

# Financing for Universal Health Coverage: Dos and Don'ts

HEALTH FINANCING GUIDANCE NOTE NO 9

CONFERENCE COPY



World Health  
Organization

# Financing for Universal Health Coverage: Dos and Don'ts

HEALTH FINANCING GUIDANCE NOTE NO 9

CONFERENCE COPY

WHO/UHC/HGF/HFGuidance/19.9

© World Health Organization 2019. All rights reserved.

This is a draft intended for review by interested parties for the purpose of consultation on the draft text. The content of this document is not final, and the text may be subject to revisions before publication. The document may not be reviewed, abstracted, quoted, reproduced, transmitted, distributed, translated or adapted, in part or in whole, in any form or by any means without the permission of the World Health Organization.

Cover photo ©Riccardo Mayer/Shutterstock.

## Contents

<b>Acknowledgements</b>	<b>iii</b>
<b>Why this guide?</b>	<b>v</b>
<b>I. Critical questions facing country policy-makers</b>	<b>1</b>
What role can health financing play in my country's progress towards UHC?	1
If measures of financial protection are improving, does this mean my system is getting better?	1
What does it mean to go "from scheme to system"?	2
Won't progress on key UHC objectives require more than health financing reform?	3
What is private health financing?	3
Should we encourage voluntary health insurance for UHC?	4
What is performance-based financing, and how might it support UHC?	5
If most of our population is not in formal employment, how can we extend coverage to them?	6
Noncontributory approaches (four options)	7
Contributory approaches (two options)	7
Estimates by international organizations suggest that my country has a big funding gap, and UHC looks unaffordable—what should we do?	9
<b>II. The details: key aspects of health financing reforms for UHC</b>	<b>11</b>
<b>1. Revenue sources</b>	<b>11</b>
Which matters more for UHC: total spending on health, or public spending on health?	12
What should public revenue raising arrangements achieve—beyond bringing in more money?	12
What are the policy implications of various revenue sources?	13
Should we shift our emphasis to social health insurance (SHI) contributions?	13
Do any fiscal policy decisions fall within the competence of health sector policy-makers?	14
Should budget priorities shift to give greater attention to health—and if so, how?	14
<b>2. Pooling</b>	<b>16</b>
We often hear about revenue raising and pooling together—so why treat pooling separately?	16
Why does pooling matter for UHC?	17
What makes for a good pooling structure?	17
What is fragmentation in pooling, and why is it a problem?	17
What are the reform options to address fragmentation or mitigate its consequences?	18
Are pooling reforms enough?	18
<b>3. Benefit design and rationing</b>	<b>19</b>
How are benefit design and rationing related?	19
How can benefit design support progress towards UHC, and what should guide decision making in benefit design?	20
Does being explicit help people understand their entitlements and obligations?	21
In a package with explicit user fees (copayments), how should the fees be designed?	21
Why do promised benefits often exceed those actually received—and how can we make sure that promised benefits are delivered?	22
If my country's system funds most services directly through the supply side—without imposing user fees (copayments)—does any role exist for benefit design?	22

<b>4. Strategic purchasing for health services</b>	<b>24</b>
What is strategic purchasing and why is it critical for UHC?	24
How can we enable purchasing to become more strategic in our health system?	25
What are the best provider payment methods?	26
What other opportunities does strategic purchasing offer for UHC?	27
<b>5. Public financial management in health</b>	<b>28</b>
How do PFM systems affect health spending today?	28
How can health ministries be more active in PFM reforms?	29
<b>6. Political economy analysis for health financing reform</b>	<b>30</b>
What makes health financing reform political?	30
How can my country best use political economy analysis to advance the adoption and implementation of health financing reform?	30
<b>III. What is the best model of health financing reform for my country?</b>	<b>32</b>
Revenue raising	32
Pooling	32
Benefit design and rationing	33
Purchasing	33
Political economy	33

## Acknowledgements

This report is the product of a collective effort by the World Health Organization (WHO) Health Financing Teams at headquarters and the regional offices for Africa, the Americas, Eastern Mediterranean, Europe, South-East Asia and Western Pacific.

This report was conceived by and produced under the guidance of Agnès Soucat, Director of the Department of Health Systems Governance and Financing Department. The authors of the report are Joseph Kutzin, H el ene Barroy, Melanie Bertram, Alexis Bigeard, Camilo Cid, Peter Cowley, Jonathan Cylus, Elina Dale, Fahdi Dkhimi, Matthew Jowett, Xu Ke, Inke Mathauer, Kenneth Munge, Claudia Pescetto, Susan Sparkes and Llu s Vinyals Torres.

Editing, design and layout by a team at Communications Development Incorporated, led by Bruce Ross-Larson and including Joseph Brinley, Joe Caponio, Nick Moschovakis, and Debra Naylor (Naylor Design).

We acknowledge the financial support provided by the United Kingdom’s Department for International Development as part of the Making Country Health Systems Stronger Programme and through the Universal Health Coverage Partnership funded by the European Union, France, Grand Duchy of Luxembourg, Irish Aid, Japan and UK Aid.



## Why this guide?

This guide aims to build understanding of key issues in financing for universal health coverage (UHC). Speaking directly to decision-makers and those advising them, the guide synthesizes lessons learned from reform experiences in a question-and-answer format. The lessons do not constitute a specific blueprint or cookbook: countries differ, and every health financing reform must be homegrown. Rather, the lessons are principles or signposts—to point in the direction of effective reform and to support periodic assessments of progress.

The lessons focus on domestic health financing policy. While external funding is and will remain important for some countries, the effective use of all resources—including those coming from donors—depends mainly on how well domestic systems function.

Interpreting health financing reform experience requires getting beneath familiar labels such as “tax funded systems” and “social health insurance”—and even “health insurance”. To draw useful lessons, one must understand a country’s policy choices on each functional element of health financing: how the country altered its revenue sources, its pooling arrangements, its purchasing methods and its policies on benefit design. All systems and reforms, whatever labels they use, must address these functional elements.

Legitimate concerns exist about the size of estimated resources needed to meet SDG health targets, and with these concerns come pressures to act more quickly. But this urgency must not degenerate into a desperate impulse to do just anything—sometimes attaching the label “innovative”

as justification. Ignoring 30 years of well-documented lessons from health financing reforms will not bring countries closer to UHC. We need to “keep calm” and keep supporting the meaningful changes, informed by evidence, that can create opportunities for sustained progress. Most of all, we need to care about whether something works, not what it is called.

Section I considers important questions and crosscutting policy concerns related to UHC and types of health financing reform. Section II presents more detailed questions and answers about specific health financing functions and aspects of reform: revenue raising, pooling, benefit design and rationing and strategic purchasing, as well as core implementation issues related to public financial management (PFM) and political economy. Section III synthesizes the preceding lessons into guiding principles on financing for UHC.

To be sure, each country must define its own approach to financing for UHC given its unique context and starting point. But no country is required to repeat the mistakes of others. We do not have all the answers; nevertheless, much is known about what works and what does not. In health financing reform for UHC, the fact that we do not know *everything* does not mean that we do not know *anything* useful to steer policy choices. In this guide, we address critical questions and policy choices that countries face. Our aim is to synthesize key principles that countries can use as signposts to inform decisions on health financing reforms—and that are based on sound evidence.



## I. Critical questions facing country policy-makers

### What is universal health coverage (UHC)?

According to WHO, universal health coverage (UHC) means that all persons are able to use needed health services (including prevention, promotion, treatment, rehabilitation and palliation), of sufficient quality to be effective, without fear of financial hardship.

Source: WHO (2010). World Health Report 2010: Health Systems financing: The path to universal health coverage. Geneva: World Health Organization. <https://www.who.int/whr/2010/en/>.

### What role can health financing play in my country's progress towards UHC?

For any country, progress towards universal health coverage (UHC) requires progress on the three UHC goals that are embedded in the definition. This is an ongoing process of:

- *Improving equity in the use of health services* (reducing unmet need).
- Improving service quality.
- *Improving financial protection* (reducing the financial hardship that households face as a consequence of paying for health services).

Health financing arrangements influence progress on these UHC goals directly, and also through their effects on three intermediate objectives with implications for UHC. The intermediate objectives that health financing reforms should focus on are:

- Making the distribution of system resources more equitable.
- Making the system more transparent and accountable.
- Making the system more efficient.

National health authorities, typically ministries of health, can use the UHC goals and intermediate objectives as a checklist for a holistic and systematic analysis of performance shortcomings. A diagnosis should identify the underlying causes of these problems. Then a country's reform agenda—often operationalized as a *health financing strategy*—should be tailored to address the specific causes of the identified performance problems, while strengthening the foundations for the system to achieve ongoing progress over time.

Because no plan is perfect, implementation should be accompanied by applied policy and operational research. The virtuous cycle to create and sustain is: *analyse, design, implement, learn, adapt*.

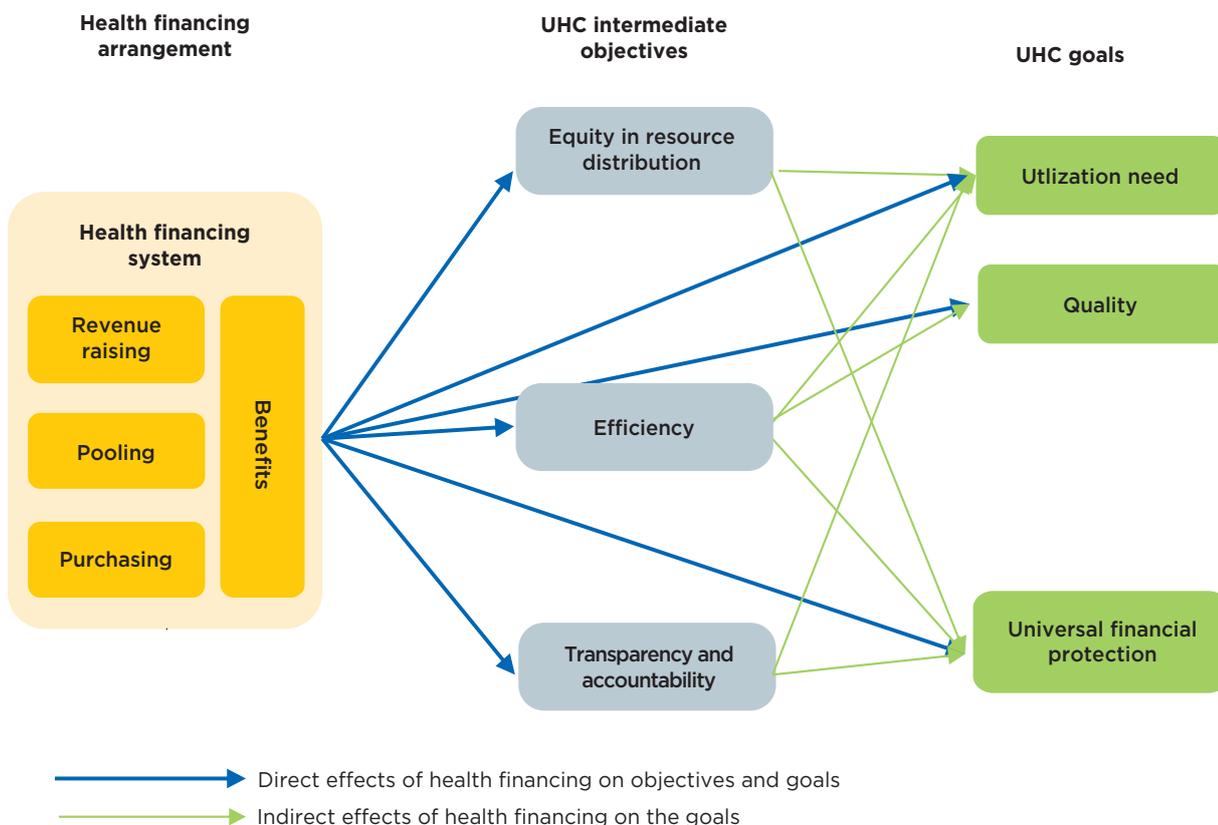
### Key references:

- WHO (2010). World Health Report 2010: Health systems financing: The path to universal health coverage. Geneva: World Health Organization. <https://www.who.int/whr/2010/en/>.
- Kutzin, J, S Witter, M Jowett, D Bayarsaikhan (2017). Developing a national health financing strategy: a reference guide. Health Financing Guidance No.3. Geneva: World Health Organization. <http://apps.who.int/iris/bitstream/10665/254757/1/9789241512107-eng.pdf?ua=1>.
- Kutzin, J (2013). Health financing for universal coverage and health system performance: concepts and implications for policy, *Bulletin of the World Health Organization* 2013;91:602–611. <https://www.who.int/bulletin/volumes/91/8/12-113985/en/>.
- McIntyre, D and J Kutzin (2016). Health financing country diagnostic: a foundation for national strategy development. Geneva: World Health Organization. [https://www.who.int/health\\_financing/tools/diagnostic/en/](https://www.who.int/health_financing/tools/diagnostic/en/).
- WHO. OASIS: Organizational Assessment for Improving and Strengthening Health Financing (Health systems financing review). Geneva: World Health Organization. [https://www.who.int/health\\_financing/tools/systems\\_review/en/](https://www.who.int/health_financing/tools/systems_review/en/).

### If measures of financial protection are improving, does this mean my system is getting better?

Assessing progress towards UHC requires assessing service coverage and financial protection *jointly*; looking at just one can be misleading. For example, because out-of-pocket spending (OOPS) occurs only when someone uses services, survey data that show low OOPS may reflect ei-

**Fig. I.1. Intermediate objectives and final goals of UHC that health financing can influence**



Source: Kutzin, J (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. *Bulletin of the World Health Organization* 91:602–611. <https://www.who.int/bulletin/volumes/91/8/12-113985/en/>.

their good financial protection or low service coverage: two scenarios with opposite implications for progress towards UHC. Conversely, where service use rises as a result of reform, or even through income growth alone, OOPS tends to rise in the short run—especially for medicines—and survey analysis may show a deterioration in financial protection concurrent with rising service coverage (assuming that the increased use reflects real need). Because progress towards UHC implies reductions both in unmet need and in financial hardship, only a joint analysis and interpretation of data on service use and OOPS can inform effective policy based on a sound understanding of change over time.

**Key references:**

McIntyre, D and J Kutzin (2016). Health financing country diagnostic: a foundation for national strategy development. Geneva: World Health Organization. [https://www.who.int/health\\_financing/tools/diagnostic/en/](https://www.who.int/health_financing/tools/diagnostic/en/).

Thomson, S, J Cylus, T Evetovits (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: World Health Organization, Regional Office for Europe. <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>.

Xu, K, A Soucat, J Kutzin, C Brindley, N Vande Maele, H Toure, M Aranguren Garcia, D Li, H Barroy, G Flores Saint-Germain, T Roubal, C Indikadahena, V Cherilova (2018). Public spending on health: A closer look at global trends. Geneva: World Health Or-

ganization. [https://www.who.int/health\\_financing/documents/health-expenditure-report-2018/en/](https://www.who.int/health_financing/documents/health-expenditure-report-2018/en/).

Wang, H, L Vinyals Torres, P Travis (2018). Financial protection analysis in eight countries in the WHO South-East Asia Region. *Bulletin of the World Health Organization* 96:610–620E. [https://www.who.int/health\\_financing/documents/financial-protection-analysis-south-east-asia-region/en/](https://www.who.int/health_financing/documents/financial-protection-analysis-south-east-asia-region/en/).

**What does it mean to go “from scheme to system”?**

Universal means *universal*: to assess a health system against the goals and objectives that define UHC, one must look at the entire system and population. What matters in such assessments is not how a given health coverage scheme affects its beneficiaries, but how it affects equity, quality and financial protection for everyone.

When health coverage schemes serve only part of a population, they often have spillover effects beyond the people they serve. For example:

- In contexts of high informality—typical of low- and middle-income countries (LMICs)—a social health insurance (SHI) scheme that serves only civil servants and private formal sector workers contributes little to UHC, given the limited population covered. Worse, it may divert scarce system resources (such as doctors) to serve the insured, limiting availability for others. This inequitable situation is compounded where such schemes receive direct government subsidies. The scheme may seem to perform

well in itself—but from a UHC perspective, considering the entire health system, its effects are undesirable.

- If a voluntary health insurance scheme excludes high-risk individuals (such as those with diabetes or HIV), the scheme makes its members better off by keeping premiums low or benefits high. But these advantages come to the scheme's participants at the expense of the rest of the population.

For policy-makers, embracing UHC means seeking reforms that will reduce these inequities. For SHI, for example, a pro-UHC design would initially cover groups such as the identified poor, persons over a certain age (such as 60) and children under 5—along with the contributors—all in the same pool and entitled to the same benefits at the same per capita funding levels.

Perhaps the most important practical step towards UHC is to ensure unified or interoperable underlying systems, especially systems related to provider payment and facility-level patient health records. Unified systems—and in particular unified databases on patient activity—are essential for systemic progress towards UHC. To effectively govern the transition to a universal health system, the data on the whole population and system should be in one place.

Unified databases are thus an essential step to *design universality in* from the early stages of reform implementation. Such unified databases can be established before (and as a precursor to) unified arrangements for financing and benefits. A country that is serious about UHC will not have entirely separate systems for different population groups or interventions; nor will partners that seriously support such a country's progress towards UHC.

### Key references:

- Kutzin J, Yip W, Cashin C (2016): Alternative Financing Strategies for Universal Health Coverage. *World Scientific Handbook of Global Health Economics and Public Policy*; pp. 267–309. [http://www.who.int/health\\_financing/documents/alternative-strategies-for-uhc/en/](http://www.who.int/health_financing/documents/alternative-strategies-for-uhc/en/).
- Soucat, A, E Dale, I Mathauer, J Kutzin (2017). “Pay-for-performance debate: not seeing the forest for the trees.” *Health Systems & Reform* 3(2):74–79. [https://www.who.int/health\\_financing/documents/pay-for-performance-debate/en/](https://www.who.int/health_financing/documents/pay-for-performance-debate/en/).
- Kutzin, J, M Jakab, S Shishkin (2009). “From scheme to system: social health insurance funds and the transformation of health financing in Kyrgyzstan and Moldova.” In Chernichovsky, D and K Hanson, Eds. *Innovations in Health System Finance in Developing and Transitional Economies*. Advances in Health Economics and Health Services Research, Volume 21, pp.291–312. Bingley, UK: Emerald Group Publishing. [https://www.emerald.com/insight/content/doi/10.1108/S0731-2199\(2009\)0000021014/full/html](https://www.emerald.com/insight/content/doi/10.1108/S0731-2199(2009)0000021014/full/html).
- Cuadrado C, F Crispi, M Libuy, G Marchildon, C Cid (2019). National Health Insurance: a conceptual framework from conflicting typologies. *Health policy*. <https://doi.org/10.1016/j.healthpol.2019.05.013>.

