



Manana Mikaberidze, 52, is a doctor from the Gori region of Georgia. She is not eligible for government-sponsored health insurance and cannot afford to join a private health insurance scheme. Manana was diagnosed with cervical cancer earlier this year and has had to rely on generous loans from her relatives to get treatment. She often uses her own salary to buy medicines for patients who cannot afford to pay for these themselves. It is hoped that major new reforms aimed at achieving UHC in Georgia will help ordinary people, like Manana, to get the health care they need.

UNIVERSAL HEALTH COVERAGE

Why health insurance schemes are leaving the poor behind

Universal health coverage (UHC) has the potential to transform the lives of millions of people by bringing life-saving health care to those who need it most. UHC means that all people get the treatment they need without fear of falling into poverty. Unfortunately, in the name of UHC, some donors and developing country governments are promoting health insurance schemes that exclude the majority of people and leave the poor behind. These schemes prioritize advantaged groups in the formal sector and drive up inequality. Rather than collecting contributions from people who are too poor to pay, the countries making most progress towards UHC have prioritized spending on health from general taxation – either on its own or pooled with formal sector payroll taxes and international aid. Donors and governments should abandon unworkable insurance schemes and focus on financing that works to deliver universal and equitable health care for all.

‘A timely, clear and important publication from Oxfam. Universal Health Coverage (UHC) is being widely promoted as a panacea for health inequities yet there are fundamental differences in its interpretation and implementation especially on financing. This publication makes it clear that health insurance schemes, often promoted by the World Bank and other donors, invariably disadvantage the poorest and unhealthiest. Without more equitable, tax based approaches, inequalities in health will continue to grow and threaten us all.’

Professor David Sanders

Emeritus Professor, School of Public Health, University of the Western
Cape

‘There will be little or no progress in achieving UHC unless countries implement reforms to raise and use domestic prepayment funds in an equitable, efficient and sustainable way. This paper highlights some of the key issues in relation to financing for UHC and promises to contribute positively to current debates.’

Professor Di McIntyre

Health Economics Unit, University of Cape Town

‘International evidence clearly shows that universal health coverage will not be achieved in low and middle income countries through voluntary or contributory-based health insurance. This Oxfam report clearly highlights the importance of adopting context specific health financing mechanisms that address the needs of the poor as well as the rich. Governments, policy makers, funders and the international community should rally behind the recommendations put forward in this report and support countries to implement reforms that ensure all people – rich and poor alike - can access good quality health care when they need it.’

Dr Jane Chuma

Research Fellow, KEMRI-Wellcome Trust Research Programme, Nairobi

SUMMARY

Described by the Director-General of the World Health Organization (WHO), Margaret Chan, as ‘the most powerful concept that public health has to offer’,¹ Universal health coverage (UHC) has risen to the top of the global health agenda. At its core, UHC is about the right to health. Everyone – whether rich or poor – should get the health care they need without suffering financial hardship. For Oxfam, UHC means that everyone has the *same* financial protection and access to the *same* range of high quality health services, regardless of their employment status or ability to pay.

UHC is not a ‘one size fits all’ journey, and governments will need to develop approaches that fit the social, economic, and political contexts of their countries. However, the lack of a ‘UHC blueprint’ does not mean that ‘anything goes’.² WHO has been explicit that countries should prioritize four key actions to finance UHC: reduce direct payments, maximize mandatory pre-payment, establish large risk pools, and use general government revenue to cover those who cannot afford to contribute.

In too many cases these guiding principles are being ignored. User fees for health care still exist in the majority of developing countries. Worldwide every year 150 million people face catastrophic health-care costs because of direct payments, while 100 million are pushed into poverty – the equivalent of three people every second.³ In the name of UHC, many governments and donors are promoting and implementing voluntary private and community-based health insurance schemes that they have been shown to have low coverage are costly to administer, and exclude the poor. India’s RSBY insurance scheme for those below the poverty line is widely praised as a success but offers limited financial protection, suffers from corruption, abuse, and cost escalation, and has skewed public resources to curative rather than preventative care.^{4,5,6,7} No country in the world has achieved anything close to UHC using voluntary insurance.

For those who recognize the pitfalls of voluntary schemes, social health insurance (SHI) has become an increasingly popular alternative. However, while SHI has worked to achieve UHC in a number of high-income countries, attempts to replicate the same kind of employment-based models in low- and middle-income countries have proved unsuccessful. SHI schemes are typically characterized by large-scale exclusion. Ten years after the introduction of SHI schemes in Tanzania, population coverage had reached only 17 per cent.⁸ Even rich countries struggled to achieve rapid scale up via SHI – it took Germany 127 years to achieve UHC. People in poor countries cannot and should not have to wait that long.

Every second, three people are pushed into poverty because they have to pay out-of-pocket for health care

Even when SHI is mandatory, it is near impossible to force people to join. SHI then becomes de facto voluntary and suffers the same problems of low coverage, adverse selection, and fragmented risk pools. Ghana's mandatory insurance scheme, widely considered an SHI success story, today covers only 36 per cent of the population.⁹

'Formal sector first' approaches increase and entrench inequality and should be avoided. Even with the best intentions, almost all low- and middle-income countries that have initiated SHI by starting with the formal sector have found it impossible to scale up coverage when this is on a contributory basis. The common result is a two-tier health system with one scheme for the formally employed and another 'Ministry of Health' scheme (usually with a more limited benefits package and poorer quality) for everyone else.

Hopes that insurance contributions from those outside of formal employment would raise significant revenue have not been realized. In Ghana, premiums paid by the informal sector contribute just five per cent towards the cost of the National Health Insurance Scheme (NHIS).¹⁰ Governments also face huge bills to cover the SHI contributions of their workers. The government of Tanzania spent \$33m on employer contributions in 2009/10; this equated to \$83 per employee – six times more than it spent per person, per year on health for the general population.^{11,12} SHI may actually reduce the overall resources available for the health sector – when SHI was introduced in Kazakhstan, the Ministry of Finance reduced the health budget by a larger amount than that collected through insurance premiums.¹³

TWO APPROACHES THAT WORK

Fortunately, a growing number of developing countries are building home-grown financing systems that are working to advance UHC. While their specific journeys differ, these countries agree that entitlement to health care should be based on citizenship and/or residency and not on employment status or financial contributions. Instead of importing ill-suited health financing models from high-income countries, low- and middle-income countries should look to build on the UHC success stories in other, more comparable countries, including Thailand, Mexico, Sri Lanka, and Kyrgyzstan.

The countries that have made most progress to date have embraced the principles of equity and universality, rejecting approaches that collect insurance premiums from those who are too poor to pay. They fall into two broad camps.

First there are examples of countries at all income levels, including Sri Lanka, Malaysia, and Brazil, which fund UHC from tax revenues. Sri Lanka and Malaysia's tax-financed health systems provide citizens with some of the highest levels of financial risk protection in Asia.¹⁴ In Brazil in the late 1980s half of the population had no health coverage, yet only two decades after the country's tax-financed Unified Health System was established, nearly 70 per cent of Brazil's 200 million inhabitants now rely on it for their health care.¹⁵ Crucially, the only low-income countries to achieve universal and equitable health coverage have done so using tax financing.¹⁶

A second option increasingly being adopted by another set of successful UHC countries, including Thailand, Mexico and Kyrgyzstan, is to collect insurance premiums from only those in formal salaried employment, and to pool these where possible with tax revenues to finance health coverage for the entire population.

Thailand's health system relies on payroll contributions for only 12 per cent of its population and finances its internationally celebrated Universal Coverage Scheme using general government revenues.¹⁷ In just ten years the number of people without health-care coverage fell from 30 per cent to less than four per cent of the population.¹⁸ People living in poverty have benefited most.¹⁹ Steps being taken in Thailand to merge different schemes will redress the current inequity of superior health-care benefits for those in formal employment.

