



# WORLD HEALTH ORGANIZATION

FIFTY-EIGHTH WORLD HEALTH ASSEMBLY  
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## Social health insurance

### Sustainable health financing, universal coverage and social health insurance

#### Report by the Secretariat

1. Policy-makers in all parts of the world, not only in low-income countries, are continually reviewing the way their health systems are financed – either in the way the funds are collected, how they are pooled to spread risks, what services are provided or purchased, and how providers should be paid. The objectives vary, but common concerns are the need to generate sufficient funds for health, improving efficiency or reducing costs, reducing the financial risks involved in obtaining care, and ensuring that the cost of care does not prevent people from receiving needed services.
2. Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving **equity in access**. The principle of **financial-risk protection** ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is **equity in financing**: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO's concepts of health for all and primary health care.
3. Realization of universal coverage is dependent on organizational mechanisms that make it possible to collect financial contributions for the health system efficiently and equitably from different sources; to pool these contributions so that the risk of having to pay for health services is shared by all and not borne by each person who is sick; and to use these contributions to provide or purchase effective health interventions. The ways in which countries combine these functions determines the efficiency and equity of their health-financing systems.
4. Financial contributions to the health system are raised in most countries from households and businesses, although external flows such as official assistance are an important source in many settings. Recent increases in the availability of external funding for health have the potential to stimulate major health improvements in poor countries. On the other hand, multilateral financial institutions and some ministries of finance have expressed concern that these inflows could affect macroeconomic stability. In addition, these funds are sometimes used to finance specific programmes, more or less independent of efforts under way to build long-term sustainable financing systems and institutions for the health system as a whole. It is important that inflows of external funds for particular activities are managed in a way that is consistent with the broader objective of developing sustainable financing systems and institutions and moving towards universal coverage.
5. Although various organizational options exist for achieving universal coverage, a key common characteristic of successful systems is that some part of the financial contributions of households is

prepaid and pooled. These contributions typically are the predominant source of domestically generated health expenditure at the national level. Experience shows that in addition there needs to be heavy reliance on compulsory sources of funding, such as taxes of various forms, payroll deductions, or mandatory insurance contributions. Voluntary prepayment can play a role in certain settings, but universal coverage is unlikely to be achieved on the basis of voluntary contributions alone.

6. Several options for establishing universal coverage exist, which can be classified into two broad strategies. The first is use of general tax revenue as the main source of finance for risk pooling, a system also referred to as **tax-funded health financing**. The second is introduction of **social health insurance**, used here to describe the situation where specific contributions for health are collected from workers, self-employed people, enterprises and the government, and are pooled into a single, or multiple, “social health insurance fund”. In the first option, all citizens (and sometimes residents) are typically entitled to services, so coverage is automatically universal. With social health insurance, entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population. Universality will be achieved only if contributions are made on behalf of each member of the population. For this reason most social health insurance schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay themselves. Social health insurance may be managed in various ways, including through a single government insurance fund or through multiple nongovernmental or parastatal funds.

7. In a number of countries, mixes of these broad approaches exist: part of the population is covered directly through general taxes, whereas other specific population groups are covered either by compulsory contributions to a social health insurance fund or by various other types of health insurance. In some countries, national agencies organize social health protection: citizens must be covered but have the right to choose private health-insurance funds, which are usually subject to strict regulation.

8. No health system meets the full cost of health services out of the prepaid and pooled funds collected by tax or insurance contributions. Most require some form of copayment, sometimes of an informal nature, at the time of use. The intention is to restrain demand and/or limit the cost to the government or insurance fund. However, it is crucial that the relative contribution made by out-of-pocket payments from patients at the time of service provision is not so high that it reduces access to care and fails to provide protection against the financial risks associated with high individual health-care costs. It is estimated that as many as 178 million people could suffer financial catastrophe as a result of out-of-pocket health payments each year, and that 104 million could be forced into poverty simply because of health payments.<sup>1</sup>

9. The fact that governments take the lead in ensuring that funds are raised and pooled to provide universal coverage does not mean that they must always provide the health services. All organizational mechanisms for raising funds and pooling them are confronted with the need to use these financial resources in the best possible way, purchasing or providing appropriate health services in an active, rather than a passive, way. These health services may be provided by private providers or by public facilities, or some mix of both. In all cases, governments need to ensure that incentives are in place to encourage providers to supply only the services that are required, at a high level of quality.