### Won't progress on key UHC objectives require more than health financing reform?

It certainly will. While health financing plays a central role, progress on other health system functions is critical. And the various elements need to be well coordinated. Specifically:

- Health financing reforms matter greatly for financial protection, but other complementary actions also play a role—for example, improving medicines management to lower prices for users.
- Health financing reforms can also make service use more equitable—but will do so only as part of a set of changes in health workforce, technology and physical infrastructure that are explicitly coordinated to alter the distribution of health services in a more equitable way.
- Ensuring that no one is left behind may also require tailored efforts within and beyond health financing to overcome demand-side barriers, such as distance, poverty, employment status and gender.
- While health financing can influence quality, it is only a supporting player—here the key driver is direct action such as training and feedback to improve service delivery.
- All health system functions must be well articulated through strong governance, led by the national health authority (typically a ministry of health).

In sum, a well-designed health financing reform strategy is useful—but this strategy should be embedded within a wider health system reform plan, with well-defined key linkages across the system. And it should be focused on addressing the obstacles to progress on the UHC goals and objectives.

### Key references:

- WHO (2000). World Health Report 2000: Health Systems: Improving Performance. Geneva: World Health Organization. [https://www.who.int/whr/2000/en/whr00\\_en.pdf?ua=1](https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1).
- Kruk, ME, AD Gage, C Arsenault, K Jordan, HL Leslie, S Roder-de-Wan et al. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet Global Health* 6(11):e1196–e1252. [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(18\)30386-3/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30386-3/fulltext).

### What is private health financing?

What makes private health financing “private” is that, as a source of funds, it is voluntary rather than compulsory: the government does not tax individuals or firms (or otherwise obligate them to pay). The main forms of private financing—other than private investment for capital costs—are out-of-pocket spending (OOPS) and voluntary health insurance (VHI).

Broadly, OOPS occurs through four main mechanisms:

- Purely private market interactions, such as an individual's payment for a visit to a private doctor.
- Official user fees, or copayments—two different labels for the same thing—specified by a government entity (such as a ministry of health) or by an agency managing a publicly funded insurance programme (such as an SHI fund).
- Unofficial (informal) payments made to health workers in government health facilities.
- Informal payments made for inputs—such as drugs, medical supplies or surgical supplies—that were meant

to be available as part of treatment (usually in a hospital), but were not so provided.

Similarly, VHI (voluntary prepayment by individuals or firms) can take several forms, including:

- Purchasing health insurance coverage from commercial insurers.
- Purchasing it from not-for-profit or “community” insurers (this includes most forms of community-based health insurance).
- Contributing as a self-employed individual to a social health insurance fund—a contribution that may be legally mandatory, but is often voluntary in practice (given the context).

Importantly, when it comes to insurance, private financing does not equal private ownership. In many countries—examples include Chile, Colombia, the Czech Republic, India and the Netherlands—private insurance companies manage compulsory financing schemes. Though the management is by a private entity, it is a public financing arrangement.

### Key references:

- Kutzin, J (2001). “A descriptive framework for country-level analysis of health care financing arrangements.” *Health Policy* 56(3):171-204. <https://www.sciencedirect.com/science/article/abs/pii/S0168851000001494>.
- Gaál, P, PC Belli, M McKee, M Szócska (2006). Informal payments for health care: definitions, distinctions, and dilemmas. *Journal of Health Politics, Policy and Law* 31(2):251-293. <https://read.dukeupress.edu/jhpol/article/31/2/251/93474/Informal-Payments-for-Health-Care-Definitions>.

### Should we encourage voluntary health insurance for UHC?

As a form of private health financing, VHI does not need encouragement but management. Private health financing tends to grow with per capita income. Why? Because as people earn more money, they are likely to spend more on health care. The evidence thus strongly links income growth to service use and OOPS—but also to widening inequities in service use and the financial burden of access.

Given the well-known problems that OOPS is commonly agreed to pose for UHC, can VHI be a good solution? The evidence on all forms of voluntary prepayment is clear: it

may generate some revenues from organized groups (as in large firms), but it does not work well for individuals. The reason is what health economists call *adverse selection*—a dynamic that causes individual VHI markets to implode without substantial government intervention.

Because of the adverse selection problem, very few countries raise more than 10 percent of their health spending through VHI. And in most of those countries, where health markets (in terms of expenditures) are large, VHI is not a complementary funding arrangement for UHC—instead it has driven large inequities, and often inefficiencies, making it a barrier rather than an enabler for UHC.

An urgent challenge today is the increase of commercial VHI in many LMICs. This increase has systemwide effects on both efficiency and equity—especially where services covered by VHI overlap with, but are funded at a much higher level than, those provided by the publicly funded system. In such cases, rising health insurance coverage constrains progress towards UHC.

Given that private health spending is likely to grow with income, a key public policy challenge is how to steer this private financing in a direction that explicitly complements public spending—supporting a benefit package for UHC, while limiting harmful spillover effects as much as possible. The first priority is a clear financing policy that specifies what will be publicly funded, with explicit space for nongovernment funding (which ideally would shrink over time). In France, for example, private insurers cover copayments of the public system’s benefit package, while public subsidies ensure inclusion and protection for low-income persons.

To obtain an indication of whether VHI is having harmful spillovers, compare the population share covered by VHI with the share of health spending that flows through such schemes. If the population share is much smaller than the health spending share, system resources are disproportionately serving the rich—raising concerns about equity and quality for the poor, especially in countries with limited availability of skilled health workers. An easily monitored indicator for any country, this side-by-side comparison of population coverage with the health spending share for VHI is illustrated by five examples in table A.

Where VHI exists and is likely to grow, an essential step in progress towards UHC is to clearly define a *complementary* role for it in the overall health financing system. A complementary role is one that precludes VHI from covering things that are covered in the public insurance arrange-

**Table I.1. Population coverage and health spending shares for voluntary insurance in five countries (spending data for 2016; coverage data for most recent year)**

Country	Voluntary health insurance		
	Population coverage	Share of health spending	Role
France	95%	7%	Complementary
Slovenia	84%	15%	Complementary
UK	9%	4%	Supplementary
Kenya	1-2%	11%	Supplementary
South Africa	16%	47%	Supplementary

Source: Spending data from the WHO Global Health Expenditure Database. Coverage data from Thomson et al. (in press) and Sagan and Thomson 2016.

ment. For example, in France and Slovenia (see table A), VHI has the role of covering copayments into national insurance programmes. However, complementary VHI may also exist for services not covered by public insurance. If complementary VHI has a high population coverage share and accounts for only a small health spending share, it contributes to UHC by filling gaps—especially where such coverage is subsidized for the poor, as in France.

The opposite of a complementary role for VHI is a supplementary role: one in which there is no clear definition of what VHI can cover. Such supplementary VHI often includes services that are part of, and also go beyond, those paid for by national public financing (for example, direct access to specialists). Where supplementary VHI schemes have a small health spending share and a large population coverage share, they are not likely to do much harm. However, where the spending share is large—as is most dramatically the case in South Africa—major equity and efficiency problems arise for the overall health financing system. The efficiency problems reflect a failure by many commercial schemes to manage expenditure growth, both in prices and in the volume of services: such schemes become expensive, while input prices—such as health worker salaries—also rise across the system. This inefficiency contributes to a systemwide equity problem: overall spending and resources concentrate on serving the privately insured, and, perhaps most harmfully, skilled health workers serve those with private insurance, reducing their availability to the rest of the population (an internal “brain drain”).

As a result of all of these risks, most systems allow only a small role for VHI. Where VHI has a large spending share compared with its population share, the resulting equity and efficiency problems can mean that VHI does more to hinder progress towards UHC than to promote it. Only when health financing policy explicitly defines what is publicly funded can VHI play a complementary role—one that contributes to progress towards UHC.

### Key references:

- Fuchs, VR (1996). What every philosopher should know about health economics. *Proceedings of the American Philosophical Society* 140(2):186–96. [http://static.stevereads.com/papers\\_to\\_read/fuchs--what\\_every\\_philosopher\\_should\\_know\\_about\\_health\\_econ.pdf](http://static.stevereads.com/papers_to_read/fuchs--what_every_philosopher_should_know_about_health_econ.pdf).
- Akerlof, GA (1970). The market for “lemons”: quality uncertainty and the market mechanism. *The Quarterly Journal of Economics* 84(3):488–500. <https://www.sciencedirect.com/science/article/pii/B978012214850750022X>.
- Solanki, G, S Fawcus, E Daviaud (2019). A cross sectional analytic study of modes of delivery and Caesarean section rates in a private health insured South Africa population. Available at SSRN: <https://ssrn.com/abstract=3350545>.
- Xu, K, A Soucat, J Kutzin, C Brindley, N Vande Maele, H Toure, M Aranguren Garcia, D Li, H Barroy, G Flores Saint-Germain, T Roubal, C Indikadahena, V Cherilova (2018). Public spending on health: a closer look at global trends. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/health-expenditure-report-2018/en/](https://www.who.int/health_financing/documents/health-expenditure-report-2018/en/).
- Kutzin J, Yip W, Cashin C (2016): Alternative Financing Strategies for Universal Health Coverage. *World Scientific Handbook of Global Health Economics and Public Policy*: pp. 267–309. [http://www.who.int/health\\_financing/documents/alternative-strategies-for-uhc/en/](http://www.who.int/health_financing/documents/alternative-strategies-for-uhc/en/).
- Pettigrew L, and I Mathauer (2016): Private Health Insurance expenditure in low and middle- income countries: Exploring trends during 1995–2012 and policy implications for progress towards

universal health coverage. *International Journal of Equity in Health* 15(67):1–19. <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-016-0353-5>.

- Mathauer I, B Mathivet, J Kutzin (2017): Community Based Health Insurance: how can it contribute to progress towards UHC? Health Financing Policy Brief No. 3. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/community-based-health-insurance/en/](https://www.who.int/health_financing/documents/community-based-health-insurance/en/).
- Thomson S, R Busse, L Crivelli, W van de Ven, C Van de Voorde (2013). Statutory health insurance competition in Europe: A four country comparison. *Health Policy* 109(3):209–225. <https://www.sciencedirect.com/science/article/abs/pii/S0168851013000158>.
- Sagan, A and S Thomson (2016). *Voluntary health insurance in Europe: role and regulation*. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/voluntary-health-insurance-in-europe-role-and-regulation-2016>.
- Thomson S, A Sagan, E Mossialos, eds. (in press). *International experience with private health insurance: history, politics, performance*. Cambridge: Cambridge University Press.
- Castro et.al (2019). Brazil's unified health system: the first 30 years and prospects for the future. *Lancet* [http://dx.doi.org/10.1016/S0140-6736\(19\)31243-7](http://dx.doi.org/10.1016/S0140-6736(19)31243-7).

### What is performance-based financing, and how might it support UHC?

In national health financing policy, reforms labelled as performance-based financing (PBF) aim to strengthen incentives for delivering a higher quantity or quality of priority services. The performance-based incentives are offered not through a standalone mechanism, but through an add-on payment method: one that is used on top of the existing base payment methods. Such a mechanism is also often called pay-for-performance (P4P) and, at times, is denoted under the general umbrella term of Results-Based Financing (RBF)—though RBF may also include specific incentives for service users, as well as for providers.

The intention of PBF—or P4P—is thus to alter incentives for service providers by creating an explicit link between the payment mechanism and the prioritized health services. When contemplating the introduction of PBF or P4P, countries should take four things into account:

- **PBF (or P4P) is not a separate financing arrangement, but needs to be explicitly designed as part of a mixed-provider payment system.** The design and evaluation of performance-based incentives must focus not only on the incentivized performance element but on the combination of this element with the base payment system. Reaching conclusions about PBF or P4P without considering the overall payment mix is misleading and cannot inform sound policy decisions.
- **For related reasons, PBF should never be considered as a workaround for a poorly functioning public finance system.** If salaries from general budgets are not being paid on time, getting money to providers through a separate PBF fund is not a sustainable solution. Any apparent successes in such contexts reflect the simple fact that the providers are being paid—not the particular mechanism used to pay them. The solution to problems in the public finance system is to fix them, not to bypass them with a short-term mechanism that operates outside the system.

- **Do no harm by starting small.** If a country decides to create a role for additional, targeted financial incentives in its health financing arrangements, the sensible approach is to start small. In contrast, starting big—and possibly having to scale down later—sets up a difficult political dynamic that can undermine an entire reform programme. In most high-income countries that use PBF (or P4P), it is small compared with the base payment system: policy-makers have recognized that even small incentives can drive behaviour changes if the base payment system is functioning, with performance-based payments as an extra stimulant. Indeed, merely giving feedback to providers using payment system data may motivate change. An LMIC considering PBF should apply these lessons in the design phase: start small, then analyse implementation and results as a basis for considering changes to the relative sizes of the base payment and the performance element—all in the context of overall health financing, public financial management and delivery reforms.
- **For overall quality improvement, payment mechanisms of any kind can play no more than a complementary role.** The main reason is the challenge of linking payment to real results, such as improved quality or outcomes. Payment incentives work best for tasks that are comparatively mechanical and for which quantity is most important, such as vaccinating a child. In contrast, if a task requires more cognitive skill and depends more on the quality of care—as with a primary care consultation—the process and results are not clearly observable, so no one can verify that it was a “good consultation” within a time frame for payments linked to this service. So PBF (or P4P) is best applied to activities with a strong correlation between quantity and health outcomes: vaccinations, screenings and the like. And to make PBF as likely as possible to have a positive impact, while reducing its potentially harmful effects to a minimum, reforms should identify and reinforce the willingness of health workers to do the right thing from a clinical perspective.
- **PBF (or P4P) policy and implementation should be designed as an explicit entry point to strategic purchasing, discussed below in section II.** A useful approach is to move towards unified information systems—possibly using the PBF initiative as an information system strengthening opportunity—while enhancing capacities to analyse and use data for future decision making.

Keeping these points in mind when it comes to design and implementation, PBF or P4P initiatives can play a constructive role in helping move systems towards UHC.

### Key references:

- Musgrove P (2011). Financial and other rewards for good performance or results: a guided tour of concepts and terms and a short glossary. Washington, DC: World Bank. <https://www.rbf-health.org/resource/financial-and-other-rewards-good-performance-or-results-guided-tour-concepts-and-terms-and>.
- Cashin, C, Y-L Chi, P Smith, M Borowitz, Thomson, S, eds. (2014). *Paying for Performance in Health Care. Implications for Health System Performance and Accountability*. Open University Press. World Health Organization on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/>

[paying-for-performance-in-health-care.-implications-for-health-system-performance-and-accountability-2014](https://www.euro.who.int/en/about-us/partners/observatory/publications/studies/paying-for-performance-in-health-care.-implications-for-health-system-performance-and-accountability-2014).

Soucat, A, E Dale, I Mathauer, J Kutzin (2017). “Pay-for-performance debate: not seeing the forest for the trees.” *Health Systems & Reform* 3(2):74–79. [https://www.who.int/health\\_financing/documents/pay-for-performance-debate/en/](https://www.who.int/health_financing/documents/pay-for-performance-debate/en/).

OECD (2016), Better Ways to Pay for Health Care, OECD Health Policy Studies, Paris: OECD Publishing. <https://doi.org/10.1787/9789264258211-en>.

Pink, DH (2010). Drive: The Surprising Truth about what Motivates us. Video. <https://www.youtube.com/watch?v=u6XAPnuFjJc>.

Huillery, E (2019). The unexpected effects of financial incentives on healthcare providers. <https://voxdev.org/topic/health-education/unexpected-effects-financial-incentives-healthcare-providers>.

### If most of our population is not in formal employment, how can we extend coverage to them?

Covering a large population share in the informal sector is a complex challenge—one that is especially likely to affect LMICs. The first step towards addressing this challenge is to get the question right.

- **The wrong question is: “How can we target the poor for subsidies and get everyone else to contribute to an insurance scheme?”** It is wrong because it assumes that the only path to UHC is through a contributory insurance scheme—effectively narrowing the range of policy options to one.
- **The right question is: “How can we reduce barriers to effective service use and improve financial protection for the poor and other people in the informal sector, while strengthening the foundations for ongoing improvement?”** From this perspective, many policy options exist within and beyond the scope of health financing. Various approaches have succeeded. Barriers in getting to health services—whether from labour force informality, poverty, gender, culture, ethnicity, living in a remote location or a combination of factors—can be tackled with a range of delivery strategies (an important agenda, if not yet a well-publicized one). Such access barriers cannot be overcome simply through health financing reforms that lower or eliminate payment at the point of service.

Within health financing, the choices for expanding coverage can be sorted into two broad approaches:

- *Noncontributory approaches*—the entitlement to benefits derives not from a specific contribution for coverage, but from some other factor such as residence, citizenship, age or poverty and vulnerability status.
- *Contributory approaches*—entitlement derives from a specific contribution made by or on behalf of each covered person.

What distinguishes noncontributory from contributory approaches is whether people’s contributions entitle them to services—not whether people contribute financially in some way. For example, noncontributory mechanisms are funded from tax revenues, so many of those benefiting may have contributed indirectly through value-added or excise taxes.

Generally, countries (and LMICs in particular) have had more success with noncontributory than with contributory

approaches. The conditions for contributory approaches to succeed are much more demanding. But of course, either approach can fail or succeed depending on the details of design and implementation.

### Noncontributory approaches (four options)

1. **Nontargeted coverage for everyone has proved viable mostly in high-income countries, and much more rarely in low- or middle-income countries.** High-income successes include Spain, Scandinavian countries and the United Kingdom; LMICs that have succeeded with this approach include Sri Lanka and, more recently, Ukraine. But the approach appears feasible for LMICs only under two conditions: a country needs a long history of supply-side development and sufficiently high population density that no one lives too far from a health facility. The Sri Lankan experience suggests, in addition, the value of having enough private providers that allow people who can pay for private care to do so, removing their “costs” while leaving their tax contributions in the universal system. Because an LMIC might meet these conditions, we mention the approach here. In practice, though, few LMICs have been able to translate the promise of such an arrangement into a reality of more equitable service coverage and financial protection for the population. Therefore, most LMICs should explore other options.

2. **Nontargeted inclusion of everyone outside the formal sector in an explicit coverage scheme, in a context where social health insurance (SHI) also exists for the formal sector, may yield some progress towards UHC.** This approach uses general budget revenues to fund coverage for the entire part of the population that is not affiliated to any formal sector SHI scheme. In many cases, the nontargeted coverage is a separate scheme, often because the beneficiaries of the formal sector scheme put up political resistance against a full merger (as in Mexico and Thailand). This approach has succeeded where both fiscal capacity and political support exist to gradually raise the per capita funding level for the fully subsidized population—enabling an equalization or near-equalization of benefits with those provided under the SHI scheme. Having a separate scheme, though not ideal in theory, has proved to be a step towards greater equity in some countries where the starting point was a highly inequitable system favouring the formal sector at the expense of the rest of the population.

