WHR 2000 to WHR 2010: what progress in health care financing?

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Introduction
The World Health Report 2000 (WHR 2000) is probably best remembered for trying to stack the health systems of different countries up against each other using a uniform set of measures (WHO 2000). Certainly, senior health officials in my own country (South Africa) repeatedly referred to our ranking of 175 out of 191 countries, in terms of overall health system performance, to highlight our plight. The problem is that nothing was done to improve our performance (Coovadia et al. 2009).

Simply knowing the ranking of individual countries’ health systems is of very little value to policy makers and health managers within these countries. Instead, what is required is clear guidance on the principles that should underlie our health systems, conceptual frameworks for approaching efforts to improve their performance and integrated analyses of key lessons from international experience.

Indeed, these issues were dealt with in the WHR 2000, but the related messages were not disseminated or received by policy makers as forcefully as the performance index ranking was. This commentary focuses on some of the useful conceptual frameworks and guidance on potentially fruitful directions for health system performance improvements in the WHR 2000, with reference to the issue of health care financing.

What did the WHR 2000 add to health care financing thinking?
From a health care financing perspective, possibly the greatest contribution of the WHR 2000 was its use of a framework developed by Joe Kutzin, which he later published in greater detail (Kutzin 2001). This framework, which built on earlier work such as that by Frenk (1995), is now widely used to present lessons from international experience (e.g. Gottret and Scheiber 2006; McIntyre 2007), but even more importantly, to guide thinking and planning at country level.

Up until that point, health care financing debates had taken place within the confines of references to a range of health system ‘typologies’ (Roemer 1991; OECD 1992), the crudest of which compared ‘Beveridge’ (largely general tax funded) and ‘Bismarck’ (largely funded by mandatory health insurance) systems. These typologies invariably failed to capture the complexity of variations in funding sources, organizational structures, allocation mechanisms and other system elements within different countries. Kutzin’s framework instead focuses on the functions of a health care financing system, namely: revenue collection, pooling of funds and purchasing of services.

From personal experience of engaging in health care financing policy debates in South Africa and a range of other African countries, this framework has assisted in moving us from ideology-laden debates about the ‘type’ of health system that may be most appropriate [peppered with comments such as ‘what we need is the Canadian (or Dutch, or British, etc.) system’], to detailed discussions about how to design each aspect or function of the financing system to achieve specific objectives, taking account of the country-specific context. In many ways, the framework was an early example of health-related systems thinking (de Savigny and Adam 2009), as it leads one to think about the full range of system elements and interactions between the different health care financing functions. It provides an important basis for more effective design and implementation of health care financing policy reforms.

Another conceptual contribution was introducing the notion of ‘fair financing’. Although there were some differences of opinion on the WHR’s definition of ‘fairness of financing’ and the most appropriate way to measure it (Wagstaff 2000), it drew attention to the importance of ensuring equitable (or fair) health care financing. It also highlighted that health systems are not only about improving health status; promoting fairness through health system financing (and delivery) arrangements has wider social value.

The WHR 2000 also marked the onset of a concerted effort to move away from direct to pre-payment health care financing mechanisms. Although there had been mounting concern through the 1980s and 1990s about the adverse consequences of user fees and other forms of direct or out-of-pocket (OOP) payments, the WHR 2000 was one of the first occasions that the WHO, as the leading multilateral health institution, took a firm
stand against OOP payments and encouraged countries to pursue pre-payment mechanisms. For example, the WHR stated that ‘Fairness of financial risk protection requires the highest possible degree of separation between contributions and utilization’ (WHR 2000: 97).

The case against OOP payments was further strengthened by later work done by WHO on the extent of catastrophic health care payments borne by households in a range of countries (Xu et al. 2003) and research by Wagstaff and colleagues about the impoverishing effect of OOP payments (Wagstaff and van Doorslaer 2003; Wagstaff 2008).

The emphasis on pre-payment financing mechanisms was re-emphasized in the 2005 World Health Assembly resolution on ‘Sustainable health financing, universal coverage and social health insurance’ (WHR 2005). This resolution explicitly called for pre-payment financing mechanisms as a way of ‘avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care’, highlighting the importance of the abovementioned evidence base in promoting the adoption of this resolution. More importantly, this resolution focused attention on universal coverage, which it defined as ‘guarantee[ing] access to necessary services while providing protection against financial risk’. Universal coverage has now become a major focus of health care financing debates, and it seems appropriate that the World Health Report 2010 will focus on this issue. Arguably, this progress may not have been possible without WHR 2000.