There is a welcome trend towards single national risk pools – combining payroll contributions, tax revenues, and development aid – in other countries too. Such reforms in Kyrgyzstan have radically reduced fragmentation and inequity and have improved health outcomes.²⁰ Entitlement to health care in South Africa's proposed National Health Insurance will be based on citizenship and legal residency rather than financial contributions.

Tax financing has played a dominant role in all UHC success stories. Unfortunately, the preoccupation with SHI as the 'default' UHC model has left the crucial question of how to generate more tax revenues for health largely unexplored in low- and middle-income countries. This blind spot should be urgently addressed. Even the poorest countries can increase domestic revenue for health by improving tax collection, adjusting tax rates, and introducing new progressive taxes as well as innovative financing mechanisms. Oxfam has estimated that strengthening tax administration alone could raise an additional 31 per cent of tax revenue across 52 developing countries amounting to \$269bn in increased domestic resources.²¹

THE NEED FOR GLOBAL SOLIDARITY

Urgent action on global tax evasion and avoidance is also crucial to ensure that countries can generate and retain more of their own resources for health. Tax dodging by multinational enterprises costs developing countries an estimated \$160bn annually – four times the amount spent by all sub-Saharan African governments on health combined in 2011.^{22,23}

Achieving UHC will require significant development assistance, at least in the short to medium term. According to WHO, only eight low-income countries will be in a position to fully finance UHC from domestic resources in 2015.²⁴ More long-term and predictable aid is vital, not only to help build effective public health systems, but also to improve public financial management and taxation systems so that countries can be self-sufficient in the future. Government to government aid via sector or general budget support is the best way to support governments on their path to UHC.

Increasing revenues available to governments in low- and middle-income countries alone will not advance progress towards UHC. Governments must also demonstrate their political commitment by increasing and protecting allocations to the health sector and moving quickly to address inefficiencies, improve quality, and ensure effective, accountable, and safe patient care. Ministries of health should prioritize comprehensive primary health care, including cost effective preventative care, and play an active role to improve performance and accountability. Political will to achieve these changes has been the cornerstone of every UHC success story.

RECOMMENDATIONS

Developing country governments

- Develop financing systems based on the four 'key ingredients' outlined by WHO. Rather than looking to adapt European-style employment-based SHI, build on the lessons from the growing number of low- and middle-income countries that are making progress towards UHC.
- Make equity and universality explicit priorities from the outset and avoid the temptation to start with the 'easiest to reach' in the formal sector. Those living in poverty must benefit at least as much as the better off every step of the way.
- Rather than focus efforts on collecting insurance premiums from people in informal employment, look to more efficient and equitable ways of raising revenue for health from tax reform.
- Move towards pooling together all government revenues for health – with formal sector payroll taxes where these exist – to maximize redistribution.
- Ensure that adequate proportions of national budgets are allocated to health, in line with the Abuja target of 15 per cent of government funds.
- Actively engage civil society in all stages of policy-making, implementation, and monitoring.

High-income country governments and multilateral organizations

- Stop promoting inappropriate approaches in the name of UHC, especially private and community-based voluntary health insurance schemes.
- Take action on tax avoidance and tax evasion, which denies poor countries much-needed revenue for universal public services. Provide support for progressive tax reform in poor countries, including technical support to strengthen tax administration capacity.
- Honour commitments to provide at least 0.7 per cent of GNI as Official Development Assistance, and improve aid effectiveness for health. Provide a greater proportion of aid as long-term sector or general budget support.
- Support developing country governments to effectively measure and evaluate progress and outcomes on UHC, especially equity.

Civil society

- Increase collaboration to exert collective pressure on governments and other stakeholders to push for a UHC approach that enshrines the values of universality, equity, and solidarity.
- Hold governments to account by engaging in policy dialogue, monitoring health spending and service delivery, and exposing corruption.
- Draw attention to cases where influential donors are promoting inequitable health financing mechanisms and hold them to account.
- Work together with civil society champions of tax justice to call for urgent action on global tax evasion and avoidance.
- Formal sector unions should act in solidarity with workers in the informal economy and advocate for universal and equitable health care.

Oxfam calls on the international health community to support UHC as the umbrella health goal for the post-2015 development framework. A focus on UHC provides the opportunity to accelerate progress on the health-related Millennium Development Goals, address the growing burden of non-communicable diseases, and most critically to move towards a more comprehensive approach to deliver on the right to decent, affordable, and equitable health care coverage for all.

1 INTRODUCTION

Universal health coverage (UHC) is a simple but inspiring concept, which has risen fast up the global health agenda. At its core UHC means that everyone - whether rich or poor - gets the health care they need without suffering financial hardship. For Oxfam, it means everyone has the *same* financial protection and access to the *same* range of high quality health services regardless of employment status or ability to pay. Good quality health care is both a human right and a building block to tackling poverty and reducing inequality.

UHC is not a 'one size fits all' journey and governments will need to develop approaches that fit the social, economic, and cultural contexts of their countries. However, the lack of a 'UHC blueprint' does not mean 'anything goes'.²⁵ WHO has been explicit that countries should prioritize four key actions to finance UHC: reduce out-of-pocket payments, maximize mandatory pre-payment, establish large risk pools, and use general government revenue to cover those who cannot afford to contribute.

In too many cases these guiding principles are being ignored. Health user fees have been internationally condemned, yet they continue to exist in poor countries. Donor support for fee removal remains unacceptably low. Although no country in the world has achieved anything close to UHC using voluntary insurance, private and community-based voluntary schemes are still being promoted as a pathway to achieving UHC. Social health insurance (SHI) is often seen as 'the route' to UHC, but the social and economic conditions in developing countries – where large informal sectors and high levels of poverty are the norm – do not provide a positive enabling environment for SHI.

Fortunately, a growing number of countries – including Thailand, Malaysia, Sri Lanka, and Brazil – are building home-grown universal and equitable financing systems that are working to advance UHC. While their specific journeys differ, these countries share a common understanding that entitlement to health care should be based on citizenship and/or residency and not on employment status or financial contributions. Rather than focus efforts on collecting insurance premiums from those who are too poor to pay, these countries have prioritized general government spending for health – on its own or pooled with formal sector payroll taxes – to successfully scale up UHC.

Despite the heavy reliance on general government revenue to cover the majority of citizens in all UHC success stories, remarkably little attention has been paid to alternative approaches to raise this revenue. This blind spot should be urgently addressed. National and international tax reform, as well as development aid, can help generate significant resources for UHC and should be prioritized.

Although UHC is concerned with how health care is delivered as much as how it is paid for, this paper focuses on financing UHC. We question the emphasis on contributory-based health insurance as *the way* to achieve UHC. Governments, donors, and civil society must work together to develop comprehensive home-grown health financing strategies for UHC

that are universal and equitable, aligned with country health plans, and which pool all sources of financing for health to maximize coverage and redistribution. We call on governments and donors to learn from the low- and middle-income countries that have advanced towards UHC and build on their progress.

UHC is a unifying goal and, while countries have different starting points, all nations – rich and poor alike – can take immediate steps to move towards universal coverage. Politicians now have to show that they are willing to take action, civil society must unite to demand change, and development partners need to step up to support them.

Box 1: Health insurance models

Community-Based Health Insurance

Community-based health insurance (CBHI) schemes – called *mutuelles de santé* in Francophone countries – are voluntary, not-for-profit health insurance schemes organized at a community level that specifically target those outside the formal sector. CBHI schemes vary a great deal in terms of who and what they cover, how they are managed, and at what cost. Premiums are usually charged at a flat rate, making this a highly regressive way of funding health care as poor people contribute a higher proportion of their income than wealthier people. While CBHI can play a role in providing some financial risk protection in situations where more widespread prepayment and pooling arrangements do not exist, their potential to be scaled up to reach UHC is limited.

