



2018

3RD ANNUAL UHC FINANCING FORUM

Greater Equity for Better Health and Financial Protection
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Equity on the Path to UHC
Deliberate Decisions for Fair Financing
Background Report (Conference Version)

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This is a forum paper (conference version) to the “Third Annual UHC Financing Forum: Greater Equity for Better Health and Financial Protection”. This paper sets the stage for the presentations and discussions at the Forum and was prepared under the guidance of the Forum Technical Working Group. The information provided in this document does not necessarily represent the views or position of the organizations represented on the Technical Working Group

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Section 1: Introduction

In 2016, the World Bank Group and USAID established the Annual UHC Financing Forum, which takes place at the World Bank Group/IMP Spring Meetings. These meetings are strategic platforms where thousands of finance and development leaders from member countries discuss, analyze and debate goals for ending extreme poverty and boosting shared prosperity.

The UHC Financing Forum is embedded in these larger discussions to dive deeply into the processes for accelerating country progress toward sustainable financing of Universal Health Coverage—which is integral to reaching the Spring Meetings’ larger goals.

This year marks the third time in which over 400 policy makers and other experts have convened to analyze and critically discuss the health financing realities that countries face. In one of the only global spaces for these necessary discussions, participants use the forum to help shape a collective agenda for tackling key financing challenges posed by some of the trickiest problems.

The Third Annual UHC Financing Forum examines equity for better health and financial protection. It complements and builds on the topics and papers of the 1st and 2nd forum, which focused on how to generate revenues to meet financing needs for quality health services and financial protection, and how to use available resources in the most efficient way.

Each year our debates are informed by a background report that examines what works and doesn’t work, while taking stock of what is controversial, innovative, of high impact or in need of clarity.

This year, we take a different approach by asking policy makers to consider equity more deliberately in their health financing choices. When policy-makers aim to redress inequities in financing outcomes, they can draw upon a well-established body of literature that evaluates and offers guidance on how best to approach policy choices. But when policy-makers pursue strategies to accelerate progress toward UHC, they seem at a loss to fully consider the equity implications of their financing decisions. Or at least that is what today’s deep inequities in health financing suggest. We think that, perhaps, equity as a criterion for decision-making is falling through the cracks.

Placing the blame on policy makers would miss the mark. The main problem is that progress to UHC does not necessarily lead to improvements for all *and the worse-off*. This, we think, is because policy-makers grapple with how best to reach the equitable endpoint of UHC while also working on higher priority objectives, like improving efficiency, overall population health, employment or economic growth. Little guidance is available to help manage difficult trade-offs between competing needs.

This paper and this year’s forum aim to close some of the information and guidance gaps, and facilitate the changes necessary to move equity considerations to the forefront of health financing policy development. We see this as a three-pronged process with a focus on i) identifying policy decisions that are deemed “unacceptable”; ii) establishing what we call “fairness of process” in decision-making; and iii) monitoring the outcomes to help identify where policies need to be adjusted for equity.

The proposed framework builds on a large body of work that has explored the meaning of equity and fairness in health financing and fiscal policy. (e.g., Wagstaff & Van Doorslaer 2000; Murray et al. 2003; Xu et al. 2007; O’Donnell et al. 2008; Van Doorslaer & O’Donnell 2011; Bastagli, Coady & Gupta 2012; Ottersen & Norheim 2014; Clements, Gaspar & Gupta 2015; Mulenga & Ataguba 2017; Fleurbaey &

Maniquet 2017; Woo et al. 2017; Evan et al, 2001). More recently, this work has been applied to UHC (WHO 2014). However, no consensus has defined the boundaries and content of the terms “equity” and “fairness” and whether and how they are different. So, following on the WHO Consultative Group on Making Fair Choices on the Path to UHC, we use the terms interchangeably in this paper. (WHO 2014).

The scope of our framework is broken down into the following sections.

In **Section 2**, we describe the challenges that countries face as they progress towards UHC while also struggling with vast inequities in service coverage and financial protection.

Section 3 maps out why health financing and the outcomes they produce matter, and how and why policies that make UHC a goal—even if it’s far from a reality—are worthwhile.

Section 4 is really the meat of this report. It identifies unacceptable policy choices, maps out approaches to establish fair processes, and discusses the value of and need for monitoring.

Section 5 outlines what countries can do to fundamentally change the way they incorporate equity concerns into their health financing policies and strategies.

Section 2: Setting the Stage for UHC

In 1978, the Alma Ata Declaration articulated an ambitious extension to the World Health Organization’s constitution by declaring *primary health care* as a basic human right. In what is now Kazakhstan, world leaders signed onto new operating principles, declaring that all people had a right to personal health and public health, with access to trained doctors, nurses, midwives and traditional healers, and to sanitation, clean water, essential drugs, immunizations and more. And they proclaimed that these services must be available “as close as possible to where people live and work.”

Signatories gave themselves until the year 2000—22 years—and implored action on the promise that *health for all* would allow everyone to lead socially and economically productive lives.

Now, 40 years later, we not only missed the mark, but we missed it by a wide margin. The good news is that the fastest progress ever in extending health service coverage occurred during the era of the Millennium Development Goals. The bad news is that, at the close of the MDG in 2015, only about half the world’s population enjoyed the basic benefits envisioned for all in Alma Ata.

The new target date outlined by the Sustainable Development Goals and the WHO Consultative Group is to reach Universal Health Coverage—with access to services *according to need* and without *financial hardship*—by 2030. If we are to take this seriously, countries need to be on the right path and stay there.

We have 12 years to do a lot of work. One of the biggest hurdles is replacing out-of-pocket payments, which limit accessibility, with other forms of health financing. Only modest progress has been made in reducing these payments, and no clear trend shows their overall burden is lightening. To the contrary, every year approximately 100 million people fall into poverty because of out-of-pocket payments.

The tragedy is that we have failed, even though the means exist to make huge leaps toward UHC by 2030, and eliminate the payment conditions that knock these 100 million people annually into poverty.

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Multiple global estimates show that the cost of a package of essential health services should run no more than \$90 per person per year. Global domestic public spending stood at \$3.9 trillion in 2015, enough to finance these essential packages for more than 40 billion people, or over ***six times the world's current population***.

The problem is we have vastly inequitable investments in health financing, service coverage and population access. In 2015, in 69 countries with a total population of 3.7 billion, average government investment in health (including both DAH and domestic sources) fell short of the \$90 benchmark needed to provide a basic package of health services. In 42 countries with a total population of 2.6 billion, less than \$25 per capita was invested in health on average by governments. Even worse, in 25 countries, average government investment in health was less than a meager \$10 per capita. One-tenth of the world's population, or 700 million people who live in these 25 countries, have been left far behind on the path toward UHC.

For many countries, DAH is currently fundamental to achieve UHC targets. However the prospects for immediate increases in DAH flowing to LICs and LMICs do not seem bright, particularly for the approximately 35 countries that are expected to soon transition from key external financing streams like Gavi, the Vaccine Alliance and IDA.

The biggest challenge now is to figure out how to boost health financing across low- and middle-income countries in ways that make health coverage a priority and are consistent with the goals of UHC.

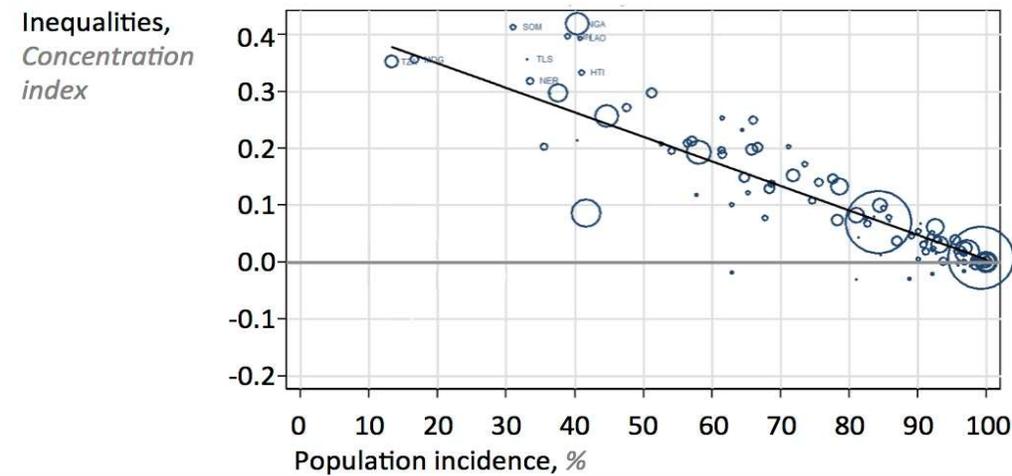
This report, and this year's health-financing forum, asks all participants to see this point in time as pivotal—as a moment of truth. If countries continue at the slow rate of progress that we saw in the last 40 years, we will fail to even come close to our goals by 2030.

