

Health systems financing and the path to universal coverage

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Donor commitments to health have increased more than fourfold since the Millennium Declaration was signed in September 2000, reaching more than US\$ 20 billion in 2008.¹ Despite this, progress towards some of the health Millennium Development Goals (MDGs) has been disappointing in many settings.² The simple act of raising more international funds cannot, by itself, achieve the Goals if the health system is too weak to support the rapid scale-up of service coverage.³ Where there are insufficient health workers and health facilities, or where people can't obtain health care because they cannot afford to pay, supporting actions are needed.

Domestic health financing systems must be robust enough to attain and sustain increased coverage. Financing for universal coverage is based on two inter-linked foundations. The first is to ensure that financial barriers do not prevent people from using the services they need – prevention, promotion, treatment and rehabilitation. The second is to ensure that they do not suffer financial hardship because they have to pay for these services.⁴

Health services cost money and someone has to pay. Even with the recent increase in external funds for health in low-income countries, these countries still have to find almost 75% of their health funding in domestic sources. The way that countries raise those funds is critical. Direct payments required when people obtain care (e.g. user charges) prevent many people from seeking care in the first place, and may result in financial catastrophe, even impoverishment, for many.⁵ Improving universal coverage requires systems that raise the bulk of funds through forms of prepayment (e.g. taxes and/or insurance), and then pool these funds to spread the financial risk of illness across the population. They require health financing systems with inbuilt incentives to ensure that these funds are used efficiently and equitably.

The World Health Organization's next world health report will be on health financing and will argue that almost every country, rich and poor, can improve service coverage or financial risk protection by ad-

ressing one or more of the core tasks of a financing system – raising sufficient funds, pooling these funds to spread financial risks and spending wisely.

The *Bulletin of the World Health Organization* has been running a series of news stories since December 2009, showing how health financing systems affect people's lives. Reports have been published in the following order from Spain,⁶ China,⁷ Thailand,⁸ the Republic of Korea,⁹ Switzerland,¹⁰ Nigeria¹¹ and, in this issue, the United States of America.¹²

In addition, some of the issues that policy-makers inevitably face as they develop their health financing systems are highlighted in perspectives published this month. In terms of raising more funds, Fryatt & Mills¹³ outline the main achievements of the high-level Taskforce on Innovative International Financing for Health Systems. They claim that it has helped maintain momentum for increased international financial support for health in low-income countries at a time of the financial crisis. In response, McCoy & Briki¹⁴ argue that the Taskforce report was disappointing. It gave only lukewarm support to a financial transactions levy, an option targeting the banking sector, while supporting consumer taxes affecting the poorer population groups. The focus on innovative financing could also backfire by encouraging countries to renege on their commitments to provide official development assistance – in fact only a few of them have kept their international promises to date.

Yates¹⁵ focuses on how funds for health are raised and makes a case for abolishing user fees, starting with services for women and children. On the other hand, Jowett & Danielyan¹⁶ claim that the debate about user-charges is not so straightforward. For example, Armenia has developed an official fee schedule for health services as a way of countering unofficial or under-the-table payments.

Finally, Leatherman & Dunford¹⁷ report that microfinance increasingly provides relatively poor people, often women,

with income-earning opportunities and suggests that it might also help people to access health services where they must pay for them.

Many countries are very close to universal coverage and others are making good progress. The *Bulletin's* articles on this topic raise fundamental questions that must be considered when thinking about how best to develop and adapt national health financing systems for universal coverage. ■

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Complete list available at: <http://www.who.int/bulletin/volumes/88/6/10-078741.html>

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Spanish health district tests a new public–private mix

With public health systems facing shrinking budgets, in part due to the global financial crisis, governments are looking at new ways to make the most of limited resources. A handful of Spanish health districts are taking the lead. Mireia Bes reports from Valencia.

Faced with ballooning deficits in its health-care budget in the late 1990s, the Spanish regional authority of Valencia decided it was time to look for new ways to fund and run its hospitals. Starting with the health district of Alzira, the authority invited a private consortium led by Adeslas, a leading Spanish private health insurance company not only to build a brand new hospital, but to run it as well. Hospital de La Ribera, built at a cost of €61 million in 1999 (US\$ 91 million on 17 November 2009), was managed by a new kind of corporate entity known as a public–private investment partnership (PPIP). PPIPs are just one way of involving the private sector in publically-funded health services, as most districts in Spain rely on a public–private mix of one kind or another.

Sir Richard Feachem, director of Global Health Group (GHG), a University of California, San Francisco “action-tank” – as opposed to think-tank – with a keen interest in the development of PPIPs, explains that this new kind of public–private hybrid goes beyond traditional public-service privatization where, typically, a private company builds a hospital, which is then managed by the public authority. In a PPIP, the public authority involves the private company in the daily running of the hospital itself as a partner in the management and provision of clinical and support services. As challenging as that might sound, the model has been enjoying positive results, notably in Spain.

“Valencia is the big success,” says Feachem, pointing out that in addition to Alzira, Valencia has subsequently created PPIPs in the health districts of Torrevieja, D nia, and Manises and will soon be starting one in the health district of Elx. Certainly the people of Alzira seem happy. “In the latest [surveys] we have a satisfaction [rate] of over 91% among the citizens of the health district, because they are happy with our services,” says Manuel Mar n Ferrer, Hospital de La Ribera’s director. The hospital has an interest in keeping its patients happy, since it has a contrac-

tual obligation to pay the health-care bills of Alzira health district patients if they are treated elsewhere. Happily for Mar n, La Ribera draws in patients rather than losing them – with about 10% of the hospital’s patients coming from surrounding health districts.

As impressive as that 91% approval rating looks, it is not much higher than the 85% customer satisfaction reported in official surveys for Spain’s public health-care system as a whole. It appears that La Ribera does shine in certain areas – prompt scheduling of surgery, for example. The hospital is also known for guaranteeing epidurals, a big draw in a region that cannot provide anaesthetists on a round-the-clock basis.

“I don’t think that any of the enterprises involved in the administrative concessions will become rich, because here we have an obligation to invest nearly everything that we earn.”

Manuel Mar n Ferrer

But where the Alzira PPIP really stands out is in its tight control of costs. Funded by the regional health ministry on a pre-agreed per capita basis, La Ribera spends 20–25% less than comparable publicly managed institutions, according to Juan Alfonso Bataller, the Valencia Regional Health Ministry Undersecretary. Bataller says that operational improvements, such as the digitalization of medical records and the sourcing of supplies based on competitive tender rather than established relationships, account for a good deal of these savings, but it’s clear that the Valencia region also benefits from the Adeslas consortium’s serious approach to investing in health.

“I don’t think that any of the



Courtesy of Hospital de La Ribera

Entrance foyer of Hospital de La Ribera.

enterprises involved in the administrative concessions will become rich, because here we have an obligation to invest nearly everything that we earn,” says Mar n. The Alzira contract in fact stipulates that profit generated by the hospital be limited to 7.5% per annum, any amount in excess of that being subject to obligatory re-investment. This is slightly below the 8% return on assets that Feachem considers to be typical and acceptable for the private partners in a PPIP, but is way above the 1.6% profit that Mar n says the Alzira consortium actually makes. According to Mar n the consortium has never cleared more than that, while the rest is being ploughed into local projects, including new health centres and improvements to the hospital itself. So doesn’t the consortium care about profits? Mar n explains that Adeslas gets a “non-tangible benefit” in the form of good publicity for its business model, from “people knowing that a private system can provide a public service and manage a public service”. It also hopes its model will be taken up in other parts of Spain.

Another crucial challenge for the Alzira PPIP is managing hospital staff, 27% of whom are public sector workers inherited from the old publicly administered health-care system, while 73% are from the private sector. Public and private staff work under two regimes with different requirements and, according to Mar n, “cohabit perfectly,” but it is clear that one of the challenges that the hospital faces on a daily basis is keeping everyone happy, especially private-sector workers who feel they are getting a raw deal compared to their public sector peers. People like Pedro Dur n, an emergency-room doctor at La Ribera

who works for the consortium and is a representative of the Sindicato de Médicos de Asistencia Pública, a local trade union.

Durán feels that La Ribera's much-vaunted leanness has come at a price. "When the company says that it is 25% more efficient than other hospitals, well, how are they getting this efficiency? With lower salaries, with fewer workers and with longer working hours," Durán says, backing up his argument with some numbers of his own. He says that a study done by staff trade unions found that the hospital needed 258 more workers in all categories in addition to the 1000 existing workers. Understaffing is exacerbated by the constant influx of patients from other districts, Durán argues, questioning official estimates of 10% inflows that the union puts closer to 20–25% of La Ribera's total patients. The stresses caused by understaffing, inadequate pay and working conditions have led to the resignation of 40 doctors from a total staff of 400 doctors since 2007, Durán says, adding: "I don't think that this has happened in any other hospital in Spain."

Marín disputes that number, arguing that losses have been closer to 20 doctors, with departures driven by the general shortage of doctors in Spain, which gives the sector "a certain mobility." Says Marín: "The mobility of doctors is not greater than in any other national hospital. And a proof of the good working environment in the hospital is an absenteeism rate of 2.5%, much lower than in any public hospital in Spain and much lower than in any



Health worker examines baby at Hospital de La Ribera.

Courtesy of Hospital de La Ribera

enterprise of these dimensions."

It is perhaps inevitable that a model that brings public and private interests into such close contact will give rise to this kind of criticism, just as the mix of politics and business makes some uneasy about the potential for corruption. Both GHG's Feachem and Jean Perrot, at the World Health Organization's (WHO) department of Health Systems Financing, stress the importance of independent control of PPIPs if public trust is to be maintained.

Since it was launched in Valencia region, the PPIP model has been taken up and is being tested elsewhere, including in Lesotho and in the British Overseas Territory of Turks and Caicos

Islands in the Caribbean. But WHO's Perrot is more sceptical as to whether the PPIP model would work in developing countries. "Public administrations don't have the technical capacities to set up such complex systems and to follow their progress," he says, adding that private consortia are not exactly lining up to jump in either.

Despite these issues, Feachem is looking forward to seeing the PPIP model tested elsewhere, particularly in developing countries where he thinks they have the potential to make rapid improvements in infrastructure and the access of ordinary people to high quality services. ■

Recent news from WHO

- GlaxoSmithKline (GSK) agreed to donate 50 million doses of **pandemic influenza A (H1N1) vaccine** for developing countries, WHO said on 10 November. GSK expected to prepare the first shipments of vaccine for delivery to WHO by the end of November. WHO has a list of 95 developing countries that are eligible to receive donated vaccines, and aims to secure enough vaccines to cover 10% of the population of these countries.
- Despite considerable progress in recent decades, societies continue to fail to meet the **health-care needs of women** at key moments of their lives, particularly in their adolescent years and in older age, according to a WHO report released on 9 November. Launching the report, entitled *Women and health: today's evidence, tomorrow's agenda*, WHO Director-General, Dr Margaret Chan called for urgent action both within the health sector and beyond to improve the health and lives of girls and women around the world. Read the report at <http://www.who.int/gender/documents/9789241563857/en/index.html>
- A comprehensive action plan to save up to 5.3 million children from dying of **pneumonia** by 2015 was launched on 2 November by WHO and the United Nations Children's Fund (UNICEF). Pneumonia is the biggest cause of child deaths in the world, killing 1.8 million children under five years of age every year, more than 98% of which occur in 68 developing countries.
- **Global life expectancy** could be increased by nearly five years by addressing five factors affecting health: childhood underweight, unsafe sex, alcohol use, lack of safe water, sanitation and hygiene, and high blood pressure, according to a report published by WHO on 27 October. These factors are responsible for one-quarter of the 60 million deaths estimated to occur annually.

For more about these and other WHO news items please see: <http://www.who.int/mediacentre>

China's new health plan targets vulnerable

Extending coverage to migrant workers is a priority for China as it overhauls its health-care system. Cui Weiyuan reports.

When 18-year-old factory worker Dou Huhai came down with a cold, after a 15-hour shift at a zipper factory on the outskirts of Beijing, he had “neither the money nor the time” to see a doctor so he just took some medicine. The following day, still drowsy from the medication, he caught his left hand in his punching machine.

The machine that snagged Dou's hand crushed two of his fingers. He was taken to the county-town hospital, and then transferred to the Armed Police Hospital, where a doctor told him that it was going to be possible to salvage most of his fingers, but when he discovered that Dou could not pay for the operation, and had no insurance coverage – at least as far as he knew – the doctor performed a simple amputation. Dou's boss paid, but when Dou demanded compensation he was fired. “I did not have a labour contract,” Dou says. “Nor do I have the health insurance through my employer. No one would hire you here, if you insisted on having one.”

Dou comes from a peasant family in Shaoyu Town, Xihe County, in China's north-western Gansu Province and is one of China's estimated 200 million migrant workers. Health coverage should now improve for people like him. Just nine days after Dou started work in the zipper factory in April 2009, the government announced plans to provide universal access to essential health care to all residents in China by 2020.

If fully implemented, the reform will spell the end of the market-based mechanisms that had been gradually introduced since the early 1980s, after 30 years of covering more than 90% of medical expenses for urban residents and providing basic, low-cost health-care services to the rural population.

The fact that Dou did not know if he had insurance coverage comes as no surprise to Wei Wei, the founder of Xiao Xiao Niao, a Beijing-based nongovernmental organization defending the few rights that migrant workers have. He says that migrant workers rarely know if they are insured and that this is partly why there are no reliable

statistics on how many are covered. A survey carried out by the China Development Research Foundation back in 2000 revealed that fewer than 3% of migrant workers were covered by health insurance schemes, and those who were covered had only limited access to health-care services. Since then, the situation has improved somewhat. Now over 30 million migrant workers are covered by the Urban Employee Basic Health Insurance Scheme (URBMI), according to the Chinese Medical Insurance Association.

“No one would hire you here if you insisted on having [a health insurance contract].”

Dou Huhai

As a result of China's 1978 economic reform, health-care coverage shrank dramatically. Among the rural population, it dropped to less than 10%. And even in the cities from the late 1970s to mid-1980s, people found themselves suddenly

vulnerable as urban medical insurance ceased to cover the dependants of salaried workers and many workers were laid off owing to restructuring of state-owned enterprises in the early 1990s. The amount of health care that consumers had to pay for out of their own pockets rose sharply from just over 20% in 1980 to a high of 60% in 2000. Just as pernicious was the impact of reform on the supply side. Having previously benefited from state funding, hospitals suddenly had to survive on patient fees. Doctors at state-owned hospitals started prescribing medicines and treatment on the basis of their revenue-generating potential – both for themselves and the hospital – rather than for their clinical efficacy, a practice that continues today.

Since 2003, the government has focused on two main types of insurance: the New Rural Cooperative Medical Schemes (NRCMS), which were initiated in 2003 for rural populations; and the URBMI, first piloted in 88 cities in 2007.

These schemes are heavily subsidized with the government paying up to 80% of the premiums. According to Dr Lei Haichao, Director of Policy Research at the Ministry of Health,



Dou Huhai, a migrant worker who damaged his fingers in a workplace accident.

WHO/Cui Weiyuan

the NRCMS now covers 833 million of the rural population, while URBMI covers 337 million. Under the reform plan announced in April 2009, more than 90% of China's 1.3 billion population will be covered by the NRCMS, URBMI or a third scheme called urban resident basic health insurance by 2011, up from 15% in 2003. By mid-2009, the government had invested 71.6 billion yuan (US\$ 10.5 billion) in the health-care reform plan, according to the State Council's Office of Health Care Reform.

This promises to change life for migrant workers who are among the most vulnerable members of China's working population. Another migrant worker who has been affected by catastrophic health expenses is Liu Mei. Her son, Ma Jilei, became ill with ankylosing spondylitis in 2003. Since then, she and her husband have spent virtually all their earnings on his medical bills. "Some of them come to us for help with catastrophic medical expenditure because some accident happens, or some family member gets severely ill," Wei says. "But we cannot help all of them." Some money comes in from charities, but it is not enough. "Relying on charitable funds to solve the burden of health-care costs is as useful as using a glass of water to put out a fire on a whole cart of wood," Wei says.

