Anything goes on the path to universal health coverage? No.

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In its 2010 world health report,[1] the World Health Organization noted that there is no single, best path for reforming health financing arrangements to move systems closer to universal health coverage, i.e. to improve access to needed, effective services while protecting users from financial ruin. However, this lack of a blueprint for health financing reforms was not meant to convey the message that "anything goes" on the path to universal health coverage. Indeed, concerns have been raised that some reforms, often implemented in the name of expanding coverage, may actually compromise equity.[2] Theory and country experience yield important lessons on both promising directions and pitfalls to avoid.

Interpretation of health financing reform experience requires getting beneath commonly used labels such as "tax-funded systems" or "social health insurance", or simply even "health insurance", which was used as the basis for a systematic review published in the September issue of the *Bulletin*.[3] Such labels hide more than they illuminate, as shown by emerging evidence on reforms that increase access and financial protection but are funded predominantly from general tax revenues (e.g. Kyrgyzstan, Mexico, Rwanda, Thailand).

Deriving meaningful lessons from innovative 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.

Revenue sources

Predominant reliance on compulsory or public financing is essential for universal coverage. No country has attained universal population coverage by relying mainly on voluntary contributions to insurance schemes, whether they are run by nongovernmental organizations, commercial companies, "communities", or governments. Compulsion, with subsidization for the poor, is a necessary condition for universality.[4] So while it is unfortunately the case that low- and middle-income countries with poor fiscal capacity may need to explore voluntary prepayment mechanisms as an alternative to out-of-pocket payments, this is not a long-term solution. And certainly, misplaced faith in voluntary prepayment should not provide an excuse for governments to direct public resources away from the health sector.

While public funding can come from general government revenues or compulsory "social health insurance" contributions (payroll taxes), general government revenues are essential for universal health coverage. Even the German government injects general revenues into the system to ensure coverage for those unable to contribute. For poorer countries, the structure of the economy, with a large share of the population outside salaried employment, makes it difficult to enforce either income taxes or payroll taxes on most citizens. Thus, increasing the size of the compulsory prepaid pool of funds requires transfers from general revenues (sourced predominantly from consumption taxes (e.g. value added tax) in most low- and middle-income contexts), and the relative need for this grows in proportion to the size of the so-called "informal sector" of the population. This further implies that moving towards universal health coverage in such contexts means moving away from the idea of a purely or even a predominantly contributory basis for entitlement and coverage.

Larger pools with more diverse populations

Universal health coverage goals of equitable access with financial protection require pooling arrangements that redistribute prepaid resources to individuals with the greatest health service needs. Fragmentation exists when there are barriers to this redistribution, with perhaps a worst-case scenario where there are different schemes for different social groups.[5] For example, in most low- and middle-income countries that have initiated financing reforms with a health insurance scheme solely for the formal workforce, attention and resources are focused on already advantaged and well organized groups, which tends to exacerbate rather than redress inequalities and leads to locking into a two-tier system.[6–7]

For countries that have not yet implemented a formal sector scheme, alternatives exist. Rwanda initiated its "community-based health insurance" system by first fully subsidizing the identified indigent from general revenues, then bringing contributions from the rest of the population into the same pools and continuing to subsidize the entire system via budget allocations for salaries and infrastructure.[8] Kyrgyzstan and the Republic of Moldova designed a universal system from the beginning of their reforms by having a single pool for both the formal sector (from contributions) and the rest of the population (from general revenues).[9] In a recently published review, common themes among nine African and Asian countries that had made sustained progress towards universal health coverage were both the use of tax revenues to extend coverage and the consolidation of risk pools.[10] These examples highlight what, on reflection, should be an obvious aim for low- and middle-income countries: to use existing scarce funding sources in an explicitly complementary way.