Countries must accelerate progress towards UHC by systematically tackling fundamental shortcomings in health financing. This report and this year's forum hone in on proven and leading edge approaches, which include giving priority to the worse-off (the sickest and the poorest); reducing and ultimately eliminating inequalities in health investments across countries and within countries; protecting people from financial ruin linked to OOPs by phasing out OOPs as a means for health financing; increasing prepaid and pooled financing; and incrementally increasing guaranteed packages so that coverage of services, and their quality, improve for everyone over time.

Countries must make faster progress toward UHC. The inequities that we see globally, however, exist also within countries. As countries accelerate progress, they run the risk of deepening these inequities.

Figure 1: Incidence and inequality in skilled birth attendance

Threshold: 10% of total consumption (n = 120 countries)

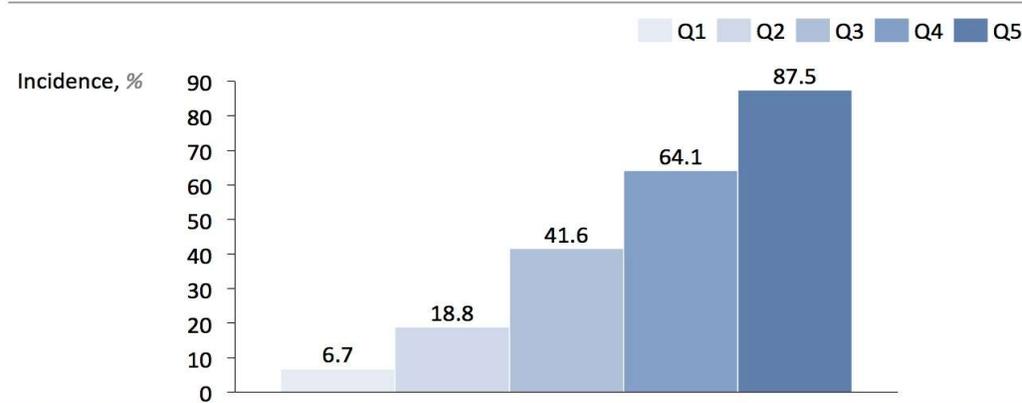


SOURCE: HEFPI 2018 Database

Notes: Based on latest available survey year; circle size is proportional to total population

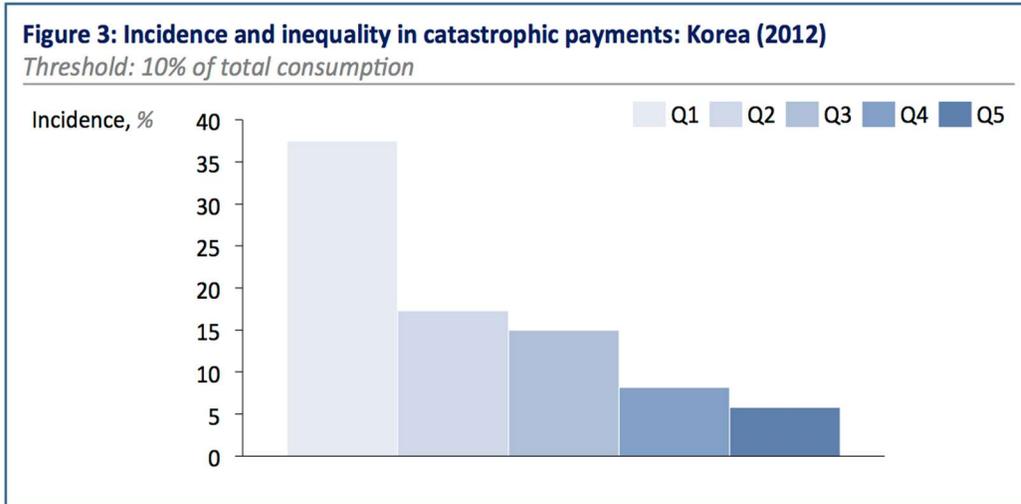
On the benefits side, the nature of the game is that the higher the coverage, the lower the inequities. Likewise, the higher the average coverage, the less the variation. For example, looking at Skilled Birth Attendance (SBA), a service commonly included in essential service packages, countries with service coverage above 80 percent, have concentration indices lower than 0.1 (Figure 1). In contrast, countries with average in service coverage between 30 and 50 percent, have concentrations indices between 0.1 (e.g., Indonesia) to close to 0.5 (e.g., Nigeria). The concentration index measures inequities by socio-economic status (SES). The index ranges from -1 to 1, with zero meaning no inequities in coverage across income groups in this case, and inequities increasing as the index approaches 1. By convention, pro-rich inequities have positive indices, while pro-poor inequities show negative indices.

Figure 2: Incidence of skilled birth attendance: Nigeria (2014), %



SOURCE: HEFPI 2018 Database

While the concentration index is an abstract concept, the illustration of coverage by income quintile provides a better sense of the depth of the inequalities. For example, the concentration index of 0.47 for Nigeria means that SBA coverage was 87.5 percent in the highest income quintile, but only 6.7 percent for the lowest income quintile (Figure 2).



SOURCE: HEFPI 2018 Database

On the burden side, the picture is less clear. Data are only available for a smaller set of countries. Multiple measures of financial protection exist, producing different patterns. Moreover, patterns need to be carefully interpreted against information on service coverage. For example, a decline in service coverage may result in reductions of OOP expenditures so the indices of financial protection might seem to improve. Nevertheless, we see deep inequalities in many countries. For the purpose of illustration, we use cata10 consumption. In most countries, inequalities tend to be overwhelmingly concentrated among the poor (Figure 3).

Like on the benefits side, the illustration of the incidence of financial catastrophe (in this case measured as out-of-pocket health expenditures exceeding 10% of total expenditures, called cata-10) by income quintile provides a better illustration of the depth of the inequalities.

For example, the concentration index of 37.39 for India means that the incidence of cata 10 was in 15 percent higher among the lowest income quintile compared to the highest quintile.

Inequalities in UHC outcomes often reflect differences in the level of investment or other health financing outcomes and functions. For example, at the turn of the century, service coverage varied in Mexico significantly between people with and without social health insurance.

Table 1: Coverage of effective access to preventive health interventions

	Uninsured	Insured
Skilled birth attendance	88.91%	94.78%
Basic vaccination schedule	71.39%	73.18%
Adults over 20 with high blood pressure control	47.73%	67.72%

Source: Urquieta-Salomon and Villarreal, 2016

While coverage for essential services such as maternal and child health was high independent of affiliation, stark differences prevailed in the coverage of services for non-communicable diseases (table 1). Effective coverage with high blood pressure control was 20 percentage points higher among the insured.

Similarly, the likelihood of those with social health insurance to suffer from catastrophic health expenditures (from inpatient visits) over a year was four times lower (Knaul et al, 2006). These differences in UHC outcomes corresponded to the levels of government financial contributions. For people with social health insurance, it was five to six times higher compared to the contributions for government health services used by the uninsured.

Section 3: The Goal

The definition of UHC holds that all people should receive promotive, preventive, curative, rehabilitative and palliative health services covered, based on health needs. Those services should be of sufficient quality to be effective, while also ensuring that people are protected from financial hardships when using the services (WHO 2010).

The goal of UHC expands on the concept of quality health care for all as a basic human right, as outlined in the WHO constitution, the Alma Ata Declaration on Health for All and a number of human right's treaties, adding protection from financial hardship.

The first critical part of UHC is about benefits, ensuring people are covered based on need. Healthy people—the better-off—need less services from the system. And unhealthy people—the worse-off—need more from the system. The spectrum of need should determine the benefits, setting up services to be rendered in an unequal, but equitable way. This we call vertical equity; the higher the need the greater the benefits. But coverage should also treat all people with the same health needs equally, so that everyone with kidney failure in need of hemodialysis receives it (if they want). This we call horizontal equity; across any given need, everyone is covered.

But within horizontal equity is the added dimension of quality or effectiveness of the available services. The effectiveness of those services is equally as important. That is, service coverage and quality combined result in effective coverage, or the capacity to achieve the desired results.

The second part of UHC is about financial burdens, ensuring people are protected from severe financial hardship when paying out-of-pocket for health services. These kinds of hardships have two widely-accepted definitions: out-of-pocket payments (OOPs) that push people into poverty or deeper into poverty, and OOPs that are not impoverishing but nonetheless prove catastrophic for the household because they lead to excessive borrowing or asset depletion, or cutting back on essential needs like education, clothing, housing and food. UHC is clear that no one should suffer these kinds of financial hardships from OOPs.