Remaining challenges

The WHR 2000 undoubtedly made an important contribution to crystallizing thinking on health care financing, both in the form of a valuable framework that has been used to unpack lessons from international experience and as a way of ‘avoiding alternative approaches to policy reforms within countries, as well as in clearly stating the imperative for relatively more emphasis on pre-payment mechanisms and less on OOP payments. We have seen some change in some countries along these lines, but unfortunately far too little.

A growing number of low- and middle-income countries, particularly in Africa, have removed user fees for some or all public health services (e.g. South Africa, Uganda, Senegal, Burundi, Zambia), sometimes with initial financial and other support from donors (particularly the UK Department for International Development). Of some concern, however, has been the almost exclusive focus on reducing OOP payments without adequate attention being paid to promoting further pre-payment financing (Gilson and McIntyre 2005). One of the exceptions to this general pattern is Ghana, which explicitly introduced a national health insurance system as a mechanism for reducing the burden of user fee payments (McIntyre et al. 2008).

This highlights one of the remaining health care financing challenges, namely the need to adopt a more system-wide perspective, rather than focusing on one specific issue (in this case, reducing OOP payments). In order to successfully reduce OOP payments, it is necessary to support user fee removal policies by interventions in all of the WHO’s ‘building blocks of the health system’ (WHO 2007). For example, it is necessary to provide information about the policy reform to the general public, to actively manage the response of health workers to the reform to avoid negative impacts on morale, to ensure adequate supplies of drugs (and other medical technologies) to cope with utilization increases, and to provide effective leadership (Gilson and McIntyre 2005). In addition, it is critical to increase public funding for health care (where public funding is defined as financial resources that can be used for the benefit of all citizens). The experience of countries such as Uganda graphically illustrates that without sustained, improved public funding of health services, quality of care in facilities that have removed fees may be compromised in the face of the increased utilization that inevitably results from reducing financial barriers to health care access. Perceptions of declining quality of care in public sector facilities has led to greater reliance on private sector health services... funded on an out-of-pocket basis (Kajula et al. 2004).

A key health care financing focus in the 2000s, especially in Africa, has been international funding, with a particularly large increase in vertical disease funds such as the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Fund to fight AIDS, Tuberculosis and Malaria, which has arguably contributed to greater system fragmentation. As the spotlight moves more firmly to universal coverage, it is becoming increasingly apparent that improved domestic public funding will be critical to achieving this goal, despite a resurgence of interest in private voluntary health insurance (Ghatak et al. 2008) and ongoing interest in community-based health insurance. Firstly, there is a need to seriously consider how universal coverage can be achieved in the context of a large informal sector, as is the case in most low- and middle-income countries. Is it more appropriate to fully fund the contributions of those outside the formal sector from public funds (particularly general tax revenue), as in Thailand and as appears to be the latest proposal in Ghana? Or is it more appropriate to encourage those in the informal sector to contribute on a ‘voluntary’ basis through vehicles such as community-based health insurance, as is currently the case in Ghana, and which may merely translate into a mechanism whereby ‘the poor simply cross-subsidize the health care costs of other poor members of the population’ (Bennett et al. 1998)? Secondly, there has been inadequate focus since the WHR 2000 on the pooling function of health care financing. Achieving the risk and income cross-subsidies (from the healthy to the ill and from the rich to the poor, respectively) necessary for achieving universal coverage is far more likely in systems with a single pool of funds, or at least a small number of large pools that are effectively integrated (e.g. through risk-equalization mechanisms), than in a highly fragmented system (McIntyre et al. 2008). Both of these issues point to the centrality of improved domestic public funding in achieving the goal of universal coverage.

The 2010 WHR, with its focus on universal coverage, holds the promise of renewing the impetus to address these health care financing system challenges. However, in order to fulfil this promise, we will need more than a report that crystallizes existing thinking or contributes new ideas. We need concerted and sustained efforts after the hype of the launch of the report to reinforce messages on strategies for achieving universal coverage and to translate these into action at the country level.
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