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 interlinked 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 addressing 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] Nigeria[11] 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 & Mills[13] 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 & Brikci[14] 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.

Yates[15] 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 & Danielyan[16] 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 & Dunford[17] 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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