Equity in UHC outcomes matter

UHC is important to improving health and reducing poverty. We see this where people lack access to health services. They often take longer to recover from an illness or injury, or never recover, leading to loss of income. In countries with social safety nets, this can end up costing more in services than the

original treatment would have cost (the penny-wise, pound-foolish problem). Where no social safety nets exist, health costs are known to tumble families into poverty and hold them there. For example, the compounding effects of poverty force families to forego the cost of education, either because they have no money for the fees or they need their children to stay home and help earn income. Where the sick are expected to pay for health services, families may end up borrowing, incurring debt that can get passed down from generation to generation.

We recognize that social determinants also play an important role in health. That is, people with perfect health coverage at affordable costs who live in a community with gun violence are still susceptible to being shot. But where the two meet, is where UHC makes health coverage reliable and affordable. People have more money to pay for other things, like better education, nutrition and living conditions (to move away from the gun violence). And that can improve health outcomes and help lift people from poverty, or at least not exacerbate it.

We see UHC as leading to outcomes that reach beyond the population's overall physical health, because they play a role in reducing financial stresses. The explicit poverty aversion aspect of this holds the potential of positively rippling out. That is, in addition to grounding health systems in the ideal that health is a human right—as much as decent living conditions are—equitable financing that protects people from economic hardship ensures that the health sector plays no part in increasing poverty.

We also see that reducing inequalities in health outcomes helps reduce income inequalities. And better health translates into higher income. This is true of health services and social determinants of health. So we have two strands. Financial protection improves income inequality, and health outcomes reduce income inequality when outcomes improve the health of the poor. We know reduced income inequality promotes growth, and that income inequality has a “negative and statistically significant impact on subsequent growth.”(Cinganro, F., 2014)

Important lessons can also be learned from several high-income countries that today face growing inequities in health outcomes and increasing rates of poverty, and that have corresponding erosion of social cohesion, advanced political polarization, and slower economic growth. (IMF Fiscal Monitor, October 2017) Closing these gaps should be the goal of all countries, and health-financing choices can help.

Dramatic global health security lessons also can be learned from lower-income countries that have been unable or unwilling to work equitably toward UHC, or otherwise strengthen their entire health systems. In these places, infectious diseases spread more rapidly in areas with weak core public health functions, sometimes in dramatic ways that put immense financial and political stress on the entire global health system. The 2014 Ebola outbreak in West Africa serves as one of the most recent acute examples. We can begin to head-off these kinds of outbreaks by bringing equity to health financing so that health systems are, at the very least, able to deliver basic diagnostic and disease surveillance tools everywhere.

Journeying to UHC

Achieving UHC is the goal. But no country is all the way there, with complete coverage of high quality services that are accessible and affordable for all. Some wealthy countries come close with relatively

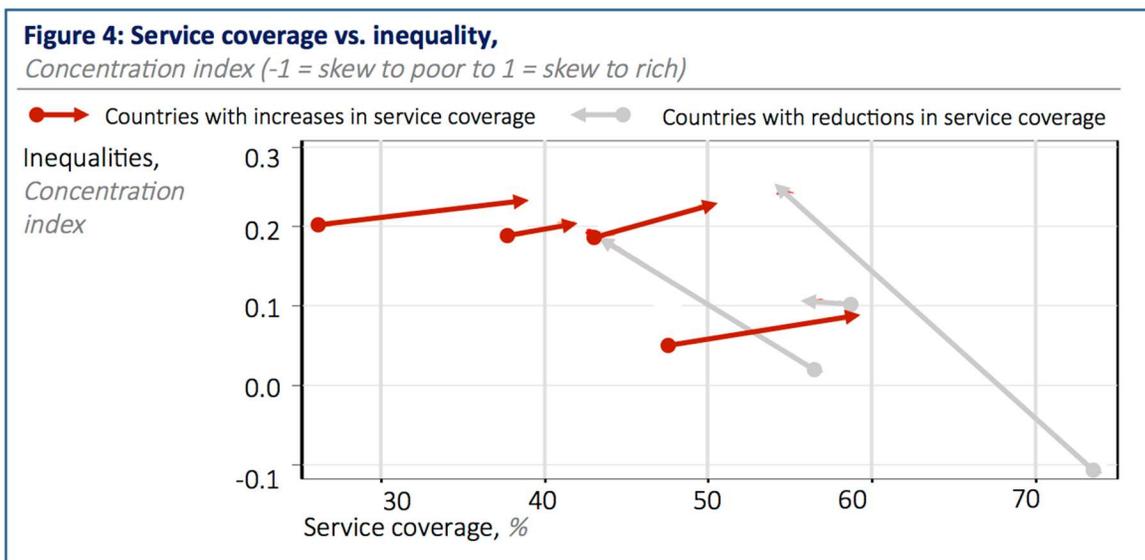
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large guaranteed coverage packages that include a broad range of health services available for low or no out-of-pocket payments.

For many countries, however, UHC is in the distant future. Too few can afford the suite of health interventions that are known to prolong and improve life, while also ensuring financial protection for all users. The goal for them is to see UHC as a journey, to start with at least a smaller guaranteed package with a baseline of essential services that are available to all, of equal quality for all and affordable. Then, over time, the size and scope of the packages should expand—all the while keeping as a goal improvements in equitability, availability and affordability of services. By starting out small, these countries are strategically and tactically set up to continue the journey to UHC.

Signposts show the way

Countries that have set UHC as a target and made the obligation to progressively stay on the journey, however, are unable to look to the UHC goals for guidance on making policy choices to help keep them on course. Indeed, as some countries made progress on service coverage overall, inequities widened (Figure 4). And during times of crisis, service coverage dropped and failed to protect the poor.



SOURCE: World Bank HEFPI 2017

So UHC shows the objective of the journey, not how to get there. We attempt to fill some of those gaps in guidance by offering policy-makers what we call signposts. They are designed to provide necessary directions for staying on course.

On the benefits side, UHC requires distribution of health services according to need. On the burden side, financing systems therefore cannot put up financial barrier to access the benefits. And that is where health financing of UHC extends beyond financial protection to providing services regardless of the ability to pay. So these two components have to be separated.

We call it decoupling. Policy-makers for UHC must develop a universal guaranteed coverage package according to their country's financing capacities. What is included in the package will be based on

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whatever country financing will allow, starting with a core set of health services and expanding it over time.

On a separate track policy-makers must raise the financing. But this must be done in a way that removes the financial burden for people who are unable to pay. The only way to do this is through prepaid and pooled financing. In practice, this means public financing -- taxes and contributions to social health insurance. To subsidize the poor, and those with large health needs, public funds should in general be raised based on the ability to pay with some degree of progressivity, that is, the richer contribute a higher share of their income.

So countries establish a guaranteed package with health services that are available to all at an affordable price (UHC). Who utilizes the services is separated from who pays for them. Utilization is based on health service need. Paying into prepaid and pooled systems is based on the ability to pay with OOPs minimized.

This provides two guideposts when developing policies toward UHC: health services according to need and contributions to prepaid and pooled financing based on ability to pay. Two tracks with separate directions for staying on the path to UHC.

On the journey to UHC come further considerations within these tracks. There is broad consensus that some priority must be given to the worse-off. On the benefits side, this means giving priority to the sickest and those with the lowest service coverage; on the burden side, this means giving priority to the poor.¹ In this way, UHC directs policy-makers to pay special attention to the most disadvantaged segments of their populations, and make decisions designed to reach them.

In countries with little potential for raising enough prepaid, pooled funds to cover a broad suite of health services, efforts have focused on identifying packages of sufficient services with guaranteed access and financial protection within the limitations of available public financing and service delivery capacities. These packages constitute the starting point for the progressive realization of UHC. Decision-makers then face the challenge of defining what is “sufficient” in a basic package, and what should be added as the package expands over time.

The challenges countries face staying on the path to UHC are many. The following are four interrelated but distinguishable choices that make policy decisions difficult.

First, the principles of benefits and burden are not absolute. For instance, with respect to benefits, should countries give priority to expanding the range of services available to all, based on need, or should they focus on improving the quality of existing services? Likewise, on the burden side, should the principle of ability to pay be interpreted as the rich pay more than the poor or that the rich pay a higher proportion of their incomes than the poor? Even if fair contributions are understood as the latter, i.e. progressive contributions where the rich pay a higher proportion of their income, policy makers must still determine how much more the rich should pay.

¹ One formalization of this approach is inherent in the ideals of progressive universalism, which dictate that at every stage on the path to UHC, to poor—who as a group are in the most need of health services *and* financial protection—should benefit at least as much as the rich.