3. **Targeted coverage of the poor and vulnerable groups for a broad set of benefits has been used in more fiscally constrained contexts—those where creating an explicit coverage mechanism for all people in the informal sector was not deemed possible.** This approach has yielded some progress towards UHC—for example, in Cambodia's Health Equity Funds and India's government-funded Health Insurance Programmes—but is no more than a step in the right direction. The reason is that such targeted approaches strand a “missing middle” of people who do not qualify for fully subsidized coverage, but also will not be affiliated to an explicit coverage programme. Implementation requires preidentifying who qualifies for subsidies or free care, typically through

means testing. This testing can be expensive and exceeds the scope of health sector responsibilities, yet in many countries, a social protection ministry already employs it for other purposes (such as case benefits or food assistance). Using such existing mechanisms is preferable to creating a new one solely for health benefits. Note that targeting is imperfect: the costs of refinement need to be balanced against the benefits of greater accuracy. Further, this coverage expansion approach tends to work only if the entitlement is explicitly reinforced by a provider payment mechanism—that is, a funded and incentivized fee exemption, as opposed to a mere declaration of fee elimination.

4. **Universalizing specific services or services in specific types of health facilities—meaning that certain defined services, or the services of certain facility types, are universally available to the population for little to no charge at the point of use—has been used by countries in very different contexts.** Avoiding the cost and complication of individual targeting, this approach appears in (for example) Burundi's free health centre services for women and children, and in Chile's defined guaranteed service package for everyone regardless of other insurance. Much like targeted coverage of the poor and vulnerable groups for comprehensive benefits (noncontributory approach 3), this approach tends to work only if backed by a provider payment method that is explicitly linked to the promised services.

### Contributory approaches (two options)

- **Nonsubsidized approaches—those that target the poor for a “full subsidy,” while hoping (or legally requiring) that the nonpoor informal sector will pay premiums—do not work.** Depending on the context, this approach may seek premiums from the nonpoor informal sector for a separate publicly managed scheme, for community based insurance schemes or for a national SHI scheme. It is an appealing approach to many policy makers and analysts because of the reality that not all persons who work in the informal sector are poor: some self-employed people could, indeed, contribute financially. But in practice, efforts to collect money on a regular basis from people who lack regular salaried employment face several hurdles. Basic problems of VHI markets are compounded, in many LMICs, by the scarcity of services (especially in rural areas): why prepay for insurance if services are not physically available? And while not all countries are fiscally able to fund a comprehensive package for all, a country that provides budget-funded coverage for the poor but not for middle income earners should have realistic expectations—prepayments from this “missing middle” will be neither high nor stable, so individual contributions from it cannot do much to fill funding gaps. Fundamentally, the matter at issue here is tax collection: the health sector cannot be expected to be better at collecting contributions from nonpoor informal sector workers than the national tax authorities do at collecting personal income tax from this group. So if a country chooses a nonsubsidized approach to extend coverage to the nonpoor informal sector, the results will likely be disappointing, and no one should be surprised.

- **Subsidized approaches**—which explicitly seek to affiliate everyone to a health insurance scheme, using subsidies both to reach those who cannot pay at all (full subsidy) and to encourage affiliation by those deemed capable of some contribution—are seen in high-income countries with SHI, but do not appear promising for LMICs. This option either subsidizes the whole insurance pool to enable universal affiliation (as in Hungary) or fully subsidizes the poor while partially subsidizing the self-employed (as in Japan and the Republic of Korea, where both groups are fairly small and tax systems are strong). For LMICs, universal affiliation through this approach has proved elusive, probably because the informal sector is large and enforcement capacity is limited: retaining enrolled individuals, so that their contributions can be relied on from year to year, is especially difficult.

Although subsidized contributory approaches—those described immediately above—can be challenging, two exceptional cases may suggest what is needed for these approaches to reach high affiliation in LMICs. These are China and Rwanda, which share four distinctive factors:

- **Subsidies are large.** The approach is explicitly complementary, recognizing the limits of dependence on individual contributions. Thus in China, the public contribution to the scheme (from both central and provincial governments), triggered when an individual enrolls, is about four times larger than the individual's contribution: that is, the government pays 80 percent.
- **Intermediaries are active.** The decision to join is not simply left to the relationship between an individual and the scheme. In both countries, local government officials actively promote affiliation. These officials either have financial incentives to raise enrolment (as in Rwanda) or are otherwise held accountable for achieving a high enrolment rate for their population (as in China).
- **Affiliation is compulsory, not voluntary.** The government's strong commitment to affiliating the population, and its ability to make this happen, makes enrolment and the related contribution function almost like a tax. The pressure to comply is strong. In Rwanda, individual participation is legally compulsory, while in China, it is technically voluntary but in practice compulsory.
- **There is an enabling political context.** In both China and Rwanda, central governments can direct local government behaviour and enforce quasi-compulsory arrangements. This factor is not easily replicable in countries with different political systems.

Although one country's political context does not reflect another's, the lessons from China and Rwanda about the need for large subsidies and the importance of active intermediaries may be adaptable to countries pursuing a contributory approach to extending coverage. That said, in most countries contributory approaches have not worked very well. Their value may lie in the implementation process, which often links a new contribution with the creation of a new—ideally strategic—purchasing agency. Overall, however, the evidence indicates that noncontributory approaches have been more successful in extending coverage to people in the informal sector. And no approach has successfully extended coverage without a strong, clearly defined role for general budget revenues.

Perhaps most fundamentally, all options should be considered—and progress towards UHC should not be interpreted simply to mean that more people have a health insurance card.

### Key references:

- Kutzin J, Yip W, Cashin C (2016): Alternative Financing Strategies for Universal Health Coverage. *World Scientific Handbook of Global Health Economics and Public Policy*: pp. 267-309. [http://www.who.int/health\\_financing/documents/alternative-strategies-for-uhc/en/](http://www.who.int/health_financing/documents/alternative-strategies-for-uhc/en/).
- Meessen, B, D Hercot, M Noirhomme, V Ridde, A Tibouti, CK Tashobya, L Gilson (2011). Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries. *Health Policy and Planning* 26(suppl 2):ii164-ii29. [https://academic.oup.com/heapol/article/26/suppl\\_2/ii16/641431](https://academic.oup.com/heapol/article/26/suppl_2/ii16/641431).
- Mathauer I, B Mathivet, J Kutzin (2017). "Free health care" policies: Opportunities and risks for moving towards UHC. Health Financing Policy Brief No. 2, Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/free-health-care-policies/en/](https://www.who.int/health_financing/documents/free-health-care-policies/en/).
- Knaul, FM, González-Pier, E, Gómez-Dantés, O, García-Junco, D, Arreola-Ornelas, H, Barraza-Lloréns, M, Sandoval, R, Caballero, F, Hernández-Avila, M, Juan, M, Kershenobich, D, Nigenda, G, Ruelas, E, Sepúlveda, J, Tapia, R, Soberón, G, Chertorivski, S, Frenk, J. 2012. The quest for universal health coverage: achieving social protection for all in Mexico. *The Lancet* 380(9849):1259-1279. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61068-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61068-X/fulltext).
- Tangcharoensathien, V, S Pitayarangsarit, W Patcharanarumol, P Prakongsai, H Sumalee, J Tosanguan, A Mills (2013). Promoting universal financial protection: how the Thai universal coverage scheme was designed to ensure equity. *Health Research Policy and Systems* 11:25. <https://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-11-25>.
- Bernal, N, M Carpio, T Klein (2015). The effects of access to health insurance for informally employed individuals in Peru. Netspar Discussion Paper No. 02/2015-023. [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2649928](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2649928).
- Mathauer I, B Mathivet, J Kutzin (2017). Community Based Health Insurance: how can it contribute to progress towards UHC? Health Financing Policy Brief No. 3, Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/community-based-health-insurance/en/](https://www.who.int/health_financing/documents/community-based-health-insurance/en/).
- Annear, PL, Ahmed, S, Ros, CE, Ir, P. 2013. Strengthening institutional and organizational capacity for social health protection of the informal sector in lesser-developed countries: a study of policy barriers and opportunities in Cambodia. *Social Science and Medicine* 96:223-231. <https://www.sciencedirect.com/science/article/pii/S0277953613000889>.
- La Forgia, G and Nagpal, S. 2012. *Government-sponsored Health Insurance in India: Are You Covered?* Directions in Development series. Washington, DC: The World Bank. <http://documents.worldbank.org/curated/en/644241468042840697/Government-sponsored-health-insurance-in-India-are-you-covered>.
- Bitran, R (2013). Explicit health guarantees for Chileans: The AUGÉ benefits package. Universal Health Coverage (UNICO) Studies Series 21. Washington, DC: the World Bank. <http://documents.worldbank.org/curated/en/308611468014981092/Explicit-health-guarantees-for-Chileans-the-AUGE-benefits-package>.
- Vilcu I, L Probst, D Bayarsaikhan, I Mathauer (2016). Subsidized health insurance coverage of people in the informal sector and vulnerable population groups: Trends in institutional design in Asia. *International Journal of Equity in Health* 15(165):1-29. <https://equityhealthj.biomedcentral.com/track/pdf/10.1186/s12939-016-0436-3>.
- Mathauer I and T Behrendt (2017). State budget transfers to Health Insurance to expand coverage to people outside formal sector work in Latin America, BMC Health Services and Research 17(145):1-25. <https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-017-2004-y>.

- Bonfrer, I, R Soeters, E Van de Poel, O Basenya, G Longin, F van de Looij, E van Doorslaer (2014). Introduction of performance-based financing In Burundi was associated with improvements in care and quality. *Health Affairs* 33(12):2179-2187. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0081>.
- Kutzin J, Yip W, Cashin C (2016): Alternative Financing Strategies for Universal Health Coverage. *World Scientific Handbook of Global Health Economics and Public Policy*: pp. 267-309. [http://www.who.int/health\\_financing/documents/alternative-strategies-for-uhc/en/](http://www.who.int/health_financing/documents/alternative-strategies-for-uhc/en/).
- Acharya, A, Vellakkal, S, Taylor, F, Masset, E, Satija, A, Burke, M, Ebrahim, S. 2012. The impact of health insurance schemes for the informal sector in low- and middle-income countries: a systematic review. *World Bank Research Observer* 28(2):236-266.
- Baeza, CC and TG Packard. 2006. *Beyond Survival: Protecting Households from Health Shocks in Latin America*. Washington, DC and Palo Alto, California: The World Bank and Stanford University Press. <https://elibrary.worldbank.org/doi/abs/10.1596/978-0-8213-6571-7>.
- Bitran, R. 2014. Universal Health Coverage and the Challenge of Informal Employment: Lessons from Developing Countries. HNP Discussion Paper. Washington, DC: The World Bank. <https://openknowledge.worldbank.org/handle/10986/18637>.
- Hou, Z, Van de Poel, E, Van Doorslaer, E, Yu, B, Meng, Q. 2012. Effect of NCMS coverage on access to care and financial protection in China. Tinbergen Institute Discussion Paper TI 2012-039/3, and Working Paper 09, Health Equity and Financial Protection in Asia Project. [http://www.bmg.eur.nl/fileadmin/ASSETS/bmg/english/HEFPA/Publications/Working\\_Papers/HEFPA\\_WP\\_09.pdf](http://www.bmg.eur.nl/fileadmin/ASSETS/bmg/english/HEFPA/Publications/Working_Papers/HEFPA_WP_09.pdf).
- Ikegami, N, Yoo, B-K, Hashimoto, H, Matsumoto, M, Ogata, H, Babazono, A, Watanabe, R, Shibuya, K, Yang, B-M, Reich, MR, Kobayashi, Y. 2011. Japanese universal health coverage: evolution, achievements and challenges. *The Lancet* 378(9796):1106-1115. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)60828-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60828-3/fulltext).
- Sekabaraga, C, F Diop, A Soucat (2011). Can innovative health financing policies increase access to MDG-related services? Evidence from Rwanda. *Health Policy and Planning* 26(suppl. 2):ii52-ii62. [https://academic.oup.com/heapol/article/26/suppl\\_2/ii52/ii62](https://academic.oup.com/heapol/article/26/suppl_2/ii52/ii62)
- Meng Q, A Mills, L Wang, Q Han (2019). What can we learn from China's health system reform? *British Medical Journal* 365:l2349. doi: <https://doi.org/10.1136/bmj.l2349>

### Estimates by international organizations suggest that my country has a big funding gap, and UHC looks unaffordable—what should we do?

The estimates of what is needed to reach the targets for UHC set in the SDGs will be difficult to reach for many LMICs. But funding gaps should not drive health financing policy or distract decision-makers from the evidence on what works and does not work in health financing reform for UHC.

Also important is to avoid conflating the international targets and indicators set for “achieving UHC” with the practical concept of “moving towards UHC”. Any country, whatever its starting point, can make progress on reducing unmet need and reducing financial hardship from OOPS. To be sure, strong evidence shows that increased public spending on health yields better service coverage and financial protection—but equally strong evidence shows that at any given level of health spending, countries vary considerably in their coverage achievements. Efficient and equitable resource use matters. Therefore, health financing reform should not be reduced to an accounting exercise focused on merely filling the gap between estimated

needs and available revenues. Such an approach is based on a false premise of “achievement” rather than a practical focus on progress, and it can divert attention away from the reforms needed to improve efficiency and equity of resource use—whatever the level of funding.

No matter how large the gaps between a country's available public resources and the funding deemed necessary to achieve UHC targets, such gaps should never spark a desperate employment of solutions that have been shown not to work. Indeed, the concern that a government lacks the fiscal capacity to reach internationally defined spending targets has often been used as an opportunity to promote voluntary, private approaches—sometimes under the ill-defined label of “innovative financing”—despite the approaches' failing track record. The proven failures of voluntary, private financing explains why high-income countries rely chiefly on public (“traditional”) funding as the main revenue source for their systems. While contexts vary, these fundamental lessons about the limits of private financing apply everywhere.

In reflecting on how to respond to funding gaps, policymakers should follow four guidelines:

- **Use country-specific analysis and data.** Never compare country-specific revenue scenarios with global health spending targets, as these global targets are averages, not country-based approaches to organize service delivery. Looking at global targets often leads to findings that call for a doubling (or more) of health budgets from year to year—a nonstarter in discussions with finance ministries. However, benchmarking your country against the expenditure levels and reforms of other countries with similar income levels or in the same region may be valuable for advancing the fiscal dialogue.
- **Understand your cost structure, and identify the real gaps.** Country-specific cost analysis is essential for identifying inefficiencies along with the key input constraints that make scaling up a challenge. The next step is to set priorities for government action: addressing inefficiencies and scaling up services are more urgent than attaining a single measure of need. Many resource shortfalls in LMICs (relative to where these countries would like to be) are in the health workforce—and such shortfalls cannot be bridged in one year through a budget increase. They instead require a clear, long-term strategy for expansion, informed by good cost data.
- **Don't try to do the finance ministry's job.** Progress towards UHC requires strong public revenues. Where tax capacity is weak, the priority for the country (and not merely for UHC) is to strengthen that capacity. The job of health policy leaders—since they cannot presume to act as tax authorities—is to get their own house in order, making the use of public resources more efficient and equitable and making the results of health reform transparent to the public. Once this approach—policy, planning and budgeting and reporting results—is routine and embedded within a realistic fiscal space analysis, the health sector will be in a better position to argue for more funding.
- **Focus on progress, not “achievement.”** No country in the world is finished with health reform for UHC—none has completely eliminated problems of quality, access

and financial protection. Countries should embrace a dynamic perspective, seeing UHC not as a threshold to cross, but as a set of goals and objectives on which to keep improving. This means giving priority to reducing unmet need and financial hardship: don't ask "What do we need?" but "What can we do?" It also means strengthening the system's foundations, putting it in a better position to use future resources more effectively.

---

### Key references:

- Jowett M, MP Brunal, G Flores, J Cylus (2016). Spending targets for health: no magic number. Geneva: World Health Organization. Health Financing Working Paper No. 1. [https://www.who.int/health\\_financing/documents/no-magic-number/en/](https://www.who.int/health_financing/documents/no-magic-number/en/).
- Pan American Health Organization. Espacio Fiscal Para la Salud en América Latina y el Caribe (Fiscal Space for Health in Latin America and the Caribbean) (2018). Washington, DC: Pan American Health Organization. <http://iris.paho.org/xmlui/handle/123456789/34947>.
- Cid Pedraza C, JP Pagano C Pescetto, L Prieto (2018). Espacio fiscal para el financiamiento sostenible de los sistemas de salud y la salud universal. *Rev Panam Salud Publica* 42:e197. <http://iris.paho.org/xmlui/handle/123456789/49723>.
- Stenberg, K, O Hanssen, T Tan-Torres Edejer, M Bertram, C Brindley, A Meshreky, JE Rosen, J Stover, P Verboom, R Sanders, A Soucat (2017). Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *The Lancet* 5(9):E875-E887. [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30263-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext).

## II. The details: key aspects of health financing reforms for UHC

### 1. REVENUE SOURCES

#### What types of revenue make up health funding?

Funding sources for the health system fall into three categories—public, private and external. The mechanisms by which funds are contributed determine how each source is classified.

*Public revenues* derive from various forms of taxation, including taxes on individual income or wealth (such as property taxes); taxes on consumption (such as value-added or excise taxes, for example on tobacco products); taxes on the profits and assets of firms or corporations; and taxes on international trade (such as import tariffs). Revenues from state-owned enterprises also form part of public revenues. Social health insurance (SHI) contributions are also taxes—typically on wages, levied on employers and employees and termed payroll taxes—but are managed separately from general government revenues. An SHI payroll tax is an earmarked tax: the law requires that the revenues be used specifically to fund health services.

*Private revenues* derive from two main mechanisms: direct payments by individuals for health services at the point of use, referred to as out-of-pocket spending (OOPS), and voluntary prepayments for health insurance. Voluntary prepayments are managed typically by private companies but in some cases by governments, local communities, nongovernmental organizations or other not-for-profit entities.

*Revenues from external sources*, which may flow through government or nongovernment intermediaries, include development assistance for health, foreign direct investment and remittances. The character of such revenues as a “source” must be distinguished from how they are actually spent. For example, development assistance often effectively contributes to public spending on health—flowing through government, usually though not always “on budget” (managed using standard government systems). But in many countries, external support also flows to nongovernmental organizations and other private entities, and when this happens,

it is a source of private health spending. Like revenues from domestic taxes, revenues from external sources may be given specifically for the health sector (that is, they may be earmarked for health), or they may be provided as general budget support that the government then allocates across different sectors.