Strategic purchasing to sustain progress

Countries cannot simply spend their way to universal health coverage. To sustain progress, efficiency and accountability must be ensured. The main health

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financing instrument for promoting efficiency in the use of funds is purchasing, and more specifically, strategic purchasing. Developing the skills and systems needed for this is at the heart of strengthening national health financing systems, as it requires ongoing use and analysis of data generated by the system, which enables countries to adapt their systems to changing circumstances. As with the term "insurance", much attention is given to initiatives described as *schemes*: "performance-based funding", "results-based financing" or "pay-for-performance", etc. The important question is not the "success" of a given scheme or project; undue attention has probably been given to trying to prove whether or not these schemes work.[11] This is not the central issue. We know that passive purchasing methods, whether in the form of unmanaged fee-for-service reimbursement or rigid line-item budgets, harm efficiency. Thus, the point is that these initiatives should be more appropriately conceived (and evaluated) as entry points to move away from passive methods and strengthen purchasing arrangements within a national health financing system, not as stand-alone projects or time-limited interventions.

From scheme to system

In a systematic review published in September by Spaan et al., most health insurance schemes were found to improve health service utilization and financial protection for their members.[3] This is hardly news and certainly no basis for a policy recommendation because a scheme can benefit its members at the expense of the rest of the population if, for example, it excludes high-risk or poor people. The real question, posed long ago, is what effects a given scheme might have on universal health coverage objectives in terms of the health system and the population as a whole.[12] Schemes can contribute to these objectives, or they may detract from them. This is truly a case in which "the devil is in the detail". But with the correct unit of analysis – the entire population – and a clear conceptual framework, appropriate lessons can be derived from country experiences on some "dos" and "don'ts" in health financing reform. Policy can best be informed when we get the questions right. There will never be a simple recipe or blueprint, but approaches that compromise equity are not desirable pathways to universal health coverage. ■

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References

1. *The world health report – health systems financing: the path to universal coverage.* Geneva: World Health Organization; 2010.
2. Gwatkin DR, Ergo A. Universal health coverage: friend or foe of health equity. *Lancet* 2011;377:2160–1. doi:10.1016/S0140-6736(10)62058-2 PMID:21084113
3. Spaan E, Mathijssen J, Tromp N, McBain F, ten Have A, Baltussen R. The impact of health insurance in Africa and Asia: a systematic review. *Bull World Health Organ* 2012;90:685–92. doi:10.2471/BLT.12.102301 PMID:22984313
4. Fuchs VR. What every philosopher should know about health economics. *Proc Am Philos Soc* 1996;140:186–96.
5. Frenk J. Comprehensive policy analysis for health system reform. *Health Policy* 1995;32:257–77. doi:10.1016/0168-8510(95)00739-F PMID:10156642
6. Kutzin J. Chapter 5. Health insurance for the formal sector in Africa: yes, but... In: Beattie A, Doherty J, Gilson L, Lamo E, Shaw P, editors. *Sustainable health care financing in southern Africa: papers from an EDI health policy seminar held in Johannesburg, South Africa, June 1996*. Washington: The World Bank; 1997. Available from: http://econ.worldbank.org/external/default/main?pagePK=64165259&theSitePK=478060&piPK=64165421&menuPK=64166093&entityID=000009265_3980625103042 [accessed 8 October 2012].
7. Savedoff WD. Is there a case for social insurance? *Health Policy Plan* 2004;19:183–4. doi:10.1093/heapol/czh022 PMID:15070867
8. Makaka A. Role of government stewardship and leadership in SHP. Presented at the: *Regional Conference on Social Health Protection in the East African Community, Kigali, 11 September 2012*. Available from: http://moh.gov.rw/english/wp-content/uploads/2012/09/Presentation-on-Governance-in-Rwanda-CBHI_-Makaka.pptx [accessed 5 October 2012].
9. Kutzin J, Jakab M, Shishkin S. From scheme to system: social health insurance funds and the transformation of health financing in Kyrgyzstan and Moldova. In: Chernichovsky D, Hanson K, editors. *Innovations in health system finance in developing and transitional economies*. Vol. 21, Advances in health economics and health services research. Bingley: Emerald Group Publishing; 2009.
10. Lagomarsino G, Garabrant A, Adyas A, Muga E, Otoo N. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *Lancet* 2012;380:933–43. doi:10.1016/S0140-6736(12)61147-7 PMID:22959390
11. Fretheim A, Witter S, Lindahl AK, Olsen IT. Performance-based financing in low- and middle-income countries: still more questions than answers. *Bull World Health Organ* 2012;90:559. doi:10.2471/BLT.12.106468 PMID:22893735
12. Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy* 2001;56:171–204. doi:10.1016/S0168-8510(00)00149-4 PMID:11399345