Second, decisions often pit benefits against burden. Often, decision-makers have to decide between the two competing interests: expanding and improving health services on the one hand, and extending financial protection on the other. Should countries prioritize the expansion of effective services for those with the greatest health-service needs, or the extension of financial protection to those with the least ability to pay? Moreover, if countries decide to focus on a mix of health service expansion and financial protection, how much weight should be given to each component? And, of course, they have to figure out how to pay for everything—which circles back to the first difficulty.

Third, prioritizing the worse-off requires data, which are scarce. While many countries are setting up systems to identify the worse off, lack of sufficient survey data has made identifying those with greater health coverage needs and lowest actual coverage difficult. One answer is to focus first on universal coverage to cast a wide net that covers a basic set of services that reach everyone, including the worse-off and poorest people. This ensures that the poor gain at least as much as the better-off during service coverage expansions, on the way to UHC.

The fourth difficulty we see is, perhaps, the trickiest. This is when policy-makers must decide between improving equity in health financing and reaching other social goals—such as stimulating economic growth or raising additional revenue rapidly. This is the focus of the next section.

Section 4

Charting an equitable path forward in financing UHC includes three policy angles that this paper defines and offers suggestions for. The first is identifying **unacceptable policy choices** that should be avoided. The second is establishing **criteria for fair processes** that will engage the public and keep policy decisions on course. And the third is **monitoring impacts** by using available data to help inform policy choices and lead to equitable outcomes—not exacerbate existing inequities or lead to new ones.

Unacceptable Policy Choices in Financing UHC

Decisions that deepen inequities in health financing need to be identified and avoided as countries move closer to UHC on aggregate. Broadly speaking, an “unacceptable policy choice” is one that creates or exacerbates an existing unfair inequality and cannot be justified by trade-offs against other policy objectives. Here we are talking about incremental policy choices within the three health financing functions: **revenue generation, pooling and purchasing**.

We arrived at these unacceptable policy choices by building on the logic of the WHO Consultative Group on Equity and Universal Health Coverage, which focused on fair choices in the prioritization of services in the progressive realization of UHC. Here, we look more broadly at financing UHC.

While examining options for improving UHC outcomes (everyone gets the health services they need, of good quality, and with financial protection), we identified potential inequalities among individuals and groups (differing by income, gender, geographic region, ethnic origin, affiliation with pooling arrangements, legal status of residency, and health or disease related problem). We then drilled down to understand the inequalities across the three health financing functions that contribute to inequalities in health outcomes.

From there we established principles of fairness in the distribution of benefits and burdens, based on the values inherent in UHC and the more widely accepted principles of fairness and equity. We then scrutinized the inequalities in UHC outcomes and those related to each health financing function; measured those inequalities against the principles of fairness; determined whether they were inequitable (i.e. inequalities that are inherently unfair); identified policy choices likely to deepen inequities, and concluded that such choices—unless justified by the need to pursue other policy objectives—are “unacceptable”.

The policy choices that we deem “**unacceptable**” in all three financing functions, based on the approach described above, meet two criteria:

- 1) They deepen inequalities identified as **unfair** in the UHC principles for benefits and burden.
- 2) They cannot be justified by the need to pursue other policy objectives. Examples include stimulating employment, maximizing revenues, controlling inflation, or stimulating economic growth.

Both criteria involve value judgments that reasonable people can debate. What we focus on is policy decisions that increase inequity, but that cannot be justified by other policy objectives that offer counterbalancing trade-offs.

Ten Unacceptable Choices

The following are ten “unacceptable” choices, by health financing function (revenue generation, pooling or purchasing) outlined in table 1 of Annex 1

The first three unacceptable choices relate to revenue generation, which is defined as raising financial resources needed to develop and run a health system.

Broad consensus is that guaranteed services must be financed largely with compulsory prepaid resources and not out-of-pocket payments. This provides better financial protection and prevents that tumbling-into-poverty effect that OOPs too often cause. We argue that the equitability of how these prepaid funds are raised matters only to the extent that the choices affect the fairness of the entire public financing system, including both contributions and expenditures. So we see health financing as a part of public financing—from individual tax revenues to firms that pay dedicated taxes or directly fund employee health services. How revenues are raised and spent, on the whole, is what matters most.

Unacceptable choice No. 1: Raise additional revenues for health that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer disposable income distribution is not less equal.

At first glance, the Philippines' 2012 decision to raise a majority of revenues for the national insurance program through taxes on tobacco and alcohol might have been seen as an unaccepted policy decision because sin taxes are known to be regressive.² However, the government used a portion of the taxes to pay health insurance premiums for the bottom 40 percent of the population (Kaiser et al, 2016). From 2012 to 2014, the program expanded health insurance coverage among the poor to 14.71 million households, up from 4.61 million—a 300 percent increase in just two years.

Data has yet to become available to confirm that the expansion counter-balanced the regressivity of the tax measure. But results from other countries that have made similar choices are encouraging. For example, Indonesia relies heavily on regressive taxes to raise revenue, but the net fiscal incidence is progressive through mostly in-kind transfers for health and education for the poor (Jellema et al, 2017). The country has since seen a decline in income inequities, as measured by a drop in the GINI coefficient from 0.394 to 0.370 (which measures changes on scale from 0 to 1, with 0 indicating perfect equality and 1 being perfect inequality).

Unacceptable choice No. 2: Increase out-of-pocket payments for universally guaranteed personal health services without an exemption system³ or compensating mechanisms.

Debates over out-of-pocket payments arise in two categories of countries: the poorest and those in crisis situations. Extremely poor countries with limited resources face the most difficult trade-offs. Their limited options for raising finances can hem them into user fees, if they see no other path to financing government-sponsored health services. Do ministries of health rely on user fees or let service delivery falter (with no medicines purchased to restock shelves, no new health workers to fill shortages, and no capital to repair crumbling health-related infrastructure)? With little evidence that exemption systems work, most look for alternative financing mechanisms.

Even in higher-income OECD countries, when faced with the 2008 financial crisis, one-third of them (including Greece and Ireland) introduced or increased user fees to shore up health financing shortfalls. Greece offers a particularly vivid example of what can happen without exemptions for the poor. There, user fees were increased for outpatient care. But even though some vulnerable groups were exempted from the charges, unforced⁴ unmet need for health services increased from 7.5 percent to 11.7 percent for the poorest people (OECD, 2015 and European Commission, 2013).

² Tobacco taxes are regressive in the burden space since smoking prevalence is consistently found to be higher among the poor, they contribute a disproportionately higher proportion of their incomes to these taxes than the rich. On the other hand, the impact of these taxes is progressive in the benefits space – the poor gain disproportionately more than the rich in terms of subsequent health benefits (Summers, 2018).

³ Given the limited evidence-base in support of such policies, proof that these systems and mechanisms is critical

⁴ Unforced unmet refers to the proportion of people who report an unmet need for healthcare due to three reasons: (i) affordability, (ii) waiting list, and (iii) distance to health facility/no means of transport

Unacceptable choice No. 3: Raise additional revenues for universally guaranteed personal health services through voluntary, prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors.

Countries with no or limited government-sponsored service packages rely on private health insurance, which have been known to set premiums based on variables such as age, gender and pre-existing health conditions. These premium schedules make insurance unaffordable for those who are poor and sick. People don't get care according to need. Yet, some countries encourage such coverage through tax exemptions.

The next three unacceptable choices relate to pooling resources, which means spreading contributions across individuals and groups in a way that reduces the financial risk associated with medical expenses.

Health systems tend to be highly fragmented into pools of funds for health financing schemes, administrative territorial units, or health programs. Health financing schemes are the financing arrangements through which health services are paid for and obtained by people. Examples include national health services, social health insurance and voluntary insurance, including community-based health insurance. Administrative territorial units within health financing schemes may constitute separate pools, where lower levels of government are responsible for service delivery and receive transfers from higher levels of government and sometimes also raise local taxes and other revenues. Financing systems may be further fragmented into programs that target certain populations and diseases, with ring-fenced funding in less developed countries, often co-financed from DAH, whether passing through government budgets or administered separately.

The problems we see are largely associated with allocating public monies in a way that makes existing inequities in the availability of funds per person across pools worse, that is, inequalities in the availability of funds unless they are justified by different needs. Inequities, though, may also arise from exclusion because people are ineligible or face other barriers to their participation in pools.

Unacceptable choice No. 4: Change per capita allocations of tax revenue⁵ or donor funds across prepaid and pooled financing schemes in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

Prior to 2003, Mexico had three major financing schemes, two of them social health insurance schemes paid for by employee and employer contributions. And the third, paid for through general government revenues, served the uninsured. The two social health insurance schemes spent nearly five to six times more per capita on beneficiaries than the government-funded program. (World Bank, 2012).