One of the main reasons for migrant workers' vulnerability is the typically informal nature of their employment. China's parliament, the National People's Congress, recently passed a new labour law providing better protection to workers. But, according to Dr Tang Shenglan, health and poverty adviser at the World Health Organization's (WHO's) country office in Beijing, its enforcement has not been very effective. Many migrant workers are hired directly by small private companies, including unregulated 'underground' sweatshops. Others find a job through a contractor – more often than not somebody the migrant workers knows from his or her hometown. "Many construction workers find jobs this way," Wei says. But even migrant workers hired by multinational companies struggle with insurance because of the fragmented regional nature of Chinese health-care financing. In recent years some migrant worker groups have advocated quitting insurance schemes

altogether because coverage cannot be transferred when they move to a new region, Wei says.

This may now be changing. In July 2009, the Chinese Ministries of Health, Civil Affairs, Finance and Agriculture and the State Administration of Traditional Medicine made a joint statement regarding the health insurance of migrants. According to Tang, more and more multinational and national companies are now registering their migrant workers with health insurance schemes. There are also ongoing efforts to simplify reimbursement procedures. According to Lei from the Ministry of Health, current policy allows migrant workers to register in either the NRCMS or URBMI if they have formal employment contracts with the enterprises.

“Relying on charitable funds to solve the burden of health-care costs is as useful as using a glass of water to put out a fire on a whole cart of wood.”

Wei Wei

While the government struggles to fine-tune insurance coverage it must also address issues on the supply side, particularly hospital funding. At present, hospitals continue to operate on a fee-per-service model. Officially Chinese hospitals are limited in what they can charge for services, but are free to generate volume to boost revenue by over provision of services and medical products including medicines. A cardiovascular specialist at a leading Beijing hospital said that he was obliged to charge fees for procedures to augment his 1500 Yuan per month salary (US\$ 220). He added that doctors at his hospital received a bonus depending on the income of different departments and on their position and contribution. In other words, the more procedures they performed – the most lucrative being the insertion of a stent in heart surgery – the more they took home in their pay check.

Inevitably this has led to uneasy doctor-patient relations. Yuan



WHO/Cui Weiyuan

Liu Mei, a migrant worker. For the last few years, she and her husband have spent nearly all the money they have earned on their son's medical bills.

Jianping, an investor relations director in Beijing and one of the beneficiaries of China's economic boom, expresses typical patient anxiety: "It seems to me that many doctors are treating patients [to] make their hospitals profitable," she says.

Chinese authorities have been looking at payment options since the 1990s when diagnosis-related group (DRG) payment was first pushed by the National Development and Reform Commission. DRG is a system to classify hospital cases into one of approximately 500 groups, this standardization is used as a basis to calculate fees.

Dr Hongwen Zhao of WHO's Department for Health System Governance and Service Delivery believes that as the broad outlines of hospital reform become clear, the payment method will also be sorted out. "Over the next three years the government will choose either a supply-side or demand-side financing model," he says, adding, "A huge amount of technical work needs to be done."

Tang adds that while alternative payment methods to fee-for-service methods to control medical costs, such as capitation and DRG, have been discussed in China for two decades, "there has been a lot of resistance from hospitals and other service providers to adopt these payment methods". ■

Thailand: health care for all, at a price

Thailand has had a universal health-care coverage scheme since 2002. In the second of our series on health financing, Apiradee Treerutkuarkul examines how renal-replacement therapy for chronic end-stage renal disease is straining the scheme's resources.

In 1998 21-year-old Thunyalak Boonsumlit fell ill so her worried parents took her to hospital. "I thought I had food poisoning," she recalls. The doctor, however, told her she had acute kidney disease and would die without immediate treatment. There was more bad news: although her parents were insured by Thailand's Civil Servant Medical Benefit Scheme, this scheme only covers dependants up to the age of 20. Boonsumlit was treated for a month and sent home.

In 2002 Thailand reformed its public health financing system. This extended the scope of coverage to 18 million people who were uninsured and to a further 29 million who were previously covered by less-comprehensive schemes.

It was the realization of a project that had been a quarter of a century in the making, starting with the creation of a social welfare scheme for the poor in 1975. The new scheme offered comprehensive health care that

included not just basics, such as free prescription drugs, outpatient care, hospitalization and disease prevention, but more expensive medical services, such as radiotherapy, surgery and critical care for accidents and emergencies. But it did not cover renal-replacement therapy due to budget constraints. Boonsumlit and thousands of fellow sufferers were on their own.

"There was a concern that renal-replacement therapy could burden the system. Major health risks leading to kidney diseases, such as diabetes and hypertension, were still not well controlled," says Dr Prateep Dhanakijcharoen, deputy secretary general of the National Health Security Office, which oversees the Universal Coverage Scheme. And renal replacement therapy is expensive. The cost of haemodialysis is about 400 000 baht (US\$ 12 100) per year. This is four times higher than the 100 000 baht (US\$ 3000) per quality-adjusted life year threshold set by the National

Health Security Office's benefit package subcommittee for drugs and treatments. This threshold was adopted as a national benchmark.

Dhanakijcharoen believes that the Universal Coverage Scheme plan should have included kidney disease from the outset, a view shared by Dr Viroj Tangcharoensathien, director of the International Health Policy Programme at the Ministry of Public Health. "It was a simple matter of fairness: "There are three health-care schemes in Thailand," he says. "Only the Universal Coverage Scheme did not include renal-replacement therapy."

In 2005 Boonsumlit became ill again and was diagnosed with end-stage renal disease. For a year her parents had to pay 400 000 baht (US\$ 12 100) to cover her dialysis. This time she was told that if a suitable donor could be found, a kidney transplant was the best option. The procedure cost 300 000 baht (US\$ 9000). Boonsumlit's mother donated a kidney, and once again she and her husband paid all the bills, including the cost of post-transplant medication required to prevent the rejection of a new kidney.

But there was increasing community pressure for change. People like Subil Noksakul, who had spent his life savings on medical treatment over a period of 19 years, were tired of being treated like pariahs. "I once managed to save 7 million baht. But all my savings are now all gone," he says. Like everyone else, he found it unacceptable that the Civil Servant Medical Benefit Scheme and the Social Security Scheme, which rely on public funds, both offered treatment for kidney disease while the Universal Coverage Scheme did not.

In 2006 Noksakul founded the Thai Kidney Club, which raised kidney patients' awareness of their rights and put pressure on the National Health Security Office to provide treatment. Finally, in January 2008, the then public health minister, Mongkol Na Songkhla, bowed to public pressure and



National Health Security Office, Thailand

The demand for haemodialysis has spiralled in Thailand.

included renal-replacement therapy in the scheme. For Boonsumlit, Noksakul and thousands of other kidney patients, it was a watershed moment.

Unsurprisingly, since 2008, demand for treatment has spiralled. According to Dhanakijcharoen, 2.5 billion baht (US\$ 76 million) of the total annual National Health Security Office budget of 120 billion baht (US\$ 3.62 billion) has been allocated to renal-replacement therapy with 8000 patients receiving haemodialysis and 4000 receiving peritoneal dialysis: to meet the full need, this treatment would require a huge increase in funding.

“The cost of renal replacement therapy is still less than 2% of the total budget,” he says, but warns the cost could blow out should Thailand fail to focus on prevention and reduce new cases.

The Ministry of Public Health’s Tangcharoensathien paints an even starker picture: “Without alternatives, renal-replacement therapy, when fully scaled up to target end-stage kidney patients, could consume more than 12% of the Universal Coverage Scheme annual budget, and push it to the verge of financial crisis,” he says.

The National Health Security Office is trying to reduce some costs by encouraging patients to perform their own peritoneal dialysis at home. This is dialysis in which patients filter their own blood by periodically injecting fluid into the abdominal cavity, which is later drained. Tangcharoensathien believes nurses can play a crucial role in



Thunyalak Boonsumlit



Subil Noksakul

training patients and family members to use equipment that is provided free of charge under universal coverage. Meanwhile, those patients who continue with the more expensive haemodialysis must now pay one third of the total cost of treatment.

“We would like to let the world know that it’s not necessary to launch a universal health-care system only when the money is there; what is important is to work steadily on it. But dedication is a must.”

Prateep Dhanakijcharoen

It is debatable whether home-treatment would have a big impact on costs, given the increased risk of infection and subsequent expenses associated with peritoneal dialysis, which costs up to 240 000 baht (US\$ 7300) annually. However, it would save rural patients the twice-weekly fares to visit a haemodialysis centre in a provincial city, which poor patients cannot afford. The National Health Security Office aims to reduce the cost of peritoneal dialysis to about 200 000 baht (US\$ 6000) per year.

More promising perhaps is the government’s broader campaign to improve the nation’s renal health. Screening for diabetes and hypertension, as part of a 2.5 billion baht (US\$ 76 million project) is due to start this year. According to the National Health Security Office’s Dhanakijcharoen, the project will cover 5500 communities and municipalities nationwide. “Although the current health-promotion fund is still insufficient, it is a good start for prevention and early detection of diabetes and hypertension among local residents,” Dhanakijcharoen says, adding that encouraging healthier lifestyles will also help to reduce the cost of chronic disease and the burden it places on the health budget.

Tangcharoensathien concurs: “If the government allocated more budget to run the scheme, the National Health Security Office would be able to invest more in reducing health risks, and people would not end up with kidney disease in the first place.”

Both men are eager to see the latest universal coverage initiative succeed. They are proud of what has been achieved on total health expenditure equivalent to 4% of gross domestic product (GDP) – compared to the world median of 6.2% of GDP and 4.5% for lower-middle income countries. Dhanakijcharoen says, “We would like to let the world know that it’s not necessary to launch a universal health-care system only when the money is there; what is important is to work steadily on it. But dedication is a must.” ■



Dr Viroj Tangcharoensathien believes that encouraging healthier lifestyles will help to reduce the cost of chronic disease.

Spectre of ageing population worries economists

Having achieved so much in extending health-care coverage over the past 30 years, the Republic of Korea is faced with ballooning costs from an ageing population. Lee Ji-yoon reports.

Eighty-one-year-old Lee Yang-soon remembers how things were before the Korean War (1950–53). “Many women died giving birth,” she says, adding that, even after the war, health services were limited. Most pregnant women did not receive prenatal checkups and gave birth at home. “Even when babies were born healthy, some of them died without the exact cause of death being verified,” Lee says. Other health-care services were also poor then. “I was suffering from a skin disease. The medical costs were too expensive and the drug didn’t work well. I used to apply a Japanese ointment that my friend who travelled to Japan frequently bought for me.”

It took another 20 years for the situation to begin to change. In 1976, the government introduced the National Health Insurance (NHI) scheme, obliging companies employing more than 500 people to offer the scheme. In the ensuing decade, this obligation was extended to smaller companies, then government and private school employees and finally the self-employed, who were brought under the umbrella of mandatory national health insurance in 1989. Running parallel to the NHI, the Medical Aid Program, a government-funded public assistance scheme, was established in 1977 to provide free medical insurance coverage to eligible low-income individuals, about 3% of the population in 2008.

In the past 30 years, average life expectancy in the Republic of Korea increased from 64.8 to 78.5 years – close to the average among member countries of the Organisation for Economic Co-operation and Development (OECD). Infant mortality also improved, from 27 deaths per 1000 live births in 1977 to 5.3 per 1000 in 2007, better than the OECD average of 6.1. “Several factors may have contributed to the overall health improvement of people in the Republic of Korea, but the implementation of the health insurance system seems to be one of the most decisive factors,” says Seo Nam-kyu, a research fellow at the Institute for National Health Insurance, an affli-

ate of the National Health Insurance Corporation.

Lee Yang-soon’s daughter-in-law, Lee In-sook, born in 1958, would be the first to agree. A cooking teacher at a local food institute in Seoul, Lee In-sook gave birth to her two daughters in 1983 and 1987 and the cost of prenatal care was never a concern. “I felt no financial burdens when I was pregnant,” she says. “I visited hospital every month to have my baby checked.” Her first daughter was born naturally but with her second she needed a Caesarean section, and for that she had to meet the entire cost of almost 1.2 million won (approximately US\$ 1000). Two years later, when the mandatory national health insurance programme started, it covered 50% of the cost of Caesarean sections, and it now pays up to 80% of the total cost.

Sharing the cost of care is a generally accepted fact of life in the Republic of Korea where, according to the OECD, the total proportion of household expenditure on health care, including payments into health insurance, stands at 10.5% – less than the OECD average of 12.9%. But it is

a system with obvious limits. Cancer patients, whose treatment might involve multiple surgical interventions, chemotherapy and a prolonged period of hospitalization, may face huge bills as the NHI covers only 75% of the cost. Lee In-sook, who lost both her mother and a sister to cancer, considers additional private health insurance a necessity, even though it is expensive. Last year her mother-in-law had hip replacement surgery. While the NHI covered 50% of the cost, the family shouldered the remainder.

The Republic of Korea has the highest out-of-pocket spending of any OECD country, with 36% of total health expenditure coming directly from patient payments at the point of service in 2007. Inevitably, this results in unaffordable bills for some: in 2007, an estimated 3% of all households in the country suffered catastrophic expenditure, defined by the World Health Organization as an obligatory disbursement greater than or equal to 40% of residual household income after basic needs have been met. Seo Nam-kyu points out that, although it is still high, out-of-pocket spending



Three generations (from left): Lee In-sook, aged 52, her mother-in-law, Lee Yang-soon, 81, and daughter Paik Soo-ryun, 28.

WHO/Lee Ji-yoon

is on a declining trend from a peak of 60% of total health expenditure in 1989, to 36% in 2007. Also, there is a yearly maximum of cost-sharing beyond which people do not have to pay.

There are two considerations here: one is health-care costs generally; the other is the proportion of those costs met by people out of their own pocket. On the costs front, there is concern. While total per capita health expenditure stands at only US\$ 1688 (compared with an OECD average of US\$ 2984), health-care expenditure is growing at 8.7%, which is faster than in any other OECD country (Turkey came second, but from a much lower base) and more than double the OECD average. A more chilling growth curve is revealed by the National Health Insurance Corporation, which reports a ten-fold jump in health expenditure from approximately US\$ 2.4 billion in 1990 to US\$ 29 billion in 2008; growth in the insured population meanwhile increased from 40 to 48 million.

There are several factors driving expenditure, including a rise in salaries and services covered, as well as over-reliance on high-tech medicine, over-prescription and high use of health facilities are all cited. The National Health Insurance Corporation records show that the number of hospitals and pharmacies nearly doubled over the past 20 years and, according to the



WHO/Lee Ji-yoon

Lee Yang-soon relied on her family to help pay 50% of the costs of hip replacement surgery.

World health statistics 2009, more than 37% of babies are born by Caesarean section. For Yang Bong-min, a professor of the School of Public Health at Seoul National University, a lack of regulatory rigour is at the heart of the problem. "Compared with other developed countries, the nation has been lenient towards over-treatment and over-diagnosis and has failed to control the whole system strictly," he says.

“If the elderly population continues using medical services and drugs at the current speed, medical expenditure in the Republic of Korea could surpass that of Japan in 2050.”

Yang Bong-min

In 2000, the government introduced reform that separated drug prescription and selling functions in the hope of reducing over-prescription and costs of medicines. But, according to Yang, the reform was inadequate and weak. "Due to pressure by doctors, pharmaceutical companies and other powerful stake-holding groups, no practical change has been made in the nation's medical system or in people's health spending," he says, adding that doctors continue to prescribe expensive brand-name drugs rather than generic alternatives. Seo, from the Institute for National Health Insurance, believes the private sector needs greater regulation.