The relative size of each contribution mechanism depends both on public policy priorities and on the capacity of domestic public finance systems to tax individuals and firms (or corporations). Each mechanism has implications for policy objectives, especially for equity in finance—how the burden of funding the health system is distributed.

#### Sources:

- OECD, Eurostat, WHO. 2011. *A System of Health Accounts*. Paris: OECD Publishing. <https://www.who.int/health-accounts/methodology/en/>.
- Xu, K, A Soucat, J Kutzin, C Brindley, E Dale, N Van de Maele, T Roubal, C Indikadahena, H Toure, V Cherilova (2018). New perspectives on global health spending for universal health coverage. Geneva: World Health Organization. [http://www.who.int/health\\_financing/documents/health-expenditure-report-2017/en/](http://www.who.int/health_financing/documents/health-expenditure-report-2017/en/).
- Xu, K, A Soucat, J Kutzin, C Brindley, N Van de Maele, H Toure, M Aranguren Garcia, D Li, H Barroy, G Flores Saint-Germain, T Roubal, C Indikadahena, V Cherilova (2018). Public spending on health: a closer look at global trends. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/health-expenditure-report-2018/en/](https://www.who.int/health_financing/documents/health-expenditure-report-2018/en/).
- Jowett, M and J Kutzin (2015). Raising revenues for health in support of UHC: strategic issues for policy makers. Health Financing Policy Brief No. 1. Geneva: World Health Organization. [http://apps.who.int/iris/bitstream/10665/192280/1/WHO\\_HIS\\_HGF\\_PolicyBrief\\_15.1\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf?ua=1).
- Cashin, C, S Sparkes, D Bloom (2017). Earmarking for health: From theory to practice. Health Financing Working Paper No. 5. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/earmarking-for-health/en/](https://www.who.int/health_financing/documents/earmarking-for-health/en/).

## Which matters more for UHC: total spending on health, or public spending on health?

For progress towards UHC, public spending is the better bet. Even though the use of health services rises with household income, health systems should not rely heavily on private spending: doing so has been shown to result in large service coverage gaps, unmet need and financial hardship. In private markets, people with low income or with medical conditions requiring regular treatment often cannot afford the expensive services that they need.

No country has made significant progress towards UHC without relying on public funds as the predominant funding source. As public funds grow and are effectively used, the population is generally better protected against financial hardship and has better access to health services. Across countries, private spending—especially OOPS—as a share of total health spending declines when public spending as a share of GDP increases. In addition, the incidence of catastrophic health spending tends to be lowest where public spending as a share of total health spending is highest. And generally (despite large variations across countries), more public spending is associated with less impoverishment resulting from OOPS. Overall financial protection is driven, for the most part, by a country's reliance on public spending for health; but how the money is pooled, allocated and spent also matters.

The failure of private financing arrangements to expand coverage to the most vulnerable appears in countries at all levels of development. It explains why most high-income countries rely mainly on public funding sources—and why most also limit the extent and scope of private spending through regulation and other policy measures. As other countries recognize the fundamental importance of public revenues to make progress towards UHC, more and more are taking explicit steps towards principally relying on public funding.

### Key references:

- Xu, K, A Soucat, J Kutzin, C Brindley, N Van de Maele, H Toure, M Aranguen Garcia, D Li, H Barroy, G Flores Saint-Germain, T Roubal, C Indikadahena, V Cherilova (2018). Public spending on health: a closer look at global trends. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/health-expenditure-report-2018/en/](https://www.who.int/health_financing/documents/health-expenditure-report-2018/en/).
- Barroy H, Vaughan K, Tapsoba Y, Dale E, Van de Maele N. Towards universal health coverage: thinking public. Overview of trends in public expenditure on health (2000–2014). Geneva: World Health Organization, 2017.
- Jowett, M and J Kutzin (2015). Raising revenues for health in support of UHC: strategic issues for policy makers. Health Financing Policy Brief No. 1. Geneva: World Health Organization. [http://apps.who.int/iris/bitstream/10665/192280/1/WHO\\_HIS\\_HGF\\_PolicyBrief\\_15.1\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf?ua=1).

## What should public revenue raising arrangements achieve—beyond bringing in more money?

Sustainable health financing for UHC requires more than just increased public spending—it also requires *predictability* and *stability* in these revenues. In turn, these attributes are enablers for greater *efficiency* in how the revenues are used.

Predictability is a key policy objective for revenue raising: challenges arise if the revenues provided (whether from domestic public or external sources) differ greatly from those planned. Realistic planning should be possible within a medium-term expenditure framework—say, for a three-year period—that is linked to the annual budget process and routinely updated and monitored.

Stability is the other key objective: revenue flows from the government budget to the health sector, and ultimately to frontline service providers, must be consistent. Long interruptions of these flows cause input shortages and prevent staff payments. As a result, the delivery of promised services is undermined, since expected inputs are unavailable and informal payments to providers may become prevalent.

A country's public financial management (PFM) arrangements—how budgets are allocated, used and accounted for—in the health sector are a key determinant of both predictability and stability. In addition, improving PFM can add fiscal space for health expansion: strong and aligned PFM systems can effectively boost revenue by making the allocation and spending of health sector funds more efficient.

Although the efficient use of funds lies outside the domain of revenue raising, health financing reform can benefit from policy alignments (linkages) that promote efficiency. If revenues are poorly planned and poorly aligned with sector priorities, or if budgets are incompletely executed, waste or underspending will result and effectively reduce fiscal space. Improving how budgets are structured represents an opportunity to get better results from available revenues: waste is more likely when budgets are planned and allocated by rigid inputs. If budget execution is chronically incomplete, corrections enhancing execution can direct resources to priority services and needs, freeing up mobilized resources for health. For all these reasons, any strategy of fiscal space for health realization should systematically integrate PFM improvements.

### Key references:

- Junquera-Varela RF, Verhoeven M, Shukla G, Haven B, Awasthi R, Moreno-Dodson B: Strengthening domestic resource mobilization: moving from theory to practice in low-and-middle-income countries. Directions in Development. Washington DC: World Bank, 2017 <http://documents.worldbank.org/curated/en/970941498201633115/pdf/116658-PUB-Date-6-16-2017-PUBLIC.pdf>.
- Cashin, C, D Bloom, S Sparkes, H Barroy, J Kutzin, S O'Dougherty (2017). Aligning public financial management and health financing. Health Financing Working Paper No.4. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/aligning-pfm-health-financing/en/](https://www.who.int/health_financing/documents/aligning-pfm-health-financing/en/).
- Barroy, H, E Dale, S Sparkes, J Kutzin (2018). Budget matters for health: key formulation and classification issues. Health Financing Policy Brief No. 4. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/making-budgets-work-uhc/en/](https://www.who.int/health_financing/documents/making-budgets-work-uhc/en/).
- Barroy, H, G Kabaniha, C Boudreaux, T Cammack, N Bain (2019). Leveraging PFM for better health in Africa: key bottlenecks and opportunities for reform. Health Financing Working Paper No. 14. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/workingpaper14/en/](https://www.who.int/health_financing/documents/workingpaper14/en/).
- Barroy, H, L Musango, J Hsu, N Van de Maele (2016). Public financing for health in Africa: from Abuja to the SDGs. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/public-financing-africa/en/](https://www.who.int/health_financing/documents/public-financing-africa/en/).

## What are the policy implications of various revenue sources?

In debates on health financing reform, the mix of revenue sources is often a central topic. But public policy decisions about this mix are driven by public finance and macroeconomic concerns—not health sector considerations.

Still, anyone working on health financing in a given country should understand revenue sources and their implications, along with the country's *fiscal context*—its specific constraints for mobilizing more public resources through various mechanisms. In any country with high informal employment and limited capacity to tax individuals, individual prepaid contributions (whether nominally mandatory or explicitly voluntary) offer very limited revenue potential; the evidence is overwhelming that this is a false path towards UHC. Authorities in such contexts must rely mainly on general budget revenues to drive progress towards UHC.

How public revenues are raised is important for progress towards UHC, because some revenue sources are more equitable than others. Analysis shows that payroll taxes tend to be proportionate (neither regressive nor progressive); income and corporate taxes tend to be progressive; and value-added taxes (VATs), like other consumption taxes, tend to be somewhat regressive. But these patterns can vary depending on each contribution mechanism's share in the total, as well as on how a mechanism is designed. For example, excluding basic food items from a VAT can make it less regressive—or even progressive. And payroll taxes often become regressive when caps or ceilings limit contributions from higher earners. Even OOPS and voluntary insurance sources can appear progressive to the extent that poorer people are unable to pay (which may imply inequities in service use)—or if targeting mechanisms effectively protect the poor, while allowing self-selection for paid services by the rich.

The greatest challenge for many LMICs, however, is not choosing the mix of revenue sources but rather the government's fundamental ability and willingness to collect taxes. Many such countries suffer from poor tax administration, in some case aggravated by generous tax exemptions to specific sectors. For these countries, progress towards UHC will depend critically on improved tax collection, following recommendations such as those in the Addis Ababa Action Agenda on Financing for Development.

---

### Key references:

- Jowett, M and J Kutzin (2015). Raising revenues for health in support of UHC: strategic issues for policy makers. Health Financing Policy Brief No. 1. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/revenue\\_raising/en/](https://www.who.int/health_financing/documents/revenue_raising/en/).
- United Nations (2015). Addis Ababa Action Agenda of the Third International Conference on Financing for Development. New York: United Nations. <https://sustainabledevelopment.un.org/index.php?page=view&type=400&nr=2051&menu=35>.
- Mathauer, I and J Kutzin (2018). Voluntary health insurance: potentials and limits in moving towards UHC. Health Financing Policy Brief No. 5. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/voluntary-health-insurance/en/](https://www.who.int/health_financing/documents/voluntary-health-insurance/en/).
- Sagan, A and S Thomson (2016). Voluntary health insurance in Europe: role and regulation. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/voluntary-health-insurance-in-europe-role-and-regulation-2016>.

Pan American Health Organization. Espacio Fiscal Para la Salud en América Latina y el Caribe (Fiscal Space for Health in Latin America and the Caribbean) (2018). Washington, DC: Pan American Health Organization. <http://iris.paho.org/xmlui/handle/123456789/34947>.

## Should we shift our emphasis to social health insurance (SHI) contributions?

Generally, no. In an LMIC with low formal sector employment, traditional social health insurance contributions (payroll taxes) cannot provide significant revenues for health. Some such countries have limited SHI to formal sector employees—but this approach has generally widened inequalities in service use and financial protection. And while some middle- and higher-income countries rely mainly on SHI contributions, many of these countries have broadened the funding base beyond taxes on labour, in view of their aging populations as well as concerns about employment and competitiveness. So, there is growing recognition of the need to diversify public revenue sources in these countries as well.

These experiences do not mean that countries cannot or should not have an entity called a social health insurance fund. But for progress on UHC, it does mean that such funds should not rely mainly on wage-based contributions. Instead, they should be financed through transfers from other kinds of taxes—possibly including both general and earmarked revenues—to enable coverage of people outside the formal sector.

Like other decisions on public revenue sources, the question of whether and how much to tax labour is a question of economic and fiscal policy—not just of health policy.

---

### Key references:

- Jowett, M and J Kutzin (2015). Raising revenues for health in support of UHC: strategic issues for policy makers. Health Financing Policy Brief No. 1. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/revenue\\_raising/en/](https://www.who.int/health_financing/documents/revenue_raising/en/).
- Szigeti, S, T Evetovits, J Kutzin, P Gaál (2019). Tax-funded social health insurance: an analysis of revenue sources, Hungary. *Bulletin of the World Health Organization* 97:335-348. <https://www.who.int/bulletin/volumes/97/5/18-218982/en/>.
- Xu, K, A Soucat, J Kutzin, C Brindley, E Dale, N Van de Maele, T Roubal, C Indikadahena, H Toure, V Cherilova (2018). New perspectives on global health spending for universal health coverage. Geneva: World Health Organization. [http://www.who.int/health\\_financing/documents/health-expenditure-report-2017/en/](http://www.who.int/health_financing/documents/health-expenditure-report-2017/en/).
- Savedoff, WD (2004). Is there a case for social insurance? *Health Policy and Planning* 19(3):183-184. <https://academic.oup.com/heapol/article/19/3/183/774149>.
- Yazbeck, AS, WD Savedoff, W Hsiao, J Kutzin, A Soucat, A Tandon, A Wagstaff, WC-M Yip (forthcoming). The Case Against Labor-Tax Financed Social Health Insurance for Lower Income Countries. *Health Affairs*.
- Cylus J, T Roubal, P Ong, S Barber (2019). Sustainable health financing with an ageing population: Implications of different revenue raising mechanisms and policy options. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/policy-briefs-and-summaries/sustainable-health-financing-with-an-ageing-population-implications-of-different-revenue-raising-mechanisms-and-policy-options-2019>.

## Do any fiscal policy decisions fall within the competence of health sector policy-makers?

Because fiscal space for health derives chiefly from changes in revenue policies, primary interventions and responsibilities lie in the realm of the national finance authorities. Effective strategies for enhancing domestic revenue mobilization include broadening the base of existing taxes (including through a reduction in tax exemptions) and strengthening tax administration to improve efficiency and compliance. Most such strategies afford no role—or at most a small role—for health stakeholders.

Nevertheless, health policy makers should engage in policy making around revenue raising when it concerns taxes and subsidies that directly influence health. Beyond noting the objectives and constraints described above, health stakeholders and decision-makers need to make the case for certain tax and subsidy mechanisms and against others. Specifically, they should:

- **Support pro-health taxes.** Imposed on the consumption of products that harm health—notably tobacco, added sugar and alcohol—such taxes benefit health (their main objective), while they also bring the government added revenues.
- **Oppose anti-health subsidies.** The main subsidies that harm human health are those that promote fossil fuel consumption. In addition, many agricultural subsidies drive production and consumption in ways harmful to health.

While a country's tax authorities are charged with designing or refining tax and subsidy mechanisms, health stakeholders have an obligation to participate so that such policies will incorporate health considerations. When a health tax is to be designed, the type of tax becomes a critical consideration for both public finance and public health. The tax rate matters too; if too low, the tax measure might be ineffective in discouraging consumption or raising sufficient revenues. Given the importance of tax design for effectiveness, health stakeholders have a role in ensuring that health taxes are properly tailored to improve both public health and public finances as much as possible.

While supporting the introduction or refinement of particular tax policies, health stakeholders should remain cautious for two reasons. First, health taxes have generally provided only a limited fiscal contribution in most countries because of their intrinsically narrow base compared with other revenue sources. Second, the extra resources generated through health taxes could be offset by reductions in overall allocations to the health sector—earmarking the revenues for health may be effective initially, but the impact on total health sector funding tends to diminish over time due to such reallocation of discretionary revenues. Although evidence and metrics on this topic have not been consistently consolidated, the available country information suggests that fiscal gains from implementing health taxes are relatively marginal—generally below 1 percent of GDP.

Accordingly, in the dialogue with national finance authorities on revenue issues for health, no particular tax should be allowed to dominate the discussion and distract the health ministry (or other health sector advocates) from the bigger picture of overall allocations for the health sector. Any specific taxes should be embedded within that larger frame.

## Key references:

- Barroy, H, S Gupta, A Tandon (forthcoming). Fiscal space for health: new considerations for implementation. Geneva: World Health Organization.
- World Health Organization (2010). WHO technical manual on tobacco tax administration, Geneva: World Health Organization. [https://www.who.int/tobacco/publications/tax\\_administration/en/](https://www.who.int/tobacco/publications/tax_administration/en/).
- Allcott H, B Lockwood and D Taubinsky (2019). Should We Tax Sugar-Sweetened Beverages? An Overview of Theory and Evidence. *Journal of Economic Perspectives* 33(3):202–227. <http://www.nber.org/papers/w25842.pdf>.
- Thow, AM, S Jan, S Leeder, B Swinburn (2010). The effect of fiscal policy on diet, obesity and chronic disease: a systematic review. *Bulletin of the World Health Organization* 88(8):609–614. <https://www.who.int/bulletin/volumes/88/8/09-070987/en/>.
- Cashin, C, S Sparkes, D Bloom (2017). Earmarking for health: From theory to practice. Health Financing Working Paper No. 5. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/earmarking-for-health/en/](https://www.who.int/health_financing/documents/earmarking-for-health/en/).
- Sparkes, SP, JB Bump, EA Özçelik, J Kutzin, MR Reich (2019). Financing Common Goods for Health: A Country Agenda. *Health Systems & Reform*: 5(4). <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1633874>.
- Pan American Health Organization. Espacio Fiscal Para la Salud en América Latina y el Caribe (Fiscal Space for Health in Latin America and the Caribbean) (2018). Washington, DC: Pan American Health Organization. <http://iris.paho.org/xmlui/handle/123456789/34947>.
- Cid Pedraza C, JP Pagano C Pescetto, L Prieto (2018). Espacio fiscal para el financiamiento sostenible de los sistemas de salud y la salud universal. *Rev Panam Salud Publica* 42:e197. <http://iris.paho.org/xmlui/handle/123456789/49723>.

## Should budget priorities shift to give greater attention to health—and if so, how?

As stakeholders seek to expand resources for the health sector, considerable advocacy has focused on increasing the share of health spending in government budgets. An example of such efforts is the Abuja target: 15 percent of the government budget allocated to health.

In spite of this advocacy for more spending, low-income countries have recently reduced the share of their budgets allocated to the health sector. From 2000 to 2016, the share fell from 7.9 percent to 6.9 percent—even as the corresponding share in all other country income groups increased.

Why is the advocates' focus on health spending not reflected in budgets? One likely reason is that its prescriptive appeal has been misaligned with national allocation processes. Budgeting is a competitive decision making process in which the priority given to a particular sector depends on various factors. External resources, for example, can influence domestic budget priorities by encouraging countries to shift resources towards underfunded sectors. In low-income countries, donor funding per capita for health more than doubled over 2000–2015—from US\$ 4 to US\$ 10—but domestic health funding per capita instead remained around US\$ 7–US\$ 9. Another factor often reported in the health sector's budget deprioritization is poor engagement by health stakeholders in budget preparation and negotiation.