⁵ Tax revenue excludes social health insurance contributions

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When the two employment-related schemes faced shortfalls, they received bailout money with no increases in allocation to the third scheme. So, in effect, the two plans servicing wealthier people with broader packages were given additional resources from the same pot of money that underfunded and provided fewer services to the general population. These allocations deepened inequities and were not justified by any other policy objectives.

Mexico rectified the entire funding levels by launching the Social Protection System in Health (SPSS), widely referred to as Seguro Popular. This program directs federal and state contributions to increase financing for the national health scheme, so that the per capita spending is now more even.

Unacceptable choice No. 5: Within financing schemes, change per capita allocations from higher to lower administrative levels in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

In federal systems, central governments typically transfer block grants to subnational entities. In Nigeria, the size of these block grants is largely determined by what is called “principle of equality,” which means all states receive an equal share of the revenues (World Bank, forthcoming). Population, size, level of social development, and fiscal capacity play only minor roles in determining each state’s share.⁶ This formula for resource allocation also fails to account for the large variations in revenue generated by the states.⁷

Under the assumption that all states give the same priority to health, disparities in available revenues lead to significant inequality in per capita allocations for health. Moreover, poorer states with smaller overall budgets often tend to give lower priority to health despite higher needs, further exacerbating inequalities.

To address this problem, the government proposed the Basic Health Care Provision Fund (BHCPF), which seeks to rectify the differences by offering additional financing to states proportional to their populations. The funds are channeled directly to frontline services with the aim to expand coverage with the Basic Minimum Package of Health Services.

The next four unacceptable choices relate to purchasing, which is concerned with decisions made on what and how to pay for, including services and inputs (covering human resources, equipment, supplies and infrastructure).

Here we make three principle distinctions. First, we differ between personal health services (such as treatment, rehabilitation, palliation as well as prevention and promotion at the personal level) and non-

⁶ For instance, population estimates only account for 25.6% of the formula.

⁷ State generated revenues range from NRA 1000 per capita in Niger state to NRA 25000 per capita in Lagos

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personal health services (such as essential public health functions, including population-based prevention and promotion as well as system governance).

Among personal health services, we distinguish between entitlements and the services that are de facto available. On the entitlement side, for example, social health insurance service packages typically guarantee for the formal sector a broader range of services than those guaranteed by government funding or insurance schemes designed specifically for the informal sector or the poor. On the availability side, guaranteed health benefits packages are in principle available to every pool member, but, in reality, contracting and payment systems may not make these services available for everyone.

Finally, for services that are actually available, we must look at key inputs (human resources, medicines, other supplies, equipment and infrastructure) The de facto availability of services hinges on the actual availability of these inputs, which often differs in quality and range across urban and rural areas.

Unacceptable choice No. 6: Within schemes or pools, change allocations of funds across diseases in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

A common example is where governments increase funding for particular disease programs that are already well-funded through external donor financing, perhaps as part of counterpart funding requirements, leaving other diseases programs addressing priority health problems with severe funding shortages.

Unacceptable choice No. 7: Introduce high-cost, low-benefit interventions to a universally guaranteed service package before achieving close to full coverage with low-cost, high-benefit services.

In many countries, public sector resources are directed towards hospitalization benefits before full coverage of basic health service is achieved. For example, in 2008, India launched the Rashtriya Swasthya Bima Yojana (RSBY) to provide insurance coverage to households living below the poverty line. RSBY is meant to address the high incidence of OOPs among the poor. The scheme offers hospitalization benefits with complete coverage in both private and public hospitals, which would previously have been inaccessible to the poor. The program has enrolled over 36 million households living under the poverty line (RSBY, 2018).

While RSBY significantly improved financial protection from hospitalization among the poorest, it did not address the need for low-cost interventions like primary and preventive care. To address this gap, the government simultaneously expanded significant resources directed towards the National Rural Health Mission (NRHM) through Conditional Cash Transfers (CCTs) and community health volunteers. And in February 2018, the government also announced the roll out of the National Health Protection Scheme

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(NHPS), which will include inpatient and outpatient care, and build 150,000 new health and wellness centers to increase access to care in underserved areas.

Unacceptable choice No. 8: Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need.

Governments tend to prioritize investments in hospital infrastructure to ensure a minimum access to life-saving services as well as to train their future health workers. These hospitals tend to be concentrated in urban areas, while people in rural areas often lack access to the most basic services.

Unacceptable choice No. 9: Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need.

Prior to 2013, Brazil had huge differences in the density of skilled health professionals. This was largely because the decentralized system that allowed sub-national entities to set their own salaries for physicians had inadvertently created disincentives for doctors to work in areas where salaries were lower. Wealthier states and cities in Brazil that paid higher wages ended up with a higher number of physicians, while other parts of the country experienced significant shortages.

Across the country more than 20 percent of municipalities had a shortage of physicians in public sector facilities, while more than 10 percent of municipalities had no doctors at all. The poorest states of Brazil had the highest shortage of health workers, forcing patients to rely on nurse-associates and community health workers with relatively lower levels of health training. (Ref: Monitoring Inequalities in the Health Workforce: The Case Study of Brazil 1991-2005, PLOS 1, 2012).

Then, in 2013, **Brazil** launched the *mais medicos* program, which offered financial and career advancement incentives for doctors to accept posts in underserved locations. This new policy addressed significant disparities in the distribution of physicians in the country and made the country's allocations for staff acceptable.

Unacceptable choice No. 10: Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities, unless justified by differences in need.

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Failures to prevent the rapid spread of the 2014 Ebola outbreak grew out of several weaknesses in **Liberia's** health system. The country's limited surveillance capacity to identify and report an outbreak was concentrated in urban areas, and almost non-existent in rural areas, where Ebola was spreading fast. This postponed detection of the disease until it was finally diagnosed for the first time in Monrovia. Skewing resources to cities allowed a deadly virus to kill people before it was finally detected.

Since then, Liberia has made significant investments in strengthening core public health functions, while addressing existing inequalities in community-level surveillance and disease reporting. The results have already been felt. During the 2018 Lassa fever outbreak there, Community Based Event Surveillance reporting showed marked improvements with completeness and timeliness of reporting. Health officials estimated that nearly all Lassa cases were reported.

Fairness of process and accountability: A framework for making decisions

Certain processes must be established to claim fairness and accountability in policy making. This is as true in health policy as it is in any other area of social policy. We recognize that complete agreement on the "fairness" of the outcomes of policy decisions is unachievable because people's perceptions of social justice vary. But we can agree on a fair process for making those decisions that the public sees as legitimate. So public participation and some level of accountability are necessary, because they help lead to decisions that create a general sense of fairness in the process, even though some people may dislike the outcome.

Here we tease out different strands of health-financing-related decisions as they relate to public involvement and accountability for reasonableness.

These first two refer to public involvement and purchasing decisions (what to buy):

- Public involvement in making one-off decisions such as where to locate a new health center often takes the shape of open discussions or debate in consensus conferences, town meetings, or citizen juries or panels. (Rowe & Frewer 2005; Abelson et al. 2008; Mitton et al. 2009; WHO 2014).
- Public inputs to longer-term decision-making have, in some countries, been formalized through representation on bodies such as hospital boards, local government health authorities, priority-setting committees and institutions, or the boards of health insurance funds (Sabik & Lie 2008; Glassman & Chalkidou 2008; Stewart et al. 2016; Byskov et al. 2017; Giedion & Guzman 2017; Simonet 2017).

These next two refer to public involvement and allocation decisions (how to spend):

- Further upstream in financing functions, citizens have been invited to participate in formal decisions on how to allocate government budgets across competing needs. This has happened

in places as diverse as Brazil, Cameroon, Europe, Peru, Sri Lanka and New York City (WHO 2014; Kasdan & Markman 2017).

- Less direct efforts by civil society organizations include, for example, the African Health Budget Network. This network of groups has influenced government allocations to health through advocacy and by encouraging African governments to adhere to the agreement made in Abuja Declaration of 2001 to allocate 15% of their budgets to health (Africa Health Budget Network 2018).

These kinds of citizen engagement can influence decisions, though they are on a relatively limited scale. For example, with formal decisions, citizen involvement in budgeting has been generally limited to lower levels of government – e.g. municipalities – and usually restricted to a relatively small proportion of the budget (Shapiro & Talmon 2017). With one-off decisions, limited evidence suggests that things like town meetings and juries influence the public’s sense of inclusion, either with respect to the quality of public debate or the resulting decisions. And those on hospital boards or citizen panels tend to be well educated and may be limited in their ability to reflect the views of the broader community (Campbell, Craig & Escobar 2017).