The need for reform is becoming more urgent as the Republic of Korea is predicted to become an "aged society" by 2018. According to the Ministry for Health, Welfare and Family Affairs, people aged 65 and older accounted for 10.7% of the total population as of July 2009 and the proportion is growing. For Yang Bong-min, this changing demographic is going to have a huge impact in future health financing. "If the elderly population continues using



WHO/Lee Ji-yoon

Lee In-sook, whose mother and sister both had cancer, considers additional private health insurance a necessity.

medical services and drugs at the current speed, medical expenditure in the Republic of Korea could surpass that of Japan in 2050," he says. According to the *World health statistics 2009*, Japan spends around US\$ 2800 per capita while the United States of America spends US\$ 6700 per capita.

"A financially separate insurance system supporting elderly people is needed before the private sector dominates medical services for senior citizens," says Yang. "The current long-term care insurance [for people aged over 65, funded by contributions as well as state and local governments] still has limits in financing." According to Seo, the National Health Insurance Corporation continues to look for ways to secure financial resources, such as from taxes on liquor and tobacco, and streamline costs through a focus on disease prevention that includes promoting regular health check-ups for the elderly.

The growing ranks of the elderly are not only expected to change the rules by force of numbers; they will also figure heavily in the inevitable public debate. "Elderly people in the Republic of Korea tend to participate in politics actively. Along with their number, their political power will become more apparent within a few years," Yang Bong-min says, adding that legislators will have to give more thought to designing policy that reflects elderly people's needs. ■

What? No waiting lists?

The Swiss health system is a model that is envied for its universal coverage and standard of care. Everyone has insurance and there are no queues for treatment. So why are people complaining? Alice Ghent reports.

Every year as Switzerland's Federal Office of Public Health (FOPH) announces the annual round of health insurance premium increases, this nation of 7.5 million people lets out a collective groan. Last year, the pain was greater than usual. Concerned about the depletion of cash reserves in insurers' coffers, the FOPH allowed rises of up to 14.6% for basic insurance premiums depending on the canton. That hurt.

Since 1999 the Swiss have seen health insurance costs rise by 50%, according to the FOPH. From 2008–2009, the price hike was significant enough to cut 0.1% from rising household disposable income.

Nadia Bouchardy does not need an announcement to know that a sizeable portion of her family's income is being spent on health. Married to an ambulance driver with two young daughters, the family has an annual income of 90 000 Swiss francs (US\$ 83 000) before taxes and insurances. Every year around 10 500 Swiss francs (US\$ 9700) or 12.5% of their income goes on health insurance and extra expenses such as dental care.

Last year, Bouchardy, who is aged 41, had an operation and had to pay 10% of the costs of the operation, medicine and her stay in hospital. (In Switzerland, out-of-pocket expenses are capped to ensure families do not suffer what is termed "catastrophic expenses").

"We are not very happy with the health insurance system in Switzerland," she says. "Every year we pay more and we get less. The lists with items that are not covered anymore by the health insurance gets longer. Some items like glasses or basic medicine are not fully covered, so we have to pay these costs out of our non-health budget. So far we are lucky we have not been forced to borrow money in order to pay the health bill."

The Bouchardy family represents how middle-income Switzerland is being squeezed financially. They earn too much to benefit from the health subsidy received by households that spend more than about 8% of their income on premiums (the level of subsidy depends on the canton). Some 40% of households receive the subsidy – either through a lower premium or tax rebate – which is the govern-

ment's mechanism for preventing the cost of insurance from unfairly disadvantaging low-income families.

Professor Alberto Holly, of the University of Lausanne, is an expert in Switzerland's health financing system. He points to a system that is envied for its universal coverage, its equity, standard of care and lack of waiting lists. "One of the strengths of the Swiss system is equity with respect to health risk and patient ratio. No one is penalized for age, gender or medical history. However, it is not totally equitable and is regressive in respect to income," he says.

“The average Swiss only has to travel about one kilometre to a doctor and five kilometres to a hospital.”

Gaudenz Silberschmidt

Under the Swiss constitution, the Federal Government is responsible for managing the health insurance system, but has limited responsibility in terms of

health policy. Instead, this energetically democratic country has a decentralized system in which the 26 cantons are autonomous and choose how to organize their own health care. This results in a wide disparity in terms of insurance premiums, which are usually paid by householders, not employers.

Since 1996, it has been illegal not to have basic health insurance in Switzerland. There are 82 not-for-profit insurers that offer policies costing around 350 Swiss francs (US\$ 325) a month per adult. No one can be turned away under this scheme, known as LAMal. Further, some 44 companies offer complementary forms of insurance, which allow benefits such as dental treatment and access to luxurious hospitals, and these companies are free to choose clients according to their risk profile.

One characteristic of Switzerland's health-financing system is its expense. "This is not an efficient system," says Holly, "in that it has not been possible to control costs." The result is that Switzerland has the third most expensive medical system in the world. The World Health Organization's national health accounts show that in 2007 total health costs carved 10.6% from Switzerland's gross domestic product. Only the United



High technology diagnostic equipment is driving up health-care costs.

States of America at 15.8% and France at 10.9% were ahead.

Gaudenz Silberschmidt, head of international affairs at FOPH, says: "It is surprising that the system is not more expensive given the wage/price level and the health resources available. We have 300 hospitals in total. The average Swiss only has to travel about one kilometre to a doctor and five kilometres to a hospital.

"The number of facilities available is too high but that does not mean that the standard of care is too high. Some parts of the system have more efficiency than others," he says.

As the cantons are responsible for health care, the Federal Government in Bern uses the insurance system to drive costs down through a range of reforms. Incentives to use generics instead of brand-name drugs have been successfully introduced; laboratory tariffs and hospital financing are being restructured; and in 2012 Switzerland will introduce Diagnostic Related Groups, a method of classifying illnesses to determine a rate of reimbursement to hospitals. Hospitals will be paid a predetermined amount of money for treating patients from a given group, regardless of the actual cost of care provided.

“No one is penalized for age, gender or medical history.”

Alberto Holly

While the Government is trying to make the system more efficient, it also worries that some insurers providing the basic insurance under the LAMal scheme are practising risk selection, although it is illegal to deny anyone insurance and premiums cannot be increased without government approval. Companies are permitted to selectively advertise but not to selectively recruit clients.

"Risk selection is a problem in the LAMal scheme because so far the risk equalization scheme has not worked sufficiently," says Silberschmidt.



In Switzerland everyone must be covered by health insurance.

As premiums are the same regardless of age and gender, insurance companies are compensated if their risk profile is overly skewed. The Federal Parliament has decided to refine the system because age and gender are known to be relatively poor indicators of insurers' risk profile.

Holly says risk selection is practised in subtle ways. "Reimbursement is delayed, discouraging people so that they change insurer. Brokers will allocate people with bad risk to companies with higher premiums, so you don't see it happening."

In 2007, the Swiss rejected a referendum that would have established one government insurance company, preferring a system that guarantees market competition and the possibility of switching companies. Until recently the rate of switching was not high, but premium increases have changed the landscape. In December last year, Comparis.ch, a web site for comparing insurance services, conducted a survey and found 15% of 6000 people had changed health insurer within the past year. For the country as a whole, this means 1.2 million people may be looking for new health insurance.

The Swiss are permitted to change insurer twice a year. For Bouchardy, this seems an onerous process. "Theoretically you can give notice to your health

insurance company every year and go to another insurance company. But in reality it is very difficult, you have to compare the fees, it is a huge administrative effort. Also it can be quite difficult to reach the health insurance company for a personal conversation about burning issues."

Inevitably there are also disputes over contracts. Last year the ombudsman for health insurance settled 2812 matters over co-payments and 549 over premiums. But Silberschmidt says surveys reveal a general happiness with the system except during the month when higher premiums are announced. "We now want to push forward on managed care," he says. "We believe that some people are ready to accept that they can pay a lower premium, in return for not choosing their own physician, as long as they get treatment when they are sick."

Bouchardy's insurer already offers her a lower premium in exchange for using a doctor on the company's list. "This does not bother me," she says. "But at the same time I would not like it to become the case for the whole country. That is fundamentally about the liberty to choose."

Additional reporting by Jan Dirk Herbermann. ■

Nigerian farmers rejoice in pilot insurance plan

A Dutch-supported foundation is 'exporting' private health insurance to Nigeria, selling a US\$ 30 health-care package for US\$ 3. Gary Humphreys reports.

In Kwara state, a poor agricultural district in western Nigeria, health insurance is a rarity. Like 70% of Nigerians, most people survive on less than one dollar a day. If they visit the doctor at all, they have to pay out of their own pockets. However, this grim situation recently changed for one group of farmers.

They are not covered by Nigeria's National Health Insurance Scheme (NHIS), which despite being set up more than a decade ago, still only serves 3.73% of the population (civil servants working for the Federal government and in Bauchi and Cross River states, and 300 000 women and children under the Maternal and Child Health Project). Nor are they one of the seven million or so Nigerians, of a total population of 148 million, who can afford to pay for private health insurance. The 35 000 farmers and their dependents are in fact the beneficiaries of a scheme put together by PharmAccess, a Dutch government-backed, not-for-profit organization that supports HIV/AIDS treatment and what it describes as "general health-care projects" in developing countries.

In Nigeria, PharmAccess is supporting the idea of private health insurance, which it is delivering through the Health Insurance Fund (HIF), a foundation set up to pilot low-cost private health insurance, which includes HIV/AIDS care and treatment for low- to medium-income groups in sub-Saharan Africa.

HIF includes among its backers The World Bank and the United States Agency for International Development (USAID) – institutions that take an interest in applying

private health insurance 'solutions' to health financing problems in developing countries. The Dutch also have a strong commitment to private health insurance in their national system. So in a sense they are 'exporting' their know-how. HIF's local partner is Hygeia, a health management organization (HMO). Hygeia is one of Nigeria's largest HMOs with a network of more than 250 clinics and hospitals.

On the face of it the HIF scheme is puzzling. After all, how can people earning less than a dollar a day pay for the kind of insurance that would give them access to, for example, comprehensive maternal health care? The answer is they don't.

Establishing precisely how much they could or would pay was one of the research goals set by Emma Coles, HIF's director. "There really is no data on this," she says. "So we look at peoples' income. We also look at what they are already spending out of pocket, which roughly matches what they are willing to pay."

According to World Health Organization statistics, total health expenditure in Nigeria is around US\$ 33 per capita, 63.4% of which comes directly out of pocket. This suggests that the farmers of Kwara state might be ready to spend around US\$ 20 annually – or slightly less given the poverty of the region.

In fact, the farmers were reluctant to pay anything like this amount. Indeed, since 2007, Hygeia has been offering the farmers a health-care package comprising comprehensive primary health care and limited secondary health care, including up to five days of hospitalization, and maternal health care (including caesarian section) – a health-care package that HIF prices at US\$ 30 a year – for slightly less than US\$ 3.

So who pays the US\$ 27 balance? According to Coles, HIF is picking up the tab for the time being. Needless to say, this raises questions about the applicability of the term 'private health insurance' in this case, and also highlights sustainability issues. According to Coles, one solution for sustainability is the support of the Kwara state government. "The state governor has refurbished three public hospitals within the scheme, has committed to co-finance its expansion of the scheme and will take over

the subsidies over a five-year period," she explains, pointing out that this is a matter of contractual commitment by state governor Dr Abubakar Bukola Saraki.

Whether that contractual commitment will ultimately be honoured is questioned by some. Dr Tolu Ayangbaya, a health economist formerly with the Nigerian Ministry of Health, for example, says, "In five years' time, the person who promised [to pay the subsidy] today will not be in the government. So who are you going to hold accountable?"

“If the insurance isn't offered to identifiable groups that can share health risks, you run the risk of adverse selection.”

Emma Coles

Coles is also hopeful that consumers will start paying more of the premium as they begin to appreciate the advantages of prepayment and see what they are getting for their money. According to Dr Abayomi Sule, programme coordinator of the Hygeia Community Health Plan in Nigeria, attitudes are already changing. "Initially people did not understand the prepayment concept but over time we have educated them," he says. "We say it is a community scheme. If they don't use it, their neighbour will."

According to Dr Peju Adenusi, chief executive officer of the Hygeia Community Health Plan, the farmers have been delighted with what they get for their money. "Utilization in one clinic has jumped from 16 people per month before the programme was started to 1500 people per month afterwards," she says. One woman was so grateful for the life-saving Caesarean section she received that she named her baby boy Hygeia.

To be fair to HIF, it needs to be pointed out that, just because people are not paying a lot for the care they receive, does not mean that quality shouldn't be



Beneficiaries show their health insurance cards in Kwara state, Nigeria.

PharmAccess

PharmAccess



People line up for a health insurance card in Afon, Kwara state, Nigeria.

rewarded. After all, the farmers can choose which clinic or hospital they walk into and, although they are only paying \$3 dollars, the clinic or hospital then bills Hygeia for the care dispensed. Theoretically at least, this provides an incentive to give quality service. According to Coles, PharmaAccess has seen a substantial increase in the quality of the clinics which it measures every six months.

However, it is questionable whether such demand-side stimulus changes much in the context of Kwara state, where, according to Adenusi, a handful of clinics and three hospitals serve a population of around three million people. Moreover, as pointed out by Adenusi herself, the Hygeia Community Health Plan operates as a monopoly in Kwara state. The farmers don't really have much choice.

They are not alone in this. Despite there being 42 HMOs in Nigeria, consumer choice is generally left out of the equation. "Part of the problem in Nigeria is that HMOs tend to be granted a state monopoly as part of a contract with NHIS," explains Dele Abegunde, a Nigerian health economist working with WHO's Essential Medicines and Pharmaceutical Policy Department. "There's a kind of free market approach inherent in the NHIS choice for managed care insurance approach but, because of peculiarities on the ground, the principles of competition are not applied and the benefits elude the consumers," he says. Abegunde also points out that many Nigerian HMOs typically rake 15% off the top. This attracts a lot of players, including financial institutions such as banks, which have neither the skills, professional

mandate nor training for operating managed care.

Neither PharmAccess nor HIF make any claim to solving Nigeria's health financing problems, but they do hold out the hope of incremental improvement by addressing what is arguably Nigeria's biggest health financing challenge – the extension of health insurance coverage to nongovernment workers. Abegunde estimates that around 90% of the total workforce is engaged in informal employment of this kind – whether in casual or freelance work or agricultural labour. Not visible on payrolls or tax returns, nongovernment workers are notoriously difficult to 'capture' in insurance schemes which are generally based on documentation of one kind or another.

HIF offers a way into the informal sector by targeting specific groups for coverage. It doesn't really matter what the group is as long as it can be readily identified. Cole explains: "If the insurance isn't offered to identifiable groups that can share health risks, you run the risk of adverse selection." In other words, the service offered would be overwhelmed by the sick and elderly, while the healthy and young would tend to stay away.

In the United Republic of Tanzania, where HIF has just launched a second pilot programme, it is working with people with micro-loans from a local financial organization and is also developing a programme for coffee farmers in the Kilimanjaro region. The approach makes sense within the terms of what HIF is trying to achieve but, from a broader health policy perspective, it leaves key challenges unmet. What happens to all the people who can't be easily grouped, for example?

No-one is going to blame HIF for excluding people from what is, after all, a pilot scheme, but there are issues with this kind of targeted approach nevertheless. For Abegunde, the problem is that ultimately the whole population needs help and thus excluding anyone, no matter what the reason, should not occur. "We need national policy and national oversight," he says. "We need solutions that work for the population as a whole."

For Ayangbaya the problem of targeting is compounded when virtually all of the funding comes from outside. "You're giving the Kwara state government a five-year break from their responsibilities – from what they ought to be doing themselves," he says. ■



Nurses at the official launch of the health insurance programme in Afon, Kwara state, Nigeria.

PharmAccess

Special collection

Reality check for American dream

Recent US legislation is designed to expand coverage and to change the way health insurance is sold, but it does not address the health system's underlying problem: costs. Gary Humphreys reports.