Private Health Insurance

Private health insurance (PHI) is offered by private entities including commercial companies. Although PHI can increase financial protection and access to health services to those able to pay, high premiums mean that few people can afford to join. More than 25 years after the introduction of PHI in developing countries, there is still no evidence that it can benefit more than a limited group of people. The contribution of PHI to UHC has been insignificant or has even had an adverse impact by increasing inequalities.

Social Health Insurance (SHI)

SHI originated in Europe as work-related programmes and coverage was gradually expanded to the non-working parts of the population. SHI models vary but they share a number of defining characteristics. In most cases membership is mandatory and members are entitled to a defined package of health benefits. Most SHI schemes do not cover the entire population from the outset and SHI is often initially restricted to formal sector employees and their dependents. Workers in the formal sector pay their contribution through a dedicated payroll tax and in most cases the employer also contributes. When schemes are open to everyone, people outside of formal employment are required to enrol and pay an annual premium to join. It is difficult to set premiums according to a sliding-scale (in the absence of reliable income records) so the contribution for the informal sector is generally a flat rate. Even when SHI is mandatory for everyone, not everyone can afford to join. In low- and middle-income countries SHI schemes therefore become *de facto* voluntary.

2 UNIVERSAL HEALTH COVERAGE

UHC is fast becoming a first order priority of the global health community. In December 2012 the United Nations General Assembly adopted a landmark resolution on UHC and there are now calls for UHC to be included in the post-2015 development agenda. At the 2013 World Health Assembly, the World Bank Group's commitment to UHC was laid out by its President, Jim Yong Kim. Governments around the world are taking action; China, Thailand, South Africa, and Mexico are among the emerging economies that are rapidly scaling up public investment in health. Many low-income countries, especially in Africa, have introduced free health care policies for some or all of their citizens as a first step towards UHC.

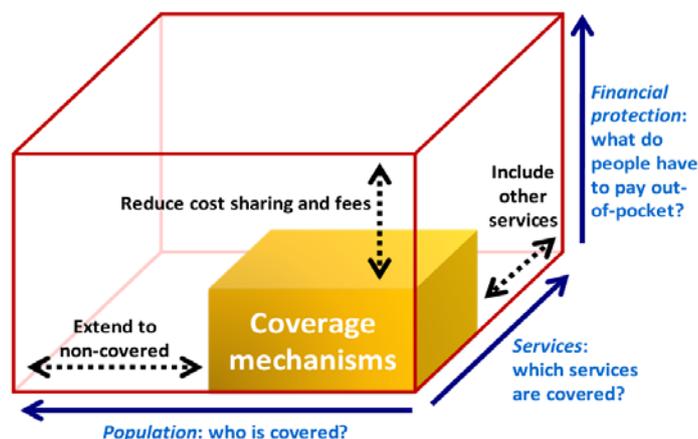
As the momentum builds, a diverse range of actors – including national governments, multilateral agencies, bilateral donors, private foundations, academics, and civil society organizations – are uniting in support of UHC. There is a danger however, that UHC will be reduced to a catchy sound bite. Already many different things are being done in the name of UHC and not all of these live up to the founding principles and objectives set out in the landmark 2010 World Health Report on health financing.

It is therefore imperative to articulate exactly what we mean by UHC. According to WHO, universal health coverage will be achieved when all people have access to quality health services (prevention, promotion, treatment, rehabilitation, and palliative care) without fear of falling into poverty. Moving towards UHC requires progress on three fronts: the range of services that are available, the proportion of the costs of those services that are covered, and the proportion of the population that is covered (Figure 1).

'All of us together must prevent "universal coverage" from ending up as a toothless slogan that doesn't challenge us, force us to change, force us to get better every day.'

Jim Yong Kim, President of the World Bank Group

Figure 1: Three dimensions to consider when moving towards UHC



Source: WHO World Health Report 2010

For Oxfam, UHC should be framed by the values of universality, social solidarity, and equity. UHC reforms must be explicit about reducing inequality in access to health services, so that everyone has the *same* financial protection and access to the *same* range of high quality health services according to need and not their ability to pay. UHC requires pooling arrangements that redistribute resources to individuals with the greatest health needs. Governments have a role to play in both ensuring that funds for health are raised equitably, and actively redistributing resources.

Above all else, UHC is about the right to health. This means moving away from the idea of an employment or contributory basis for entitlement. People must be entitled to receive benefits by virtue of their citizenship and/or residency – because first and foremost they are people – not because they are formally employed or have paid to join a scheme. To achieve UHC, in its truest form, governments, donors, and civil society actors alike must adopt this as a starting point.

Critically, ‘progressive realization’ of UHC should not be interpreted to mean starting with the easiest to reach, namely those in formal employment and/or with higher incomes, and then slowly expanding access to the rest of the population. Instead, equity must be designed into the system from the beginning with governments and donors committing to ‘progressive universalism’, ensuring that the poor benefit at least as much as the better off at every step of the way towards universal coverage.²⁶

NO SINGLE ‘UHC RECIPE’ BUT FOUR KEY INGREDIENTS

The 2010 WHO World Health Report outlines four actions that significantly increase a country’s likelihood of making sustained progress towards UHC. Taken together, these key ingredients can create fair and effective financing systems, which improve access to health services and avert the poverty that results from catastrophic health care costs.

1. Promote equitable access by removing financial barriers, especially direct payments

There is now broad consensus that health user fees ‘punish the poor’²⁷ and prevent people from accessing life-saving treatment. According to WHO, user fees are ‘the most inequitable method for financing health-care services’.²⁸ Worldwide every year 150 million people face catastrophic health-care costs because of direct payments, while 100 million are pushed into poverty – the equivalent of three people every second.²⁹ Revenue previously raised through user fees should be replaced with more efficient and equitable prepayment mechanisms.

A number of low-income countries have abolished health user fees for some or all of their citizens as a first step towards UHC. In Mali, the

‘Even tiny out-of-pocket charges can drastically reduce [poor people’s] use of needed services. This is both unjust and unnecessary.’

Jim Yong Kim, President of the World Bank Group

government has introduced policies to provide selected services free of charge, including caesarean sections. Between 2005 and 2009 caesarean rates in Mali doubled and facility deliveries increased from 53 per cent to 64 per cent.³⁰ Burkina Faso, Sierra Leone, Niger, Benin, and Senegal have introduced similar initiatives for priority groups. Just 12 months after user fees were removed for pregnant women and children in Sierra Leone, use of medical care by children increased by 214 per cent and maternal mortality declined by 61 per cent.³¹ The number of children treated for malaria tripled over the same period.³² Other countries, like Zambia, Nepal, and Afghanistan have gone a step further and made all basic health care free at the point of use. In Afghanistan, utilization increased by 400 per cent in the first year.³³ A study published in the British Medical Journal in 2005 estimated that 233,000 deaths of children under the age of five could be prevented every year by removing user fees in 20 African countries.³⁴

Removing user fees across 20 African countries could prevent the deaths of 233,000 children under the age of five every year.