These final points refer to the need for accountability (transparency with fair process):

Answerability and enforceability are fundamental to accountability. So decisions that affect the population’s wellbeing must be transparent and justified. And individuals and institutions engaged in fraud or other misconduct must face censure or sanctions, perhaps backed by the judiciary (Schedler 1999; WHO 2014, Gruskin & Daniels 2008; Rumbold et al. 2017; Yamin 2017).

A common motivation for establishing accountability comes from the human rights framework, which sees the State as acting on behalf of its citizens (Yamin 2000; Farmer 2003). Informed public scrutiny, in turn, requires a reliable monitoring system, meaningful public participation in processes, and transparency and access to information (Yamin 2008).

A growing body of literature points to the advantage of infusing decisions with accountability and transparency. Foremost is the Accountability for Reasonableness framework applied to the rationale for purchasing services in pooled funds (Daniels 2000; Daniels 2008; Daniels and Sabin 2008; Daniels 2016; WHO 2014; Petricca & Bekele 2017). This framework establishes four conditions:

1. **Publicity:** Details of decisions made need to be readily available to the public, along with the justification for those decisions;
2. **Relevance:** The organization or authority making the decision must provide a reasonable explanation of the criteria it uses to make decisions;
3. **Revision and appeals:** Mechanisms for challenge and appeal need to be available with opportunities to modify decisions over time, for example, when new evidence becomes available (which requires adequate data collection, discussed in the next section);
4. **Regulation:** Formal rules are needed to ensure the first three conditions are fulfilled.

While most of these conditions are relatively straightforward, the relevance condition can be tricky. On the whole it simply means that fair-minded people can and should agree on decision-making criteria that are clear and easy to understand—and be accessible to the public. This approach is increasingly used for decisions on budget allocations during scarcity and for other difficult decision-making areas, like policy responses to climate change. But not everyone will agree on what constitutes reasonable criteria. And even when the criteria are accepted as reasonable, decision-makers may reasonably disagree on how to weigh the different criteria. For example, “value for money” (or bang for the buck) as a criterion for allocating scarce resources might shortchange equity considerations. In this case, additional criteria (cost-effectiveness versus equity) are needed to fully inform rationing decisions (e.g. WHO 2014; Baltussen et al. 2017; Badano 2018).

But, on the whole, having decision-making bodies explain the criteria for their decisions feeds into this greater sense of fairness in process. Box 1 and 2 offer good examples.

Box 1: Participatory Budgeting in Brazil

A process pioneered in Porto Alegre in 1989, called “participatory budgeting”(WHO 2014-Making fair choices), invited the public into the decision-making process and explicitly prioritized improving health services in poorer communities. Civil society organizations had demanded greater representation in these decisions to bring balance to what they perceived as a corrupt political establishment. Within 10 years of its implementation, public participation in the municipality’s budget processes for things like how to use bonds for capital improvements included over 40,000 people each year. [Bhatnagar, Prof. Deepti; Rathore, Animesh; Torres, Magüi Moreno; Kanungo, Parameeta (2003), Participatory Budgeting in Brazil (PDF), Ahmedabad; Washington, DC: Indian Institutes of Management; World Bank.] And the share of the total budget dedicated to health and education tripled to 40 percent by 1996, up from 13 percent in 1985. (Rebecca Abers, “From Clientelism to Cooperation: Local Government, Participatory Policy, and Civic Organizing in Porto Alegre, Brazil,” *Politics & Society* 26 (1998), pp. 511–538.)

Since then, participatory budgeting has spread to Brazil’s public health system, called Sistema Único de Saúde (SUS). Half of the health councils set up in nearly all Brazilian municipalities are regular citizens who are users of SUS (mainly patients). The remainder includes health workers, administrators, and managers. These councils are responsible for oversight functions that include strategic planning, approving the annual health budget, and monitoring the disbursement of funds. (Martinez MG & Kohler, JC. Civil society participation in the health system: the case of Brazil's Health Councils. *Globalization and Health* 2016.) This drove change and people’s preferences are now reflected.

Absent from this framework is the question of oversight.

That is, does an organization or body need to be created to ensure fairness in the decision-making process? For example, the WHO Consultative Group argued that one option would be to establish a “standing national committee on priority setting to handle particularly difficult cases” (WHO 2014). These kinds of bodies can ensure public debate and involvement when combined with the principles behind the Accountability for Reasonableness criteria.

Public involvement and accountability for reasonableness could be applied to any of the key health financing decisions around revenue generation, pooling or purchasing. This would include involving the

public in decision making; making public all information about the decisions and motivations behind them; creating appeal and review processes; and setting clear criteria that lay out what factors should influence decision outcomes. Criteria for reasonableness, however, would differ depending on the question. For example, decisions on contracting (which health services or inputs should be purchased and at what price) are driven by factors such as efficiency, the costs of administration and enforcement, incentives for quality, and the risk of fraud. The extent to which the public could feasibly be engaged in each type of decision would need to be determined on a case-by-case basis. But broad public debate would be warranted.

The question of overall tax policy—decisions about how much to raise, who should contribute and when—is even more complicated and requires deeper consideration. These decisions are usually made in parliament, by elected representatives who theoretically act on behalf of citizens. Changes to tax policy usually generate wide public reaction. And decisions made usually follow widely publicized debates among members of parliaments. But the outcomes—the way the votes tally—do not necessarily represent public sentiment. Views vary on whether this is sufficient to ensure accountability and fairness in processes. For example, adding an additional layer of complexity to re-enforce process fairness may not be justified when the purpose of a parliament is to represent the people. However, many countries have elected officials who are relatively wealthy and who represent wealthy constituencies. They will often have a conflict of interest when it comes to raising more taxes or making a tax system more equal. So other ways of influencing these decisions need to be found.

Box 2: Social Accountability in Ethiopia

Ethiopia is now in its third phase of a long process that is bringing the public into government decisions on health, education, agriculture, rural road projects, and water and sanitation. Since 2011, the Ethiopia Social Accountability Program has helped set up Social Accountability Committees (SACs) in 223 of the country's 770 local districts, called woredas.

The committees are made up in equal parts of locally elected council members, locally appointed administrators and civil society organizations. Their main purpose is to ensure that local administrative units are transparent and held accountable to citizens.

These SACs help build strong systems for evidence-based service performance measures, using five social accountability tools: Community Score Cards (CSCs) that use focus groups for self-assessments; Citizen Report Cards (CRCs) that survey households to assess the level of services they are receiving; Participatory Planning and Budgeting (PPB) and Gender Responsive Budgeting (GRB) for citizen engagement in budget planning; and the Public Expenditure Tracking Survey (PETS) for assessment of budget execution.

One example of a well-functioning SAC is in Malga Woreda, in southwestern Ethiopia. The SAC there started by using household surveys and measured an insufficient number of health workers to serve the community. That put pressure on the local government to allocate more resources. And, as a result, health centers recruited and trained additional midwives, health officers, and record officers. Through purchasing, clinics received needed medical equipment and medicines. And infrastructure money was allocated to build roads to health centers in Tenkaro and Haro, and create a new water source in Manicho town.

These SACs, as with participatory budgeting in Brazil, create inclusion and bring fairness to the process,

which make the local governments accountable to the citizens they represent.

Monitoring

Tracking Progress is a Must

Countries must get more serious about data collection, or the quest for equity will be meaningless. This, of course, requires tracking UHC outcomes. But it also requires tracking inequities in the three components of health financing (revenue generation, pooling and purchasing) that can affect UHC outcomes.

Decision makers cannot adjust their policies over time unless knowledge is available on where health-related outcomes are getting better and, more importantly, where they are getting worse. This requires tracking those who are covered, the quality of health services they are receiving, and the extent to which they are protected from financial hardship. Without these aggregated data, policy makers are unable to focus on the most disadvantaged—which they must do to remain in keeping with the goals of UHC.

At a minimum, policy makers need regularly collected data disaggregated by gender, income (or wealth), and geographical location (for example, rural or urban). Countries should add on other determinants that apply to their unique populations, like, for example, ethnicity, age, family structure, type of health problem, and capacity to deliver. The important point here is that disaggregated data will allow the health financing-related inequities to be measured and tracked over time, which is so critical to producing equity during policy adjustments, and keeping health financing decisions on track for UHC.

For example, on revenue generation, data needs to be collected to understand who is suffering severe financial hardship from out-of-pocket payments for which type of service, and whether adjustments to policies are reducing the burden. On pooling, data is needed to track how domestic revenues are allocated to financing schemes to ensure tax money is used equitably and not to subsidize already well-endowed pools. And on purchasing, inequities in the distribution of health workers and other inputs such as essential medicines need to be monitored, because this function determines whether the services people need are available, close to them, and of good quality.

To support fairness of process, these data then must be analyzed accurately and presented to policy makers in an easy-to-understand format (see Hosseinpoor et al 2018). The other half of supporting fairness of process is to also ensure that data are shared with the public and other stakeholders in a way they can digest.