"There's a lot of confusion out there," says Janet Witt, from the National Committee to Preserve Social Security and Medicare, the scheme that provides insurance to people aged over 65. Witt has been trying to explain what President Obama's health-reform legislation means. It has not been easy. "There are a lot of rumours," says Witt. The legislation itself is nearly a thousand pages long and will take years to implement. Its impact will depend partly on how individual states – many of them hostile to change – put it into effect.

The law extends insurance coverage to 32 million previously uninsured Americans. This extension will be paid for by increasing premiums, imposing new taxes and making cuts to Medicare. Almost all Americans will be obliged to get coverage by 2014 or face being fined.

From 2013, individuals earning more than US\$ 200 000 a year and households earning more than US\$ 250 000 will pay higher Medicare contributions, while high-income taxpayers will start paying a 3.8% tax on income such as dividends and interest. There will also be a 40% tax on so-called "Cadillac plans" – those with an annual cost exceeding US\$ 10 200 for individuals or US\$ 27 500 for families (not including optical and dental benefits). The self-employed and those working in small business will be among the main beneficiaries of the reforms.

Other immediate changes to Medicare include free preventive services, such as screenings for colon, prostate and breast cancer. Senior citizens caught in a Medicare funding gap for prescription drugs (referred to as the "doughnut hole") will receive a one-off rebate of US\$ 250 and, from 2011, they will be eligible for a 50% discount on brand-name pharmaceuticals.

A notable change will be reductions in subsidies to Medicare Advantage, a scheme introduced in 1997 to promote the use of private insurers within the main Medicare programme. Offered by private health insurance companies, Medicare Advantage plans are funded partially by Medicare and partially by charging members an additional monthly premium

to cover extra items such as prescription drugs, dental and optical care. Currently 24% of Medicare beneficiaries participate in Medicare Advantage plans. However, average Medicare payments to private insurers under this scheme are estimated at between 9–13% more than what would have been paid in the traditional programme. The reform will reduce these excess subsidies to the private insurers while concurrently offering bonus payments to insurers that score well in a quality rating system.

“The new law will improve access for people who have been disadvantaged by the system.”

Linda Blumberg

Patricia Nemore, a senior policy attorney at the Center for Medicare Advocacy in Washington DC, welcomes these changes. "Medicare Advantage was unfair to the taxpayers because part of it was funded by general revenues, and it was unfair to every single Medicare beneficiary because they were paying their

premiums but were not all enrolled in Medicare Advantage," she says.

Revenue from these changes will allow the government to increase participation in Medicaid, a means-tested programme serving people on low-incomes or with certain disabilities. This will increase coverage to an extra 20 million people and increase Medicaid eligibility in some states by 50% or more.

But Professor Randy Ellis, a health economist at Boston University and supporter of the reforms, warns: "We have now increased the number of people eligible for Medicaid without changing the number of doctors or beds." However, Dr Robert Wachter, at the University of California San Francisco Medical Center, says increased Medicaid enrolment will not necessarily pose a problem. If the reform encourages people to use primary care, hospital use may not be significantly increased.

Just as dramatic as the extension of coverage is the change to how health insurance will be sold. From 2014, private insurance will be sold in state-based "exchanges". Insurers will be unable to reject applicants based on health status or increase premiums beyond regulated levels. Policies sold through the exchanges must cover hospitalizations, doctor visits,



Dartmouth Hitchcock Medical Center

New health reforms will extend coverage to 32 million previously uninsured Americans.

prescription drugs, maternity care and certain preventive tests.

A major flaw in the American system has been that many people – particularly the self-employed and those working for small employers – have not had access to large group insurance. Risk pooling ensures that each contributor to a scheme does not individually carry the risk of having to pay for health care. The larger the pool of contributors, the cheaper the insurance.

Linda Blumberg, a health policy expert at the Washington-based Urban Institute, believes that, while falling short of some people's desire for a "public option" (i.e. a government-run health insurance plan), "the new law will improve access for people who have been disadvantaged by the system – especially those without access to group coverage". Many people have had access only to small group-rated or individual risk-rated plans that are either more expensive than large group plans or provide limited benefits. In addition, people with this insurance risk large premium increases or losing coverage if their health deteriorates (e.g. if a person is diagnosed with an illness in 2010, they may lose coverage or face paying higher premiums for this condition in 2011).

“If costs continue to skyrocket then insurance will be unaffordable.”

Robert Zirkelbach

"Fundamental to the whole concept of risk pooling is to have a large group of people with different risks so that the pooling enables cross-subsidy from the healthy to the sick," says Joseph Kutzin, health financing specialist at the World Health Organization. "As it currently stands, the individual and small group market in the United States works directly contrary to this principle."

So why is this going to take another four years? Blumberg cites the size and complexity of the task and less obvious congressional reasons – a 10-year budget cycle. "By holding off reform until 2014, you don't have to show a full 10 years of costs," she says. The delay makes the plan look cheaper than it is.

Some things are changing straight away. For example, insurers can no longer refuse coverage for children, deny coverage

to children with pre-existing illnesses or set lifetime coverage limits. Dependent adults younger than 26 will remain covered by their parents' policy if they are not offered health coverage at work. Small companies (with 25 or fewer employees with an average wage of up to US\$ 50 000) can get tax credits to offset up to 35% of the cost of premiums this year, rising to 50% in 2014.

On 1 July, US\$ 5 billion in federal funds become available for a high-risk insurance pool. This is a way to provide coverage for the people most in need, but who are currently excluded unless they can afford to pay very high premiums.

The high-risk pool is of great interest to many who are too young to qualify for Medicare and too well off to qualify for Medicaid – people like Carol Klapste, a 58-year-old woman living in rural Wisconsin. She has a thyroid problem, precisely the type of "pre-existing" condition that private insurers can refuse to cover. Until last year, Carol was covered by her architect husband James's employer-sponsored policy. Since James lost his job, the Klapstes have continued coverage under a scheme that allows employees to stay insured for 18 months after losing their job if they meet the full cost. But this will end soon, leaving Carol Klapste with the much more expensive option of taking individual coverage.

So now, the Klapstes, like millions of others, are hoping to get into the high-risk pool where they will be able to survive until 2014 – precisely what it is designed to do. But Blumberg warns some people risk being disappointed: "There's some lack of understanding on how restrictive [the high-risk pool] is," she says, referring to the requirement that people must have been uninsured for six months before application, a rule designed to prevent people dropping more expensive coverage. The high-risk pool is designed, in other words, to help people who have no coverage. "It's not perfect," admits Blumberg, "but at least it's something."

Robert Zirkelbach, a spokesman for America's Health Insurance Plans, the industry's lobby, has expressed concern about what he sees as the reform bill's absence of provisions for reducing health-care costs. According to the Organisation for Economic Co-operation and Development (OECD), the USA spends US\$ 7290 per capita on health care. This is more than any other country, roughly two and a half times the average of other high-income countries. High health-care costs are driven



Dartmouth Hitchcock Medical Center

The USA has the highest health-care costs in the world.

by a system in which doctors are paid more for supplying a higher volume of services and consumers have no incentive to limit spending either when their insurer pays the bills.

According to the Congressional Budget Office, health-care reform will cost US\$ 938 billion over a decade but increased taxes and fees and billions of dollars in Medicare payment cuts will shrink the federal budget deficit by US\$ 143 billion over 10 years. Beyond that, the issue of rising medical costs is largely unaddressed. There are plans to establish a board to oversee Medicare spending, but it is unlikely to start applying the brakes for several years.

The prospect of ballooning costs is a problem for several reasons. As Zirkelbach points out, costs drive insurance premiums. "If costs continue to skyrocket then insurance will be unaffordable," he says. In other words, if the private-for-profit insurers have to make big payouts to providers, they will have to raise premiums accordingly. There are provisions for government to step in if people cannot afford to pay for insurance, but the penalties for refusing to buy (US\$ 95 in the first years) are perceived to be too low to encourage participation. Some American corporations are talking about dumping their employee insurance packages, preferring to pay the fines.

Without participation, the system would run into trouble. "There is widespread agreement that, for the market reforms to work ... you need to get everybody participating in the health-care system, otherwise you will just have a system where people will wait until they are sick to purchase insurance, which drives up costs for everybody else," Zirkelbach says. ■

India tries to break cycle of health-care debt

Most of India's estimated 1.2 billion people have to pay for medical treatment out of their own pockets. In our continuing series on health financing, Patralekha Chatterjee reports on a scheme that is providing health care to families living below the poverty line.

Over the past year, 28-year-old Parameshwari Arun, a part-time maid in south Delhi, has borrowed the equivalent of US\$ 1000 to pay for her six-year-old son's medical treatment. Despite this expenditure, they still do not know what ails their son or whether he is likely to get better.

"This medical problem, which started innocuously when my son Vigneshwaram came home from school one day complaining of a pain in the leg, has thrown our family finances out of gear," says Arun. She and her husband, a chauffeur, together earn about US\$ 250 a month, barely enough to feed a family of four in Delhi.

The Aruns are not covered by health insurance, so the unforeseen expenditure on doctors' fees, tests, medicines and their son's hospitalization has strained their finances. The couple, which has one other child, live in Dakshinpuri, one of several resettlement colonies established in the late 1970s for rural migrants who previously were forced to squat alongside open drains, river banks and railway tracks in India's capital.

About 10 kilometres from Dakshinpuri, 40-year-old Sunita Gupta, a shack dweller, flashes her biometric smart card. It is one of her most prized possessions, giving her access to the government-sponsored National Health Insurance Scheme for families living below the poverty line.

The National Health Insurance Scheme was launched by India's Ministry of Labour and Employment in April 2008. "Recently, I had to have an operation," says Gupta. "I went to a private clinic. The smart card took care of the hospitalization charges. Now I am back at work. This cashless insurance scheme is a big help."

“The estimated share of household out-of-pocket expenses in total health spending is one of the highest in the world.”

Varatharajan Durairaj

Arun and Gupta exemplify the emerging challenges and opportunities in India, where the majority of the estimated population of 1.2 billion – spread across 28 self-governing states and seven territories within the federal republic – does not have access to quality health care.

One of the major reasons that India's poor incur debt is the cost of health care. "Less than 15% of the population in India

today has any kind of health-care cover, be it community insurance, employers' expenditure, social insurance etc," noted a July 2009 report by the Federation of Indian Chambers of Commerce and Industry.

"As a percentage of GDP the overall health expenditure in India is low," says Dr Varatharajan Durairaj from the World Health Organization's Department of Health Systems Financing. It was estimated to be 4% in 2008, according to the most recent National Health Accounts. Given that the government share of health spending is low, out-of-pocket payments are the dominant source of health financing.

India's health-financing system is much more complex than those found in other developing countries. "It does not fit into the definition of a tax-based or an insurance-based system. It is still evolving," says Durairaj. "The flow of money from communities, philanthropists and households, for example, is not well documented. While the amount and flow of government spending are known to a larger extent, estimates on private spending are based on responses from surveys of households. However, the estimated share of household out-of-pocket expenses in total health spending is one of the highest in the world, with more than US\$ 40 billion spent."

There are centrally funded schemes, but public health care is largely the responsibility of state governments, and financing varies from state to state. "Workers in the organized economic sector in India make up less than 10% of the total workforce," says Ravi Duggal, a senior trainer and health analyst with the International Budget Partnership, which aims to reduce poverty and improve the quality of governance around the world. "Corporate insurance schemes are insignificant, though in numbers, given India's size, they may sound huge."

Additionally, India has several community health insurance schemes promoted by nongovernmental organizations, but Duggal sees these as transitory measures and argues for universal health care.

"The biggest challenge is getting this unregulated and unorganized system under a single umbrella for providing universal access," says Duggal. "The reining-in process is not going to be easy as many of the



Parameshwari Arun borrowed the equivalent of US\$ 1000 to pay for her six-year-old son's medical treatment.

schemes' operators are too accustomed to being unregulated. But the world over, the only solution is organizing the entire health system of a country under a single-payer mechanism that regulates it. All resources are pooled in a single authority, such as the National Health Insurance in Canada or the National Health Service in the United Kingdom. Brazil and Thailand have also moved in this direction."

In India, financing outpatient care for the poor is a key concern. Financial constraints cause many to skip antenatal care or postpone treatment for minor ailments. In response, the Federal Government's flagship National Rural Health Mission has used conditional cash transfers to give money to households in return for specific actions, such as regular attendance at school and health clinics, and participation in immunization campaigns.

While debate continues on the best model for India's health-care financing, initiatives such as the National Health Insurance Scheme are getting off the ground. "About 75% of the financing for this scheme is provided by the national government, the remainder by state governments," says Anil Swarup, the director general of labour welfare in the Federal Ministry of Labour and Employment. "The National Health Insurance Scheme is doing well. In the Garhwa district of Jharkhand state, for instance, there has been 80% enrolment of beneficiaries. The private sector is play-

ing a critical role in the National Health Insurance Scheme. In some places, such as Kerala, it has increased the earnings of government hospitals, and some institutions are using the money to strengthen their infrastructure."

The scheme aims to protect households living below the poverty line from liabilities arising from hospitalization. Beneficiaries are entitled to up to 30000 rupees (US\$ 640) of cover for most of the diseases that require hospitalization. Coverage extends to five family members, including the head and spouse and up to three dependents. Beneficiaries pay less than US\$ 1 to register. The central and state governments then pay the premium to the insurer, which is selected by the state government.

Participating households can choose between public and private hospitals. Every beneficiary family is issued with a biometric smart card that stores members' fingerprints and photographs. After the insurance company is selected, it must engage both public and private health-care providers based on prescribed criteria. These hospitals are required to install the hardware and software to process smart-card transactions. The scheme provides an incentive to everyone involved.

"There have been three evaluations of the National Health Insurance Scheme to date," says Swarup. "They were conducted in Kerala, Delhi and one district in Uttar

Pradesh. The satisfaction rating was 90% (good to excellent) in Kerala, 86% (good to excellent) in Delhi, while Jaunpur district in Uttar Pradesh showed a 70% satisfaction rating. We are collating the feedback from the field and using it to improve the design of the scheme."

The National Health Insurance Scheme has distributed more than 15 million smart cards across 26 states, covering more than 55 million people. But as it scales up, it is facing challenges on several fronts.

"We have to build capacity at every level – hospital, bureaucracy, insurance companies – for effective implementation of the scheme," says Swarup. "Second, there is a need for greater awareness of the scheme among the public. Third, we need to improve quality of services at the hospitals. Until there is a buy-in at every level, it will not be a huge success."

Arun Nair, a researcher at the Delhi-based National Health Systems Resource Centre, says the information gap between patients and hospitals needs to be addressed. Many patients are not fully aware of their entitlements, and can be exploited in the absence of standard treatment guidelines.

Ish Kain, a National Health Insurance Scheme field coordinator in Gupta's neighbourhood of Tigri, agrees: "Many patients are semi-literate or illiterate. They are not aware of the full range of benefits under the scheme, nor aware of their rights. Sometimes hospitals take advantage of their ignorance."

"I did not have to pay for my uterus operation," says Gupta, "but I was charged for diagnostic tests." She is not sure whether such tests are paid for under the scheme, and in any case, has not been given any receipts.

Despite these problems, the scheme offers some hope to the poor of India requiring affordable health care. "The National Health Insurance Scheme is the first integrated effort by the central and state governments to provide social health protection to the informal sector," says Nair. "That is a big step forward."

However, sustainability is a key question. "The National Health Insurance Scheme will remain as a transitory measure unless its long-term sustainability is assured and it is linked with universal coverage plans," says WHO's Durairaj. "At present, the impact of the scheme on social health protection and its links with universal coverage plans are unclear as it is still evolving. At the same time, we cannot doubt its potential impact." ■

WHO/Patlekhya Chatterjee



Sunita Gupta has access to the government-sponsored National Health Insurance Scheme.

Rough roads to better care

Afghanistan is rebuilding its health system almost from scratch. In our continuing series on health financing, Julius Cavendish reports on a system sustained mostly by donor aid.