Box 2: Indirect impact of user fees on women: evidence from Mali

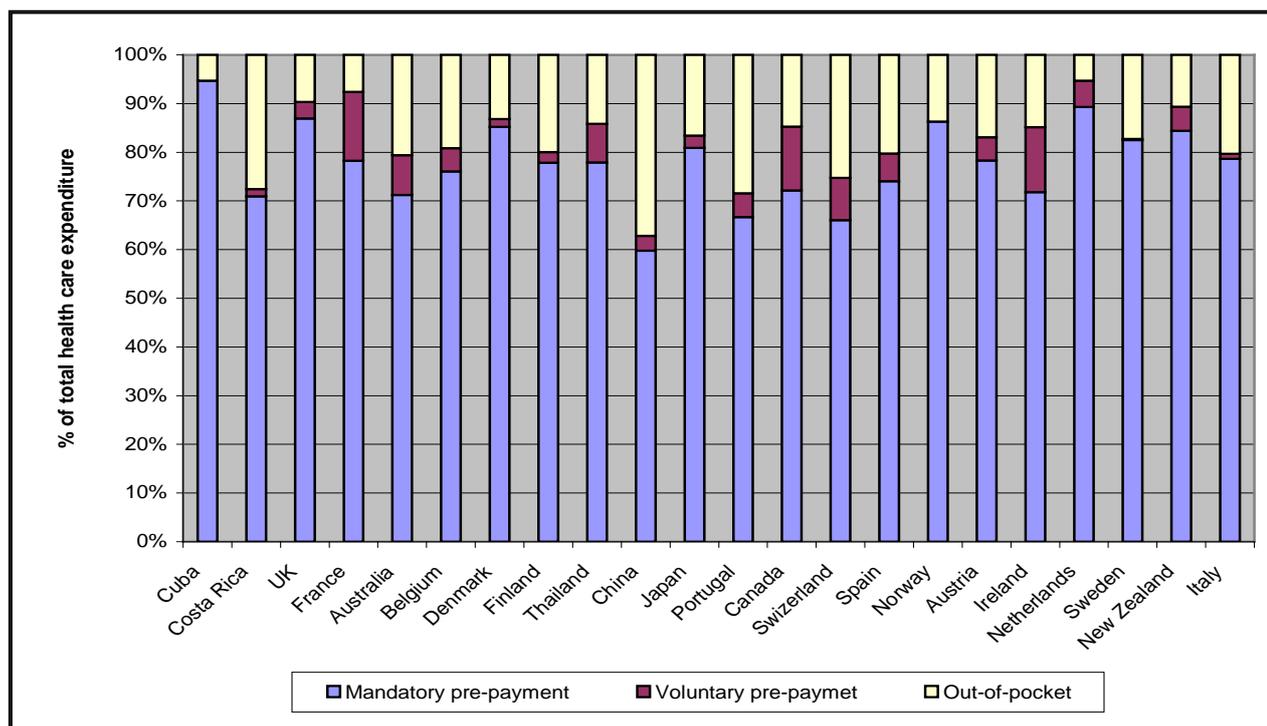
A 2012 ethnographic study on the indirect impact of health user fees on women in Mali found that fees reinforced gender inequality.³⁵ Health user fees reduced agency for women in health care decision-making. In situations where women lacked personal income to pay fees for care for themselves or their children, they explained how they must wait for their husbands to decide whether to provide the resources necessary for seeking care. The study describes how user fees 'trap women and their families in cycles of poverty, disease, and powerlessness'. Families living in poverty and women with limited decision-making power in their relationships were most severely affected.

2. Prepayment must be compulsory

No country in the world has achieved anything close to UHC using voluntary insurance as its primary financing mechanism. The 2010 World Health Report unequivocally states 'It is impossible to achieve universal coverage through insurance schemes when enrolment is voluntary'. Prepayment for those who can afford to contribute must be compulsory; if it is not, the rich and healthy will opt out and there will be insufficient funding to cover the needs of poor people and those who are sick.

As can be seen in Figure 2, mandatory prepayment constitutes well over 60 per cent of health expenditure in countries with universal systems. This figure presents data for the Organization for Economic Co-operation and Development (OECD) countries and for a few middle-income countries that are widely regarded as having universal coverage. The USA, which relies predominantly on voluntary insurance, is the only country in the original set of OECD countries that does not currently have universal coverage.³⁶

Figure 2: Domestic revenue sources for funding universal health coverage, 2011



Source: adapted from McIntyre (2012). Updated by author using 2011 data from WHO National Health Accounts dataset.

3. Large risk pools are essential

The principle of social solidarity requires maximum redistribution in the form of income cross-subsidies – from rich to poor – and risk cross-subsidies – from the healthy to the ill. This can only be achieved through having large risk pools (with the gold standard being a single national risk pool). Pooling arrangements that place funds raised from individuals in a single national risk pool together with general revenue, supplemented where necessary with donor funds, allow for cross-subsidization and are most likely to support UHC.³⁷

Small risk pools that protect the health needs of a small number of people (such as those found in voluntary schemes) cannot spread risk sufficiently. Having multiple schemes for different social groups, each with their own administration and information systems, is also inefficient and not financially viable in the long run.

Countries with single-fund schemes, such as South Korea, Estonia, Hungary, and Slovenia, have lower administrative costs than those with multiple schemes, like Austria, France, Germany, and Luxembourg.³⁸

4. Governments need to cover the health costs of people who cannot afford to contribute

To achieve UHC countries must raise sufficient public funds to cover the health care costs of those who cannot afford to contribute. Even in European countries with well-established health insurance systems,

governments inject general revenues into the system to ensure coverage for those who are too poor to pay (see Box 3).

In poorer countries where a large proportion of the population live on low wages and work in the informal sector, general government revenues are especially important. In a recent review published in the Lancet, a common theme among nine African and Asian countries that have made sustained progress towards UHC was the use of tax revenues to expand coverage.³⁹

Box 3: Germany increases the proportion of general revenue

In Germany around 70 million people (out of a population of 82 million) are members of one of the country's 134 health insurance schemes. The insurance schemes receive funding through the National Health Fund. The National Health Fund pools all mandatory payroll contributions (15.5 per cent split between employer and employee), and redistributes them risk-adjusted to the different schemes. Almost a quarter of all members (e.g. the unemployed, children and spouses of the insured, and parents on parental leave) are not on any payroll and do not contribute directly to the fund, but they receive the same level of benefits as those who do contribute.

Payroll contributions alone are increasingly insufficient to cover the health care costs of members. High administrative costs, an aging population, cost escalation, and an increasing number of people – primarily the better off – opting out in favour of private insurance, mean that the government is relying more and more on general tax revenue to fill the financing gap.

About a decade ago the German government started injecting resources from general tax revenue to keep the system afloat. In 2006 Germany allocated €4.2bn to the National Health Fund. This has quickly risen to €14bn in the years since 2009. Today it covers close to ten per cent of the statutory health insurance schemes' expenses.

UHC IS NOT BUSINESS AS USUAL

In too many cases the four UHC guiding principles are being ignored and business as usual prevails.

Despite health user fees being publicly condemned by the Director-General of WHO, and more recently, the President of the World Bank Group, progress on removing fees has been disappointing and international support remains unacceptably low.

Voluntary insurance schemes have been shown to have low coverage rates, to be costly to administer, and exclude women and men living in poverty.⁴⁰ Yet some governments and donor agencies, including the World Bank Group, the International Labour Organization (ILO), the Dutch government, and more recently UNICEF⁴¹, continue to provide financial and technical support to initiate and attempt to scale up these voluntary schemes. Such approaches do not follow WHO recommendations, and may block progress towards UHC.

Box 4: India's RSBY – the most innovative social security scheme.....?

Introduced in 2008, Rashtriya Swasthya Bima Yojna (RSBY) is India's flagship national health insurance scheme for people living Below the Poverty line (BPL). Evidence suggests the high praise given to RSBY by influential agencies including the World Bank Group and the ILO is both premature and dangerously misleading.

As of July 2013, 35 million households had been enrolled in RSBY and it is claimed that 50 per cent of BPL households are enrolled in the 460 districts where RSBY operates. These impressive figures hide concerning disparities - just eight per cent of families in the Shivpuri district in Madhya Pradesh are enrolled compared to 90% in Kozhikode district in Kerala.⁴² In the first year of RSBY male enrollment was over 1.5 times higher than for females – only five people can enroll per household and male members tend to be given priority.⁴³ There is also scope for gross overestimation of coverage - data on renewals is not published so it is impossible to know how big a gap exists between the active and cumulative count of enrollees.⁴⁴ In Ghana when only active national health insurance enrollees were counted, the official coverage was revised down in 2010 from 66 per cent to just 34 per cent of the population.

