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## Technical discussion on

# Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015

The share of out-of-pocket health expenditure remains relatively high in many countries of the Region. As a result, each year, many households are exposed to the risk of financial catastrophe and impoverishment. Meanwhile, progress in implementing social health protection in low and middle-income countries has been relatively slow. The strategic directions proposed provide practical steps to expedite the move towards universal health care coverage, while recognizing the diversity among Member States and building on existing initiatives and policy reforms.

A draft resolution is attached for consideration by the Regional Committee.

## Contents

## Executive summary

The world spent US$ 5.8 trillion on health care in 2008. However, there are wide variations in per capita health care expenditure and health services utilization between and within different countries of the world and of the Eastern Mediterranean Region. The share of out-of-pocket health expenditure remains unacceptably high, up to 80% in some countries. Consequently, over 150 million households every year in the world face financial catastrophe as a consequence of ill health, and almost half of them are pushed into poverty as a direct result of having to pay out-of-pocket for health services. In addition, many households are forced to use their savings, borrow money, or sell their livelihood to pay for needed health services. Moreover, some households forgo seeking needed services at the appropriate time and live with the consequences of ill health, because of financial barriers. Equity studies carried out in some middle-income countries of the Region have shown that up to 5% of households face financial catastrophe following ill health and that half of them are pushed into poverty. Some vulnerable groups, including the poor and people living in slum areas, face even higher risks.

Evidence suggests that out-of-pocket payment is the main culprit for households suffering from financial catastrophe and its consequences. Universal health care coverage paves the way for reducing out-of-pocket expenditure and for reducing financial barriers in accessing health services. The move towards universal coverage is a move towards reorganizing the health system, focusing on its financing arrangements and on how the health services are delivered. There are various models for financing universal coverage and for delivering health services. However, health financing and service delivery systems are interlinked and the interface between these two components of the health system is crucial for a successful move towards universal coverage.

In this paper, following global and regional review of health financing and six strategic directions and related actions are proposed in order to facilitate and expedite the move towards universal coverage in the Region: mobilizing sufficient resources for universal coverage; developing prepayment schemes; promoting and supporting strategic purchasing; promoting, supporting and generating knowledge for evidence-based health financing policies and achievement of universal coverage; coordinating national and international partners and improving aid effectiveness; and monitoring and evaluation of equity and extent of universal coverage.

Obviously, the path and the time it takes for different countries to achieve universal coverage will be different. However, the experience from countries that have achieved universal coverage in recent years indicates that, with proper planning and political will, all countries can expedite their move towards universal coverage and that universal coverage could indeed be within the reach of many countries in the Region.

## 1. Introduction

The attainment of the highest possible level of health is a fundamental human right enshrined in the WHO constitution as well as in the constitutions of many of its Member States [*1*]. Health is also a form of human capital and contributes to individual productivity and performance [*2*]. In addition, the health sector is an industry that accounts for a large share of labour force employment and contributes to overall economic growth and development. Evidence suggests that health services make significant contribution to good health. This indicates the importance of having effective, efficient and equitable health services coverage to promote the health and well-being of the population [*3*].

When family members become sick, many households find themselves obliged to borrow money, use their savings and/or sell their livelihood to obtain needed health services [*4*]. Every year, hundreds of millions of people seek health services. In doing so, over 150 million of them become exposed to financial catastrophe and half of them are pushed into poverty because of having to pay for health services. In addition, some households forgo seeking needed services at the appropriate time and live with the consequences of ill health and disability, because of financial barriers [*4*]. Evidence suggests that out-of-pocket payment is the main culprit for households suffering from financial catastrophe and its consequences. Therefore, developing social health protection schemes – financed through health insurance and/or general government revenues – and moving towards universal coverage provides a direct route to alleviate the burden associated with the need and demand for health services.

The World Health Report 2008 provides a framework for the revival of primary health care in Member States [*5*]. Universal coverage is one of four policy reforms articulated in that report which has been adopted globally as part of the revival of primary health care. Universal coverage reforms are intended to ensure that health systems contribute to health equity, social justice and the end to exclusion, by moving, and expediting the move, towards universal access to health services and social health protection.

The development of social health protection and revival of primary health care is high on the policy and political agendas of countries of the Eastern Mediterranean Region. However, the Region lacks an overall strategy with clear directions for expediting the move towards universal coverage. The World Health Report 2010, which focuses on health system financing and universal coverage [*6*] and which will be launched in November 2010, could pave the way to implementing regional strategies to achieve universal coverage. The objective of this paper is to propose strategic directions for 2011–2015 for improving health services financing in the Region by reducing out-of-pocket payment, and thereby limit the risk of financial catastrophe and impoverishment and expedite the move towards universal coverage. The strategic directions proposed are based on the most recent global and regional knowledge in health financing and follow consultation with regional and international health financing experts.

Key concepts discussed in the paper are defined as follows.