Mohammad Qasim, a portly man from southern Afghanistan, has criss-crossed some of the most dangerous terrain on earth in search of a cure for his haemorrhoids. Sitting on a hospital bed in Kabul, the Afghan capital, he explained how he had travelled down dirt roads dotted with homemade mines to see doctors capable of treating his condition. "It's a big problem for me," he says. "A lot of people with this problem haven't been cured and now they're in big pain. I am trying to solve it before it gets that bad."

At clinic after clinic Qasim says doctors prescribed pills that had no effect, or left him feeling worse. From his home of Gereshk he went south to the provincial capital of Lashkar Gah. From there he made the difficult 500 kilometre overland journey to Kabul, and back again. He is now in Kabul a second time, about to undergo surgery after various medications have failed to ease the pain. "I took a lot of pills," he says. "Now I'm just trying to be careful with my diet." He reckons he has spent around US\$ 200 on tablets, doctor's fees and transport – the equivalent of three months' pay.

The lengths to which Qasim has gone may seem extreme, but many Afghans venture back and forth across their ravaged country to seek medical attention.

In the same hospital in Kabul was a man from the suburbs of the northern province of Takhar, who had made the day-and-a-half journey across the backbone of the Hindu Kush to get orthopaedic treatment.

Another patient had spent the past month travelling between Kabul and his home in Ghazni province – along one of the country's most dangerous highways – for an operation, and then further care after complications set in. In the southern city of Kandahar, one person interviewed derided the regional hospital as a place you go to "if you want to die". Some 60% of patients in the Pakistani city of Quetta are said to be Afghans who prefer travelling abroad to making do with the health-care facilities at home.

Since the overthrow of the Taliban regime in 2001 and the ensuing flood of aid money, the Afghan government and donors have established a nationwide health-care system almost from scratch. The government has contracted nongovernmental organizations to provide a basic package of services in areas that it cannot cover. This arrangement has left the government and more precisely the Ministry of Health to focus on a stewardship role that involves policy and strategy setting,

coordination, contract management and monitoring and evaluation.

Despite its flaws, health-care experts say the funding and delivery of health care in Afghanistan have taken remarkable strides over the past few years. Merlin is a nongovernmental organization that delivers health services to people living in inaccessible regions, such as Badakhshan province in north-eastern Afghanistan. "The gains...have been fantastic," says Ben Mascall, country director for Merlin. "Some of the people we reach have never seen a doctor before," he says. Although some serious medical conditions require treatment that is not available, the presence of basic community clinics helps limit out-of-pocket expenses for minor complaints.

Although there have been enormous gains, Dr Abdul Wali Ghayur, from the Ministry of Public Health, admits that "by all measures, the people of Afghanistan fare far worse, in terms of their health, than any other country of the region". He also claims that the services delivered to the population over the last six years have increased substantially with impressive results. "Now attention should be paid to improve the quality of the Basic Package of Health Services, improve hospital and referral systems and initiate partnerships with private providers in the hospital sector to make sure the health problems are addressed. This will require sustained efforts of all partners."

Financing for the health system comes from three main sources: external funding from donors, public funding from the government and out-of-pocket spending by patients. Community health insurance is not known in Afghanistan: pilots held in 2004–2006 were not promising and the government has no concrete plans to introduce it.

Of the sources of funding, donor contributions exceed government spending by a ratio of more than nine to one, with foreign assistance to Afghanistan's health sector standing at just over US\$ 223 million for 2008, according to government figures. The three main donors are The World Bank, the United States Agency for International Development and the European Commission.



WHO/Chris Black

Many parts of Afghanistan's north-eastern Badakhshan province are accessible only by foot and it can take days to reach health care.



Dr Abdul Bashir provides health checks in a Merlin-led monthly clinic in Khaspak, Badakhshan.

Significant contributions also come from several United Nations agencies, the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Meanwhile, a European Commission report suggests that out-of-pocket spending makes up somewhere between 73% and 79% of the total. A separate estimate by WHO puts the figure at a more modest 60%. (The discrepancy is an indication of how difficult reliable data is to come by in Afghanistan.)

But in either case, “the most important thing in a poor country like this is the out-of-pocket expenses,” says WHO medical officer, Dr Ahmed Abd El Rahman. “Afghanistan has made substantial progress in health care over the past few years. But the strange thing is that while the public sector is growing, the private sector is flourishing more.”

There are several reasons for this. First is the overall lack of public resources facing the health sector. Research from 2003 into how much the provision of a basic health-care package would cost in Afghanistan came back with a figure of US\$ 4.55 per capita – a figure that has been cited repeatedly since then. But the Ministry of Public Health’s Wali Ghayur warns that: “considering the information constraints in conducting this exercise, it would seem that US\$ 4.55 can only be a very vague indication of what costs might be.”

Ilkhom Gafurov, a senior health adviser with the Swedish Committee for Afghanistan, says that level of funding is completely inadequate. “Maybe for 2003 it was okay to provide minimum services. Maybe that was acceptable to start with but, over the years, this was never reversed. WHO has been recommending US\$ 20–30 per capita,” he says.

The implications of underfunding are tremendous, he continues. “You basically have to sacrifice something to run something. You sacrifice training or you limit your services. If you have a low budget for health care and patients come, what do you do? You tell them they have to buy their medicines. So, although health care is declared to be free, in fact it is not. It pushes people to the private sector because they think they will receive better service. Patients perceive ‘this clinic has a bad director, they don’t have medicines. If I go to the private sector I will get a good doctor and there will be medicines.’”

Compounding the costs for many patients is the perception that hospitals in Kabul are better than clinics nearby, no matter what the ailment – “so many [people who] could be treated at clinic level are treated in hospitals even though there are fewer hospitals than clinics,” says Gafurov.

Afghanistan’s forbidding geography also plays its part. Anecdotal evidence suggests that patients living in remote ar-

reas tend to head for large hospitals rather than small clinics if they do decide to seek medical attention. Clinics in Samangan, a province isolated by its mountainous terrain, receive roughly one third of the patients of those received in Laghman, where the terrain is gentler and there is access from the main road from Kabul to Pakistan.

In part, this may be because there is a better representation of women on the staff at Laghman – meaning expectant mothers and children prefer to receive treatment there. But Gafurov points out that there is also an element of wanting to do things properly. “If they have to make an effort to come down from scattered villages in the mountains, they would rather travel an extra 50 kilometres to get good service,” he says.

The tendency for patients to choose tertiary health-care facilities ahead of clinics puts added strain on an already under-funded system. Patients often pay their own way to get better services, even in the public system where health care is nominally free. Experts say that it is impossible to gauge the extent to which unofficial payments occur in the health system. According to Gafurov, this is most common at tertiary level. “Patients make these kinds of payments in order to stay comfortable,” he says. “It is something that happens frequently. Certainly it’s a problem.” But that said, “it is not extortion and it is only at the hospital level for very clear reasons – the hospitals are over-burdened. Patients will get [treatment] in any case but some people choose to accelerate the process.” ■



A nine-month-old baby with pneumonia and malnutrition is watched over by his grandmother at Samangan provincial hospital.

Brazil's march towards universal coverage

Brazil's landmark reform in 1988 has brought health coverage to millions of people, but the system is underfunded, report Claudia Jurberg and Gary Humphreys in a continuing series on health finance.

In 1988, half of Brazil's population had no health coverage. Two decades after establishing its Unified Health System (*Sistema Único de Saúde*), more than 75% of the country's estimated 190 million people rely exclusively on it for their health care coverage.

One beneficiary is 44-year old Marlene Miranda da Cruz, who lives in the Manguinhos slum of Rio de Janeiro and receives care through the Family Health Programme (*Programa de Saúde da Família*).

Da Cruz, who struggles to make a living by selling beauty products, has two sons, one of whom has a neurological disorder and is bedridden. "My son needs care 24 hours a day," she says, "meanwhile I have to look after my four grandchildren." Today she has come to the Family Health Programme clinic because one of her grandchildren has contracted chickenpox. "I know that I will be well attended here," she says.

Da Cruz is one of 35 000 people served by the Manguinhos clinic, which is run by 11 teams of health workers, including physicians, nurses, dentists and community agents. "At the end of the year there will be 16 teams to take care of 45 000

Manguinhos residents," says Alex Simões de Melo, the clinic's managing director.

The Family Health Programme, which covers some 97 million Brazilians, is a key part of the national Unified Health System. It employs more than 30 000 teams of health-care workers who make concerted efforts to reach the country's poor and isolated communities.

“If the budget of the Health Ministry was still based on the legislation of 1988, it would be more than double what it is today.”

José Noronha

Apart from offering primary health care free at the point of service, mainly through the Family Health Programme, the Unified Health System provides a wide range of hospital services, including heart surgery, sophisticated medical imaging and laboratory diagnostics. It also supports a

robust vaccination programme, prevention campaigns, basic dental care and 90% subsidization of many essential medicines.

Decentralization has played a fundamental part in Brazilian health-financing reform. In 1996, legislation transferred part of the responsibility for the management and financing of health care to the country's 26 states and more than 5000 municipal governments. States are required to allocate a minimum of 12% of the total budget to health while municipal governments must spend 15% of their budget on health. The federal government also contributes money raised from taxes. At the municipal level this system seems to work well: 98% of the municipalities meet the 15% budgetary requirement and some spend more than 30%, according to Antônio Carlos Nardi, health secretary and president of the National Council of Municipalities Secretaries for Health (*Conselho Nacional de Secretários de Saúde*).

"Communities are actively involved in decisions about municipal budgets," says Professor Sulamis Daim, of the State University of Rio de Janeiro.

"Maringá municipality is a particularly striking example of popular participation," says Nardi, with the community "participating in discussions at city hall, in how budgets are allocated, in the supervision of accounts and in the approval of the annual management reports." Maringá municipality, 400 kilometres west of Sao Paulo in Paraná state, has committed more than 20% of the total budget to health in the past six years, well above the 15% required.

This kind of commitment is less evident at the state level, with more than half of the 26 states failing to meet the required 12% funding target. "One of the weaknesses of this system is that there is a very broad concept of health expenditure," says Dr Francisco de Campos, national secretary of the Secretariat of Human Resources for Health at the Ministry of Health. "Some states have used the money for sanitation or additional health insurance for civil servants. While this may indirectly affect the health of the population, we need to define health expenditure more precisely."



Marlene Miranda da Cruz with her grandchild Wesley and a health worker at the Family Health Programme clinic in Manguinhos.

Claudia Jurberg

At the federal level, the main problem is the lack of funds. According to the *World health statistics 2010* published by the World Health Organization (WHO), Brazilian per-capita government health expenditure in 2007 was US\$ 252, putting it behind neighbouring Argentina at US\$ 336 and Uruguay at US\$ 431. According to Dr Gilson Carvalho, an adviser from the National Council of Municipal Health Secretaries, around US\$ 73 billion of public funds are needed to sustain Brazil's comprehensive system of universal coverage. This suggests that the government needs to spend more than US\$ 100 extra per person than it currently does.

In 1996, the federal government introduced a tax on financial transactions specifically to fund health which, in 2007, raised approximately US\$ 20 billion. However, the tax was dropped due to concerns over the excessive tax burden and concerns that the funds were not being entirely devoted to health care as intended. "This caused an immediate drop in revenue for the Ministry of Health," says de Campos.

José Noronha, former health secretary both in Rio de Janeiro state and in the Ministry of Health, points out: "If the budget of the Health Ministry was still based on the legislation of 1988, it would be more than double what it is today."

In the 1988 constitutional reform that set up the Unified Health System, 30% of the budget set aside for social

security was to be allocated to health care. "If 30% of the social security budget had really been committed to health care in the past 20 years of the Unified Health System, we would be heading in the direction of the kind of comprehensive public system that exists in Europe and Canada – in line with the principals of universal, comprehensive, equitable coverage with social participation in the financing," says Nelson Rodrigues dos Santos, president of the Health Rights Institute (*Instituto de Direito Sanitário Aplicado*).

“If we just put more money in the system without monitoring expenditure, this won't necessarily improve services.”

Francisco de Campos

Daim, if the state university in Rio de Janeiro, also notes a lack of commitment on the part of the federal government, which she says has a direct impact on the Unified Health System. "Today, there is a significant decrease in the percentage of federal spending on health relative to tax revenues. Since the creation of the Unified Health System, underfunding

has precluded investment in expanding the supply of services, as well putting a brake on remuneration for services and procedures," she says.

Inadequate funds are linked to problems in the basic health infrastructure and shortages of hospital staff. Many patients, instead of accessing primary health-care services, only come into the health system at the last minute, sometimes via hospital emergency departments. "Services are overcrowded as a result, with long waits and queues," says dos Santos.

Not surprisingly, many Brazilians opt for the private sector to avoid these kinds of delays and frustrations. Brazil runs a two-tier system, offering businesses and individuals the possibility of purchasing health care through private insurers regulated by the National Supplementary Health Agency (*Agência Nacional de Saúde Suplementar*). People who buy private insurance get a tax rebate but still have to contribute to the Unified Health System through their income taxes. The percentage of subscribers to private insurance has increased since 1988 and last year more than 20% of the population opted for private coverage. Needless to say this option is only open to people on higher incomes; poorer people must make do with the Unified Health System.

Despite the various financing issues, there have been significant improvements in health-care outcomes in Brazil. "Decentralization, the emphasis on primary health care and the establishment of automatic federal funding transfers to the municipalities have had a significant impact on health indicators," says Noronha. Infant mortality has decreased from 46 per 1000 live births in 1990 to 18 per 1000 live births in 2008. Life expectancy at birth, for both sexes, has also risen from 67 years in 1990 to around 73 years in 2008. Regional inequalities have also decreased. The difference in life expectancy at birth, for example, between the wealthier south and the north-east was eight years in 1990; this gap had closed to a five-year difference by 2007.

"Brazil has made tremendous progress but there's still a lot to do," says de Campos. "We need a combination of managerial expertise and money. If we just put more money in the system without monitoring expenditure, this won't necessarily improve services." ■



Claudia Jurberg

Patients receiving treatment at the Emergency Unit in Manguinhos.

New Zealand cuts health spending to control costs

New Zealand's health-care system is undergoing a series of cutbacks to reduce costs, but critics are concerned that the health of people on low incomes and in some population groups may suffer. Rebecca Lancashire reports in our series on health financing.

When Robyn Pope was diagnosed with breast cancer in 2008 she was told that she would have to wait two months for a mastectomy if she wanted breast reconstruction as part of her treatment in the public health system. "Two months may not seem like a long time," says Pope, a mother of three, who lives on the Kapiti Coast of New Zealand, "but a day lived knowing that you have cancer in your body is like an eternity".

The underlying reason for the delay was a familiar one – funding. Like other countries offering universal health care, New Zealand struggles to meet the steadily growing demand for a full range of high-quality health services offered largely for free to everyone, while remaining cost efficient. In the past eight years, New Zealand's total health expenditure has doubled to 3.6 billion New Zealand dollars (NZ\$) (US\$ 10 billion). In the face of economic slow down, the government is calling for reform to rein in this expenditure.

"High-income countries with ageing populations need to look for efficiencies in their health systems," says Riku

Elovainio, a health economist at the World Health Organization. "But the pursuit of efficiency should not result in deterioration of the system's quality nor in its equity. Governments that make cuts to primary health care services usually regret this decision, as it can end up costing more in the long run."

“We Maori are living longer in the past 10 years but I am worried now that we might go backwards.”

Jules Taniwha

While Pope was unhappy about the two-month wait, she says that her primary health care providers – particularly the community oncology nurses – were “fantastic” and her entire treatment was free. Relief for other patients is now in sight. Reducing waiting times for critical cancer treatment, in particular radiation waiting

times, is one of the government's health targets to be achieved by the end of 2011.

Some health services, such as those offering cancer treatment, may receive more funding under government plans to improve quality and efficiency, while others face cuts. But the cuts, critics say, mean that fewer services may be available to some population groups and doctors' fees remain prohibitively expensive for some people.