RSBY provides inadequate financial protection to enrollees – the insurance scheme covers only limited hospitalization costs yet in India 74 per cent of out of pocket health expenditure goes on outpatient care and medicines.⁴⁵ As costs are covered for inpatient care only, RSBY skews public spending on health away from more cost effective primary and preventative health care.⁴⁶

Cost escalation is a major problem. As the number of hospitalization claims increase insurance companies have argued that the government reimbursement of Rs. 750 (\$12) per RSBY household is insufficient. In Kerala companies are already charging the government ten per cent more per household enrolled than the official maximum reimbursement amount.⁴⁷ Further cost escalation is inevitable in the long term due to population aging, epidemiologic transition and rising medical costs.⁴⁸

Sadly there is significant evidence that health care providers and insurance companies are maximizing profits by gaming the system. Hospitals have engaged in misconduct by introducing illegitimate charges, making false claims and providing unnecessary treatments, to the point of clear fraudulence.⁴⁹ In the district of Dangs in the State of Gujarat, several private hospitals submitted false claims for several months, driving the claims ratio⁵⁰ for the district above 200 per cent.⁵¹ Contracted insurance companies have been known to delay issuing membership cards in order to reduce the number of claims. A study in Karnataka revealed that about 38 per cent of households did not have their insurance cards six months after registration.⁵² More serious claims of fraud include the alleged enrollment of thousands of 'ghost' beneficiaries by ICICI Lombard — India's largest private sector insurance company.⁵³ The losses to government, though not yet fully calculated, are believed to run into tens of millions of rupees.

Private health insurance

The role of private health insurance (PHI) in developing countries remains limited. Of all 154 low- and middle-income countries, only 11 fund more than 10 per cent of their health care through PHI.⁵⁴ A number of donor agencies including the World Bank Group (and particularly the International Finance Corporation) have been influential in driving the growth of PHI markets. Backing for PHI has also come from Dutch institutions such as PharmAccess and the Health Insurance Fund, which have been actively promoting PHI as a strategy for extending coverage to the informal sector.⁵⁵

South Africa and the USA are among the only countries globally that rely heavily on PHI (accounting for 42 per cent and 32 per cent of total health spending, respectively).⁵⁶ Neither of these countries has achieved UHC and they are currently amongst the most inequitable health systems in the world.⁵⁷

A number of defining characteristics make PHI an inappropriate financing mechanism for UHC:

- Although PHI can increase financial protection and access to health services to those able to pay, high premiums mean that only those on higher incomes can afford to join.
- PHI does not support risk sharing. Private insurance companies tend to design policies with the aim of attracting people with lower-than-average health risks and exclude those with higher health risks – a practice commonly known as cream-skimming. This can lead to discrimination and the exclusion of specific groups including women, elderly people, and people living with HIV.
- Without strong government regulation, PHI can lead to rising costs and inequitable access. Even in high-income countries like the USA, regulating PHI is a major challenge. Most developing countries lack the capacity for effective regulation.

Box 5: Private health insurance in Georgia

Georgia's Medical Insurance Program for the Poor (MIP) was launched in 2006 to improve financial protection for the poorest 20 per cent of the population. MIP is tax-funded and implemented by private health insurance companies. In 2011 MIP accounted for 43 per cent of the health budget.

Members are entitled to a fairly comprehensive package of health services with no co-payments. However, most drug costs are not covered. Problems with the eligibility system mean that about half of the poorest quintile is still not enrolled⁵⁸ and some patients are still paying for services that ought to be covered by MIP.⁵⁹ Out-of-pocket payments have been reduced slightly but remain exceptionally high at around 70 per cent of total health spending, at least half of which is spent on pharmaceuticals.⁶⁰ MIP has had no impact on utilization or reported health status.⁶¹ Meanwhile, insurance companies have made huge profits – in 2010 some companies were making profits of up to 50 per cent.⁶²

For those not covered by MIP only a minority can afford private health insurance or have employment-based cover. In 2012 half of all Georgians had no coverage and were paying out-of-pocket for health services in a privatized and largely unregulated health system.⁶³

Following the 2012 elections, the new government announced major reforms aimed at achieving UHC, including the creation of a state fund to purchase services directly from providers for those not covered by MIP. The new fund will by-pass private insurers. The commitment is laudable but significant challenges remain. Spending on health is low and the quality of primary health care is poor, largely due to the dominance of unregulated private providers. Questions remain over the design of the benefits package (especially pharmaceuticals) and the issue of copayments.

Community-based health insurance

CBHI schemes – called *mutuelles de santé* in Francophone countries – are increasingly popular with governments and donors as a ‘pathway’ to UHC. These voluntary, not-for-profit health insurance schemes are organized at a community level and specifically target those outside the formal sector. Some NGOs see CBHI as a way of increasing community participation in health service decision-making, but schemes vary and there is limited evidence on the extent of empowerment.⁶⁴ While CBHI can play a role in providing some financial risk protection in situations where more widespread prepayment and pooling arrangements do not exist, their potential to be scaled up to reach UHC is limited. There are several key reasons for this:

- Enrolment rates are often very low. Coverage at country level rarely exceed a few per cent⁶⁵ and so far CBHI schemes cover two million people in Africa, out of an estimated population of 900 million.⁶⁶ There is strong evidence to suggest that most CBHI schemes fail to cover the poorest groups.⁶⁷
- Premiums are usually charged at a flat rate, making this a highly regressive way of funding health care as poor people contribute a higher proportion of their income than wealthier people.⁶⁸
- CBHI schemes generate little revenue and are not financially viable in the long-run. Premiums tend to be low and the cost of collecting premiums can be high; the average cost-recovery ratio (money raised as a proportion of the amount spent) is only around 25 per cent.⁶⁹ Voluntary schemes do not generate the revenues required to cover those unable to pay premiums, which is a major concern in countries with high levels of poverty.
- CBHI schemes have small risk pools. A review of 258 CBHI schemes found that only two per cent had more than 100,000 members; more than half had membership below 500 people.⁷⁰ With insufficient funds to cover large health costs CBHI schemes tend to cover either a limited number of primary health care services or expensive specialist/inpatient care only, severely limiting the financial protection offered.

3 SOCIAL HEALTH INSURANCE

For those who recognize the pitfalls of voluntary schemes, SHI has become an increasingly popular alternative. Numerous international conferences and workshops have been dedicated to the issue, and the question of SHI design and implementation in low- and middle-income countries has been the subject of rigorous academic scrutiny.⁷¹

In theory, SHI has great potential – it relies on mandatory pre-payment and pools health revenues so that they can be distributed equitably across the population. However, while SHI has worked to achieve UHC in a number of high-income countries, attempts to replicate the same kind of employment-based models in low- and middle-income countries have proved unsuccessful. A recent systematic review concluded that ‘there is no strong evidence to support widespread scaling up of social health insurance schemes as a means of increasing financial protection from health shocks or of improving access to health care.’⁷²

In developing countries SHI schemes are typically characterized by large-scale exclusion and the bigger the informal sector the bigger the coverage gap. Ten years after the introduction of SHI schemes in Tanzania, coverage had reached only 17 per cent (see Box 6).⁷³ Kenya’s National Hospital Insurance Fund – established nearly 50 years ago – today insures only 18 per cent of Kenyans. Low levels of enrolment have been reported as a major and recurring challenge in a number of other countries, including Vietnam, Ghana, and Nigeria. Even high-income countries struggled to achieve rapid scale up via SHI – in Germany UHC took 127 years to achieve. People in poor countries cannot and should not have to wait that long.

Insurance premiums and co-payments act as a major financial barrier, even when they are considered low. For example, in Ghana unaffordable insurance premiums prevent many citizens from joining the National Health Insurance Scheme (NHIS).^{74,75} Twenty-nine per cent of Ghana’s population lives in poverty and yet just a quarter of this group are members.^{76,77} While most schemes exempt certain people from paying premiums (e.g. elderly, people living in poverty, and disabled people), subsidies are rarely sufficient to cover all those unable to pay. Insurance premium exemptions also experience the same exclusion and inclusion errors suffered by user fee exemption schemes.⁷⁸ In the absence of reliable income records, premiums are generally charged at a flat rate, for example \$10 per person, per year. This is a very regressive way of funding health care, with the poorest people paying more as a proportion of their household income.

