all. This approach can be viewed as pro-poor in terms of providing quality public health care at low cost, and pro-rich by allowing access to better consumer quality private health care. These mixed models exist in diverse settings and yet use similar mechanisms to combine public and private funding to maximize coverage, financial protection and consumer choice.

However, these mixed models are not without problems. The tendency for the middle class to seek out and pay for better consumer quality in the private sector, creates problems for political leaders to manage, since it is often the vocal middle-class less able to pay the costs of private

18. Kutzin, J. (2012) *Anything goes on the path to universal health coverage?*
19. Rannan-Eliya, R., Amarasinghe, S. and Nilaudeen, A. (2016). *Universal health coverage: the potential contribution of hybrid funding strategies.*
20. The World Bank (2017). *Health expenditure, public, % of GDP.*

health care that becomes frustrated by the lower consumer quality of the public system. There is also the risk that the poor may opt to use private health care in the belief that it provides better clinical care, thereby putting themselves at financial risk. It is also clear that in many settings the private health care system is poorly regulated both in terms of clinical quality and service charges. An important priority is to improve the regulation of private health care so that its clinical quality is consistent with public health care. Further, an unrestrained private sector could adversely impact the public sector by encouraging health care workers to move from the public sector to private sector.

Many countries with mixed public/private health care models have links to the Commonwealth which possibly reflects common institutional histories and sets of shared values. This gives the Commonwealth a special opportunity and responsibility to better understand and share these experiences with the wider global community.

## What needs to be done and how?

A significant number of countries are embracing the goal of UHC as the right thing to do for their citizens. UHC promotes social equality, social cohesion, and stability. Achieving UHC is also one of the health goals of the Sustainable Development Goals. UHC that provides equitable access to needed health services for the entire population without exposing them to financial hardship is a priority for civil society across the Commonwealth. Commonwealth Health Ministers need to involve all sectors of government and civil society stakeholders in their countries in decisions about how UHC is to be provided and financed.

In addition, steps need to be put in place to define 'high priority' health services based on cost-effectiveness; prioritizing health services for the poor; and providing financial risk

**Key indicators for selected mixed model systems and comparable peers (2013)**

| | Hong Kong | Ireland | Australia | UK | New Zealand | Germany |
|---|---|---|---|---|---|---|
| Health system type | Mixed | Mixed | Mixed | Beveridge | Beveridge | Bismarck |
| Infant mortality rate (deaths/1,000 live births) | 1.8 | 3.2 | 3.4 | 3.9 | 5.2 | 3.2 |
| Life expectancy at birth (years) | 84 | 81 | 83 | 81 | 82 | 81 |
| Skilled birth attendance (%) | 99 | 100 | 99 | 99 | 97 | 99 |
| Hospital discharges per 100 people | 18 | 13 | 17 | 13 | 15 | 25 |
| Doctor consultations per person | 11 | 4 | 7 | 5 | 4 | 10 |
| Government health spending (%GDP) | 2.6 | 5.5 | 5.9 | 7.0 | 7.6 | 8.4 |
| Private health spending (% of total health expenditure) | 36 | 32 | 33 | 16 | 17 | 23 |

*Source: World Health Statistics 2015 (World Health Organization 2015), and Food and Health Bureau, Government of the Hong Kong Special Administrative Region (http://www.fhb.gov.hk) for additional statistics for Hong Kong [accessed 10 May 2016].*

**Key indicators for selected mixed funding model systems (2013)[18, 19]**

| | Sri Lanka | Jamaica | Malaysia | Hong Kong |
|---|---|---|---|---|
| Income category | Lower-middle | Upper-middle | Upper-middle | High |
| GDP per capita (USD constant 2005) | 1,977 | 4,094 | 7,052 | 33,639 |
| Infant mortality rate (deaths/1,000 live births) | 8.7 | 14.4 | 6.4 | 1.8 |
| Life expectancy at birth (years) | 74.7 | 75.5 | 74.6 | 83.8 |
| Skilled birth attendance (%) | 99 | 99 | 99 | 99 |
| Government health spending (%GDP) | 1.6 | 3.4 | 2.2 | 2.6 |
| Out-of-pocket health spending (% of total health expenditure) | 44 | 25 | 36 | 36 |

protection. Monitoring indicators could include coverage of these 'high priority' health services; household expenditures on heath as a share of total household expenditure and income; percent of GDP spent on health (public/private); health outcomes such as infant mortality and life expectancy; and measures of financial risk protection, such as out of pocket expenditures on inpatient and outpatient care by income group.

