Back to basics: designing an appropriate health financing system

In striving for Universal Health Coverage, Jo Kemp advocates for a well-rounded assessment of health financing options

Governments are issuing inspiring declarations of intent to provide health coverage for all citizens. Development partners are promising to back their efforts and Universal Health Coverage (UHC) has made it on to the shortlist for adoption as a post-2015 goal.[1] This should be good news for the world's poor.

Ultimately, UHC is about ensuring that all citizens have access to accessible, affordable, quality health provision, regardless of their wealth, gender or other circumstances. We are, however, a long way from this target. Every day, 800 women die during pregnancy or childbirth, while 8000 new born babies die during their first month of life.[2] Each year, 100 million people are pushed into poverty by health costs.[3] Crucially, health inequality remains a life-and-death issue: being born into a poor household in sub-Saharan Africa typically raises the risk of child mortality by a factor of three.[4]

Finance is at the heart of the problem.[5] Governments too often spend too little of their limited resources on health, and allocate scare resources in an inefficient and inequitable manner. The World Health Organization recommends that for a developing country to provide a basic package of essential services it must spend at least US$34 per capita, per annum. Yet in 2012, 22 countries across Africa spent less than $50 per capita, per annum and eight countries spent less than $25 per capita.[6] The result is limited coverage and poor quality services that people have to pay for when they fall ill. Around two-thirds of health spending takes the form of out-of-pocket payments[7] - and no money means no treatment.

So, if finance is at the heart of the problem, what can be done? In the first instance, governments can take a critical look at how their health systems are financed to deliver the desired outcomes, and assess options for the future. There are a number of key principles that can be applied in this regard:

- Understand the inputs, demographic trends, outputs, and outcomes of the system that is being addressed;
- Analyse options from the perspective of three basic principles of public finance: revenue collection, risk pooling, and allocation of revenues across a range of services. Healthcare financing reform implies introducing changes to one or more of these key functions of financing.
  - *Revenue collection* is the way health systems raise money from households, businesses and external sources. Revenue for the health sector may include taxes and charges, grants and loans from development partners, private and community insurance payments and out-of-pocket expenditure by health users. Functional health financing systems seek to raise an adequate and sustainable level of revenue in an efficient and equitable manner.
  - *Risk pooling* involves combining resources so that the members of the pool (health users) share collective health risks, thereby protecting

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them from large, unpredictable and catastrophic health expenditures.
    - *Resources* need to be allocated to maximise health outcomes and ensure equitable access to good quality health services. Health services may be purchased by a government agency, social and private insurance providers, employers and individuals. An understanding of health financing will necessitate analysis of the different purchasers.
- Guide financing design decisions by taking into account the following criteria:
    - Is the mechanism (e.g. government financed, social health insurance, private health insurance and/or community-based health insurance) sustainable and feasible?
    - Does the mechanism pool risks and ensure financial protection?
    - Does it lead to greater efficiency in revenue collection and allocation? and
    - Will its application enhance equity in financing and access to services?
- Take a medium-to-long-term perspective, and ensure political and institutional factors are at the forefront of any assessment.

Application of this approach is not new – policymakers within Ministries of Health and central government make macro level financial decisions to steer their health systems to deliver. Yet much of the recent debate is focused on 'new' financing models (e.g. results based financing (RBF)), the degree of risk sharing between public and private, and a relentless push for a 'back to basics' approach within the public financial management community.

As a 'new' topic, RBF for health refers to any programme that transfers money or goods to either patients when they take health-related actions (such as having their children immunised) or to healthcare providers, when they achieve agreed performance targets (such as immunising a certain percentage of children in a given area). Overall evidence suggests that RBF programmes increase utilisation of services, but results are ambiguous as to how it affects health system measures such as quality, efficiency and outcomes.

Crown Agents with HERA (an international team of highly-skilled professionals, with expertise in health and development research, programming, evaluation and policy), is currently responsible for scaling up a RBF model across 42 districts in Zimbabwe, in close partnership with the Ministry of Health. The programme hopes to deliver improved quality, access and utilisation of primary and maternal, newborn and child health services. This will be achieved through the removal of user fees for pregnant and lactating women, and children under 5 years, as well as through the incentivisation of specific services by health facilities (and support and supervision by district and provincial health executives). The programme aims to achieve improvements in both quantity and quality, the latter achieved through greater community participation in health service delivery, as well as improved support and supervision. What is already clear is that having good health information systems are key to the success of RBF.

Governments and development partners understand the importance of supporting UHC - good health improves labour productivity, facilitates learning, and contributes to economic growth and poverty reduction - but policymakers need evidence. RBF approaches, if monitored and evaluated, can provide this evidence; but implementing RBF alone may not deliver improvement in all health outputs or outcomes. It would be folly to consider any new innovation as the silver bullet to strengthening health systems. Instead we must continue to be guided by the principles of health financing and then consider innovative approaches. Undoubtedly taking a holistic view – technical, institutional and political - may be more onerous to measure, but without doing so we are less likely to see sustainable, long-term change.

References

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3. http://www.who.int/whr/2010/10_chap01_en.pdf
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