‘There is no strong evidence to support widespread scaling up of social health insurance schemes as a means of increasing financial protection from health shocks or of improving access to health care’

Systematic review on the impact of insurance on the poor and the informal sector (2012)

Box 6: Multiple health insurance schemes in Tanzania

Health insurance in Tanzania remains highly fragmented, with a variety of schemes in operation. The National Health Insurance Scheme (NHIS) is mandatory for formal sector workers, especially government employees. A six per cent payroll contribution is split equally between the employer and the employee. Members and their dependants can access health services at government facilities as well as accredited NGO-run services, private facilities, and pharmacies.

The Community Health Fund (CHF) is a district-level voluntary prepayment scheme that targets rural populations in the informal sector. Households join by paying a flat-rate annual fee of between \$3 and \$6. Members are entitled to a package of curative and preventive services but benefits are much less than those afforded to NHIS members and expensive hospital care is not covered.⁷⁹ Inability to pay contributions is a significant barrier preventing poor families from joining the CHF.⁸⁰

It was anticipated that 60 per cent of households would be covered by health insurance by the end of 2003.⁸¹ However, official figures for the NHIF and CHF combined placed coverage at just 17 per cent in 2010/11. Meanwhile, the remaining population – 38 million citizens – continue to pay out-of-pocket.

Even when SHI is mandatory, membership is difficult to enforce. There are no formal mechanisms to deduct contributions from the majority population in informal employment and not everyone can afford to join. In low- and middle-income countries SHI schemes therefore become de facto voluntary. As such they suffer the very same problems as voluntary schemes, including low coverage, adverse selection, and risk pools that do not support cross-subsidies from rich to poor or from the healthy to the ill. Ghana's mandatory NHIS, widely promoted as an SHI success story, covers only 36 per cent of the population (see Box 7).

Box 7: Ghana's National Health Insurance Scheme

Ghana's NHIS was introduced in 2004, promising to deliver UHC. Yet after nearly ten years of implementation, the NHIS covers just 36 per cent of Ghanaians.⁸² The remaining 64 per cent of the population continue to make out-of-pocket payments to access health care.

For its members the NHIS covers the direct costs of health services and medicines for most common diseases in Ghana. The scheme is financed from a 2.5 per cent levy on VAT (70 per cent), payroll deductions from formal sector workers (22 per cent), and annual premium contributions from informal sector workers (five per cent).⁸³

Although the insurance premiums paid by informal sector workers are subsidized, large numbers of Ghanaians cannot afford the NHIS premiums, which range from \$3 to \$22 per year. So while every citizen pays for the NHIS through the 2.5 per cent levy on VAT, the majority of families on low incomes are not enrolled in the NHIS and therefore do not benefit.

Many countries are tempted to initiate SHI by covering the formal sector first; Zambia and Uganda are currently exploring this strategy. Even with the best intentions, countries that have taken this approach have struggled to expand coverage beyond the formal sector. Experience in Latin America has shown that once SHI is established first for salaried workers, there may be considerable opposition from employers and employees who do not want to see their benefits 'diluted' and/or are unwilling to subsidize membership for poorer members. Recent attempts to merge separate schemes in Tanzania have been met with similar resistance.⁸⁴ Very often, the end result is a two-tier health system with one scheme for the formal sector and another 'Ministry of Health' scheme (usually with a more limited benefits package) for everyone else.

Hopes that health insurance premiums from the informal sector would raise additional revenue for health have not been realized. It is complicated and expensive to collect premiums from people who are not formally employed. In Ghana, premiums paid by the informal sector contribute just five per cent towards the cost of the NHIS.⁸⁵ In Rwanda, revenue from the CBHI scheme accounted for just five per cent of all health spending in 2006, and is now probably closer to three per cent.⁸⁶

As major employers, governments also face huge bills to cover the SHI contributions of their own workers. The government of Tanzania spent \$33m on employer contributions in 2009/10; this equated to \$83 per employee – six times more than it spent per person, per year on health for the general population.^{87,88} Using government resources to subsidize better health services for an already privileged group is fundamentally unfair and undermines the core principles of UHC.

Introducing SHI may actually reduce the overall resources available for health, as perceived additional income from premiums can take pressure off ministries of finance to raise tax revenues for the health sector. In Kazakhstan, SHI triggered a reduction in budget allocations to health by a larger amount than that collected through insurance premiums.⁸⁹

SHI is ill-suited to the social and economic realities in poor countries and the usual manner in which it is implemented (with coverage starting with the formal sector first) is actually harmful for equity and the advancement of UHC. In high-income countries, several structural features have provided a positive enabling environment for SHI, including: large formal sectors, low poverty rates, small family sizes, and strong government capacity to administer and regulate insurance funds.⁹⁰ Crucially, these enabling factors are absent in most low- and middle-income countries.

Instead of importing inappropriate health financing models from high-income countries, developing country governments should look to learn from the increasing number of home-grown UHC success stories in other, more comparable countries.

In 2009/10 the Government of Tanzania spent \$33 million on employer insurance contributions. This equated to \$83 per government employee – six times more than it spends per person per year on health for the general population.

4 TWO APPROACHES THAT WORK

A growing number of countries – including Thailand, Malaysia, Sri Lanka and Brazil – are making significant progress using home-grown health financing systems which are equitable and universal. While each journey differs, successful countries have recognized that collecting premiums from those outside formal employment is complicated and expensive. Instead, they rely heavily on public financing to cover the majority of citizens. These countries are working to pursue the WHO recommendations to remove direct payments, maximize mandatory pre-payment, establish large risk pools, and use general government revenue to cover the majority of the population. Most importantly, these countries are basing entitlement for health care on citizenship and/or residence and not on employment status or financial contributions.

The countries that have had the most success with progressing towards UHC to date fall into two broad camps. First, there are examples of countries at all income levels, including Sri Lanka, Malaysia, and Brazil, which fund UHC from tax revenues.

Sri Lanka's tax-financed health system is unusually pro-poor and provides modern medical treatment to all at low cost. Year-on-year efficiency improvements ensure better health outcomes than most other developing countries, despite only seven per cent of the government budget being spent on health. Sri Lanka and Malaysia's tax-financed health systems provide citizens with some of the highest levels of financial risk protection in Asia.⁹¹ Only 0.3 per cent of households are pushed into poverty each year in Sri Lanka as a result of health-care costs.⁹² While Sri Lanka continues to face a number of public health challenges and there is an urgent need to address social and environmental determinants of health, the significant progress made on financing is a step in the right direction.

In Brazil in the late 1980s half of the population had no health coverage, yet only two decades after the country's tax-financed Unified Health System was established, nearly 70 per cent of Brazil's 200 million inhabitants now rely on it for their health care.⁹³ Rather than covering the easiest to reach first, Brazil's *Programa Saúde da Família* (Family Health Programme) was designed to initially increase coverage amongst disadvantaged groups, which it has largely achieved. The doubling of public health-care spending in Brazil between 1995 and 2011 coincided with the fastest fall in under-five mortality ever recorded.⁹⁴ However, Brazil continues to face a number of challenges. The universal scheme has been underfunded since its creation and standards of health care have suffered as a result. It is significant that, among other things, popular protests in 2013 focused on insufficient spending on health.

Advantages of tax financing include its inherent ability to create a national-level risk pool and provide a broader potential revenue base than SHI, especially in countries with high levels of informal employment. Tax financing also removes the need for expensive insurance administration systems, and has proved the most equitable system in terms of raising and distributing health resources most fairly across the whole population.⁹⁵

A second option increasingly being adopted by another set of successful UHC countries is to collect insurance premiums only from those in formal employment, and where possible, to pool these with general government revenue to finance health coverage for the entire population.