"The public system in New Zealand is generally quite good and deals well with serious illness," says Don Matheson, Professor of Health Policy at Massey University, Wellington, and a former Deputy Director-General, Public Health, for the Ministry of Health. Its patient-centred system and well-coordinated care are seen as exemplary by other countries, he adds. But, he says, equity is "a glaring problem". When significant numbers of New Zealanders cannot afford to go to the doctor, this creates a "knock-on effect through the system – they won't access care and their health outcomes will be worse".

While the majority of public services are provided free to patients, including almost all public hospital treatment, care during pregnancy and birth, and basic dental care for children, most New Zealanders can expect to pay between NZ\$ 17 and NZ\$ 75 per visit to the general practitioner. Visits to doctors are free for most children aged less than six years and cost less than NZ\$ 20 for very low-income earners. According to the Commonwealth Fund's 2010 survey of world health systems, 32% of low-income earners in New Zealand said they did not visit a doctor in 2009 due to the fees.

Most of the country's primary health care services are organized by Primary Health Organizations (PHOs) – with services provided by groupings of doctors, nurses, counsellors and other health professionals – that provide a wide range of first-line curative and preventive health services and serve more than four million people, some 95% of the population. As part of its reform, the government plans to halve the number of PHOs through mergers and closures. So far, the original



Jules Taniwha and Justine Thorpe of Well Health primary health organization.

Rebecca Lancashire

81 PHOs that were established since 2002 have been reduced to 70.

The country's health delivery model is in flux but is currently made up of 20 District Health Boards (DHBs) located throughout the country, funded by the Ministry. The DHBs plan, fund and deliver most publically funded health services, including hospitals. In 2009/2010, DHBs incurred a deficit of almost NZ\$ 100 million.

Both DHBs and PHOs are facing cuts to their budgets. How these and any further cuts will affect New Zealanders' health is difficult to gauge in the short term. At the moment, the health of New Zealanders is in good shape, according to Deborah Roche, the Ministry of Health's Deputy Director-General, Strategy and System Performance. Roche points to the 2008 and 2009 figures which show life expectancy and infant survival have increased markedly since 2000. The past three years have also seen a steady increase in immunization and decline in smoking.

Despite these improvements Maori, who constitute 14.5% of New Zealand's 4.3 million population, and Pacific people (6.9%) both have disproportionately poor health outcomes compared with the rest of the population. These include high rates of chronic diseases, such as diabetes and heart disease, and childhood illnesses such as rheumatic fever, which is linked to poor living conditions such as damp, overcrowded homes and poor nutrition.



Courtesy of Don Matheson

Don Matheson, Professor of Health Policy at Massey University, Wellington.

"It's not about the number of PHOs – it's about PHOs being capable and fit for purpose to address these issues across populations at a local level," says Roche, pointing out that around one third of New Zealanders are enrolled in just four PHOs, while 12% of the population is spread thinly across 41 smaller ones, which struggle to achieve efficiencies of scale and the integration of services across the system.

Many smaller PHOs facing merger or closure argue that their services are already highly efficient. "The key role of the PHO is to get to know the community and you can't do that if you're too big," says Justine Thorpe, co-manager of the Well Health PHO in New Zealand's capital city, Wellington.

“We can make the system more efficient by providing more operations for this particular dollar or more consultations for that, but the question is who actually gets those extra services and are they the people who need them most?”

Don Matheson

Jackie Cumming, associate professor and director of the Health Services Research Centre at Victoria University, Wellington, shares Thorpe's view: "Smaller PHOs can be really effective and help reduce inequalities by working very closely with the community and health professionals to ensure those services are actually working," she says, adding that there has not been enough analysis of the effectiveness of individual PHOs to know whether mergers are a good idea.

Neither is size necessarily an indication of impact, Thorpe says, pointing out that some smaller PHOs, such as Well Health's two branches serving low-income communities in Newtown and Porirua, deal with high numbers of clients with several chronic diseases.



New Zealand Ministry of Health

Deborah Roche, Deputy Director-General, Strategy and System Performance, at the New Zealand Ministry of Health.

Says Thorpe: "Well Health may have just over 13 000 clients but it is a high-needs population. We have 20% refugees and migrants and 35% Pacific Island, 19% Maori and the rest European." A high percentage of this population requires services for mental health and diabetes.

Thorpe is wary of a deficit reduction policy that, in her view, simply throws up a financial barrier to access. Thorpe says that government pressure on DHBs to reduce their deficits "straight away puts a huge pressure on us". "We can't put [those costs] onto our clients. Many can't afford to pay, and yet they are the ones who most need these services".

Jules Taniwha, who has diabetes and respiratory illness, is a patient with Well Health's Newtown Union Health Service and an advocate for several local community health groups. She is also concerned that funding cuts may mean PHOs are forced to raise their fees. "We Maori are living longer in the past 10 years but I am worried now that we might go backwards," she says.

Matheson says equity is not a problem that can be solved simply by making the system more cost effective. "We can make the system more efficient by providing more operations for this particular dollar or more consultations for that," he says, "but the question is who actually gets those extra services and are they the people who need them most?" ■

Bridging the gap in South Africa

The South African government's proposed national insurance scheme aims to tackle the stark divide in health care between rich and poor. Claire Keeton reports.

When she was four years old, Thando (not her real name) came for treatment at a public hospital in Johannesburg because she was very ill with AIDS. "I first saw her in 1998 with advanced disease and her CD4 count was less than 50," says Professor Ashraf Coovadia, a paediatrician at the Rahima Moosa Mother and Child Hospital. "In 1999 we managed to get her antiretrovirals (ARVs) through a research project."

Prior to 2003, ARVs were not available in the public health system in South Africa, the country with the highest number of people with HIV/AIDS in the world. As a result, private patients could get the life-saving drugs and buy their survival while many patients in the public sector died.

It is this stark public-private divide that the South African Government hopes its proposed National Health Insurance (NHI) scheme will deal with by providing universal access to health care "based on need rather than ability to pay". Thando was lucky to get therapy in time and this "lovely teenager", raised by her aunt, is the longest attending patient at the hospital's paediatric clinic. "Prior to the rollout, we had a handful of children accessing ARVs, less than 5%. Now the majority who need it are on ARVs and doing well," says Coovadia.

Access to HIV/AIDS treatment has expanded dramatically in the past decade and, since the 1994 democratic elections, access to health services in general have improved for poorer South Africans. However, the standard of care in the public sector has been steadily deteriorating.

"South Africa has had difficulty post 1994 in grappling with the HIV epidemic – that was a real curveball," says Professor Helen Schneider, chief researcher at the University of Cape Town's (UCT) Centre for Infectious Diseases Epidemiology and Research. She identifies the failure of the district health system and poor governance and management of hospitals as some of the major challenges.

Recent research reports also cite underfunding and mismanagement, shortages of health professionals and deteriorating infrastructure as contributors to the decline in the quality of public health services.

"The past 15 years have shown how quickly a reasonably well-functioning health infrastructure can be run down and how expensive it is to build up again," stated Dr Mamphele Ramphele, a former UCT vice-chancellor and former managing director of The World Bank, in a report urging the public and private sectors to join ranks to deliver better care.

South Africa's public sector strike in August, which involved the withdrawal of care by striking health workers, is alleged to have caused dozens of patient deaths and required the transfer of high-care patients to private hospitals, thereby highlighting the gulf between these parallel systems.

Health Minister Dr Aaron Motsoaledi told the *Bulletin*: "the starting point for the NHI is to close the increasing gap between the rich and the poor. If I am sick, I get the best care. If people are unemployed, they can forget it." He describes the existing health-care system as "very expensive, destructive, unaffordable and not sustainable".

"We are spending more money (8.6% of gross domestic product in 2007) than many middle-income countries and our outcomes are poor." For this he blames the way funds are distributed and escalating costs.

UCT's Health Economics Unit reports that private health insurance spending per member almost doubled between 1996 and 2003, while public health sector spending per patient decreased.

Dr Mphata Norman Mabasa, chairman of the South African Medical Association, finds the disparity in access and care between public and private sector patients jarring.

"I've seen many instances of patients in the public health system dying when hospitals can't keep them longer. If you've got money, you can buy and save lives. In the public sector, for example, kidney dialysis is rationed." He adds that even within the private sector, members on low-cost schemes come off worse, with a narrower range of services covered and patients needing to spend a higher proportion of their incomes. Mabasa also points out the marked disparity between urban and rural care, with many rural patients having to travel into cities to access services.

Government spending on health care comprises less than half of total health expenditure even though the public system serves more than 80% of the population (i.e. around 40 million South Africans) without private health insurance. Around 70% of all doctors and most special-



Marianne Schwankhart

Patients wait for treatment during the recent strike at Chris Hani Baragwanath Hospital in Johannesburg.

ists only work in the private sector, the remaining 30% serve the public sector.

Sixteen per cent of the population use private doctors and hospitals which are covered by their health insurance, often with a monthly contribution from their employers. Their premiums and direct payments to health providers (about a third of which are not reimbursed) cost in total about 11 000 South African rand (R), (US\$ 1571) each year.

The public sector covers 68% of people who do not use any private care at all, spending about R1900 per person. Another 16% of the population rely on the public sector for hospital care but use the private sector for primary care, paying out of their own pockets, with total spending about R2500 per person.

In September, the ruling African National Congress (ANC) released its current proposals for the NHI for wide consultation. According to Dr Zweli Mkhize, chairman of the ANC's health committee, the scheme is expected to cost an extra R11 billion on top of the R117 billion in the government's health budget for 2012. Taxation to pay for this compulsory medical insurance scheme is expected to start in 2012, with a plan to phase it in over 14 years.

Mike Waters, health spokesman from opposition party, the Democratic Alliance, expressed reservations about the NHI. "The priority in providing quality public health care is not to change the financing mechanism for the public health

Box 1. The key goals of the national health insurance scheme

- to provide universal coverage for all South Africans;
- to pool risks and funds;
- to improve negotiations with providers for supply of services and rational payment levels with quality assurance;
- to create one public fund with adequate reserves and funds for high-cost care;
- to promote efficient and effective service delivery in both public and private sectors; and
- to assure continuity and portability of national health insurance within the country.

system, as the ANC believes, but rather to improve the basics of delivery and ensure that the money available is used for its intended purpose."

He raises concerns that the NHI "represents more bureaucracy and more centralization, and therefore in fact will only worsen the problems that public health care faces". Waters also suggests that the burden of added taxes could force middle-income earners back into the public system, which is already overextended.

"Data from the Health Department at the end of last year showed a 35% year-on-year increase in nurse and doctor vacancies...Hospersa (the health worker trade union of South Africa) argued that a staggering 80 000 new posts would have to be created."

On the other end of the spectrum, analysts are concerned that NHI proposals could transfer a significant part of the burden of the public health problems to the private sphere.

A private economic consultancy, Econex, has published an extensive critique of the proposals, teasing out some

of the implementation challenges, chief among them the enormous anticipated cost of the system as currently conceptualised. In April Dr Nicola Theron, director of Econex, warned that the envisaged cost of funding an NHI could total R216 billion per annum. "Even if the most economical model were to be applied, the figure would still equate to a total of R197 billion; a number close to South Africa's entire personal income tax contributions," she says.

Even cost models produced for the Congress of South African Trade Unions, which strongly supports the introduction of NHI, suggest an additional funding requirement of around R189 billion, before administrative savings. According to Theron, anticipated savings are likely to be less than currently assumed, while usage pressures and capacity constraints are likely to place the system under enormous stress.

Factors that have not been given sufficient attention, says Theron, are the cost and administrative complexity, South Africa's unique disease burden and the enormous demand pressures that are likely to be unleashed by the introduction of a comprehensive benefit package with zero co-payments.

On the other hand, NHI would introduce other new dimensions to the South African health financing system, notably the possibility of using public resources through strategic purchasing of services for the population. "International experience clearly demonstrates that changing the way of paying providers is necessary to secure greater value for money," Professor Di McIntyre, from UCT's Health Economics Unit, states in a recent analysis. "An integrated pool of funds is the only way to ensure that all the available human resources are used more effectively and efficiently. Then everyone will be able to access health services on the basis of their need for care and not on the basis of their ability to pay." ■



Marianne Schwankhart

The national health insurance scheme aims to create a pooled fund with reserves for high-cost care.

Linking health to microfinance to reduce poverty

Sheila Leatherman^a & Christopher Dunford^b

Introduction

At the forefront of global health priorities are the achievement of the United Nations' Millennium Development Goals (MDGs) and the strengthening of health systems. The MDGs focus the worldwide development agenda on reducing extreme poverty as well as improving health, education and human rights by 2015. At the same time, the World Health Organization is emphasizing the need to build health-system capacity, a global challenge that is most elusive in rural and resource-poor environments. Meeting global health needs calls for more inter-sectoral approaches. One that holds real promise, though largely underutilized, is the linking of microfinance with appropriate health-related services.

Numerous impact evaluation studies support the effectiveness of microfinance and its impact on poverty. Research funded by The World Bank examined the impact of three microfinance institutions in Bangladesh over a seven-year period and found dramatic decreases in overall poverty, with the highest impact on those families in extreme poverty.¹ However, microfinance is not a silver bullet; legitimate issues exist, such as the ability to address the needs of extremely poor people, the level of debt burden for individuals, and the uneven performance of microfinance institutions worldwide.

Microfinance institutions and health

More than 3500 microfinance institutions around the world provide credit and other financial services to more than 155 million households in support of income generation and consumption. According to conservative estimates from United States Agency for International Development (USAID) studies, at least 34 million of these households are very poor, representing 170 million people, many of whom live in remote areas beyond the

reach of health agencies, both private and government.

Every day, thousands of microfinance workers travel to poor communities to provide microfinance services, often to groups of women convening on a regular basis over months and years to repay loans and deposit savings. Many microfinance institutions in Africa, Asia and Latin America already successfully offer services beyond microfinance, including training in business and financial management. An increasing number also offer health-related services, such as education, clinical care, health financing (loans, savings and health insurance) and establishing linkages to public and private health providers to facilitate access to health care. This is a vast, private-sector infrastructure of service delivery that is mostly self-financed by interest on loans.

Microfinance institutions offer a unique opportunity, admittedly with challenges, to employ this global infrastructure for delivery of health-related services to those most in need. The world's poorest people bear a hugely disproportionate share of disease and ill-health. The World Bank study, *Voices of the poor*,² gathered views from more than 60 000 poor people and reported that ill-health and inability to access medical care emerged as key factors inducing and resulting from poverty. In a subsequent publication, *Dying for change*,³ thousands of interviewees most

frequently identified illness – even ahead of losing a job – from among 15 causes of a downward slide into poverty.

Why would microfinance institutions expand their services to include health? There are two basic reasons: health services are a natural extension of their mission of financial security and social protection of the client, and healthier clients better serve the microfinance institutions' goals of growth and long-term viability. Clients are not the only beneficiary; when a family member is ill, this affects productivity. Thus access to health-related programmes and services generally includes the household, not just the client.

Evidence of impact

Studies of microfinance institutions delivering health-related services show increasing evidence of positive impact. Multiple studies show that adding health education alone, usually delivered during the routinely scheduled microfinance group meetings, improves knowledge that leads to behavioural change. These behaviours are associated with positive health outcomes in diverse areas that are critically important to achieving the MDGs, such as maternal and child health, and infectious disease (Box 1).

Microfinance institutions provide health programmes that have positive impact on leading causes of death due to undernutrition, which constitutes 53%

Box 1. Areas with positive outcomes from health education combined with microfinance

- Reproductive health
- Preventive and primary health care for children
- Child nutrition
- Breastfeeding
- Child diarrhoea
- HIV prevention
- Domestic abuse/gender-based violence
- Sexually transmitted disease
- Malaria

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of all childhood deaths, and diarrhoea, which is the most common cause of illness and the second leading cause of child deaths in the world. In the Dominican Republic, Dohn et al.⁴ found significant improvements in the treatment of diarrhoeal disease. A control group that received microcredit only showed no change in diarrhoea incidence but, in the group that received health education only, incidence decreased by 29% and, in the group that received both microcredit and education, incidence decreased by 43%. In the Plurinational State of Bolivia and Ghana, research shows that mothers' health and nutrition practices can be changed by an integrated programme of village banking and child-survival education, with resulting behaviour changes in breastfeeding and management of diarrhoea that lead to significant increased height-for-age and weight-for-age for children of participants.⁵

In South Africa, Pronyk et al.⁶ found a positive impact of a comprehensive training and education programme on microfinance group members, for whom the risk of physical or sexual abuse by intimate partners was reduced by more than half as compared to a control group of microcredit-only members and to the general community.

