



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.

NOTES

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