Thailand's health system relies on payroll contributions for only 12 per cent of its population and finances its internationally celebrated Universal Coverage Scheme using general government revenues (see Box 8).⁹⁶ Mexico introduced and scaled up its tax-funded popular health insurance scheme, *Seguro Popular*, over a period of 10 years to cover the 52 million people outside of the formal social security system to achieve UHC.⁹⁷ Challenges remain in Thailand and Mexico however, due to separate risk pools and superior health care benefits for those in formal employment, particularly government employees.^{98,99}

Box 8: Universal health coverage in Thailand

Before Thailand introduced its Universal Coverage Scheme in 2002, nearly a third of the population had no health coverage.¹⁰⁰ The vast majority of people who remained uncovered were in informal employment and many were too poor to pay insurance premiums. Recognizing this, the Thai government chose to use general revenues to fund the scheme, which pools funds for nearly 50 million people.

In just ten years the scheme has reduced the proportion of the population without health coverage to less than four per cent, increased access to services, and improved financial risk protection.¹⁰¹ People living in poverty have benefited most; the proportion of families in the lowest income group facing catastrophic health care costs dropped from four per cent in 2000 to 0.9 per cent in 2006 when UHC was achieved.¹⁰²

Thailand's success can also be attributed to large-scale investment in primary health care and action to ensure adequate supplies of essential medicines and human resources. Strong political commitment and active civil society engagement were crucial.

A more just and arguably more efficient solution is to create a single national risk pool combining all resources for health, including tax revenues, formal sector payroll contributions, and international aid, to provide equal quality health coverage for all. There is a welcome trend in this direction. Kyrgyzstan and the Republic of Moldova are among a small but growing number of countries financing UHC by pooling payroll

taxes from the formal sector with tax revenue.¹⁰³ The reforms in Kyrgyzstan have radically reduced fragmentation and inequity, revitalized primary care, and improved health outcomes (the infant mortality rate reduced by almost 50 per cent between 1997 and 2006).¹⁰⁴ In Moldova the pooled health budget (one third from payroll contributions and two thirds from general tax revenue) has enhanced equity and reduced the burden of out-of-pocket payments for all income groups.¹⁰⁵

Thailand is taking steps to merge its separate insurance funds to promote equity and improve efficiency. South Africa's proposals to redress significant health inequities by introducing National Health Insurance (NHI) indicate that all citizens and legal long-term residents will be provided with essential health care through a defined set of comprehensive health service entitlements, regardless of employment status or ability to make a direct monetary contribution to the NHI fund.¹⁰⁶

Box 9: The shift from passive to active purchasing of health care

Pooling of resources for health is critical to achieve UHC but so too is the active role of governments in ensuring available funds translate into effective health services for all.¹⁰⁷ It is a common misunderstanding that a purchaser-provider split, often associated with insurance models, is the only route to create incentives for improved provider performance and ensure accountability. In reality, as the World Bank's Adam Wagstaff has stated, 'there is no compelling evidence that SHI purchasers are more effective than tax-financed purchasers; in fact, there are some who argue the opposite.'¹⁰⁸

Rather than promote unproven blue print institutional arrangements, more attention should be paid to how successful governments have made the shift from passive to active purchasers across different health financing systems. It is critical to understand how these governments identify the health service needs of the population, align services to these needs, pay providers in a way that creates incentives for the efficient provision of quality services, monitor the performance of providers and take action against poor performance.¹⁰⁹

5 SCALING UP TAX FINANCING TO ACHIEVE UHC

Tax financing has played a dominant role in all UHC success stories. Unfortunately, the preoccupation with SHI as the 'default' UHC model has left the crucial question of how to generate more tax revenues for health largely unexplored in low- and middle-income countries. This blind spot should be urgently addressed.

The common assumption by governments and donors that there is insufficient fiscal space to increase government spending on health must be challenged. Even the poorest countries can increase domestic revenue by improving existing tax collection systems, removing unnecessary tax exemptions, adjusting tax rates, and introducing new progressive taxes and innovative financing mechanisms. The IMF has studied the ratio between countries' fiscal potential and actual government revenues, finding that low-income countries are reaching only 78 per cent of their potential, while lower-middle-income countries reach only 63 per cent.¹¹⁰ Analysis by the Kenya Institute for Public Policy Research and Tax Justice Network estimates Kenya's overall untapped tax capacity to be KSH 244bn (\$2.86bn) – enough to more than double government spending on health.^{111, 112}

IMPROVING TAX ADMINISTRATION AS A FIRST STEP

Gaps in national tax revenue may be due to a lack of capacity in revenue authorities, domestic tax evasion, and corruption in tax and customs authorities. Strengthening tax administrations to address these problems is therefore a critical first step to closing tax gaps. Oxfam has estimated that improving tax collection in 52 developing countries could raise an additional 31.3 per cent in tax revenues, or \$269bn.¹¹³ Indonesia has improved the performance and efficiency of its tax system with substantial benefits for government spending (see Box 10).

Box 10: Indonesia simplifies its tax administration system

In 2001 Indonesia created a single registry of taxpayers and simplified its tax administration system to encourage compliance. The government drafted tax laws that were clear, accessible, and consistently applied, and adopted a policy of zero tolerance towards corruption. Donors have actively supported tax authorities by building technical capacity, for example, by developing electronic systems for reporting taxable income. In the first five years, Indonesia increased its non-oil tax revenue by a massive 38 per cent in real terms.¹¹⁴

SCALING UP PROGRESSIVE TAX FINANCING

Indirect taxes such as VAT have become increasingly popular in developing countries, due in part to tax policy advice from the IMF and other agencies. However, VAT is typically regressive, with the poorest people paying more as a proportion of their household income. A range of more progressive tax options exist.

In many countries there is scope to increase personal income and company tax rates for those with greater means. Top marginal personal income tax rates in OECD countries average 40 per cent, but in developing countries it is rare to see tax rates greater than 25 per cent.^{115,116,117} Tax competition in attracting foreign direct investment has led to a proliferation of unnecessary tax exemptions. Developing countries forego an estimated \$138.9bn each year through corporate tax exemptions.¹¹⁸ According to a recent World Bank Group survey, 93 per cent of investors in East Africa said that they would have invested regardless, had tax incentives not been on offer.¹¹⁹

Property taxes and excise taxes on luxury goods such as cars and electronics can raise additional revenue to finance UHC. In Indonesia, luxury items are subject to a VAT surcharge of 10-200 per cent.¹²⁰ So-called 'sin' taxes on tobacco, alcohol, and high sugar content foods have the advantage of raising funds and improving health at the same time. WHO estimates that a 50 per cent increase in tobacco excise taxes in 22 low-income countries would generate \$1.42bn in additional funds.¹²¹

Box 11: Kenya rapidly increases its tax potential

In the last 10 years Kenya has increased its tax to GDP ratio from 15 per cent to nearly 20 per cent. Much of the increase is due to robust corporate and personal income tax revenues, which account for 9.9 per cent of GDP. The government has also introduced innovative sources of financing, such as a financial transaction tax on electronic money transfers, expected to raise 0.1 per cent of GDP in additional tax.

Kenya has increased transparency of public spending by creating local and national development funds. The Local Authority Transfer Fund (LATF) receives five per cent of national personal income tax revenues, has a district level accountability, and is monitored by civil society organizations such as the National Taxpayers' Alliance (NTA) using citizen report cards.

A number of countries are exploring innovative financing mechanisms such as small levies on financial transactions or levies on large and profitable companies. Gabon raised \$30m for health in 2009 using a 1.5 per cent levy on the post-tax profits of companies that handle remittances and a 10 per cent tax on mobile phone operators.¹²² Different forms of financial transaction taxes have been introduced in approximately 40 developing countries.¹²³

Non-tax income from extractive industry royalties could also be used to finance UHC, in Africa especially. According to the IMF, 20 of the 45 countries in sub-Saharan Africa are significant exporters of natural resources.¹²⁴ Among them, 10 already collect more public revenues from natural resources than from all other sources together. Providing measures are put in place to ensure revenue is distributed fairly, new discoveries of extractive resources constitute major revenue potential. Lessons can be learned from countries like Botswana where good governance and transparency have ensured that revenues from diamond exports are being used to fund public services.