This means many countries will have to change the way they monitor, share and evaluate progress in their health systems. Needed are records of patient attendance and treatment at health facilities. These can be collected through household surveys, but are routinely available if they are systematically and accurately collected at the time of service and quickly aggregated and reported. These records may be supplemented by other sources, such as cancer registries. But they vary across countries in number and quality and generally fail to provide information on quality of services, levels of financial protection, and a baseline (who needs services).

A push is being made now to use electronic medical records and specifically input systems, which capture comprehensive information on patient care, including symptoms, diagnoses, etiologies, procedures and outcomes. (“Toward greater integration of care and improved efficiency: A critical review of EHIF’s payment system, World Bank 2017, page 46.)

Other methods for undertaking the required analysis include tracking outcomes of adult, maternal and child mortality (e.g. Marmot et al 1991; Mackenback et al. 1997; Gwatkin 2000; Victora 2003; Moser et al. 2005; Barros et al. 2010; Bendavid 2014; Wagstaff, Bredenkamp & Buisman 2014; Gwatkin 2017). They also include measuring progress in increasing overall coverage and reducing inequalities in coverage with core health interventions, largely focused on targeted diseases of the MDGs (e.g. Rao et al. 2014; Alkenbrack et al. 2015; Restrepo-Méndez et al. 2016; Hogan et al. 2017; WHO & World Bank 2017; Wong et al. 2017; Victora et al. 2017).

A number of different methods have been used to document OOPs-related financial catastrophe and impoverishment, which has helped policy makers understand who is suffering the most (e.g. Xu et al. 2003 & 2006; Wagstaff & Lindelow 2014; Bredenkamp & Buisman 2016; Khan, Ahmed & Evans 2017; Wagstaff et al. 2017a and b; Ghimire et al. 2018). Disagreement over which ones work best have led to studies that include results from two or more of these methods (for example, WHO and World Bank 2017).

A shortcoming in the overall approach to tracking progress towards UHC, as it relates to service coverage and financial protection, is that the methods developed fail to drill down deep enough to unearth all the inequalities associated with health-financing functions (e.g. Boerma et al. 2014; WHO and World Bank 2017). Improvements that have been made relate to:

- examining whether fiscal policy is pro-poor, while taking into account the net impact of what they pay in and what they receive in cash or in-kind benefits (e.g. Lustig 2016 & 2017; Jellema et al. 2017; Lustig 2018).
- inequalities in the availability of services and in key inputs, such as health workers (e.g. O’Neill et al. 2013; WHO 2015; Speybroeck et al. 2012).

Tools to help country analysts undertake this work are now being developed. They are designed to give guidance on 1) estimating the absence of financial protection and inequalities in the health financing functions (Wagstaff et al. 2007; Wagstaff 2008; Saksena, Hsu & Evans 2014; Wagstaff & Eozenou 2014; World Bank 2018a), and 2) analyzing inequalities in health outcomes and health service coverage (Hosseinpoor 2016 & 2018; World Bank 2018).

For countries with resources to do household expenditure surveys, the World Bank has established the ADePT Resource Center with software that allows analysts to upload their survey data and produce indicators of inequalities and unsustainable health-related financial burdens. (World Bank 2018a). Approaches to rapid service availability and readiness, which can be used to track geographic inequalities, have also been developed, including the Service Availability and Readiness Tool (WHO 2018b).

But for countries lacking the resources for these expensive, time-consuming and labor-intensive household surveys, the World Bank has developed the Swift Survey approach. This is a low cost, rapid

way of measuring incomes and tracking progress in the reduction of poverty (World Bank 2018b). This approach offers hope of lower-cost and timely ways of obtaining the necessary data for UHC tracking.

The main message here is that tools are available to help countries. But we recognize that finding funds to pay for monitoring is challenging, especially in low-income countries. This area of health systems is generally underfunded. Most OECD countries invest less than 4 percent of total health expenditures in information systems, and low- and middle-income countries invest less than 1 percent. (WHO, OECD, World Bank, 2018)

Robust information so necessary to monitoring, which provides policy makers and the public with needed data to help establish fair processes and assess whether a decision is unacceptable, must be a priority.

Section 5: Seeing the Way Forward

This exercise in mapping out what equity in financing UHC means is to show the need for a fundamental shift in policy making. We know that many, many countries have committed to UHC. We are still seeing deep inequities in service coverage and financial protection that are associated with equity in financing. This tells us that something is going wrong in decision-making processes. We believe that taking a more mindful approach—applying the three prongs outlined in this paper—will make a difference. The reward will be more equitable UHC outcomes and greater societal and economic benefits.

Countries must chart a way forward. Whether already on the right path or trying to find a way there, the approach mapped out in this report should help. It is designed to fill some gaps in guidance for those who have committed to UHC. And while most technical details of what can and should be done have to be domestically determined, we know health assistance plays a role. The principles laid out here also apply to development assistance; they show that equitable outcomes must be the ultimate goal.

So for country ministries and policy makers, the starting point is to establish or expand basic guaranteed packages, with progressive realization (expanding the reach over time to include more and better services). Based on an extension of the logic of UHC, every country should start with some level of guaranteed coverage with some priority given to the worse-off, financed by prepaid and pooled systems, according to ability to pay. Once committed to this UHC policy-making path, we believe the three-pronged approach mapped out in this report will bring clarity to difficult decisions.

Only countries can know what needs to be done, and in what order— identifying and avoiding unacceptable decisions, inviting in civil society and establish processes that communities can agree are fair, or setting up data collection processes for better monitoring.

These three prongs are intrinsically linked. When the public participates in decisions and feels that processes are fair, all decisions moving forward carry that important quality. Decisions, of course, are best made based on evidence, which requires data collection and monitoring. But policy-makers need to move forward with public involvement as a means for establishing process fairness, regardless of where they are in data collection. Slow progress on one should not lead to slow progress on the other. Likewise, countries can go through this process and look forward—and maybe add to the list of 10 unacceptable outcomes we've identified thus far—regardless of where they are in setting up public

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involvement or data collection and monitoring. These other two prongs will eventually prop up the ability to identify unacceptable decisions so they may be corrected, and will help avoid making future decisions that lead to inequities.

The global community should help facilitate this shift using a parallel three-pronged approach.

As with country decisions, development partners should systematically introduce equity considerations into all engagements on health financing policies, and assess the equity implications of their financial support. The goal here is the same: to see whether health sector financial support is leading countries to make unacceptable choices. Development partners also should use their financial and technical support to increasingly build country capacities and institutions that produce and support processes to tease out unacceptable choices, establish fairness in process, and create better data collection and monitoring. And, finally, development partners should develop the tools, methods and approaches essential to carrying out these workstreams—as global public goods.

ANNEX 1

Table 1: Inequalities and Inequities in UHC Outcomes and UHC Financing, Including Unacceptable UHC Financing Policy Choices

UHC Outcomes			
Outcomes	Inequalities	Inequities	
Effective Coverage with Needed Health Services	Differences across people or groups in effective coverage with health services (personal health services, public health (including non-personal health services) and governance functions	Differences in the effective coverage of health services (including non-personal health services) and governance functions unless justified by differences in health needs ¹ No differences in effective coverage of health services when there are differences in health needs ²	
Coverage with Financial Protection	Some people or groups are pushed into poverty or further into poverty due to out-of-pocket payments (OOPs) for health services	Some people or groups are pushed into poverty, or deeper into poverty due to OOPs because of lack of access or in using quality services guaranteed by compulsory prepaid and pooled financing arrangements	
	Differences across people or groups in the incidence or extent of catastrophic OOPs for health services	Differences across people and groups in the incidence or extent of catastrophic OOPs because of lack of access or in using quality services guaranteed by compulsory prepaid and pooled financing arrangements	

1 Horizontal equity

2 Vertical equity

Health Financing Functions	Inequalities ³	Inequities ⁴	Unacceptable Financing Policy Choices ⁵
Revenue Generation			
	Differences across people and groups in net contributions to the public finance system (including, but not limited to health) ⁶	Revenue generation systems with differences across people and groups in net contributions to the public finance system (including, but not limited to health) which make the post-tax, post-transfer disposable income distribution less equal than the pre-tax distribution	1. Raise additional revenues for health that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer disposable income distribution is not less equal.
	Differences across people and groups in the incidence of OOPs for health services	<p>Some people or groups are pushed into poverty, or deeper into poverty due to OOPs because of lack of access or in using quality services guaranteed by compulsory prepaid and pooled financing arrangements</p> <p>Differences across people and groups in the incidence or extent of catastrophic OOPs because of lack of access or in using quality services guaranteed by compulsory prepaid and pooled financing arrangements</p> <p>Differences across people and groups in the incidence of OOPs that deter them from using quality services guaranteed by compulsory prepaid and pooled financing arrangements</p>	2. Increase out-of-pocket payments for universally guaranteed personal health services without an exemption system ⁷ or compensating mechanisms.