In the long run, a more effective way to promote sustained change in sector allocations is to engage more actively in defining multiyear budget proposals. Such

proposals must be results-oriented. They also must be well-designed and well-costed-out. Towards these ends, policy-makers should ensure that three elements are present:

- **Sustained political commitment to investment in the health sector.** High-level political commitment for more public investments in health often determines future budget allocations, even though it is rarely sufficient for real and sustained increases. Examples include bipartisan support for upgrading health coverage in Ghana, Burkina Faso's increased budget share for health to support free care programmes and Kenya's UHC presidential programme. For countries where such commitment has been lacking—as evidenced by a consistently low share of public spending allocated to health—a political response may be elicited in part by benchmarking against relevant countries (neighbouring countries, countries from the same region or countries with similar income).
- **Results-oriented policies and programmes.** Several countries have increased the health sector's budget share after the development and marketing of output-oriented budget proposals for increased health investment—proposals that were well-designed and well-costed-out. One example is Rwanda's expansion of service coverage through budget transfers to cover the poor. Another is Thailand's launch of its budget-funded universal coverage scheme.
- **Strengthened budgeting processes.** Engaging more actively in budget preparation through strengthening and aligning health planning, costing and budgeting processes may be an effective long-run strategy for health

stakeholders pursuing a sustained change in budget allocations. Special attention should also be paid to budget negotiation processes, in which the alignment of power, politics and technical preparation is likely to make the difference in getting a higher budget share dedicated to health.

---

### Key references:

- Barroy, H, S Gupta, A Tandon (forthcoming). Fiscal space for health: new considerations for implementation. Geneva: World Health Organization.
- Barroy, H, K Vaughan, Y Tapsoba, E Dale, N Van de Maele (2017). Towards UHC: thinking public. Health Financing Working Paper No. 7. Geneva: World Health Organization [https://www.who.int/health\\_financing/documents/towards-uhc/en/](https://www.who.int/health_financing/documents/towards-uhc/en/).
- Xu, K, A Soucat, J Kutzin, C Brindley, N Van de Maele, H Toure, M Aranguren Garcia, D Li, H Barroy, G Flores Saint-Germain, T Roubal, C Indikadahena, V Cherilova (2018). Public spending on health: a closer look at global trends. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/health-expenditure-report-2018/en/](https://www.who.int/health_financing/documents/health-expenditure-report-2018/en/).
- Tandon A, L Fleisher, R Li, WA Yap (2013). Reprioritizing government spending on health: pushing an elephant up the stairs? HNP Discussion Paper 85773. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/911331468331765809/Reprioritizing-government-spending-on-health-pushing-an-elf-phant-up-the-stairs>.
- Cid Pedraza C, JP Pagano C Pescetto, L Prieto (2018). Espacio fiscal para el financiamiento sostenible de los sistemas de salud y la salud universal. *Rev Panam Salud Publica* 42:e197. <http://iris.paho.org/xmlui/handle/123456789/49723>.
- Pan American Health Organization. Espacio Fiscal Para la Salud en América Latina y el Caribe (Fiscal Space for Health in Latin America and the Caribbean) (2018). Washington, DC: Pan American Health Organization. <http://iris.paho.org/xmlui/handle/123456789/34947>.

## 2. POOLING

### What is pooling?

*Pooling* is the accumulation of prepaid funds—from any or all of taxes, compulsory insurance contributions and voluntary prepayments—to be used on behalf of some or all members of a population, protecting them from the need to pay fully out of pocket for health services at the time of use. Such pooling spreads the risk of the costs of care across a group. The need for this in the health sector is largely driven by uncertainty about who will have a health condition requiring costly services (an uncertainty that does not apply to other sectors, such as education). All countries have some pooled funds, because all have at least some public financing for the health system.

Pooling is not just a function of something called an “insurance scheme”. Many different agencies can pool funds. Funds may be pooled in health ministries, in sub-

national governments, in national health programmes (such as those for HIV or tuberculosis), in social or national health insurance agencies and in for-profit or not-for-profit entities that manage voluntary health insurance.

### Sources:

- Kutzin, J (2001). “A descriptive framework for country-level analysis of health care financing arrangements.” *Health Policy* 56(3):171-204. <https://www.sciencedirect.com/science/article/abs/pii/S0168851000001494>.
- WHO (2010). World Health Report 2010: Health Systems financing: The path to universal health coverage. Geneva: World Health Organization. <https://www.who.int/whr/2010/en/>.

### We often hear about revenue raising and pooling together—so why treat pooling separately?

While revenue raising and pooling are often implemented by the same agency, they are two separate health financing functions. Revenue raising refers to the funding sources, or mechanisms whereby funds are contributed to the health system (see section II.1). This is important for understanding the question of “who pays” for the health system—and especially whether the overall contribution structure is equitable. Do the rich pay more, as a share of their capacity to pay, than do the poor, when considered across all the contribution mechanisms used in a country?

Pooling arrangements, in contrast, do not directly concern the question of who pays for the health system and whether the burden is distributed equitably. Instead, pooling has greater relevance to the question of “who gets” or “who benefits” from health spending—because the pooling structure sets the potential (the limits) for the extent to which prepaid funds can be redistributed across the population.

Many promising health financing reforms entail pooling funds from distinct revenue sources. The practice departs from historical patterns in many countries that linked each source to a separate pool—for example, general budget revenues may have been pooled and managed by a ministry of health, and social insurance contributions by a social health insurance agency. Indeed, pooling reforms can occur without any change in revenue raising.

Separating reform decisions on pooling from those on revenue raising is vital in settings with highly skewed income distributions. The separation enables coverage arrangements to extend beyond the traditional contributing groups—such as formal sector workers—by changing how general budget revenues flow through the system, and by pooling them with other sources of funds.

### Key references:

- Kutzin, J, S Shishkin, L Bryndová, P Schneider, P Hroboň (2010). Reforms in the pooling of funds. In Kutzin, J, M Jakab, C Cashin, Eds. *Implementing Health Financing Reform: Lessons from Countries in Transition*. Copenhagen, Denmark: World Health Organization, on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/implementing-health-financing-reform-lessons-from-countries-in-transition-2010>.
- Mathauer, I (2015): State budget subsidization of poor and vulnerable population groups in health insurance type schemes in low- and middle-income countries: A global overview and trends in institutional design. Prince Mahidol Awards Conference paper, Bangkok: Prince Mahidol Awards Conference. [https://www.who.int/health\\_financing/topics/budget-transfers/state-budget-transfers-pmac-short-paper2015.pdf](https://www.who.int/health_financing/topics/budget-transfers/state-budget-transfers-pmac-short-paper2015.pdf).
- Vilcu I, and I Mathauer (2016). State Budget Transfers to Health Insurance Systems for Universal Health Coverage: Institutional Design Patterns and Challenges of Covering Those outside the Formal Sector in Eastern European High-Income Countries, *International Journal of Equity in Health* 15(7):1-19. <https://equity-healthj.biomedcentral.com/articles/10.1186/s12939-016-0333-9>.
- Mathauer I, M Theisling, B Mathivet, I Vilcu (2016). Government Budget Transfers to Health Insurance Funds to Cover Vulnerable and Otherwise Uninsured Population Groups: Institutional Design and Challenges in Low- and Middle-Income Countries of the WHO European Region. *International Journal of Equity in Health* 15(57)1-20. <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0321-0>.
- Vilcu I, L Probst, D Bayarsaikhan, I Mathauer (2016). Subsidized health insurance coverage of people in the informal sector and vulnerable population groups: Trends in institutional design in Asia. *International Journal of Equity in Health* 15(165):1-29. <https://equityhealthj.biomedcentral.com/track/pdf/10.1186/s12939-016-0436-3>.
- Mathauer I, and T Behrendt (2017). State budget transfers to Health Insurance to expand coverage to people outside formal sector work in Latin America. *BMC Health Services and Research* 17(145):1-25. <https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-017-2004-y>.

## Why does pooling matter for UHC?

How funds are pooled has implications for both the goals and the intermediate objectives of UHC. To meet the population's health service and financial protection needs, prepaid funds must be redistributed. The central objective of pooling is to make the most of this redistributive capacity. When people with greater need of health services benefit most from prepaid funds, the distribution of system resources becomes more equitable, and the system also achieves greater equity in service use and financial protection.

Effective pooling may also lead to greater equity in funding the system—both to the extent that poorer persons have greater health needs, and also to the extent that pooling and revenue raising arrangements delink contributions from an individual's health risk. Finally, where the agencies that pool funds also purchase services (as in most health systems), pooling arrangements can affect health system efficiency. Multiple pools, for example, imply multiple and separate management structures and other administrative costs—a common cause of inefficiency associated with vertical programmes.

### Key references:

- WHO (2010). World Health Report 2010: Health Systems financing: The path to universal health coverage. Geneva: World Health Organization. <https://www.who.int/whr/2010/en/>.
- Baeza, CC and TG Packard (2006). *Beyond Survival: Protecting Households from Health Shocks in Latin America*. Washington, DC and Palo Alto, California: The World Bank and Stanford University Press. <http://documents.worldbank.org/curated/en/315921468202777133/Beyond-survival-protecting-households-from-health-shocks-in-Latin-America>.
- Kutzin, J (2001). "A descriptive framework for country-level analysis of health care financing arrangements." *Health Policy* 56(3):171-204. <https://www.sciencedirect.com/science/article/abs/pii/S016885100001494>.

## What makes for a good pooling structure?

For UHC objectives, three attributes of pooling arrangements are critical: *size*, *diversity* and *participation*.

- **Size.** The larger the pool, both in its funding and in the number of people served, the greater its redistributive capacity.
- **Diversity.** The population served by a pool should be diverse in its health risk, mixing relatively healthy with less healthy people. Health financing systems should distribute resources and services from the healthy to the sick, so both need to be in the same pool.
- **Participation.** Participation should be either compulsory or automatic. Compulsory participation means that a legal requirement exists for specific individuals, groups or the entire population to join the pool (linked to a mandatory contribution made by or on behalf of the covered persons). Automatic participation means that certain groups or the entire population are included in the pool on another basis such as poverty or vulnerability status, citizenship or residence, delinked from any specific contribution.

In cases where participation in a pool is voluntary—meaning that it is linked to a financial contribution, but the contribution is not mandatory—younger and healthier people tend not to join: they opt out, leaving the composition of those in the pool less healthy than the overall population. Pools are better able to promote UHC objectives if they are large, diverse in risk and compulsory or automatic in enrolment.

### Key references:

- Fuchs VR. 1996. What every philosopher should know about health economics. *Proceedings of the American Philosophical Society* 140(2):186-96. [http://static.steereads.com/papers\\_to\\_read/fuchs--what\\_every\\_philosopher\\_should\\_know\\_about\\_health\\_econ.pdf](http://static.steereads.com/papers_to_read/fuchs--what_every_philosopher_should_know_about_health_econ.pdf).
- Kutzin, J, S Shishkin, L Bryndová, P Schneider, P Hroboň (2010). Reforms in the pooling of funds. In Kutzin, J, M Jakab, C Cashin, Eds. *Implementing Health Financing Reform: Lessons from Countries in Transition*. Copenhagen, Denmark: World Health Organization, on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/implementing-health-financing-reform-lessons-from-countries-in-transition-2010>.
- Van de Ven, WPMM, K Beck, F Buchner, E Schokkaert, FT Schut, A Shmueli, J Wasem (2013). Preconditions for efficiency and affordability in competitive health care markets: are they fulfilled in Belgium, Germany, Israel, The Netherlands and Switzerland? *Health Policy* 109(3):226-245. <https://www.sciencedirect.com/science/article/abs/pii/S0168851013000122>.

## What is fragmentation in pooling, and why is it a problem?

A pool is fragmented when barriers hinder the redistribution of prepaid funds, dividing the population into two or more separate pools. The barriers imply that funds can be redistributed within a pool but not across pools. The fewer the barriers, the greater the redistributive capacity from a given level of prepaid funding—and, thus, the greater the potential for improving service coverage and financial protection.

Fragmentation can take many forms, including these examples (which are not mutually exclusive):

- The coexistence of multiple insurance funds and of separate budgets managed and allocated to providers by the health ministry.
- One or more vertical health programmes, each managing its own funds and allocating them to providers and services.
- Subnational government units managing separate health budgets.
- A social health insurance (SHI) fund serving the formal sector, coupled with funds managed by the health ministry or subnational governments serving the rest of the population.

Beyond fragmentation's constraints on redistributive capacity, in several low- and middle-income countries (and some high-income countries, such as the United States), pools are effectively organized by socioeconomic group. In such cases, certain pools serve higher-income people (as with SHI for the formal sector), while other pools serve

poorer people (often the budget managed by the ministry of health). Typically, the pools that serve higher-income people have higher per capita public funding. An explicit inequity built into the design of the health system, this situation is termed *population segmentation*.

### Key references:

- WHO (2010). Fragmentation in pooling arrangements. Technical Brief No. 5. Geneva: World Health Organization. <http://www.who.int/healthsystems/topics/financing/healthreport/FragmentationTBNo5.pdf?ua=1>.
- Frenk J (1995). Comprehensive policy analysis for health system reform. *Health Policy* 32:257-77. <https://www.sciencedirect.com/science/article/abs/pii/S016885109500739F>.
- Londoño JL and J Frenk (1997). Structured pluralism: towards an innovative model for health system reform in Latin America. *Health Policy* 41(1):1-36. <https://www.sciencedirect.com/science/article/abs/pii/S0168851097000109>.
- McIntyre, D and J Kutzin (2016). Health financing country diagnostic: a foundation for national strategy development. Geneva: World Health Organization. [https://www.who.int/health\\_financing/tools/diagnostic/en/](https://www.who.int/health_financing/tools/diagnostic/en/).

### What are the reform options to address fragmentation or mitigate its consequences?

Countering fragmentation is possible but often difficult. The main difficulty is political: any reform that will change the distribution of existing resources is likely to encounter resistance from those who gain most from the existing arrangements.

Although the identification of feasible options will depend on a country's political context, four approaches have proved effective in different countries. They are:

- **Consolidation.** The most radical option merges existing schemes or pools into one. General budget transfers are used to ensure coverage for all.
- **Compensation.** This creates an explicit coverage scheme for people working outside the formal sector. Funding is increased to narrow the per capita funding differences between schemes for the formal and informal sectors.
- **Equalization.** Actions enable a flow of funds between pools or increase it (pooling across pools that were fragmented into different insurance funds or geographic areas). Ideally, compensation is provided for the relative risk of the populations covered by different pools.
- **Mitigation.** Actions reduce the effects of fragmentation beyond pooling reforms. An example is the harmonization of benefits, provider payment methods and information platforms across schemes. Such actions may also create a basis or impetus for future pool consolidation.

### Key references:

- Kutzin, J, S Shishkin, L Bryndová, P Schneider, P Hroboň (2010). Reforms in the pooling of funds. In Kutzin, J, M Jakab, C Cashin, Eds. *Implementing Health Financing Reform: Lessons from Countries in Transition*. Copenhagen, Denmark: World Health Organization,

on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/implementing-health-financing-reform-lessons-from-countries-in-transition-2010>.

- Ökem ZG, M Çakar (2015). What have health care reforms achieved in Turkey? An appraisal of the "Health Transformation Programme." *Health Policy* 119(9):1153-63. <https://www.sciencedirect.com/science/article/pii/S0168851015001633>.
- Jongudomsuk P, S Srithamrongsawat, W Patcharanarumol, S Limwattananon, S Pannarunothai, P Vapatanavong, K Sawaengdee, P Fahamnuaypol (2015). The Kingdom of Thailand: Health system review. Manila: World Health Organization on behalf of the Asia-Pacific Observatory on Health Systems and Policies. [http://www.searo.who.int/entity/asia\\_pacific\\_observatory/publications/hits/hit\\_thailand/en/](http://www.searo.who.int/entity/asia_pacific_observatory/publications/hits/hit_thailand/en/).
- Knaul, FM, E González-Pier, O Gómez-Dantés, D García-Junco, H Arreola-Ornelas, M Barraza-Lloréns, R Sandoval, F Caballero, M Hernández-Avila, M Juan, D Kershenobich, G Nigenda, E Ruélas, J Sepúlveda, R Tapia, G Soberón, S Chertorivski, J Frenk (2012). The quest for universal health coverage: achieving social protection for all in Mexico. *The Lancet* 380(9849):1259-1279. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61068-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61068-X/fulltext).
- Agustina R, T Dartanto, R Sitompul, KA Susiloretni, Suparmi, EL Achadi, A Taher, F Wirawan, S Sungkar, P Sudarmono, AH Shankar, H Thabrany (2019). Universal health coverage in Indonesia: concept, progress and challenges. *Lancet* 5:393(10166):75-102. <https://www.sciencedirect.com/science/article/pii/S0140673618316477>.
- Smith, PC (2008). Formula funding of health services: learning from experience in some developed countries. Discussion Paper No. 1. Geneva: World Health Organization. <https://apps.who.int/iris/handle/10665/85690>.
- Smith PC and SN Witter (2004). Risk pooling in Health Care Financing: The implications for Health System Performance. Health Nutrition and Population Discussion Paper. Washington DC: The World Bank. <https://openknowledge.worldbank.org/handle/10986/13651>.

### Are pooling reforms enough?

No. Pooling merely creates the potential for redistribution. Actual redistribution occurs when the money is spent. Accordingly, actions to reduce fragmentation in pooling must be aligned with purchasing and service delivery reforms.

In health reforms generally, acting on one dimension is unlikely to yield positive results and could make things worse. Pooling reforms are no different. For example, if a unified pool is created but provider payment is still driven by inputs—or even by service use—the unified pool may widen inequities by reinforcing existing patterns of human resource and service distribution. This does not mean that pools should remain fragmented, but rather that the supply-side and provider payment factors that are driving inequities should be addressed.

### Key references:

- Mahendradhata, Y, L Trisnantoro, S Listyadewi, P Soewondo, T Marthias, P Harimurti, J Prawira (2017). The Republic of Indonesia: Health system review. New Delhi: World Health Organization on behalf of the Asia-Pacific Observatory on Health Systems and Policies. [http://www.searo.who.int/entity/asia\\_pacific\\_observatory/publications/hits/Indonesia\\_HIT/en/](http://www.searo.who.int/entity/asia_pacific_observatory/publications/hits/Indonesia_HIT/en/).

### 3. BENEFIT DESIGN AND RATIONING

#### What is benefit design?

Benefit design policy is not just a list of services (including relevant medicines and diagnostics) to be funded—it includes related policy decisions that are important to sustain a country's progress towards UHC. In particular, benefit design includes decisions about what pooled public revenues will pay for, and under what restrictions or conditions of access.

A service or medicine may be fully subsidized and meant to be free at the point of service to the user. Or it may be partially subsidized, requiring the user to make a copayment (also referred to as a user fee). A commonly used condition of access is a requirement that users adhere to a defined referral mechanism: thus, nonemergency specialized or inpatient care may be covered *only if* the patient first seeks primary care. Such requirements may be further refined. For example, services may be covered at providers with which a user is

registered, but not covered elsewhere—or the user may be “less covered” (face higher copayments) for these services elsewhere.