*Universal coverage* ensures that the health system makes available to all people a range of needed promotive, preventive, curative, and rehabilitative health services, without the risk of financial hardship. It contributes to health equity and social justice. Universal coverage is a process that has three dimensions: breadth (percentage of population covered), depth (range of services covered) and cost coverage (percentage of cost covered), as shown in Figure 1. Policy-makers in developing countries, particularly in low and middle-income countries, are forced to find compromises between the speeds with which they push each of the three dimensions, in their move towards universal coverage. Throughout the process, policy-makers need to set priorities as

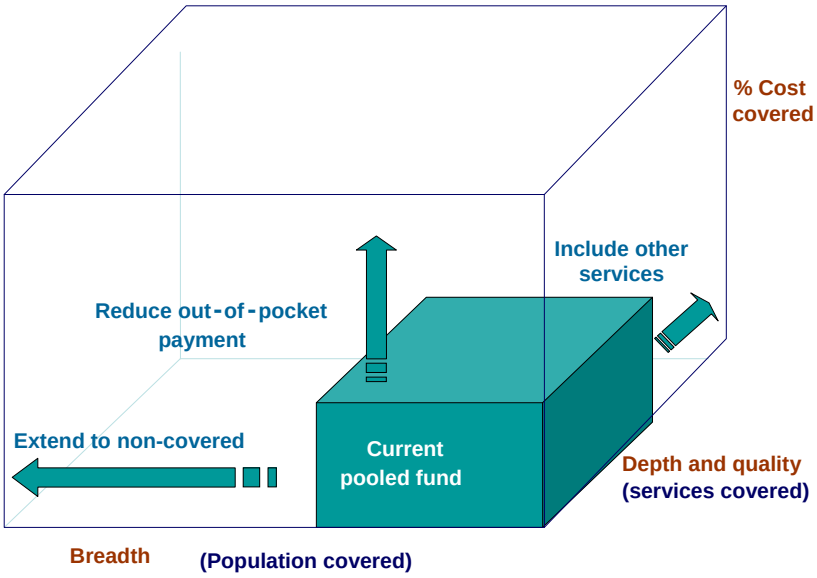



**Figure 1. Moving towards universal coverage**

to what services should initially be covered and what services should be added as additional resources become available.

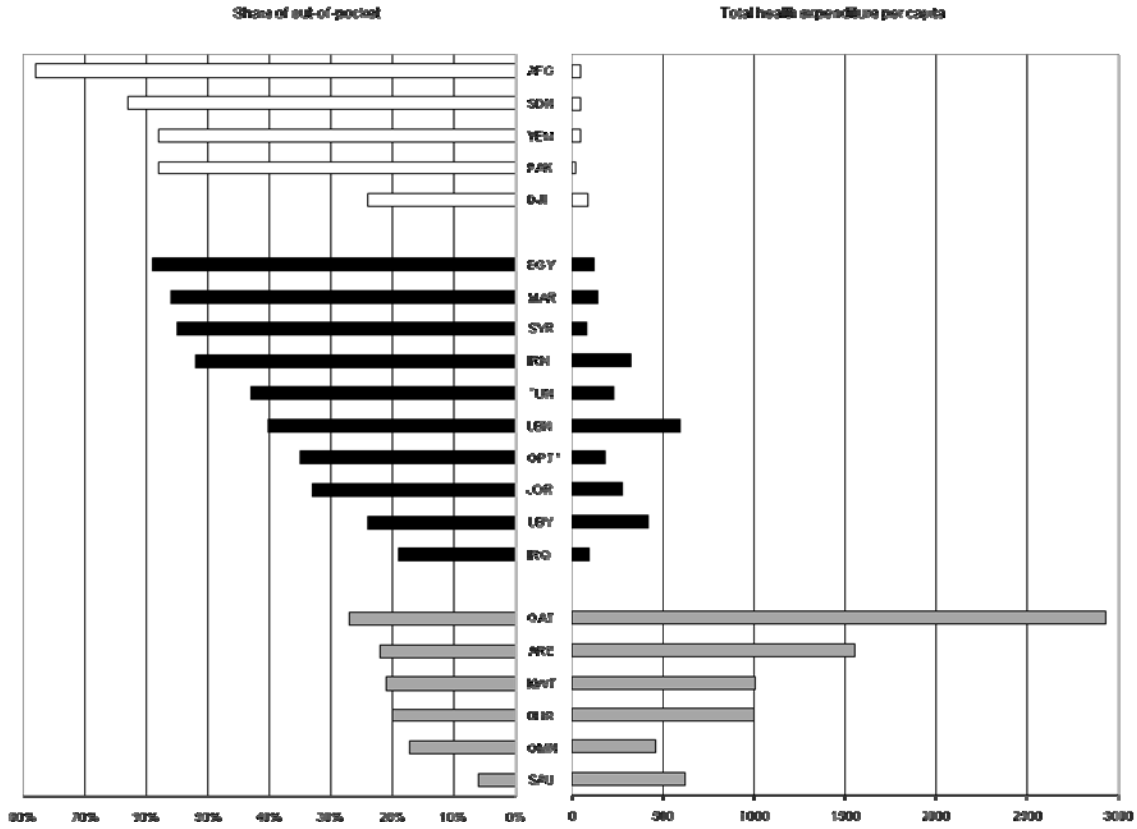
*Out-of-pocket payments*, also called direct payments, are payments made by households at the point of receiving health services, which are not reimbursed by a third-party, such as a health insurance organization. Households' out-of-pocket payments constitute payment to both public and private health care providers.