In Ghana, de la Cruz et al.⁷ found that microfinance institutions can effectively contribute to community and national malaria initiatives by increasing knowledge, leading to increased insecticide-treated bed net ownership

and use by vulnerable members of the household (children under the age of five and pregnant women).

In Uganda, Barnes et al.⁸ found that 32% of women receiving education about HIV/AIDS prevention through their microcredit groups tried at least one HIV/AIDS prevention practice, compared to 18% of non-clients.

Beyond the potential contributions to disease and mortality reduction, microfinance can strengthen health systems. This capacity-building ranges from national initiatives to targeted local strategies. Perhaps the best illustration of how microfinance and health programmes strengthen national capacity is in Bangladesh. There, institutions such as BRAC (Bangladesh Rural Advancement Committee) have launched integrated programmes over the past three decades to combat poverty by combining health, education and credit services, including partnering with the national government for large-scale tuberculosis- and malaria-control initiatives.

Demonstrating the possibilities for local capacity-building, two studies from Uganda examined a project in which a variety of private health providers were given micro-loans and business skills training with the tandem goals of increasing the capacity of small-scale private health-care practices and improving public health outcomes. These clinics showed increased patient attendance and a significant improvement in clients' perceptions of quality of care.⁹

Conclusion

Single solutions are not enough to solve the prevalent and persistent problems of infectious disease, high maternal and infant death rates, and the rising incidence of chronic illness. Poor populations need access to a coordinated set of financial and health services to have income security and better health.

Microfinance institutions have already shown themselves capable of contributing to improving health-care capacity and health outcomes by educating clients, facilitating access to public and private providers, making referrals to higher levels of skill and resources, providing health financing options (such as loans, savings and micro insurance) and even directly delivering clinical care.

Worldwide, health systems are proving to be inadequate at meeting population needs. The global health community could broaden its contribution to achievement of the MDGs and strengthening of health systems worldwide through intersectoral programming that utilizes a microfinance platform to reach poor and underserved populations. ■

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Is there a role for user charges? Thoughts on health system reform in Armenia

Matthew Jowett^a & Elizabeth Danielyan^b

Introduction

Patient user charges are widespread in health systems worldwide and are an increasingly controversial aspect of health financing policy. This paper discusses the current plan in Armenia to introduce formal patient user charges for hospital services. This measure has the potential to improve financial access to health services if carefully implemented as part of a broader package of reforms.

The problem

In Armenia, out-of-pocket payments comprise 40% of total health spending. Only 10% of these payments are made as official patient charges. The remaining 90% are unofficial cash payments to health workers and payments for diagnostic tests, medical supplies and medicines. These unofficial payments take place almost entirely in hospitals. The amount paid varies considerably across departments, facilities and individual practitioners. For example, treatment in a department of general surgery in a hospital in the capital city of Yerevan can range from between 100–200 000 Dram (260–530 United States dollars, US\$), with treatment in other departments generally lower at around 10–50 000 Dram. To put this in context, per capita income was US\$ 3350 in 2008. In contrast to hospital services, primary health-care services were declared free at the point of service following reforms in 2006 and evaluations show that unofficial payments are now negligible.

In addition to the adverse effects of unofficial payments on both treatment-seeking behaviour and financial protection for patients, tackling unofficial payments is high on the government's agenda for several reasons. First, they are considered symptomatic of broader corruption in society, an issue receiving widespread media coverage. Second,

tax authorities are demanding that these payments are formalized so that they can be taxed; most hospitals are managed as profit-motivated companies and hence are liable for corporate taxes.

Reasons for unofficial payments

Unofficial payments form part of a vicious cycle in which an over-concentration of low-paid doctors in Yerevan seek to make additional income from patients. Relatively low service usage exacerbates the problem; inpatient admissions were 8.85 per 100 population in 2007 (half the European average), with only 30% of people with injuries or illness actually seeking care. The reason for low utilization is partly because patients are uncertain about what they will be asked to pay, as well as having problems "finding the money for treatment", according to 65% of women who reported problems accessing care in a national survey.¹

Widespread unofficial payments are the result of much deeper problems in the health system. Formalizing co-payments alone will not eradicate unofficial payments but can play an important part in reducing them.

Low government spending

Following independence from the former Soviet Union in 1991, Armenia entered a period of economic collapse with a reduction in its gross domestic product (GDP) of more than 50% between 1990 and 1993; a 42% drop in 1992 represented the "steepest annual rate of decline recorded for any post-Soviet state".² As a result, total health spending fell from US\$ 152 per capita in 1990 to US\$ 27 in 1995, recovering to US\$ 119 in 2007. More importantly, government spending remains very low; at 1.50% of GDP in 2008,³ it is one of the lowest levels in the world. Despite substantial

increases in government allocations to the health sector in recent years, overall taxation in the economy is very low and, as a result, the health budget only nominally funds the extensive basic benefit package (BBP) which covers approximately half the population. Essentially there is a severe mismatch between the promise of free services and the available financial resources. This leads to shortages of supplies, for example, and patients end up paying for these themselves.

Expensive hospital services

As in most former Soviet Republics, Armenia's service delivery system is dominated by hospitals. Following independence in 1991, the price of fuel, medical supplies and other critical inputs increased rapidly, while subsidies from the Russian Federation and domestic tax receipts plummeted, making the hospital-heavy system financially unsustainable. Substantial infrastructure downsizing took place in the 1990s but focused heavily on rural hospitals. As a result, despite the current ratio of 407 hospital beds per 100 000 population, slightly below the European average, capacity remains heavily concentrated in Yerevan which hosts 32% of in-patient medical facilities and 52% of hospital beds. Despite positive reforms in primary health care over the past four years, many people continue to seek care directly from hospitals.

Poorly paid doctors

The concentration of hospitals in Yerevan skews the distribution of human resources for health. While the country's 344 physicians per 100 000 population looks reasonable compared with the average of 340 per 100 000 in Europe as a whole, 68.3% of physicians are located in the capital. With a high supply of doctors, and relatively low activity in terms of patients, physician wages are low, and were estimated to average US\$ 134 per month

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in 2006, equivalent to 88% of the average national wage.⁴ Market forces are not the only explanation; low doctors' wages were a feature of the Soviet Union, the health sector being considered part of the "non productive sphere" and explicitly a low priority. This attitude persists and leads to many doctors demanding unofficial payments to supplement their income. In many cases these payments are necessary to earn a living wage, but sometimes such payments represent pure profiteering.

Current reform plans

The current policy of promising a generous benefit package free at the point of service is not working, and unofficial payments continue to be the norm for hospital services. Any attempt to tackle this problem needs to recognize the underlying problems already discussed to have any chance of success. In Kyrgyzstan, reforms focused on making patient payments more transparent and improving the efficiency of allocations by reducing fixed costs in hospitals. Financial protection for patients has improved significantly as a result although unofficial payments still comprise 26–34% of total health expenditures.⁵

The reform measures under consideration by the Armenian government focus on better aligning promises with available resources, and increasing transparency and control over patient payments. In summary they aim to: (i) increase the amount paid by the state health agency to hospitals for services provided under the BBP. The assumption is that salaries of medical professionals will increase as a result, although whether private facilities can be forced to allocate greater revenue

in this way remains an open question; (ii) reduce the scope of services included in the state-funded BBP; (iii) reduce the population eligible for free care; and (iv) introduce an easy-to-understand co-payment system for BBP hospital services.

Missing from this agenda, however, are measures to further reduce the dominance of hospital services, especially in Yerevan. Any such measures would benefit from the formalization of patient payments; as long as significant hospital revenues remain under the radar, government policies will have limited effect. Finally, regulating co-payments will be critical to their success. Patients must be made aware of their rights and encouraged to make complaints, and sanctions must be imposed on practitioners who continue to demand unofficial payments. Without such measures, official payments may simply be seen by hospitals as an opportunity to increase revenues further.

Official user-charges

The starting point in Armenia is very different from most low- and middle-income countries, with poor financial protection the result of a combination of economic collapse, inadequate government funding of the BBP, heavy reliance on hospital services and an over supply of poorly paid medical professionals, all exacerbated by low patient utilization.

Introducing an easy-to-understand system of patient charges would remove the uncertainty patients now face over their financial obligations. State funding could target priority patients more effectively and improve financial protection if reforms were made to align available government funding with realistic promises

of free care, as well as to achieve further efficiencies in service delivery. Research from Kyrgyzstan shows some success in substituting formal for informal payments through reforms which focused on the centralized pooling of funds, output-based provider payments, greater provider autonomy and a transparent system of formal co-payments.⁵ Conversely in Tajikistan a BBP was implemented without complementary reforms and, as a result, levels of informal payments have not reduced.⁶

Conclusion

Continuing to declare user charges for BBP services in hospitals as illegal will not improve the situation for Armenians, many of whom don't seek treatment for injury and illness due to both uncertainty over payment amounts and an inability to pay. Politically, there is a strong desire to formalize charges but there is limited appetite for substantial reductions to the scope of services in the BBP or to eligible groups.

Experience shows that no single measure will improve financial protection under such circumstances. The Government of Armenia has substantially increased allocations to the health sector but it still cannot meet existing promises of free care. Only by making patient payments more transparent, further matching promises with available funds and tackling broader inefficiencies in service delivery, can the government start to gain greater control and introduce measures that will reduce patient payments and in turn improve financial protection. ■

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Women and children first: an appropriate first step towards universal coverage

Rob Yates^a

There is a growing consensus that achieving universal health coverage is an appropriate, feasible and important goal for all nations. Under a rallying cry of “All for universal coverage”, Garrett et al. explain in a *Lancet* paper that attaining universal coverage will be vital if we are to reach health, poverty eradication and human rights goals.¹

Since the World Health Assembly resolution WHA58.33 of 2005,² the World Health Organization (WHO) has been leading international efforts to achieve universal coverage. This was defined as “securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost”. In particular, WHO has been keen to focus attention on perhaps the most important factor in determining levels of coverage: health financing.

When setting health financing policy, policy-makers have often treated equity as a lesser priority. As a result, many countries have inequitable coverage rates and wide differences in health outcomes across income groups.³ If we are to achieve the United Nations Millennium Development Goals (MDGs) for health by 2015 we must scale up coverage rates quickly and equitably. The best way to do this is to target the least-covered and most-needy groups first. In particular, as the MDGs specifically target child and maternal mortality, we should focus on women and children first.

In recent months, the international community has been giving a much greater priority to improving the health of women and children. This effort has been encapsulated in the Consensus for Maternal, Newborn and Child Health (MNCH)⁴ which is built on five pillars: (i) political leadership and community engagement; (ii) effective health systems; (iii) removing barriers to access; (iv) skilled and motivated health workers; and (v) accountability.

This consensus has been agreed by virtually all of the major health agencies

and contains one policy recommendation that, if implemented properly, could accelerate effective health-care coverage for billions of women and children. Under the pillar of “removing barriers”, it is recommended that countries should consider providing free health services for women and children at the point of use. This statement marks a compromise made among leading agencies following decades of debate over whether countries should charge user fees for health services. The evolution of this consensus can be traced through a series of consultations hosted by Save the Children,⁵ the United Nations Children’s Fund (UNICEF) and the European Commission. These events included representatives from multilateral and bilateral agencies, academic institutions and civil society organizations. In each case, the final policy recommendation was the same: that when phasing-out user fees, women and children should benefit first. This common position was fed into and adopted by the MNCH consensus discussions.

Already there has been high-level commitment to this position. On 23 September 2009, at a special meeting at the United Nations General Assembly, the British Prime Minister, the Director-General of WHO and the President of The World Bank all publicly supported the concept of free services at the point of delivery. In addition, the heads of state of five low-income countries (Ghana, Liberia, Malawi, Nepal and Sierra Leone) announced that they would extend the benefits of free public services in their countries. In her speech, WHO’s Director-General explained the significance of the MNCH consensus and highlighted user fees as the biggest barrier to universal coverage. In addition, a taskforce set up by the Japanese Government in 2008 recommended that developing countries should remove user fees, starting first with services relevant to MDGs 4, 5 and 6.⁶

This policy recommendation is gaining traction because it appears to address several key political, economic and health-related issues. Specifically, it is an appropriate compromise for the following reasons:

- There is overwhelming research evidence that out-of-pocket payments (user fees) are an inefficient and inequitable health financing mechanism.⁷
- Whereas many governments seem reluctant to remove user fees for their entire population, most appear keen to exempt high-need groups.
- Whereas attempts to exempt people from fees on economic criteria have tended to fail, women and children are easily identifiable groups.
- There are historical precedents for prioritizing women and children for health-care coverage in the developed and developing world and some services (e.g. immunizations and antenatal consultations) are generally provided free of charge.
- These reforms have been implemented without opposition from men who tend to have more control over family income and therefore better access to private alternatives. There is therefore no reason to believe that this policy will have an adverse impact on men’s health.
- This targeting makes sense for countries attempting to achieve MDGs 4 (reducing child mortality) and 5 (maternal mortality).
- As women and children tend to have less access to financial resources, removing fees for these groups will have a greater impact on their use of services.
- While providing free care for women and children, countries could continue to charge fees for lesser priority groups.
- Ensuring that a free option is available does not mean that all providers must not charge fees. Indeed, it could be more efficient to channel people

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who have a greater ability to pay into the private sector. This would make the benefit incidence of public health financing more equitable.

- Providing services free at the point of delivery is compatible with all other financing mechanisms that rely on pre-payment methods, for example tax financing, social health insurance, community and private insurance.
- Countries could decide themselves which health services will be provided free of charge, depending on their priorities and the resources they have at their disposal. These should include proven cost-effective interventions such as those outlined in the MNCH consensus.
- Several low-income countries have already launched free health services targeted at women and children and more are set to follow. Since fees were removed in 2006, Burundi has witnessed a trebling in outpatient consultations by children and deliveries in health units have increased 146%. Sierra Leone launched free health-care services for pregnant and lactating women and children in April 2010.
- Launching free health services has proved to be a very popular social policy in several countries and has therefore been an attractive intervention for political leaders.

For all these reasons, it makes sense for countries with poor health-care coverage to provide a package of essential health services free at the point of delivery

for women and children. This policy is particularly relevant to most of the 98 low-income and lower-middle income countries that still charge user fees.

However for such a policy to be successful, it is imperative that other financing mechanisms replace fee income and that additional funds are found to increase the availability and quality of services. Political leaders must realize that free health services do not exist – somebody has to pay and, if they don't secure additional resources for health, populations will consider their pronouncements as political gimmicks.

Providing free public health services for large population groups in developing countries need not be prohibitively expensive. Many low-income countries (such as Nepal, Uganda and Zambia) have introduced free public services with public health expenditure of around 2% of gross domestic product. As lower-middle income countries such as Sri Lanka have shown, universal coverage can be achieved with public funding levels of US\$ 23 per capita if public financing is used efficiently. In many developing countries there is a lot of scope to improve the efficiency of existing public funds.⁸

As well as finding additional domestic public funds, aid flows to health systems must increase. It is therefore very important that this policy of prioritizing free health care for women and children is rooted in the overall MNCH consensus. As well as addressing the removal of financial barriers, this stresses the importance of strengthening health systems. It will only be through dealing with demand-side and supply-side constraints

simultaneously that women and children will be able to truly benefit from effective health-care coverage.

