

## TOPIC TEN | FINANCING UNIVERSAL HEALTH COVERAGE

### Main Takeaways

- *Governments should support progressive public financing schemes, not private insurance markets, in order to achieve resilient, equitable and universal health systems.*
- *Governments should also ensure multi-sectoral planning and budgeting, and integrated service delivery, where people's health needs are considered along other rights, as opposed to fragmented and siloed models.*
- *External financing, and removal of structural constraints, are essential to ensure that adequate resources can be mobilized to combat the pandemic and to rebuild their health and economic systems.*

### Why is this topic important in the context of COVID-19?

The ways health systems are structured and financed determines how the burden of health-related suffering is distributed—within and between countries. This was already clear before the COVID-19 pandemic. It's an undeniable fact now.

COVID-19 struck a world already impacted by multiple waves of austerity. Neoliberal economic dogma has driven cuts in public spending for the social determinants of health (e.g. employment conditions, adequate housing), as well as budget cuts for public health and increased privatization of health care.

In the Global South, international financial institutions (IFIs) have played no small part in driving this trend. Since the late 1980s, their loan conditions have prompted steep cuts in public health spending.

Although there is substantial variation in the way health systems are financed and organized, the ones that have been most successful during the pandemic are those that are integrated, comprehensive public health systems (public health and care), which are primarily financed through progressive taxation.

### What is being proposed?

COVID-19 has boosted momentum around the need for comprehensive public health and UHC. According to the World Health Organization (WHO), UHC means “that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from

health promotion to prevention, treatment, rehabilitation, and palliative care.”

**Integrated, comprehensive public health care systems:** An integrated, comprehensive publicly-funded health system is one in which all levels of care and the necessary related services are available through a single public system. Coupled with public financing, public provision of care tends to facilitate health system strengthening, increase overall equity, and reduce transaction costs.

In contrast, a mixed system is one in which service delivery is financed and provided by a variety of public and private actors. Mixed systems are more likely to entrench and promote inequitable resource allocation, inefficient use of resources and erect barriers to systemic governance.

The WHO has indicated its support for integrated comprehensive service delivery with a major or dominant role for the public sector in order to achieve UHC. The Pan-American Health Organization has been even more explicit by redefining concepts of “coverage and access to health,” by stressing the values of solidarity and equity, and recognizing “financing as a necessary, though insufficient, factor in reducing inequities and increasing financial protection for the population.”

**Pre-paid pooled funding and fair, transparent priority-setting:** The chart below, known as the UHC cube, illustrates some of the choices that governments need to make in financing their health systems. Fair financing requires pre-paid pooled funding that spreads risk and seeks to eliminate out-of-pocket payments, which are inherently regressive. The health systems that have the largest available pool of funds are publicly financed through progressive taxation and are able to spread risk more evenly across different groups. By contrast, private health insurance markets, create



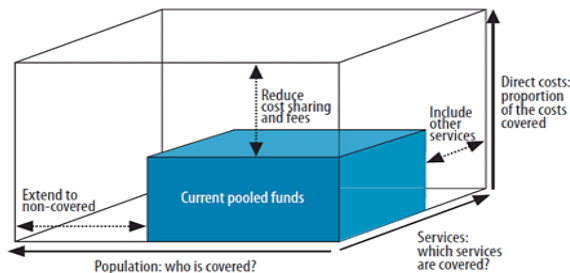
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smaller, fragmented resource pools based on people's ability to pay. The result is that such systems do not distribute risk and exclude those who cannot afford good coverage.

Generally, the entire population should be covered before adding services. However, sometimes marginalized or discriminated groups, or persons with significant impairments, may require additional services for effective enjoyment of health-related rights. Any trade-offs in financing the three axes of the UHC cube should be made explicitly and transparently, and must include the voices and views of those affected.



Three dimensions to consider when moving towards universal coverage

In absolute terms, financing for integrated delivery systems should contemplate the multiple needs of every health system user, known as the “5S’s” -- Staff, Stuff, Space, Systems, and Social Supports in the [Partners In Health \(PIH\) model](#).

As the WHO notes, it will be difficult for any country to achieve UHC without health spending of at least 5% of GDP, and accounting for emergency preparedness in the wake of the pandemic increases the amount. Governments mobilize these resources in varied ways, but the most equitable has been shown to be enacting progressive taxation (see [Topic 4](#)).

**External financing and Removal of Structural Constraints:** For many low and lower-middle income countries, there is simply not enough tax capacity to mobilize the resources required to achieve UHC and comprehensive public health. External financing (i.e. from foreign sources) is required to close the funding gap. [For 34 LICs alone, the annual external financing gap is estimated to be \\$50 billion.](#) This potentially includes increased foreign aid from donors and/or multilateral institutions, grants and loans (which should not come with onerous conditions).

The IMF and the UN Conference on Trade and Development (UNCTAD) have estimated that approximately [\\$2.5 trillion will be needed to support economic and health system recovery in developing countries](#) over the next decade, including \$500

billion for a “Marshall Plan” for emergency health services and related social relief programs.

All too often, conditions placed on external financing reinforce structural global inequities, in health and beyond. To meet the long-term goal of supporting countries to increase national taxation and regulatory capacity, and to be independent of external assistance requires a fairer global economy, including intellectual property and multinational taxation rules.

Decreasing external assistance without making the global economy fairer serves to further undermine the health and human rights of the most vulnerable people in the global South.

## What are the human rights arguments in favor of these proposals?

Most countries have ratified binding treaties that commit them to using the *maximum of their available resources* to progressively realize economic, social and cultural rights, including the right to health (see [Topic 1](#)).

Without adequate financing, no health system can ensure that health facilities, goods and services are available, accessible, acceptable and of good quality for all, without discrimination. Therefore, governments must ensure sufficient resources raised and allocated in an equitable manner, as well as effectively regulate private actors that impact costs of health financing (e.g. pharmaceutical industry).

As all governments cannot do this alone, global public investment and meaningful international cooperation are essential to health financing (see [Topic 2](#)). This includes debt relief (see [Topic 4](#)), increased and redesigned financial and technical support, and revised intellectual property rules (see [Topic 6](#)).

### Critical Questions

- ▶ What percentage of GDP is used to finance health? How does it compare to other areas of the budget, such as debt financing? How is it divided between federal government & sub-national units?
- ▶ Do out-of-pocket costs systematically affect certain population groups more than others in your country?
- ▶ How much external financing does the health sector receive and in what form?
- ▶ How can the health and economic effects of the pandemic be used to demand adequate public financing of a universal health system?