³ Linked to UHC outcomes

⁴ Linked to UHC outcomes

⁵ Unacceptable as they exacerbate inequities in UHC outcomes

⁶ Net contributions are gross contributions minus transfers received in cash or kind

⁷ Given the limited evidence-base in support of such policies, proof that these systems and mechanisms is critical

Health Financing Functions	Inequalities ³	Inequities ⁴	Unacceptable Financing Policy Choices ⁵
	Differences across firms in their net contributions to the public finance system ⁸	Revenue generation systems with differences across firms in their net contributions to the public finance systems that cannot be justified by some compensating benefit for the economy	
	Differences across individuals or groups in contributions to voluntary prepaid and pooled financing arrangements	Differences across individual or groups in contributions to voluntary prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors	3. Raise additional revenues for universally guaranteed personal health services through voluntary, prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors.
Pooling Function			
	Ineligibility across people and groups to participate in any pool or differences in eligibility across people and groups to participate in pools	Ineligibility of people and groups to participate in any pool or differences in eligibility across people and groups to participate in pools unless justified by differences in need ^{9,10}	
	Differences across people and groups in enrolment with private health insurance including insurance for services not guaranteed by compulsory prepaid and pooled financing arrangements	Differences across people and groups in enrolment with private health insurance including insurance for services not guaranteed by compulsory prepaid and pooled financing arrangements unless justified by differences in need	

⁸ For example, tax holidays, exemptions from social contributions, profit shifting, etc.)

⁹ Differences in need include both health and income. Those with lower health need more health services, and those that are poor are less able to pay for needed health services.

¹⁰ It is acceptable when eligibility is restricted to the worse off (sicker and poorer), but not the better off (healthier and richer).

Health Financing Functions	Inequalities ³	Inequities ⁴	Unacceptable Financing Policy Choices ⁵
	Differences in per capita allocations (of domestic general government revenue or donor funds) to prepaid and pooled health financing schemes (including publicly funded health services, social health insurance, voluntary insurance) ¹¹	Differences in per capita allocations (of domestic general government revenue or donor funds) across prepaid and pooled schemes units unless justified by differences in need or the availability of funds from other sources	4. Change per capita allocations of tax revenue ¹² or donor funds across prepaid and pooled financing schemes in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.
	Within financing schemes, differences in per capita allocations from higher to lower autonomous, administrative units	Within financing schemes, differences in per capita allocations from higher to lower autonomous, administrative units unless justified by differences in need or the availability of funds from other sources	5. Within financing schemes, change per capita allocations from higher to lower administrative levels in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.
	Within schemes or pools, differences in allocations of funds across diseases	Within schemes or pools, differences in allocations of funds across diseases that are not justified by differences in need or the availability of funds from other sources	6. Within schemes or pools, change allocations of funds across diseases in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.
Purchasing Function			
	Differences in entitlements of guaranteed service packages, implicit or explicit, across people and groups ¹³	Differences in entitlements of guaranteed service packages across people and groups unless justified by differences in need ⁹	7. Introduce high-cost, low-benefit interventions to a universally guaranteed service package before achieving close to full coverage with low-cost, high-benefit services.

¹¹ Health care financing schemes are the main types of financing arrangements through which health services are paid for and obtained by people. Here we refer to pooled schemes rather than to OOPs, including national or sub-national health services funded from government revenues (sometimes with donor funds as well), social health insurance, voluntary insurance (OECD 2011).

¹² Tax revenue excludes social health insurance contributions

¹³ Entitlements reflect the services and levels of financial protection to which people are entitled de jure. Whether people receive these entitlements de facto is a matter for purchasing.

Health Financing Functions	Inequalities ³	Inequities ⁴	Unacceptable Financing Policy Choices ⁵
	Differences across people or groups in the availability and quality of personal health services ¹⁴	Differences across peoples and groups in the availability and quality of universally guaranteed personal health services unless justified by differences in need ¹⁵	8. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need.
	Differences across people or groups in the availability of key services inputs ¹⁶	Differences across people or groups in the availability of key inputs to produce a universally guaranteed set of personal health services unless justified by differences in need	9. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need.
	Differences across people and groups in the availability and quality of core public health functions ¹⁷	Differences across people and groups in the availability and quality of core public health functions unless justified by need	10. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need.

¹⁴ Availability means that services exist and people can use them.

¹⁵ As for health services, this includes both horizontal and vertical equity considerations – e.g. where needs differ, the availability and quality of a set of services should differ.

¹⁶ For example, health workers, equipment, medicines, and infrastructure etc.

¹⁷ For example, population-based health promotion, surveillance, outbreak control etc.

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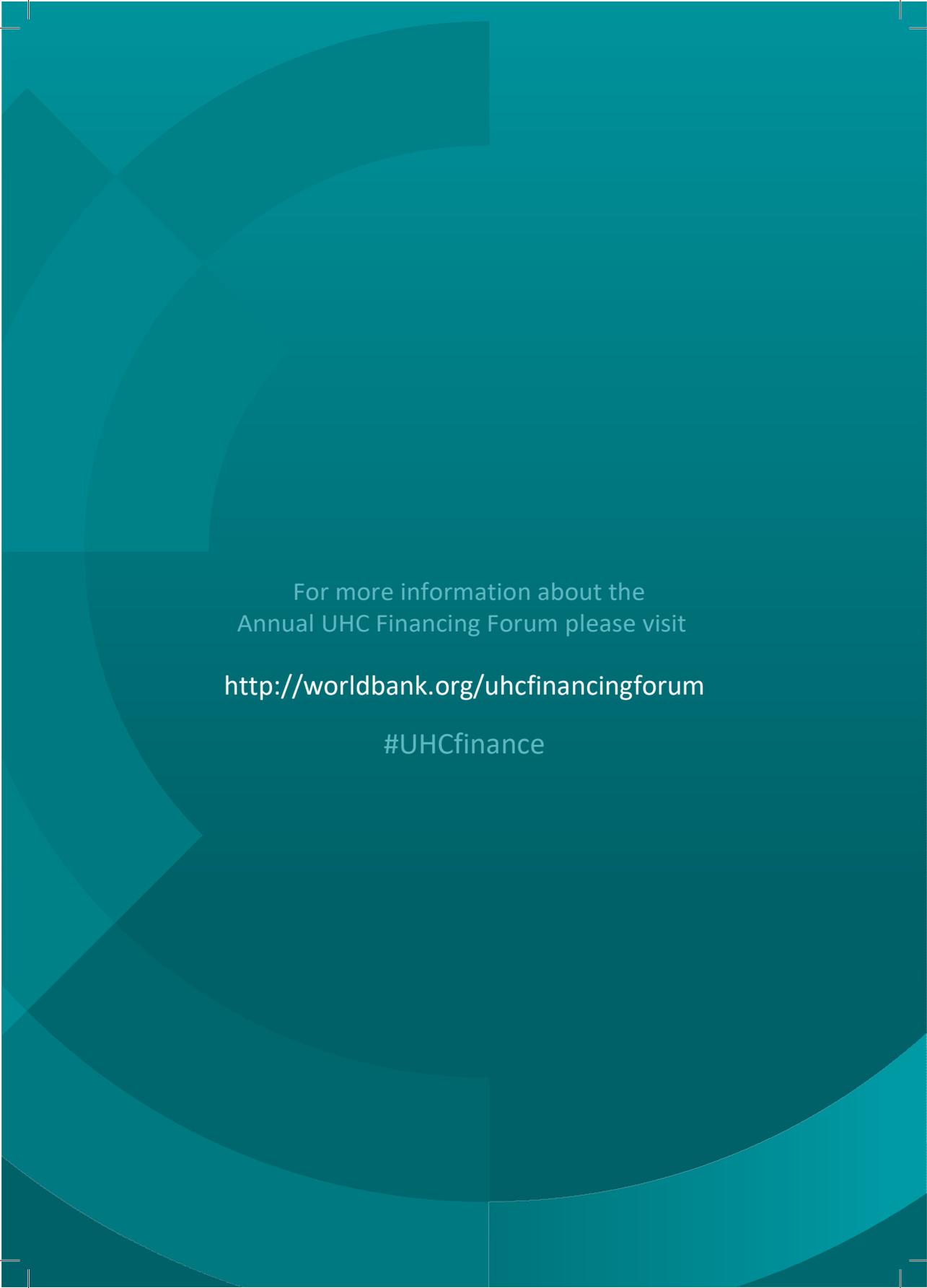
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