With the United Nations MDG summit approaching, 2010 is going to be an extremely important year if the world is going to step up progress towards the goals set for 2015. As the health-related MDGs are so far off track, it is essential that the international community provides coherent policy advice and additional resources to help countries achieve universal coverage. In this respect, it would be useful if global leaders could agree on a timetable for achieving universal coverage compatible with the timeline of the MDGs.

The world health report 2010 will demonstrate how health financing reforms can have a major impact in reaching universal coverage. But the MNCH consensus has already given us a practical policy recommendation for a first step towards this goal. If we can raise additional funds, allocate and manage them well and remove financial barriers, we really should be able to guarantee effective coverage for the world's women and children. Providing services free at the point of delivery for women and children makes sense from a technical, ethical and political perspective. Furthermore by phasing-in universal coverage this way, we would just be following the common practice of saving lives in other emergency settings where "women and children first" is seen as an appropriate response to limited life-saving resources. ■

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Taskforce on Innovative International Financing for Health Systems: showing the way forward

Robert Fryatt^a & Anne Mills^b

When the high-level Taskforce on Innovative International Financing for Health Systems was launched in September 2008, with a 12-month timetable, it faced a vast array of challenges. A global financial crisis was gaining momentum, leading many to think that there was no chance of getting political support for raising additional funds for the United Nations Millennium Development Goals (MDGs) for low-income countries. Other challenges included differing views on how to define and handle international investments in "health systems", concerns by some donors on the value for money of much official development assistance, and a growing number of competing priorities such as the food crisis and climate change.

However, by the end of the 12-month period, a large number of world leaders met in New York to announce expanding support to several initiatives valued at more than 5 billion United States dollars (US\$) in low-income countries, with a particular focus on maternal and child health services. These announcements came at the end of a year of detailed analyses by some leading figures in international health and a series of lively consultations and debates that have brought much needed energy to previously ignored areas. This paper summarizes how the taskforce was conducted, its key achievements and progress made since the work was completed. A detailed description of the challenges the workforce faced has already been published.¹

The taskforce

The taskforce was an innovation itself in the way it was set up and run. Prime Ministers Gordon Brown (United Kingdom of Great Britain and Northern Ireland) and Jens Stoltenberg (Norway) were the original driving force, using their offices to bring in The World Bank president, Robert Zoellick, as co-chair and the Director-General of the World Health Organization (WHO), Margaret Chan. Japan and the

Netherlands joined later in 2009, drawn in by the process of consensus building. Final membership consisted of three heads of state (Liberia, Norway, United Kingdom), two heads of international institutions (The World Bank and WHO), six ministers (Australia, Ethiopia, France, Germany, Italy and the Netherlands), two special advisers (for Japan and the United Nations Secretary-General) and a representative of civil society (Graça Machel). The taskforce met four times: at the Conference on Financing for Development in Doha in December 2008, in Downing Street, London, before the G20 Summit in March 2009, in Paris during the French-led Leading Group on Innovative Financing for Development conference in May 2009, and in New York during the United Nations General Assembly in September 2009. Its secretariat was provided by the International Health Partnership Plus (IHP+) and the United Kingdom's Department for International Development.

Key achievements

Articulation of needs

When the taskforce started its work, different groups expressed the main constraints to scaling up health services in disparate ways. In many areas, important ideas were not being clearly articulated to national and international policy-makers. Through a large, widely representative working group, the final report from taskforce working group 1 successfully expressed the main constraints and policy responses to scaling up health services in low-income countries.²

Unified costing

At the start of the taskforce's work, different international groups were promoting a plethora of costing tools and approaches to developing countries. The taskforce chose to publish two cost analyses based on quite different assumptions – one

focusing on high levels of early capital investment and the other on more gradual increases in capital.^{1,2} The effort promoted close collaboration and allowed more detailed discussion on standards for future work. This will hopefully reduce the current confusion in countries and allow more efficient support by the United Nations and The World Bank. Given the limited time available, the intention was to produce plausible aggregate numbers rather than numbers that were robust at the country level. The country data used to produce the aggregates has not been made public. However the aim is to continue to develop country plans and related costs, as has already started under the IHP+ and related initiatives.

Improved domestic finance

Although not in the terms of reference of the taskforce, the analysis clearly showed the fundamental importance of improving domestic health financing policy to meet the health MDGs in an equitable way. These conclusions were quickly highlighted by those advocating for more funds for health in developing countries. A landmark consultation between taskforce members and African parliamentarians in Addis Ababa, Ethiopia, focused on the potentially greater impact that a relatively small amount of international funds could have if used in conjunction with domestic finances. The final recommendations of the taskforce echo the sentiments of that meeting.³

Innovative finance

The taskforce decided to recommend only those innovative financing mechanisms that had a clear sponsor for implementation. However, the analysis in the working group 2 report and the submissions made to the taskforce provide a rich array of ideas for countries to consider, both for health and other social sectors.⁴ Some mechanisms clearly required further work before they could be put into action. The

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inclusion of the currency transaction levy in one of the recommendations, for example, was a key step in helping to promote it to a wider set of stakeholders, led by civil society activists and the Government of France.

Making better use of funds

The taskforce recommended expansion of support to the IHP+, which aims to better link international financial aid to results in countries. Central to these efforts are more robust country-level planning, costing, budgeting and monitoring. IHP+ was closely involved in the work of the taskforce and its momentum continues to grow. In addition, the United States of America is also aligning its support more closely with national policies and plans of developing countries with proactive governments.

Health systems strengthening platform

One of the key outcomes of the taskforce was the recommendation of a more efficient approach to health investments by the three main multilateral health sector donors – The World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. Some countries are now piloting a closer collaboration across agencies on result-driven investments within their national health plans and strategies. But it is an area where there is still a lot to be learnt. However, this could be key to unblocking many constraints to expanding health services and improving efficiency of the international health architecture.

Monitoring commitments

Another key success of the taskforce was the agreement to a regular Health and Development Forum where global and country commitments can be more openly monitored. This started under the IHP+, but will now be a broader group of coun-

tries given that the previous IHP+ ministerial meeting was criticized for missing out many of the poorer countries which have not had as much international support.

Challenges

A paper recently published¹ outlines the many problems the taskforce faced, including the short timeframe for completing technical work and mobilizing political support for the recommendations, limitations in the evidence base and areas of disagreement – particularly over the role of non-state actors and public–private partnerships. On the other hand, the tight timeline may have actually contributed to its success, reducing opportunities for confusion and delays. An extended reporting period may have encountered more problems due to political changes in donor countries.

Concerns have been expressed that the “innovative finance” proposals may detract public and government support in some donor countries for the United Nations target of 0.7% of gross national income for official development assistance. However, some members of the taskforce argued forcefully that more innovative mechanisms could lead to greater public engagement and support. Examples include the International Finance Facility for Immunisation (IFFIm) bonds, and joint government and business initiatives such as the “D-Tax” (announced by Italy), which aim to encourage the general public to support and be engaged in international health aid in low-income settings.⁴

Progress

Progress on many of the final announcements is already well underway in 2010. This includes US\$ 1 billion to expand health system investments through IFFIm and US\$ 400 million to expand the Health Results Innovation Trust Fund held by The World Bank. Some of the

announcements reaffirm support for ongoing work, such as for Advance Market Commitments for vaccines and the Debt-2Health initiative by the Global Fund. Some areas were completely new and have yet to prove they can deliver, such as the D-Tax and the “Massive Good” initiative managed by the Millennium Foundation for Innovative Finance for Health. An independent assessment of this initiative by The World Bank suggested that US\$ 3.2 billion could be raised before 2015 through a coordinated effort within the travel industry. As with the airline tax used to fund UNITAID, those who initially scoffed at these innovations may well be proven wrong.

Conclusion

The taskforce delivered on its terms of reference and produced recommendations, despite the dire global financial circumstances. Perhaps its most important outcome was driving the momentum for health aid in developing countries – not an easy task given that donors and ministers of finance have many other competing interests. Political engagement at the highest level was critical to this. The consultations with civil society, particular those hosted by Graça Machel in Africa, and with African parliamentarians in the Economic Commission for Africa in Addis Ababa, showed the growing importance of engaging with regional and national lobbies in low-income settings. Of course, not all will be content with the taskforce findings and many will, no doubt, be concerned that they were not adequately consulted. However, the taskforce has started on the right track by linking international, regional and national efforts to mobilize resources for health in the poorest countries more effectively, in a way that aims at giving value for money. ■

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Taskforce on Innovative International Financing for Health Systems: what next?

David McCoy^a & Nouria Brikci^b

Introduction

The high-level Taskforce on Innovative International Financing for Health Systems was set up in 2008 and chaired by Gordon Brown, Prime Minister of the United Kingdom of Great Britain and Northern Ireland, and Robert Zoellick, President of The World Bank. Its aim was to identify innovative and additional sources of funding for health systems strengthening in the 49 lowest-income countries of the world. The taskforce delivered its final recommendations in September 2009 together with two detailed working group papers.^{1,2} Here we summarize the main outputs and recommendations of the taskforce according to three areas: (i) costing the financing gap; (ii) new and innovative sources of finance; and (iii) making development assistance for health work better (Box 1). We then examine their limitations and propose further actions for the international health community.

Gaps and challenges

Costing

Three issues stand out. The first relates to the models used for calculating the costs of scaling-up essential health services, including the assumptions on what is required to achieve that scale-up.¹ The different models used by the taskforce did not just produce alternative costings, but also reflected different approaches to health systems strengthening as well as different levels of ambition.

The World Health Organization (WHO)'s normative approach, for example, was bolder and advocated the simultaneous scaling-up of facility and community-based services, while The World Bank and the United Nations Children's Fund (UNICEF) were less ambitious and advocated expanding low-cost, community-based services before undertaking any strengthening or

expansion of facility-based services. In addition to the confusion of having different costing models, the taskforce reveals fundamental differences in opinion about the minimum requirements to strengthen health systems and the best way to expand coverage of essential health services.

The second issue is that the individual country costings used to produce an aggregated "price tag" for all low-income countries are unavailable. And yet a full and proper discussion about the best way to fund and scale-up essential health services can ultimately only be conducted at the country level. In addition, the costings generated for health systems inputs such as "governance" are novel and need further empirical testing. A disaggregation of the data by country is therefore a vital next step.

Third, an implicit recommendation of the taskforce is that a significant proportion of funding should come from private expenditure, in spite of the need to reduce the burden of health expenditure on poor households. This suggests that the required future funding from governments and donors has been underestimated.

Innovative finance?

There are several problems with the recommended sources of new and innovative finance, namely; their lack of ambition, their orientation towards a voluntary and charitable approach (rather than one that is rights-based) and the largely consumption-based nature of the proposed levies.²

The opportunity to link revenue generation to a global redistributive and

Box 1. Summary of recommendations by the high-level Taskforce on Innovative International Financing for Health Systems³

New sources of finance:

- Extend the mandatory solidarity levy on airline tickets to more countries (currently in place in several countries and used primarily to finance paediatric AIDS treatment through UNITAID);
- Explore the viability of levies on tobacco and currency transactions;
- Encourage voluntary private giving through: (i) voluntary levies on the purchase of airline tickets and mobile phone minutes (expected to raise US\$ 3.2 billion by 2015); and (ii) a scheme called a "de-tax" which would earmark a share of value added tax receipts when participating businesses agree to add a share of their profits (estimated potential of US\$ 220 million in 2010);
- Secure more private investment in health systems through establishing capital/risk mitigation fund(s). Out-sourcing to non-government providers and encouraging greater use of advanced market commitments, such as for vaccine purchases, were also mentioned as ways of securing investment from private sector actors.

Making development assistance for health work better:

- More frontloading (i.e. concentrating payments at the beginning of an agreement) and predictability of aid, possibly by expanding the mandate of the International Financing Facility for Immunization.
- Expand the use of results-based "buy-down" (use of grant funding to reduce the cost of loans when specific performance targets are met) funding and more performance-based donor funding for the health sector.
- Establish a common health systems funding platform for the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and The World Bank.
- Undertake a review of technical assistance, in view of evidence that it consumes a large proportion of aid and appears to be poor value for money.

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environmental agenda was ignored. The taskforce neither recommended carbon, luxury or capital flow taxes, reducing illicit capital outflows from low-income countries, nor did it recommend leveraging a higher domestic return on the natural resources and primary commodities of poor countries. Instead, the focus was mostly on low-value commercial transactions of ordinary consumers.

The idea of a currency transaction levy was barely supported despite its potential to raise as much as US\$ 33 billion every year (even at a rate as small as 0.005%).⁴ The timidity of the taskforce is now more apparent in light of the current political momentum within the G-20 (Group of 20 industrialized and emerging-market countries) in favour of a higher rate currency transaction levy and additional financial transaction taxes that could also be used to regulate the global financial system.⁵

The suggestion to expand private (profit-seeking) investment through the use of public funds to mitigate risk was alarming. Low-income countries suffer from a lack of investment in public services combined with an unregulated commercially-driven health system. This recommendation would therefore make the problem worse.

Finally, the taskforce ignored the agenda of expanding the domestic resource base of low-income countries. Many of these countries could increase their volume of domestic public finance by reducing capital flight, promoting more effective tax policy and improving their tax collecting systems. Such an agenda would have the added benefit of placing greater attention on the broader challenges of economic development, and improving democratic and accountable governance. The reason why the taskforce excluded domestic finance from its remit is unclear.

More effective assistance

The recommendations for making development assistance more effective and efficient were undermined by inconsistencies and contradictions. One

of the working group reports included an assessment of the evidence on several “controversies” about health systems development including: (i) the desirable mix of public and private financing; (ii) the desirability of expanding the for-profit sector; (iii) the appropriateness of scaling-up community-based health insurance; and (iv) whether and how vertical, disease-based programmes should be embedded into comprehensive health systems development.¹

Despite commissioning this analysis, the taskforce appears to have disregarded the evidence by recommending the expansion of private (for-profit) investment finance. Similarly, the enthusiastic promotion of results-based funding does not tally with the more equivocal evidence on the effectiveness and efficiency of performance-based finance.⁶

However, the recommendation to create a common funding platform for health systems strengthening across the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and The World Bank must be welcomed, given the current fragmentation and disorganization of development assistance for health. However, these agencies have, at best, a mixed track record on health systems strengthening.⁷ The lack of clarity about the way that this common funding platform would work in practice is therefore a limitation that requires further attention.

What next?

Given the scale of the world’s health challenges, it seems hard to escape the conclusion that the taskforce has turned out to be a major disappointment. It has not met its primary objective of raising significant new and more predictable finance for global health. Meanwhile, in the background, high-income countries continue to fall short of their responsibility to allocate 0.7% of their gross national income to development assistance.

In this context, innovative finance is a potential smokescreen for renegeing on donor commitments (certainly the

case with Italy), as well as a distraction from the need to create a new global agreement for a more systematic transfer of resources to low-income countries. Disappointingly, the taskforce chose not to build on the work of the WHO Commission on the Social Determinants of Health and to make an important contribution on the underlying structural determinants of under-resourced health systems.

The international health community, including WHO, should ignore many of the financing recommendations of the taskforce (with the exception of the half-hearted mention of a currency transaction levy) and focus instead on other actions that will provide a better political and economic environment for health systems in low-income countries. These include expanding the domestic finance base for development, reducing the loss of capital and resources from low-income countries and establishing principles and mechanisms for a more systematic transfer of resources from high-income to low-income countries.

The costing work of the taskforce was, however, more valuable and now needs to be developed. Specifically, country-specific data should be made available and should be used to support country-specific discussions about health systems and financing policy. WHO’s normative costing model would be a good starting point.

Finally, although the taskforce has helpfully pushed The World Bank, the Global Fund and GAVI to work in a more integrated manner, there is still a need to establish clearer principles and positions on health systems policy. The disjuncture between the evidence and the pro-market recommendations of the taskforce needs to be challenged, while a clearer normative vision on the key ingredients of an equitable, comprehensive, efficient and accountable health system is expressed. ■

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