Benefit design produces a population's benefit package—that is, its entitlements (services) and its obligations (such as copayments and referral requirements). Benefit design is thus broader than defining a list of health services or medicines to be funded; it constitutes one of several sets of policy decisions that must be aligned for countries to sustain progress towards UHC.

#### Source:

Kutzin, J (2001). “A descriptive framework for country-level analysis of health care financing arrangements.” *Health Policy* 56(3):171–204. <https://www.sciencedirect.com/science/article/abs/pii/S016885100001494>.

#### How are benefit design and rationing related?

All systems ration access to care, whether explicitly or implicitly (figure II.3.1). If a government is to explore the full range of policy options for progressing towards UHC, it must first recognize this fact.

In more organized systems that follow good practice, rationing is *explicit*: the government sets priorities among various services. For example:

- Explicit rationing occurs where pooled funds pay for some services only partially—for example, when patients must pay defined copayments or user fees (the terms are interchangeable) in order to receive a service.
- Explicit rationing occurs where a service has an official waiting list—especially if the service is covered but deemed not to be urgent (for example, elective surgery).
- Explicit rationing occurs where a service is excluded entirely from the publicly defined benefit package—someone who wants the service must pay for all of it.

In less organized systems that lack explicit service priorities, rationing is *implicit*. Implicit rationing can take several forms:

- Nonprice mechanisms may effectively ration services through the inputs and capacities available at various levels of the health system.
- Providers may ration services at the point of use by diluting, delaying or denying them as resources grow scarce.
- Price rationing may occur in systems that are not explicit about benefits and copayments, as users must make informal payments if they want to receive services.
- Price rationing will effectively occur in an unregulated market system, where the use of services depends on willingness and ability to pay—creating inequity in the ability to use needed services.

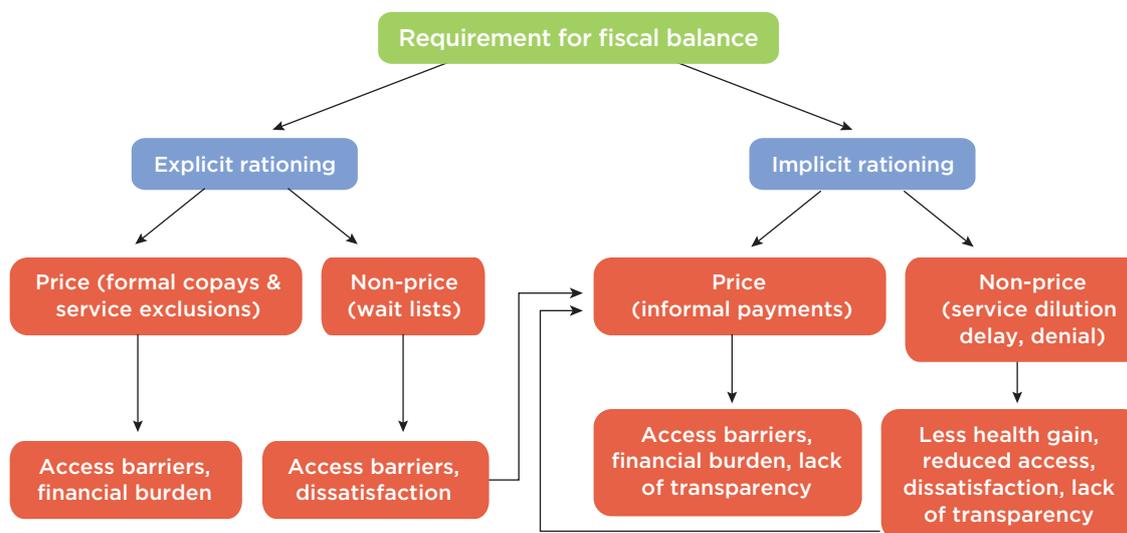
**Note that where services are explicitly rationed through copayments—that is, user fees—any policy on benefits is also a policy on fees.** Benefits are what the system will pay for from pooled, public funds. Therefore, copayments or user fees are what the system will not pay for. Such non-payment may be partial because a copayment is required for certain services, or total because services are entirely excluded from the package.

No system in the world pays in full for all possible health services and related products. Accordingly, every decision about what benefits to fund is also a decision about what not to fund (what services patients must pay for directly). Choices on the design of rationing measures such as copayments—as well as policies about how, where and to whom to apply these measures—are essential aspects of priority setting within health financing policy, and they need to be aligned with overall UHC goals.

In sum, because there is no escape from rationing, there is no escape from tradeoffs in the extent of services covered, in the quality of services possible with the inputs available or in the extent to which users must pay out of pocket. To manage these tradeoffs—and align policy design with UHC objectives—a health system should follow best practice and be explicit about both benefits and rationing.

#### Key references:

- Reinhardt UE (2019). *Priced Out: The Economic and Ethical Costs of American Health Care*. Princeton, New Jersey, USA: Princeton University Press. <https://press.princeton.edu/titles/30316.html>.
- Kutzin, J (2001). “A descriptive framework for country-level analysis of health care financing arrangements.” *Health Policy* 56(3):171–204. <https://www.sciencedirect.com/science/article/abs/pii/S016885100001494>.
- Fuchs, VR (1996). What every philosopher should know about health economics. *Proceedings of the American Philosophical Society* 140(2):186–96. [http://static.stevereads.com/papers\\_to\\_read/fuchs--what\\_every\\_philosopher\\_should\\_know\\_about\\_health\\_econ.pdf](http://static.stevereads.com/papers_to_read/fuchs--what_every_philosopher_should_know_about_health_econ.pdf).

**Figure II.3.1. Mechanisms and consequences of explicit and implicit rationing**

Source: Thomson, S, J Cylus, T Evetovits (2019).

Thomson, S, J Cylus, T Evetovits (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: World Health Organization, Regional Office for Europe. <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>.

### How can benefit design support progress towards UHC, and what should guide decision making in benefit design?

Benefit design can influence many policy goals and objectives, including:

- **Health gain, efficiency and financial protection.** The choice of services to prioritize, including the extent to which each service is covered (paid for with public funds), should reflect the impact of various services on health and financial protection—along with the value for money (efficiency) achieved in making progress on these goals. Benefits need to be considered not only from the perspective of the individual receiving services, but also with attention to their effects on others. This is the main reason systems should fully subsidize without user fees the prevention and treatment of communicable diseases.
- **Transparency.** A benefit package is a promise of service entitlements for the population. Accordingly, the design of service benefits and copayments and their communication to the population will make a system more or less transparent.
- **Alignment with the rest of health financing and service delivery.** Even a transparently communicated promise is just a promise: people need not only to understand their entitlements, but to realize them in practice. To enable effective service delivery, policies must ensure that funding is sufficient—and services actually avail-

able and of adequate quality—throughout the wider health system.

Public revenues should be spent on those services and related products that maximize progress towards health sector goals. For most countries, this means spending public money on services, medicines and products that will do the most to reduce unmet health needs, while also protecting patients as much as possible against catastrophic OOPS. These goals have a strong equity dimension: vulnerable population groups often require specific attention. In practice, then, several objectives need to be balanced and prioritized.

Countries increasingly define clear criteria and processes to guide benefit design—making decisions more evidence-based, systematic and transparent. Health system objectives have been envisioned as a “coverage cube” in three dimensions: service coverage, cost coverage and population coverage. Because trade-offs among the three dimensions are inevitable, benefit design should identify and manage the trade-offs through a technical and political process that considers data and evidence. For example, as key stakeholders seek agreement on priorities for services in the benefit package, their dialogue should incorporate evidence on the cost-effectiveness of newly proposed health interventions and the budgetary implications of these proposals. The processes and mechanisms for this should be institutionalized as a routine part of informing budgetary decision making and, ultimately, political decisions about priorities.

#### Key references:

- Terwindt, F, D Rajan, A Soucat (2016). Priority-setting for national health policies, strategies, and plans. In Schmets, G, D Rajna, S Kadandale, eds. *Strategizing national health in the 21st century: a handbook*. Geneva: World Health Organization. <https://www.who.int/healthsystems/publications/nhpsp-handbook/en/>.
- WHO Consultative Group on Equity and Universal Health Coverage (2014). Making fair choices on the path to universal health cov-

erage: final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization. [https://www.who.int/choice/documents/making\\_fair\\_choices/en/](https://www.who.int/choice/documents/making_fair_choices/en/).

Baltussen, R, MP Jansen, L Bijlmakers, N Tromp, AE Yamin, OF Norheim (2017). Progressive realisation of universal health coverage: what are the required processes and evidence? *BMJ Global Health* 2(3): e000342. doi:10.1136/bmjgh-2017-000342. <https://gh.bmj.com/content/2/3/e000342>.

Glassman A, U Giedion, PC Smith, eds. (2017). *What's in, what's out: designing benefits for universal health coverage*. Washington, DC: Center for Global Development. <https://www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage>.

Jowett, M, J Kutzin, M. Bertram et al (forthcoming). Benefit design: the perspective from health financing policy. Health Financing Policy Brief. Geneva: World Health Organization.

### Does being explicit help people understand their entitlements and obligations?

Yes, being explicit helps—and simplicity can be equally important. To help users understand a benefit package, the results of technical work to define that package must be conveyed in words that the population understands. Benefit design will not be effective if people need a medical degree to figure out whether their condition is covered.

When the population is unclear about its benefits, this unclearness itself becomes a barrier to access. It is also a problem for providers, who may be unsure what services they do or do not have to charge for, or which patients they should charge and how much. Similarly, when a large mismatch exists between promised and available benefits, services will be limited implicitly—that is, nontransparently. This situation is widespread in many countries. Patients may be asked to make unofficial payments, and services and medicines may prove unavailable or may become available only after unpredictable delays.

To communicate benefits explicitly and effectively for a particular purpose, full details on services and on user obligations (such as prices) may or may not be required. For example, the benefit “consultation at a health centre” is *explicit but not detailed*, and such simplicity often enhances understanding. The same is true of the statement that health centre visits are free, while hospital admissions require a copayment of €50. Such information is explicit, but it is not fully detailed—and it does not need to be.

In contrast, communications that are *both explicit and highly detailed* may be problematic. Examples include a list of diagnoses or symptoms covered at a particular health centre and a detailed fee schedule showing 100 prices. Such details will likely be too complex for the average person to understand. However, some detail can be added on specific primary care services if people are likely to understand them and the detail is likely to encourage their use: one example is immunization.

In sum, it is helpful to be explicit—but it is not always helpful to be highly detailed. Any communication strategy must keep in mind the essential objective of enabling people to understand their entitlements and obligations. In general, basic service benefits can be usefully defined by level of care (such as free health centre visits at primary level). Greater specificity is warranted to convey explicitly what is or is not included at referral levels of care, since such services typically require a diagnosis. Where inter-

ventions that are new or otherwise easily understood are included at primary level—for example, antiretroviral treatment or immunization—they can also be usefully specified.

One size will not fit all: there is no all-purpose approach. What matters is that messages to the population about benefits be understandable to the average person.

---

### Key references:

Jowett, M, J Kutzin, M. Bertram et al (forthcoming). Benefit design: the perspective from health financing policy. Health Financing Policy Brief. Geneva: World Health Organization.

### In a package with explicit user fees (copayments), how should the fees be designed?

As with any policy, the design of user fees should be guided by policy objectives and available evidence. The evidence on user fees is very clear: even low copayments are an obstacle to service use, and evidence does not support the belief that the requirement to pay will only deter “unnecessary” use of services. In addition, evidence shows that user fees cannot constrain health system costs without severe equity tradeoffs—fees pose large barriers for the poor. In contrast, provider incentives are far more powerful, and serious efforts to improve efficiency and manage cost growth should begin with these (see section II.4, below).

Given these objections, why impose user fees? Simply because public resources are not unlimited: in any honest policy that sets explicit priorities, some services will be covered by public funds only partially—or not at all. If a policy promises everything for free at the point of use but cannot fund everything, informal payments will result, reflecting a lack of transparency in the health system. So reformers need to design policies for rationing service access in a way that balances resource limitations with UHC objectives.

For this purpose, a simple copayment design works best. Copayments should be low and fixed. They should not follow a highly differentiated and complicated fee schedule. Most important, they should not be defined as a percentage of the price (sometimes called coinsurance). If patient charges are defined as a percentage, someone who needs more services must pay more for them—in effect, “the sicker you are, the more you pay”. This is directly opposed to equity and financial protection objectives. Percentage copayments also compromise transparency, since patients do not know how much they must pay until they receive the bill. Such uncertainty impedes seeking care.

A flat, fixed copayment is easy for people to understand and thus reduces uncertainty about fees. Other approaches that limit uncertainty and financial hardship include exemptions for poorer people and annual caps on individual copayment liability (especially valuable for patients with chronic conditions). However, individual means-tested exemptions and annual caps require a health facility to instantly link people seeking care with their exemption status or a summary of copayments made to date—presuming fairly advanced information systems that may be lacking in contexts with lower administrative capacity. In contrast, geographically targeted exemptions (such as free services in rural health centres), plus flat copayments in referral centres, are administratively easier—and in principle could be used anywhere.

In addition, if user fees (copayments) are used, the collected revenues should be retained entirely or mostly by the health facility—not returned to the public treasury. In countries where health facilities must return user fee revenues to the public treasury and have the fees counted against their overall budgets, several harmful effects have been observed. First, because the health facility gets no direct benefit from the fees, it is likely either not to collect them or to collect but not report them: OOPS is thus driven underground and becomes informal payment. Second, this approach essentially turns the health facilities into tax collectors, with user fees acting simply as a tax on the sick. Third, because reported fees count against the health facility's overall budget, the funding mix for health shifts undesirably towards OOPS: fee revenues replace tax revenues.

Enabling facilities to retain and use collected user fees (copayments)—while ensuring that these revenues supplement prepaid funds rather than replace them—can be an important step towards giving providers some managerial autonomy. Such autonomy is needed if, for example, reforms are introduced later to eliminate fees and replace them with a prepaid source—as in many PBF reforms that eliminate the financial barrier while maintaining the fees' productivity incentives.

What about the legitimate concern that facilities in richer regions will collect more than those in poorer regions? To mitigate this potential equity problem, countries should compensate the poorer facilities with more prepaid funds (for example, through larger budget allocations). They should not embrace the administrative expense and potentially harmful incentives of redistributing fee revenues.

The main drawback of fee retention is that it can make providers overly concerned with collecting revenues. Effectively using fee retention means setting up strong accountability mechanisms—as well as incentives—to ensure that the poor are served, and that the culture of provision does not orient itself more towards collecting cash rather than serving patients.

In short, mitigating at least some of the harmful effects of user fees requires that they be kept simple and clear and low- with protection for the most vulnerable, and with room for the health facilities that charge user fees to retain and use these revenues as a flexible resource.

---

### Key references:

- Thomson, S, J Cylus, T Evetovits (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: World Health Organization, Regional Office for Europe. <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>.
- Gilson, L, S Russell, K Buse (1995). The political economy of user fees with targeting: Developing equitable health financing policy. *Journal of International Development* 7(3):369–401. <https://onlinelibrary.wiley.com/doi/abs/10.1002/jid.3380070305>.
- Kutzin, J (1998). The appropriate role for patient cost-sharing. In Saltman, RB, J Figueras, C Sakellarides, eds. *Critical Challenges for Health Care Reform in Europe*. Buckingham, UK: Open University Press. <http://www.euro.who.int/en/publications/abstracts/critical-challenges-for-health-care-reform-in-europe-1998>.

### Why do promised benefits often exceed those actually received—and how can we make sure that promised benefits are delivered?

If promised benefits exceed those that are actually available, services will end up being rationed implicitly—that is, nontransparently. Services and medicines may become unavailable, or available with unpredictable delays. Patients may be asked to make unofficial payments. These problems are widespread.

To avoid such implicit rationing, a system must be both explicit and realistic about benefit entitlements—and must align service delivery, purchasing mechanisms and PFM processes. Also important is linking funding decisions with expected implementation budgets. We encourage the use of both cost-effectiveness and budget impact as decision criteria. But a benefit package has little value if it is unrealistic or is merely a declaration not translated into practice.

Many factors must therefore be coordinated to ensure the delivery of promised benefits. Critically, funds need to flow to high-priority services—something that often does not happen where purchasing is passive (see the next subsection) or where PFM processes do not match budgets to service or population priorities.

Why is funding for health services so often disconnected, in practice, from the priorities set by official government strategic documents? One reason is that under traditional line item budgeting systems, most public money flows to existing health facilities and staff—a pattern that may not reflect strategic policy approaches. The shift towards programme budgeting in health, and strategic purchasing more generally, aims to direct money towards priority services and to create incentives for higher service efficiency and quality.

---

### Key references:

- Thomson, S, J Cylus, T Evetovits (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: World Health Organization, Regional Office for Europe. <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>.
- Kutzin, J, C Cashin, M Jakab, A Fidler, N Menabde (2010). Implementing health financing reform in CE/EECCA countries: synthesis and lessons learned. In Kutzin, J, C Cashin, M Jakab, eds. *Implementing Health Financing Reform: Lessons from Countries in Transition*. Copenhagen, Denmark: World Health Organization, on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/implementing-health-financing-reform-lessons-from-countries-in-transition-2010>.

### If my country's system funds most services directly through the supply side—without imposing user fees (copayments)—does any role exist for benefit design?

Yes: to inform service delivery and make it more efficient. Benefit design is not only used to make entitlements explicit and readily understood. It is also used to decide which health interventions—clinical and nonclinical—should be provided by which staff in which facilities. So, even without

a purchaser-provider split, a benefit design analysis can inform allocation decisions and training to drive supply-side capacities.

Note that when a system budgets most services through the supply side, with no insurance fund and no explicit agency with defined responsibility for purchasing services, benefits may be implicitly rationed by being restricted to the services available at a given health facility. Such rationing reflects supply-side choices, which can incorporate technical processes for benefit design—notably health technology assessment.

---

**Key references:**

- Terwindt, F, D Rajan, A Soucat (2016). Priority-setting for national health policies, strategies, and plans. In Schmets, G, D Rajna, S Kadandale, eds. *Strategizing national health in the 21st century: a handbook*. Geneva: World Health Organization. <https://www.who.int/healthsystems/publications/nhpsp-handbook/en/>.
- Glassman A, U Giedion, PC Smith, eds. (2017). *What's in, what's out: designing benefits for universal health coverage*. Washington, DC: Center for Global Development. <https://www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage>.