Achieving and funding UHC is a significant challenge for countries, particularly low-income countries. Although calls to increase the overall proportion of GDP allocated to UHC should be supported, it is also important that quality core clinical care is provided in the most cost-effective manner if UHC is to be achieved. Kutzin comments that: "deriving meaningful lessons from reform experiences requires a deeper understanding of how countries have altered their funding sources, pooling arrangements, purchasing methods, and policies on benefits and patient cost-sharing. All systems, regardless of what they are called, have to address these functions and policy choices".[21] The WHO note that countries will take differing paths toward UHC depending on where and how they start. They will also make different trade-offs and choices on the proportion of the population to be covered; the range of services to be made available; and the proportion of the total costs to be met.[22]

Empirical evidence suggests that amongst low and middle-income economies, mixed public/private health care models as described earlier have performed well in terms of health outcomes and have generally achieved this at a lower cost than the better-known UHC models, Beveridge and Bismarck. It is therefore important to examine the role of the private sector in achieving UHC, as well as what regulatory frameworks are required to achieve better health outcomes. The Commonwealth is in a unique position to examine the financing models of Commonwealth countries who have achieved, or mostly achieved UHC, to identify key characteristics and share these within the Commonwealth.

## Policy recomendations

- It is recommended that Commonwealth Health Ministers involve other Ministries and civil society stakeholders at the national level in decisions to be made about how UHC is to be provided and financed.
- It is recommended that Commonwealth Health Ministers request the Commonwealth Secretariat to systematically and critically evaluate the funding models of Commonwealth countries that have achieved UHC, including those Commonwealth countries that use mixed public/private health care models, and make recommendations as to how the evidence and the lessons learned can be transferred to other Commonwealth countries as appropriate; and that the Commonwealth Secretariat report their findings to the 2018 Commonwealth Health Ministers' Meeting.

21. Kutzin, J (2012). *Anything goes on the path to universal health coverage?*
22. World Health Organization. *Health systems financing: the path to universal health coverage.* p.14.

## References


- Commonwealth Medical Association (2016). *The Colombo Declaration*. Available at: https://www.thecommonwealth-healthhub.net/colombo-declaration-plan-collaborative-action/ [Accessed 16 May 2017]
- Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, Bustreo F, Evans D, Feachem RG, Frenk J, Ghosh G, Goldie SJ, Guo Y, Gupta S, Horton R, Kruk ME, Mahmoud A, Mohohlo LK, Ncube M, Pablos-Mendez A, Reddy KS, Saxenian H, Soucat A, Ulltveit-Moe KH, Yamey G. (2013) *Global health 2035: a world converging within a generation*. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24309475 [Accessed 16 May 2017]
- Jowett M, Brunal MP, Flores G, Cylus J, World Health Organization (2016). *Spending targets for health: no magic number*. Available at: http://www.who.int/health_financing/documents/no-magic-number/en/ [Accessed 16 May 2017]
- Jowett, J. and Kutzin, J. Raising (2015) *Revenues for health in support of UHC: strategic issues for policy makers. WHO Health Financing Policy Brief No.1. p.2*. Available at: http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf [Accessed 16 May 2017]
- Kutzin, J., World Health Organisation (2012). Anything goes on the path to universal health coverage? Available at: http://www.who.int/bulletin/volumes/90/11/12-113654/en/ [Accessed 16 May 2017]
- Rannan-Eliya, R., Amarasinghe, S. and Nilamudeen A. (2016). *Universal health coverage: the potential contribution of hybrid funding strategies*. Available at: http://www.chpa.co [Accessed 16 May 2017]
- United Nations (2015). Sustainable Development Goals: goal 3. Available at: http://www.un.org/sustainabledevelopment/health/#7e9fb9b0ec8c8e6e6 [Accessed 16 May 2017]
- World Bank (2017). *Health expenditure % GDP*. Available at: http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.TOTL.ZS&country [Accessed 16 May 2017]
- World Health Organisation (2015). Tracking universal health coverage: first global monitoring report. p.4,8. Available at: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf [Accessed 16 May 2017]
- World Health Organization (2010). *Health systems financing: the path to universal health coverage in the World Health Report*. Available at: http://www.who.int/whr/2010/en/ [Accessed 16 May 2017]
- World Health Organization (2010). *Health systems financing: the path to universal health coverage in the World Health Report*. p.14. Available at: http://www.who.int/whr/2010/en/ [Accessed 16 May 2017]

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