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<sup>1</sup> Preliminary global estimates on the population subjected to catastrophic expenditure and impoverishment. WHO, November 2004.

10. Health-financing systems that provide universal coverage have generally evolved over a number of years; population coverage was typically incomplete during this period. In countries that do not yet have universal coverage, different groups are covered by different mechanisms, for example, tax-based service provision, community and mutual health insurance, or other forms of nongovernmental or private health insurance. These will continue to coexist for some time during the transition to universal coverage, but the disparate parts will need to be brought together in a way that ensures universal coverage.

11. The transition to universal coverage may take several years, even several decades. A number of factors determine the speed of transition. Essential elements are the relative acceptance of the value and concept of solidarity in society, the effectiveness of government stewardship, and the population's trust in government and its institutions. A critical limiting factor is the ability of governments to mobilize tax revenues or insurance contributions. High economic growth enhances people's capacity to contribute to a health-financing scheme. When accompanied by a growing formal sector, it also makes it easier for any health-financing system to assess incomes and draw contributions from households (i.e. to collect taxes or insurance contributions). A further factor is the availability of skilled administrative personnel to facilitate the effective administration of a nationwide system.

12. No specific health-financing mechanism is optimal and recommendable in all settings. Indeed, of the 30 OECD Members, 15 have a system funded predominantly from contributions that are pooled in social health insurance funds, 12 have largely general tax-funded systems, and three have a mixed health-financing system. Virtually all countries that rely on pooled contributions also receive financing from government budget revenues in order to provide coverage for particular population groups, such as the poor. In addition, all have some copayments for specific types of services or for pharmaceuticals. Little advantage is discernible in one financing system over another in terms of impact on health outcomes, responsiveness to patients, or efficiency.

13. However, the impact of a health-financing system depends on the way in which funds not only are raised, but also are pooled and then used to provide or purchase health services. Attention should focus not solely on the question of revenue collection, which lies sometimes outside the control of the ministry of health. Improvements in efficiency and equity can also be made by examining the way in which revenues are pooled, then used to purchase and provide health services and interventions. Organizations that are part of the health-financing system – whether ministry of health, other ministries, health insurance funds, or private providers – require appropriate incentives in order to reach the objective of universal coverage through adequate revenue collection, and suitable arrangements for pooling and purchasing.

14. At some point various constraints and possibilities of a social, economic and/or political nature will entail specific choices in the transit of a health-financing system towards universal coverage. An initial crucial factor is the organizational context: the possibility of building upon successful existing institutions. Second, government stewardship and notably a strong political will to engage in a particular health-financing reform is essential. Third, the state of the economy is important, in terms of both overall growth and the extent of formalization of employment; economic growth and a growing formal sector facilitate the ability of governments to mobilize compulsory funding for universal coverage. Lastly, a concern common to all health-financing options is whether skilled administrative staff are available in sufficient numbers to undertake all the financing functions.

15. Ultimately, a country's decision on how to modify its health-financing system should be guided by decisions on collection, pooling, and purchasing, and the associated organizational arrangements that are most likely to lead to universal coverage in the context of that particular country, taking account of its society's values and collective objectives. Methods of prepayment and pooling of

resources and risks are basic principles in financial protection that require special attention in cases where these mechanisms are not well developed. The way to purchase or provide services using the pooled funds also needs careful consideration so that the needs of the population and the question of equity are optimally addressed.

16. When reforming a health-financing system, governments need to retain their important stewardship role in order to steer implementation while maintaining a certain degree of pragmatism, since societies and economies are dynamic, and the transition to universal coverage is likely to spread over several years.

17. The Executive Board at its 115th session debated the subject of sustainable health financing, universal coverage and social health insurance, and adopted resolution EB115.R13 for submission to the Health Assembly.<sup>1</sup>

### **ACTION BY THE HEALTH ASSEMBLY**

18. The Health Assembly is invited to consider the draft resolution contained in resolution EB115.R13.

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<sup>1</sup> See document EB115/2005/REC/2, summary record of the fifth meeting, section 2.