## 4. STRATEGIC PURCHASING FOR HEALTH SERVICES

### What is purchasing, and how does it matter for health services?

In health financing, *purchasing* is the allocation of pooled funds to health service providers (a generic function). Because all health systems allocate funds to providers, all perform purchasing, even if it is not recognized or explicit. Purchasing involves choices about:

- **What to pay for.** This policy area includes benefit design (see II.3).
- **How to pay.** This decides provider payment methods.
- **Whom to pay.** This is often operationalized through decisions about which providers to contract with.

Just as funds can be pooled by various agencies, so with services: they can be purchased by health ministries, by public and private health insurance funds, by subnational governments that manage health budgets or by vertical programmes that allocate funds to service providers.

Purchasing differs from procurement. *Purchasing* refers specifically to health *services* (which may include medicines and other supplies used to provide care) that are provided to individuals (personal health services) and to groups (population-based health services). In contrast, *procurement* is the process of obtaining inputs: it includes both commodities, such as medicines and laboratory supplies, and aspects of capital investment, such as medical devices.

Why does purchasing matter? Because the ways in which resources flow to providers—*provider payment mechanisms*—create incentives that influence the providers' behaviour, affecting system efficiency and equity. Evidence shows that providers drive health resource use far more than patients do, so understanding provider incentives is central to diagnostics for health financing reform. While financial incentives are not the only factor in provider behaviour, they are important and often problematic. Reform is never about creating incentives where none exist: rather, it is about changing the existing incentive structure.

### Sources:

- Mathauer I, E Dale, M Jowett, J Kutzin (2019). Purchasing of health services for universal health coverage: How to make it more strategic? Health Financing Policy Brief No. 6. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/how-to-make-purchasing-health-services-more-strategic/en/](https://www.who.int/health_financing/documents/how-to-make-purchasing-health-services-more-strategic/en/).
- Cashin, C., et al., *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage*. 2015, Joint Learning Network for Universal Health Coverage. <http://www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w/>.

### What is strategic purchasing and why is it critical for UHC?

No country can simply spend its way to UHC—progress requires using the money effectively, and strategic purchasing is the main health financing instrument for doing so. Strategic purchasing uses *data* to inform and align resource allocation decisions with policy objectives. While purchasing is the allocation of resources to providers, *strategic purchasing* links such allocations to information on how well providers operate, and on the health needs of the populations they serve, while managing expenditure growth.

By better aligning resources with promised services, strategic purchasing can make resource use more efficient and equitable. It can also improve service quality and health outcomes by giving health providers incentives to deliver highly cost-effective interventions—especially those with large social benefits, such as immunization and tuberculosis treatment.

Strategic purchasing does not matter only for dedicated purchasing agencies such as health insurance funds. It matters for integrated public systems with budgets and salaries, and for systems with separate purchasing and providing functions. Fundamentally, it is about holding providers accountable for meeting specific service delivery objectives, an aim that can be pursued no matter what

institutional arrangement may be in place for purchasing.

While useful, strategic purchasing is not a magic solution, and care is needed to avoid pitfalls. In particular, financial incentives are powerful and must be designed and introduced with caution. No health system should become dominated by financial considerations—such dominance undermines the intrinsic motivation of providers, reorienting health system culture away from professionalism and towards material gain. Accordingly, financial incentives should be part of a wider, multifaceted approach to raising the quality of service delivery while making it more efficient and equitable.

### Key references:

- Mathauer I, E Dale, M Jowett, J Kutzin (2019). Purchasing of health services for universal health coverage: How to make it more strategic? Health Financing Policy Brief No. 6. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/how-to-make-purchasing-health-services-more-strategic/en/](https://www.who.int/health_financing/documents/how-to-make-purchasing-health-services-more-strategic/en/).
- Tangcharoensathien, V, S Limwattananon, W Patcharanarumol, J Thammatacharee, P Jongudomsuk, S Sirilak (2015). Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy and Planning* 30(9):1152–1161. <https://doi.org/10.1093/heapol/czu120>.

## How can we enable purchasing to become more strategic in our health system?

*Strategic purchasing* means not just using provider payment methods and setting prices, but also analysing data on patient and provider activity and the underlying epidemiological situation. Such analysis should guide decisions about:

- What providers to contract and at what price or budget.
- What services and interventions to prioritize.
- What administrative mechanisms to use to control for potential provider abuses.

The opposite of strategic purchasing is *passive purchasing*: passing funds to providers without looking at data on service use or provider performance. Two extremes of passive purchasing are:

- Excessively rigid state control. Providers are paid using line item budgets, with amounts driven by inputs (such as the number of staff or hospital beds), and budget decisions are made bureaucratically without considering the level, composition or quality of services provided. Such budgets are often rigidly centralized, preventing facility managers from shifting funds across budget lines (from utility costs to medicines, for example) unless they can obtain permission from central finance authorities.
- Unmanaged free markets. The purchaser is essentially a cashier, reimbursing any activity a provider reports, without setting prices or reviewing whether services were needed (or even delivered)—a situation ripe for conflicts of interest. For example, providers that own diagnostic centres where tests are paid on a fee-for-service basis can earn money by referring patients to their own centres.

Strategic purchasing involves constantly moving the health system away from such passive purchasing habits and towards more information-driven policies. Strategic purchasing is thus not a threshold to cross, but a continual and dynamic process of gradual improvement through analysis and adjustment.

Progress from more passive to more strategic purchasing can take many forms with varying degrees of complexity. It can range from using relatively simple mechanisms—such as ensuring that physicians have medical degrees before contracting them for services—to sophisticated systems that use large claims datasets to inform changes in payment mechanisms.

While strategic purchasing reform is not easy, it can be introduced gradually. Steps in the process may include:

- Building the information management system.
- Specifying benefits to align with payment methods, and payment methods to align with benefits.
- Modifying payment methods and rates to improve service provision.
- Establishing quality improvement systems, including accreditation and other measures.

The strengthening of skills and systems—essential measures for strategic purchasing—can also be gradual, en-

abling each step in turn: from data generation, to data analysis, to data use.

Because these steps to drive system change are within the domain of the health sector, they often can be steered by the ministry of health (unlike, say, revenue raising reforms). In addition, these steps can be taken before other issues are tackled that may prove more challenging—whether for political reasons or because of a ministry's limited span of influence (for example, pooling reforms, or raising increased revenue to finance expanding coverage to the informal sector). Despite political and technical obstacles, many countries at all income levels have progressed towards UHC through strategic purchasing reforms in the past two decades: some examples are Argentina, Burundi, Cambodia, Ghana, Kyrgyzstan, the Philippines, Thailand and Turkey.

Strategic purchasing will not work, however, unless providers are empowered to respond to new incentives. This is a critical requirement—mere reforms at purchasing agencies are not enough. Although responding to incentives is not especially challenging for nongovernment contractors, it can be for public providers. Government hospitals, for example, cannot act on new incentives unless facility managers have some managerial control. And yet this autonomy should be neither absolute nor unmanaged, especially in the early stages.

Throughout strategic purchasing reforms, countries should keep their central purpose clearly in view: to make public and private providers increasingly accountable for delivering the results that are contracted by a public (or publicly mandated) purchasing agency.

---

### Key references:

- Mathauer I, E Dale, M Jowett, J Kutzin (2019). Purchasing of health services for universal health coverage: How to make it more strategic? Health Financing Policy Brief No. 6. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/how-to-make-purchasing-health-services-more-strategic/en/](https://www.who.int/health_financing/documents/how-to-make-purchasing-health-services-more-strategic/en/).
- Langenbrunner, J, C Cashin, S O'Dougherty, eds. (2009). *Designing and Implementing Health Care Provider Payment Systems: How-To Manuals*. Washington, DC: The World Bank and USAID. <https://openknowledge.worldbank.org/handle/10986/13806>.
- WHO (2010). World Health Report 2010: Health Systems financing: The path to universal health coverage. Geneva: World Health Organization. <https://www.who.int/whr/2010/en/>.
- Josephson, E (2017). National Health Insurance in Low and Middle Income Countries: A suggestion for a component-based sequencing. Health Financing in Africa: Le Blog. <http://www.healthfinancingafrica.org/home/national-health-insurance-in-lics-and-lmics-a-suggestion-for-a-component-based-sequencing#>.
- Resilient and Responsive health systems (RESYST) (2014). *What is strategic purchasing for health?* Topic Overview 4. London. <https://resyst.lshtm.ac.uk/resources/what-is-strategic-purchasing-for-health>.
- Cashin, C, R Eichler, L Hartel (2018). Unleashing the potential of strategic purchasing. Bethesda, Maryland, USA: Health Finance and Governance Project. <https://www.hfgproject.org/unleashing-potential-strategic-purchasing/>.
- Gertler P, P Giovagnoli, S Martinez (2014). Rewarding Provider Performance to Enable a Healthy Start to Life: Evidence from Argentina's Plan Nacer. Policy Research Working Paper No. WPS 6884; Impact Evaluation Series No. IE 126. Washington, DC: World Bank Group. <http://documents.worldbank.org/curated/en/910221468002421288/Rewarding-provider-performance-to-enable-a-healthy-start-to-life-evidence-from-Argentin-Plan-Nacer>.

- Jakab, M and E Manjjeva (2008). The Kyrgyz Republic: Good Practices in Expanding Health Care Coverage, 1991-2006. In Gotret, P, GJ Schieber, HR Waters, Eds. *Good Practices in Health Financing: Lessons from Reforms in Low- and Middle-Income Countries*. Washington, DC: The World Bank. <http://documents.worldbank.org/curated/en/987711468315362167/Good-practices-in-health-financing-lessons-from-reforms-in-low-and-middle-income-countries>.
- Tangcharoensathien, V, S Limwattananon, W Patcharanarumol, J Thammatacharee, P Jongudomsuk, S Sirilak (2015). Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy and Planning* 30(9):1152-61. <https://academic.oup.com/heapol/article/30/9/1152/663037>.
- World Bank (2013). Turkey: Performance-Based Contracting Scheme in Family Medicine—Design and Achievements. Washington, DC: The World Bank. <http://documents.worldbank.org/curated/en/880861468338993763/Turkey-Performance-based-contracting-scheme-in-family-medicine-design-and-achievements>.
- Honda, A, D McIntyre, K Hanson, V Tangcharoensathien, Eds. (2016). *Strategic Purchasing in China, Indonesia and the Philippines*. Comparative Country Studies, Volume 2, No. 1. Manila: World Health Organization on behalf of the Asia-Pacific Observatory on Health Systems and Policies. <https://apps.who.int/iris/handle/10665/252763>.
- Schieber, G, C Cashin, K Saleh, R Lavado (2012). *Health Financing in Ghana*. Washington, DC: The World Bank. <http://documents.worldbank.org/curated/en/612121468032980083/Health-financing-in-Ghana>.
- Annear, PL, Ahmed, S, Ros, CE, Ir, P. 2013. Strengthening institutional and organizational capacity for social health protection of the informal sector in lesser-developed countries: a study of policy barriers and opportunities in Cambodia. *Social Science and Medicine* 96:223-231. <https://www.sciencedirect.com/science/article/pii/S0277953613000889>.
- Bonfrer, I, R Soeters, E Van de Poel, O Basenya, G Longin, F van de Looij, E van Doorslaer (2014). Introduction of performance-based financing in Burundi was associated with improvements in care and quality. *Health Affairs* 33(12):2179-2187. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0081>.
- Cid C, RP Ellis, V Vargas, J Wasem, L Prieto (2016). Global Risk-adjusted Payment Models. *World Scientific Handbook of Global Health Economics and Public Policy*: pp. 311-362. [https://www.worldscientific.com/doi/abs/10.1142/9789813140493\\_0006](https://www.worldscientific.com/doi/abs/10.1142/9789813140493_0006).

### What are the best provider payment methods?

No payment method is inherently the best: each creates incentives that drive provider behaviour in both positive and negative ways for various policy objectives. However, a best method (or mix of methods) may exist for a particular country at a particular point in time, given its policy priorities. Generally, payment methods fall into two broad categories:

- *Prospective* payment methods pay providers before they provide services: examples include budgets, salaries and capitation. Prospective payments are good for controlling expenditure growth—but generally not good for productivity.
- *Retrospective* payment methods reimburse providers after service provision, as in fee-for-service and case-based payment. Retrospective payments are better for productivity, but they can also drive a rise in expenditures.

Countries should combine payment reforms with administrative mechanisms to prevent abuses. With prospective payment methods, service use should be monitored, and

comparative productivity data should be used to check for underprovision of needed services and the selection of healthier patients (meaning the avoidance of sicker ones). And with retrospective payment methods that pay more for each additional claim, claims must be reviewed to ensure that the number and complexity of reported services do not exceed those that are actually provided or appropriate.

To reduce confusion and inform better policies, policy-makers should also understand *prospective* and *retrospective* in ways that distinguish the time when payment rates are set from the time of actual payment. For example, *retrospective payment methods*, such as fee-for-service payment and case-based payment, are often based on *prospectively defined rates*—while prospective payment methods are always based on prospectively defined rates. In each case, the prospective use of information is a key input for decision making on payment mechanisms and thus contributes to more strategic purchasing of services.

To mitigate the negative effects of single payment methods, many countries have implemented *explicitly mixed payment methods*. For example, they may combine prospective salaries or capitation with retrospective reimbursement for specific output targets (such as immunization)—or they may combine fee-for-service or case-based payment with an overall budget cap. A related and highly relevant consideration is to distinguish payment mechanisms for activity (services produced) from payment mechanisms for fixed costs (such as salaries, equipment and facilities). This distinction recognizes the need to pay providers both for what they “are”, which is reflected in their fixed costs and should thus be paid for prospectively (in both definition and execution of payment), and for what they “do”, which is reflected in their activity and could be paid either prospectively or retrospectively (in both definition and execution). Mixed payment systems not only mix forms of payment but combine retrospective and prospective payment, recognizing the possible need to cover fixed costs differently from variable costs.

Because problems change over time, provider payment arrangements require continuous monitoring and periodic adjustment. Some providers may adapt to new incentives by finding new ways to game the system. For this reason, countries should not legislate particular provider payment methods. Instead, they should set the principles and objectives in law while enabling change through regulatory reform.

### Key references:

- Barnum, H, J Kutzin, and H Saxenian (1995). “Incentives and provider payment methods.” *International Journal of Health Planning and Management* 10(1):23-45. <https://onlinelibrary.wiley.com/doi/abs/10.1002/hpm.4740100104> and/or as World Bank Working Paper <http://documents.worldbank.org/curated/en/748491468766812001/pdf/multi-page.pdf>.
- Langenbrunner, J, E Orosz, J Kutzin, M Wiley (2005). Purchasing and paying providers. In Figueras, J, R Robinson, E Jakubowski, eds. *Purchasing to improve health system performance*. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies. <http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/purchasing-to-improve-health-systems-performance-2005>.
- Mathauer I and F Dkhimi (2018). Analytical guide to assess a mixed provider payment system. Health Financing Guidance No. 5. Geneva: World Health Organization. [https://www.who.int/health\\_](https://www.who.int/health_)

financing/documents/analytical-guide-to-assess-mixed-provider-system/en/.

World Health Organization (2017). Strategic purchasing for universal health coverage: unlocking the potential. Summary and key messages. 2017. Geneva: World Health Organization. [https://www.who.int/health\\_financing/events/strategic-purchasing-meeting-2017-report.pdf?ua=1](https://www.who.int/health_financing/events/strategic-purchasing-meeting-2017-report.pdf?ua=1).

Cid C, RP Ellis, V Vargas, J Wasem, L Prieto (2016). Global Risk-adjusted Payment Models. *World Scientific Handbook of Global Health Economics and Public Policy*: pp. 311-362. [https://www.worldscientific.com/doi/abs/10.1142/9789813140493\\_0006](https://www.worldscientific.com/doi/abs/10.1142/9789813140493_0006).

Newhouse, JP (1996). Reimbursing health plans and health providers: efficiency in production versus selection. *Journal of Economic Literature* 34(3):1236-1263. [https://www.jstor.org/stable/2729501?seq=1#page\\_scan\\_tab\\_contents](https://www.jstor.org/stable/2729501?seq=1#page_scan_tab_contents).

### What other opportunities does strategic purchasing offer for UHC?

In some cases, without directly changing payment methods, health system governance can be made more effective by using data systems to support purchasing—especially if the systems are unified or interoperable across the entire health system (whatever the number of coverage schemes and programmes). Concurrently, skills must be developed to use these data for identifying and addressing health system challenges.

Analyses of provider payment databases can be used to inform decision making, or as an input to evaluate the quality of care. For example, payment data can be used to:

- Identify variation in clinical practices across the country, such as caesarean section rates or antibiotic prescription rates.
- Assess the extent of hospital admissions for conditions that could be prevented with effective primary care.

In these examples, payment system data can support strategic purchasing—even if the data are not ultimately used to reform payment rates or mechanisms.

In practice, such uses of data for strategic purchasing and for progress towards UHC tend to be challenging in many ways because of fragmented health financing architecture. In many countries, each purchasing agency has its own data management system and manages its own information flows, processing only data relevant for its own operations and accountability obligations (target population, target services, enlisted providers and so on). Because this fragmented information is difficult to use for decision making, unification or interoperability is a key early step in contexts with pool fragmentation.

Interoperability enables information exchange across different systems: with interoperability, data from various sources are harmonized at some stage of the information management process. The data can then be collated and analysed at the system level. Today's digital revolution in health information management affords an unprecedented opportunity to make systems interoperable. But to protect sensitive personal information, prior action is needed to govern the information environment.

---

### Key references:

Mathauer, I, E Dale, B Meessen (2017). Strategic purchasing for Universal Health Coverage: Key policy issues and questions. A summary from expert and practitioners' discussions. Health Financing Working Paper No. 8. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/strategic-purchasing-discussion-summary/en/](https://www.who.int/health_financing/documents/strategic-purchasing-discussion-summary/en/).

Cashin, C, R Eichler, L Hartel (2018). Unleashing the potential of strategic purchasing. Bethesda, Maryland, USA: Health Finance and Governance Project. <https://www.hfgproject.org/unleashing-potential-strategic-purchasing/>.

World Health Organization (2017). Strategic purchasing for universal health coverage: unlocking the potential. Summary and key messages. 2017. Geneva: World Health Organization. [https://www.who.int/health\\_financing/events/strategic-purchasing-meeting-2017-report.pdf?ua=1](https://www.who.int/health_financing/events/strategic-purchasing-meeting-2017-report.pdf?ua=1).

## 5. PUBLIC FINANCIAL MANAGEMENT IN HEALTH

### What is public financial management, and why does it matter for UHC?

The rules that govern the allocation, use and accounting of public funds are known as public financial management (PFM). A country's PFM systems affect health financing in the level and allocation of public funding (budget formulation), in the effectiveness and targeting of spending (budget execution) and in financial transparency and accountability towards results (budget reporting). Best practices in PFM include reliable, stable, predictable budgets that are aligned with sector needs, executed flexibly according to plan and accounted for transparently with a focus on achieved results.

