

Exploring the features of universal coverage

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Designing and implementing a health financing policy for universal coverage is relatively simple in principle but complex in practice. This issue of the *Bulletin* explores how it can be done, drawing lessons from several country experiences.

Equity of access to health services of all types is key to universal coverage policy. High levels of out-of-pocket payments, including user fees, are still pervasive in many countries, limiting the ability of people to use services. Lagarde and Palmer (839–848) reinforce earlier evidence that removing or reducing user fees increases utilization, at least in the short term. Leive and Xu (849–856) illustrate another problem of out-of-pocket payments, showing that many households in 15 African countries cope by borrowing or by selling assets, i.e. they use their savings and go into debt, thereby restricting long-term economic survival.

An important challenge therefore is to shift away from out-of-pocket payments through the development of prepayment schemes. The development of such health financing schemes may take time and the overall country context matters; these two issues are discussed by Carrin et al. (857–863), who also address the importance of establishing appropriate rules and incentives for the organizations that are involved in implementing these policies. The development of strategies for universal coverage will vary according to country circumstances and constraints, illustrated by El-Idrissi et al. (902–904) for Algeria and Morocco. Prepayment schemes can take many forms on the road to universal coverage. In Mali, membership of community or mutual health insurance schemes has a positive effect on access to priority health services, shown by Miller Franco et al. (830–838).

Moving towards prepayment is important but in many settings additional

funds will also be critical. Prakongsai et al. (898–901) examine the advantages and disadvantages of earmarking revenues specifically for health, a mechanism often advocated by health professionals. Kaddar and Furrer (877–883) show that international debt relief initiatives can be used to supplement other sources of funding for health and that ministries of health can seek access to these resources.

The role of external aid in expanding the funding for health in the African region is debated in the round table (889–895). Kirigia and Diarra-Nama propose several key strategies that would allow countries to eventually wean themselves off international donor funding, essentially involving the better use and management of domestic resources. Ooms and Van Damme highlight, however, the huge gaps between current health expenditures in most low-income settings and any realistic concept of the minimum expenditure necessary to ensure universal access. They argue that sustained, increased and predictable international health aid is essential. Masyie agrees that enhanced effective mobilization and use of domestic resources should be part of Africa's strategy.

From a macroeconomic point of view, large inflows of aid risk, at least in theory, increasing domestic inflation and appreciating the real exchange rate with subsequent harmful effects on economic growth, as is explained by Cavagnero et al. (864–870). They show, however, that in practice the magnitude of this risk varies across countries and in most cases could be managed appropriately.

Available funds must also be raised and pooled in a way that allows cross-subsidization across income groups and the financial risks of illness to be shared between the sick and the healthy. In general, multiple, small risk pools (e.g. insurance schemes or district health services funded by local taxes) will

not be viable without some mechanism for transferring funds between them according to the risk profiles and incomes of their populations. McIntyre et al. (871–876) bring together experience from Ghana, South Africa and the United Republic of Tanzania to illustrate the significance of enhanced integration of health financing mechanisms in terms of contribution schedules and benefit packages. Smith (884–888) draws on the long experience of formula funding in England's National Health Service to show how funds can be transferred between geographical areas in the interest of equity and efficiency.

Resource allocation towards health promotion activities within the context of the social health insurance schemes in Japan and Mongolia is scrutinized by Bayarsaikhan (896–897). In both countries, social health insurance revenues can be tapped as a novel source of financing health promotion.

Finally, Mathonnat (905–906) comments on Herbert Klarman's classic article on public intervention in financing health and medical services. He reminds us that Klarman's views, on the role of philanthropy in health financing and on the need for governments to stimulate more efficient health systems and to pay particular attention to health-care access for the poor, are still valid today; they are particularly relevant on this 30th anniversary of the Alma-Ata conference and the renewed focus on health for all.

There is now general consensus that health financing systems should be developed to achieve universal coverage. This *Bulletin* theme issue aims to illustrate the diversity of factors that policy-makers must consider when devising appropriate financing policies. We hope that it helps countries to move more quickly in their chosen direction. ■

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