THE NEED FOR GLOBAL SOLIDARITY

Urgent action on global tax evasion and avoidance is also vital to ensure that poor countries can generate and retain more of their own resources. Oxfam estimates that at least \$18.5 trillion is hidden by wealthy individuals in tax havens worldwide, representing a loss of more than \$156bn in tax revenue. The missing money is twice that required for every person in the world to be living above the \$1.25-a-day “extreme poverty” threshold.¹²⁵ Tax dodging by multinational enterprises costs developing countries an estimated \$160bn annually.¹²⁶ This is more than four times the amount spent on health by all sub-Saharan African governments combined in 2011.¹²⁷

As a result of mounting pressure on rich country governments to act, some progress was made at the recent G8 summit in the UK and the G20 summit in Russia where world leaders agreed to new measures to share tax information. Significant political commitment will be required to see this important change through to full implementation.

Achieving UHC will also continue to require significant development assistance, at least in the short to medium term. According to WHO, only eight of 49 low-income countries will be in a position to fully finance UHC from domestic resources in 2015.¹²⁸

But aid must be delivered in a way that supports democratic country ownership, empowering developing country governments and their citizens, in line with the principles of the Busan Partnership for Effective Development Cooperation. Government to government aid via sector or general budget support is the best way of supporting governments in their advance towards UHC. Directing development aid through government funding channels in Ethiopia has led to significant health gains. Nine international partners finance Ethiopia’s MDG Performance Fund which fills critical gaps in the national health sector plan, including infrastructure and human resources.¹²⁹

More long-term and predictable aid is vital, not only to help strengthen health systems, but also to improve public financial management and taxation systems so that countries can be self-sufficient in the future. If high-income countries were to immediately keep their international pledges, external funding for health in low-income countries would more than double overnight.¹³⁰

Oxfam estimates that lost tax revenue from tax havens is costing governments more than \$150 billion – twice the amount required for every person in the world to be living above the \$1.25-a-day “extreme poverty” threshold.

If rich countries were to immediately keep their international pledges, external funding for health in low-income countries would more than double overnight.

Increasing revenues available to governments in low- and middle-income countries alone will not be enough to achieve UHC. Governments must also demonstrate their political commitment by dedicating sufficient funds to the health sector and moving quickly to address inefficiencies, improve quality, and ensure effective, accountable, and safe patient care. Ministries of health need to consider how to allocate funds in the most efficient and effective way in order to achieve maximum health gains, by prioritizing primary health care – including preventative care – and by playing an active role in improving performance and accountability. Political will to achieve these changes has been the cornerstone of every UHC success story.

6 CONCLUSION AND RECOMMENDATIONS

The growing momentum for UHC is welcome, exciting, and challenging. UHC has the potential to transform the lives of millions of people by bringing life-saving health care to those who need it most. Developing country governments, aid donors, and civil society all have a part to play in making it happen.

UHC should be framed by the values of universality, social solidarity, and equity. Equity must be built into the system from the beginning,¹³¹ ensuring that people living in poverty benefit at least as much as those who are better off at every step of the way.¹³² If not, health financing reforms carried out in the name of UHC may actually reinforce inequality by prioritizing already advantaged groups and leaving the most poor and marginalized – especially women – last in line to benefit.

While UHC is not a ‘one size fits all’ journey, policy makers should prioritise WHO’s four key principles on health financing. Approaches that reduce direct payments, maximize mandatory pre-payment, establish large risk pools, and use government revenue to cover the majority population, are most likely to succeed.

In too many cases these guiding principles are being ignored. Health user fees have been internationally condemned, yet they continue to exist in poor countries. Three people are pushed into poverty every second because they are forced to pay out-of-pocket for health care. No country in the world has achieved anything close to UHC using voluntary insurance, but private and community-based schemes are still being promoted by influential donors. And there is ‘no strong evidence to support widespread scaling up of social health insurance schemes as a means of increasing financial protection from health shocks or of improving access to health care’.¹³³

Fortunately a growing number of low- and middle-income countries are building universal and equitable financing systems that are working to advance UHC. While their specific journeys differ, these countries share a common understanding that entitlement to health coverage should be based on citizenship and/or residency and not on employment status or financial contributions. Instead of collecting insurance premiums from those who are too poor to pay, these countries have prioritized general government spending for health – either on its own or pooled with formal sector payroll taxes – to successfully scale up UHC. Governments and donors should use the recent lessons from these countries and build on them.

There is indisputable evidence that public financing is the key to ensuring access to quality health care for all, yet the crucial question of how to generate more tax revenues for health has been largely overlooked. This blind spot should be urgently addressed. Even the poorest countries can increase domestic revenue for health by improving tax collection, adjusting tax rates, and introducing new progressive taxes. Such efforts must be supported and complemented at the global level with international tax reforms to address tax evasion and avoidance. More long-term and predictable development aid is also critical. Government to government aid via sector or general budget support is the best way to support countries to achieve UHC.

All countries can take immediate steps to move towards UHC and those that do will reap the rewards. Governments, donors, and civil society must work together to develop national health financing strategies for UHC that are universal and equitable, aligned with country health plans, and include all sources of financing for health. At the same time they must halt unproven and risky policies that threaten to derail progress.

RECOMMENDATIONS

Developing country governments

- Develop financing systems based on the four 'key ingredients' outlined by WHO. Rather than looking to adapt European-style employment-based SHI, build on the lessons from the growing number of low- and middle-income countries that are making progress towards UHC.
- Make equity and universality explicit priorities from the outset and avoid the temptation to start with the 'easiest to reach' in the formal sector. Those living in poverty must benefit at least as much as the better off every step of the way.
- Rather than focus efforts on collecting insurance premiums from people in informal employment, look to more efficient and equitable ways of raising revenue for health from tax reform.
- Move towards pooling together all government revenues for health – with formal sector payroll taxes where these exist – to maximize redistribution.
- Ensure that adequate proportions of national budgets are allocated to health, in line with the Abuja target of 15 per cent of government funds.
- Actively engage civil society in all stages of policy-making, implementation, and monitoring.

High-income country governments and multilateral organizations

- Stop promoting inappropriate approaches in the name of UHC, especially private and community-based voluntary health insurance schemes.
- Take action on tax avoidance and tax evasion, which denies poor countries much-needed revenue for universal public services. Provide support for progressive tax reform in poor countries, including technical support to strengthen tax administration capacity.
- Honour commitments to provide at least 0.7 per cent of GNI as Official Development Assistance, and improve aid effectiveness for health. Provide a greater proportion of aid as long-term sector or general budget support.
- Support developing country governments to effectively measure and evaluate progress and outcomes on UHC, especially equity.

Civil society

- Increase collaboration to exert collective pressure on governments and other stakeholders to push for a UHC approach that enshrines the values of universality, equity, and solidarity.
- Hold governments to account by engaging in policy dialogue, monitoring health spending and service delivery, and exposing corruption.
- Draw attention to cases where influential donors are promoting inequitable health financing mechanisms and hold them to account.
- Work together with civil society champions of tax justice to call for urgent action on global tax evasion and avoidance.
- Formal sector unions should act in solidarity with workers in the informal economy and advocate for universal and equitable health care.

Oxfam calls on the international health community to support UHC as the umbrella health goal for the post-2015 development framework. A focus on UHC provides the opportunity to accelerate progress on the health-related Millennium Development Goals, address the growing burden of non-communicable diseases, and most critically to move towards a more comprehensive approach to deliver on the right to decent, affordable, and equitable health care coverage for all.

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