For progress towards UHC, funding sources—which should be chiefly compulsory (taxation of some kind)—must be used efficiently to drive the provision of priority services. Health services face fundamental challenges if public resources are not disbursed in a timely way, using appropriate allocation and payment mechanisms,

following best practices in PFM. Furthermore, inflexibility in resource management—especially at the provider level—can introduce inefficiencies into health systems.

#### Sources:

Cashin, C, D Bloom, S Sparkes, H Barroy, J Kutzin, S O'Dougherty (2017). Aligning public financial management and health financing. Health Financing Working Paper No.4. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/aligning-pfm-health-financing/en/](https://www.who.int/health_financing/documents/aligning-pfm-health-financing/en/).

Piatti-Fünfkirchen, M and L Smets (2019). Public Financial Management, Health Financing and Under-Five Mortality: A Comparative Empirical Analysis. IDB Working Paper Series No. IDB-WP-976. Washington, DC: Inter-American Development Bank. <https://publications.iadb.org/en/public-financial-management-health-financing-and-under-five-mortality-comparative-empirical>.

### How do PFM systems affect health spending today?

Historically, weak PFM systems have affected health spending in low-income and middle-income countries through chronic bottlenecks at all stages of the budget cycle. Health budgets have often been disconnected from sector planning and costing, resulting in misaligned allocations. Weak budgeting and inefficient expenditure management have often led to inappropriate spending and the underuse of allocated budgets.

Most countries have begun cross-sector reforms to strengthen PFM systems, often with the support of international financial institutions (the World Bank, regional development banks and the International Monetary Fund). A fairly standard package of interventions includes:

- *Multiyear budgeting* to make resources more planned and predictable.
- *Budget structure reforms* to align resources with priority policies: for example, the introduction of programme-based budgets.
- *Computerized financial management systems* to improve the financial accounting and reporting of expenditure.

In high-income countries, evidence suggests clear benefits from the general PFM reforms: budgets perform better, resources are more efficiently allocated and public funds are used more transparently and accountably. In lower-income settings, evidence highlights some benefits from these reforms, with some advances in the credibility of budgets, resource management and overall accountability of public funds. The health sector has benefited from these general improvements.

The results of PFM reforms, however, are heterogeneous across countries. In many cases, the health sector continues to confront fundamental PFM obstacles. And moving

beyond pilots has been a challenge. For instance, while several LMICs have introduced programme budgets in health (making it a pilot sector), few have institutionalized this practice. Finance laws continue to be approved by inputs, and even where finance laws have been modified, money is generally still disbursed by inputs—limiting flexibility and accountability towards results.

The design of budgetary programmes has proven to be complex in health. Despite its potential merits, the introduction of programme budgeting in LMICs has not automatically addressed the disconnect between resource allocation and health sector priorities. Experience suggests that where programmes are not well-designed, programme budgets lead to needless complexity in resource management, to a loss of accountability and to reduced efficiency in health spending.

A clear set of general design features exists—clear in the number, size, type and structure of programmes—that should be more systematically applied by health ministries. In this way, the health ministries could more effectively ensure that their programmes fit the overall budget architecture and follow best practices. In addition, both the health and the finance authorities need to take greater account of health-specific considerations for the design of health ministry budgetary programmes, to ensure good alignment with sector priorities and with an approach based on the overall health system.

Individual disease responses should not be treated as separate budgetary programmes. Such separation risks crystallizing the vertical allocation of domestic resources and is likely to increase financial fragmentation at the facility level. In a context of transition from externally funded operations, most countries with programme budgets have addressed this concern by integrating disease interventions into broader budgetary programmes—generally at the level of subprogrammes or activities—with disease-specific indicators built into performance monitoring frameworks.

### Key references:

- Fritz V, M Verhoeven, A Avenia (2017). Political Economy of Public Financial Management Reforms: Experiences and Implications for Dialogue and Operational Engagement. Washington DC: World Bank. <https://openknowledge.worldbank.org/handle/10986/28887>.
- Barroy, H, G Kabaniha, C Boudreaux, T Cammack, N Bain (2019). Leveraging PFM for better health in Africa: key bottlenecks and opportunities for reform. Health Financing Working Paper No. 14. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/workingpaper14/en/](https://www.who.int/health_financing/documents/workingpaper14/en/).
- Barroy, H, E Dale, S Sparkes, J Kutzin (2018). Budget matters for health: key formulation and classification issues. Health Financing Policy Brief No. 4. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/making-budgets-work-uhc/en/](https://www.who.int/health_financing/documents/making-budgets-work-uhc/en/).
- Barroy H, Lakin J, Dale E, Mills L (forthcoming): Designing budgetary programmes in health: key considerations for policy-makers. Geneva: World Health Organization.
- WHO repository of health budgets: The repository of health budgets consolidates open source information on finance laws and related documents applicable to the health sector for more than 100 countries: [https://www.who.int/health\\_financing/topics/budgeting-in-health/repository/en/](https://www.who.int/health_financing/topics/budgeting-in-health/repository/en/).

### How can health ministries be more active in PFM reforms?

While many PFM issues cut across the public sector, health ministries need to become more active to enable progress towards UHC. To better meet health sector needs, PFM needs to be improved to clear spending blockages at the facility level. In particular, health facilities need greater autonomy and flexibility in financial management. Making this possible will require explicit coordination with other health financing reforms—especially in strategic purchasing.

Generally, health ministries should focus on three complementary areas of engagement with their finance ministries:

- **Keep informed and up to date on general PFM reforms.** For example, ministries should monitor multiyear budgeting approaches to make health financing more predictable.

- **Contribute to the design and implementation of key PFM reforms for health.** The design of budgetary programmes should help align allocations with sector priorities.
- **Lead policy development for PFM interventions specific to health.** For example, regulatory frameworks should shape financial autonomy for health facilities.

More specifically, health sector leaders need to:

- **Speed the institutionalization of programme budgets in health.** Such budgets should align allocations more closely with sector priorities, make expenditure management more flexible and increase accountability by measuring resource use against results.
- **Identify causes of deficient budget execution.** If funds are not allocated according to priorities, are not disbursed on time, are not flexible or are underused, corrective action is needed to balance flexibility with accountability for results.
- **Establish a new accountability contract.** Such a contract should establish a single framework to consolidate and streamline the monitoring of financial and operational performance. As a technical requirement for monitoring performance, the accountability contract would provide a transparent commitment to the population.
- **Strengthen PFM capacities in the health sector, both in the central health ministry and among the managers of frontline providers.** Shifting from traditional planning by inputs to programming and accountability for results requires long-term upgrading of staff at all levels. Where relevant, development partners can help by mainstreaming PFM system strengthening in their health sector operations.

### Key references:

- Barroy, H, G Kabaniha, C Boudreaux, T Cammack, N Bain (2019). Leveraging PFM for better health in Africa: key bottlenecks and opportunities for reform. Health Financing Working Paper No. 14. Geneva: World Health Organization. [https://www.who.int/health\\_financing/documents/workingpaper14/en/](https://www.who.int/health_financing/documents/workingpaper14/en/).

## 6. POLITICAL ECONOMY ANALYSIS FOR HEALTH FINANCING REFORM

### What is political economy analysis, and how does it matter for health financing reform?

Political economy analysis is used to assess the power and position of key actors—a first step in developing and implementing strategies to make desired reforms more politically feasible. Analysing the political economy of reform also sheds light on the broader forces that affect the distribution of health and resources within and across populations.

#### Sources:

Sparkes, SP, JB Bump, EA Ozcelik, J Kutzin, MR Reich (2019). Political economy analysis for health financing reform. *Health Systems & Reform*, 2019. **5**(3) <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1633874>.

Campos, P. and M. Reich (2019). Political analysis for health policy implementation. *Health Systems & Reform* 5(3). <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1625251>.

Gilson L, E Erasmus, J Borghi, J Macha, P Kamuzora, G Mtei (2012). Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project. *Health policy and planning* 27(suppl\_1):i64–76. [https://academic.oup.com/heapol/article/27/suppl\\_1/i64/602445](https://academic.oup.com/heapol/article/27/suppl_1/i64/602445).

PAHO (2017). Health Financing in the Americas. In *Health in the Americas 2017*. Washington, DC: Pan American Health Organization. <https://www.paho.org/salud-en-las-americas-2017/?p=178>.

### What makes health financing reform political?

Health financing reform is political partly because changes in health financing functions alter the distribution of entitlements, responsibilities and resources in the health sector and in society at large. For example, revenue raising, pooling, purchasing and PFM reforms all have redistributive implications. They can also shift the balance of power among individuals, groups and institutions. And while certain health financing policies may technically reflect best practice in progressing towards UHC, these policies may also bear on a country's core social values.

Because the centrality of public financing to progress towards UHC requires government intervention—whether across levels (such as national and subnational authorities) or across agencies (such as health and finance ministries)—health financing reform is often a political agenda item. But for the reasons just presented, putting technical ideas into practice requires a politically informed approach. Otherwise, potentially good health financing strategies are likely to remain dead documents.

#### Key references:

Sparkes, SP, J Kutzin, A Soucat, JB Bump, MR Reich (2019). Introduction to Special Issue on Political Economy of Health Financing Reform. *Health Systems & Reform*, DOI: <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1649915>.

Shiffman, J (2019). Political Context and Health Financing Reform, *Health Systems & Reform*, DOI: <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1633894>.

### How can my country best use political economy analysis to advance the adoption and implementation of health financing reform?

Political economy analysis can help policy-makers confront the political challenges of policy change. One approach appears in WHO's recently published framework for analysing the political economy of health financing reform as a way to support progress towards UHC. Un-

derstanding each stakeholder's power and position relative to a policy or reform objective clarifies the challenges and opportunities of reform. Adoption and implementation strategies can then be developed and sequenced to address these political economy dynamics and move reforms forward.

In particular,

- **Technical work matters.** Evidence of both the need for reform and the possible effect of changes can sway support for (or against) reform. Such technical evidence can be especially powerful when embedded in political strategies that advance adoption and implementation. But while political windows of opportunity are helpful, even more important is to be technically ready for the moment when the window opens—with specific implementation details in place.
- **Strategic implementation sequencing is critical.** The greatest obstacle or barrier is not necessarily the first one that reforms should tackle. A politically informed sequencing of various reforms—as part of an overall package—can reduce resistance from key stakeholders. For example, countries often work to harmonize data systems and then benefit packages across different financing schemes, before they take on the more contentious issue of merging fragmented pools.
- **Compromise is almost always needed.** Political economy challenges often require adjustments that depart from what might technically be the “best” reform for a given context. Reform leaders make strategic compromises so that the reforms can proceed, but not in a way that undermines their core objectives.

#### Key references:

Gilson, L (2019). Reflections from South Africa on the Value and Application of a Political Economy Lens for Health Financing Reform. *Health Systems & Reform* 5(3). <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1634382>.

De Habich, M (2019). Leadership Politics and the Evolution of the Universal Health Insurance Reform in Peru. *Health Systems &*

- Reform* 5(3). <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1635415>.
- Fox, AM and Y Choi (2019). Political Economy of Reform under US Federalism: Adopting Single-Payer Health Coverage in New York State. *Health Systems & Reform* 5(3). <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1635414>.
- Tangcharoensathien, V, W Patcharanarumol, A Kulthanmanusorn, N Saengruang, H Kosiyaporn (2019). The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries. *Health Systems & Reform* 5(3). <https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1630595>.
- PAHO (2017). Health system transformations toward universal health. In *Health in the Americas 2017*. Washington, DC: Pan American Health Organization. <https://www.paho.org/salud-en-las-americas-2017/?p=73>.

### III. What is the best model of health financing reform for my country?

No “best model” of organizing financing arrangements exists—none applies to all countries at all times. But as noted in the introduction to this guide, not knowing everything does not mean knowing nothing.

As sections I and II showed, much is known about how health financing can support progress towards UHC—and about how it can create obstacles. This section synthesizes those lessons as a set of principles to guide health financing reforms, and reformers, at country level. The challenge remains for reformers to develop a path to UHC tailored to their unique context. In doing so, they may use these principles as signposts to check whether the reforms they are considering are likely to move their systems towards or away from UHC.

#### Revenue raising

**1. Move towards a health system that relies predominantly on compulsory funding sources.** Taxation in some form is central to progress towards UHC.

- a. Health economic theory and the practical experience of countries around the world yield a consistent lesson: voluntary sources of funding (out-of-pocket payments and voluntary health insurance) cannot lead to UHC. Just hoping or assuming that these mechanisms will be complementary is not enough: the technical requirements are stringent, and a large role for private financing is likely to drive inequities.
- b. “Compulsory funding sources” means taxation in some form. It does not mean compelling every individual to make a direct contribution for health coverage. In low- and middle-income countries, most public revenues are sourced from indirect taxes and allocated from general government budgets—although addressing problems in collecting corporate and income taxes, as well as eliminating regressive tax exemptions, should certainly be explored.
- c. In contexts of high informality, individual contributions for health insurance cannot realistically be expected to yield substantial revenues.

**2. Increase multiyear predictability in the level of public funding likely to be available.** Include explicit links to annual budgets.

- a. Multiyear predictability is an important contributor to medium-term planning and reflects good practice in budgeting.
- b. In countries where external funding is relevant, the need for multiyear predictability applies to donor funding as well.

**3. Make the flow of public funds more stable.** Use regular budget execution to ensure such stability during the course of any given year.

- a. Stable funding flows enable effective implementation—and they require attention to PFM mechanisms in health and throughout the public sector, an effort that must involve close collaboration with the finance ministry.
- b. Stable funding flows enable delivery of what is promised in benefit packages (and in contracts with providers).
- c. Stable funding flows reduce the need for patients’ informal OOPS for inputs that were meant to be regularly funded.

**4. Promote pro-health tax and subsidy policies as a part of national fiscal policy.**

- a. Taxes on the consumption of products that harm human health (such as tobacco and added sugar) are effective health improvement measures. So are reductions in subsidies that harm human health.
- b. The revenue stream from these tax and subsidy policies should be only a secondary consideration—and budget dialogues with finance authorities on public health funding levels should not focus just on one type of tax, but on the entire revenue envelope.

#### Pooling

**5. Reduce fragmentation in pooling, or mitigate its effects.** Reducing fragmentation can enable increased redistributive capacity and improved efficiency.

- a. Consider the options of consolidation, compensation, equalization and mitigation.
- b. Because pooling reforms are redistributive, they are political—usually more than other aspects of health financing. Apply political economy analysis in the se-

quencing of reform steps. Ensure that the technical basis for pooling reforms (especially information systems) is ready in advance.

6. **To make pooling effective for UHC, ensure a large pool size, a diverse pool of health risks in the population and compulsory or automatic participation.**
7. **Limit the role of voluntary health insurance.** Its harmful effects on the wider system create obstacles to UHC.
  - a. Although voluntary health insurance can play a complementary role in progress towards UHC, enabling it do so is difficult. A necessary first step for complementarity is a clear policy on what will be purchased from public funds, which can in turn define explicit gaps that need to be filled—at least temporarily—from private funds.
  - b. Avoid tax subsidies for the purchase of voluntary health insurance, unless restricted explicitly to the poor. Without such restrictions, the subsidies will inevitably be pro-rich.

### Benefit design and rationing

8. **Ensure coherence between explicit policies on benefits and on rationing (typically through patient copayments).** These are two sides of the same coin.
9. **Convey benefit packages to the population in terms that are easy for nonspecialists to understand—no matter how technical and complex the methods that were used to develop the packages.** Typically, define service and cost coverage by level of care (as in the description “free health centre consultation”), and use the most effective means to communicate this to the population.
10. **Establish or strengthen formal processes for regularly reviewing proposed changes to promised benefits—especially the addition of new medicines and procedures.**
  - a. At a minimum, analyse the cost effectiveness and budget impact of any proposed addition.
  - b. Anchor these processes in law or regulation to reduce the risk of overly politicized coverage expansions.
11. **If, despite their shortcomings, the health financing system includes user fees (copayments), design them in a way consistent with policy objectives.**
  - a. Make user fees simple, clear and low—with additional protections for the vulnerable. Avoid defining fees as a percentage of charge or cost: such definitions increase the financial burden on a patient who needs more services, and they also make it harder to understand the size of the required payment. In countries with greater administrative capacity, establish exemptions for poor households, and put an annual cap on individual copayment liability.
  - b. In LMICs, consider eliminating fees at lower-level facilities in poorer regions. Such geographic targeting may be more feasible than individual exemptions based on means testing. Facilities should be compensated for exemptions or fee elimination with increased budgets.

- c. Let facilities charging fees retain the collected fees as a supplement to their budget, rather than requiring them to return this money to the treasury.

### Purchasing

12. **Move towards more strategic purchasing of health services.** Over time, increase the extent to which payment of providers is driven by information on their performance and on the health needs of the population they serve—while managing expenditure growth.
  - a. Focus on reforms to provider payment methods, to contracting and to the governance of purchasing agencies.
  - b. If nothing else, avoid the two extremes of rigid input-based line budgets and unmanaged fee-for-service reimbursement.
  - c. Avoid open-ended commitments in payment systems; operate within a budget and move towards formula-based payment systems.
13. **To anticipate and mitigate the harmful effects of a single payment method, move towards explicitly mixed payment methods.** Ensure that administrative processes limit the potential for abuse.
14. **Build or strengthen data systems on patient activity that are unified or interoperable across the health system.** Concurrently, build or increase the capacity to use these data in purchasing decisions and in wider system governance.
15. **Afford public providers at least some autonomy in managing their financial resources.** Otherwise, payment reforms will have no effect.
  - a. Engage continually on PFM issues.
  - b. Combine provider autonomy with accountability and reporting mechanisms to check that facility behaviour is aligned with public policy objectives.
16. **Align payment arrangements with defined benefits.** Enable the promise to be fulfilled.

### Political economy

17. **Incorporate political economy considerations into health financing design, adoption and implementations reform plans.** Health financing reform is an inherently political process, and political economy analysis can help develop more effective strategies to navigate challenges and advance implementation.

### Key references:

- Kutzin J (2012): Anything goes on the path to universal health coverage? No. *Bulletin of the World Health Organization* 90:867-868. <http://www.who.int/bulletin/volumes/90/11/12-113654.pdf>.
- Kutzin J, Yip W, Cashin C (2016): Alternative Financing Strategies for Universal Health Coverage. *World Scientific Handbook of Global Health Economics and Public Policy*: pp. 267-309. [http://www.who.int/health\\_financing/documents/alternative-strategies-for-uhc/en/](http://www.who.int/health_financing/documents/alternative-strategies-for-uhc/en/).