*Financial catastrophe* is defined as when a household pays directly "out-of-pocket" a relatively high share (over 40% in this paper) of its capacity to pay (household total expenditure minus a subsistence level of spending) for health services. Hence, out-of-pocket payment for health services is the root cause of households facing financial catastrophe due to health spending.

## 2. Situation analysis: global and regional health care expenditure patterns and trends

Total health expenditure as a share of world gross domestic product increased from 3% in 1948 to over 9.6% in 2008 [*7*]. Demand for health services has been increasing in the world, and in the Eastern Mediterranean Region, because of: increase in GDP per capita in most countries; introduction of new and sometimes expensive technology, which affects the expectations of both patients and health providers; and epidemiological and demographic transitions. The world spent US$ 5.8 trillion on health in 2008 compared to US$ 2.7 trillion in 1998. That is equivalent to an annual per capita health expenditure growth rate of 6.6%. However, there are large inequalities in health expenditure between and within countries. Indeed, high-income countries, which accounted for 15% of world population in 2008, consumed around 84% of global total health expenditure. At the same time, the low-income countries, which account for 15% of the world's population accounted for only 0.4% of global total health expenditure. The same pattern is observed in the Eastern Mediterranean Region, where total health expenditure reached US$ 92 billion in 2008, which represents 1.6% of world health care spending for 8% of the global

population. Here too, while high-income countries in the Region accounted for 6.6% of the population, they accounted for over 34% of regional total health expenditure in 2008. At the same




Source: [7]
*Preliminary data

**Figure 2. Share of out-of-pocket and per capita total health expenditure, Eastern Mediterranean Region, 2008**

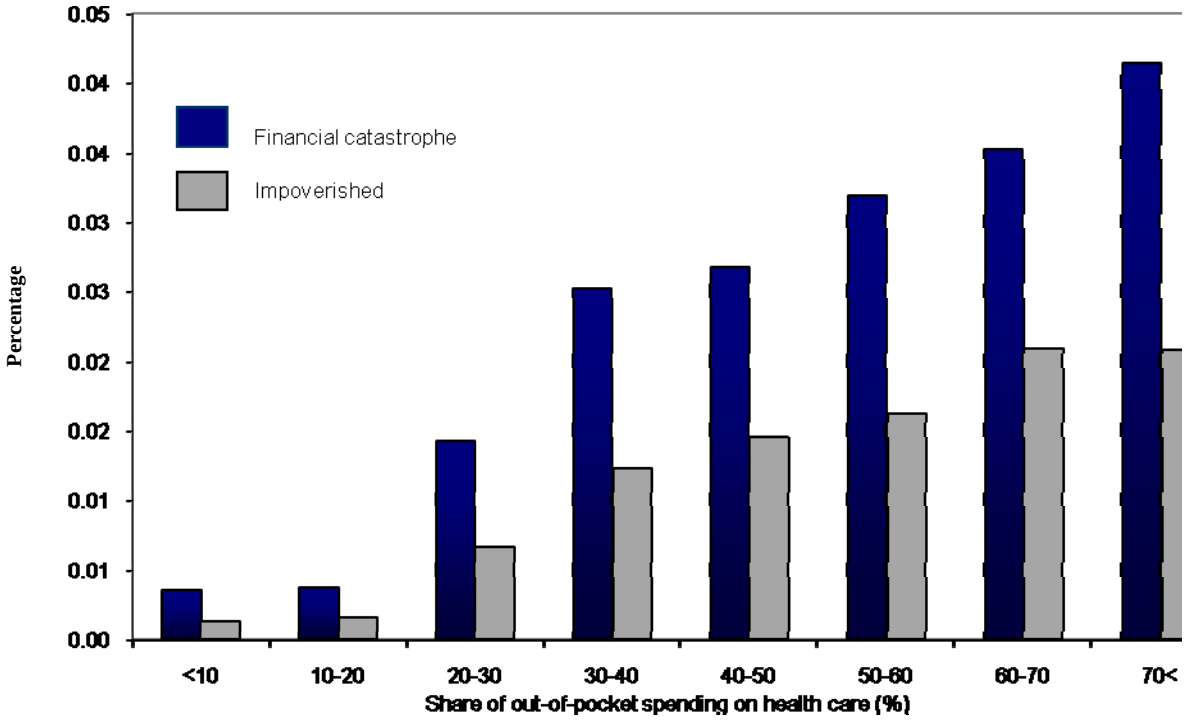
time, low-income countries of the Region, which accounted for 36% of the population in 2008, were responsible for only 6.1% of regional total health expenditure [*7*].

In 2008, the per capita health expenditure in the Region ranged from less than US$ 25 to over US$ 2900 (Figure 2), compared to over US$ 3500 in countries of the Organization for Economic Cooperation and Development (OECD). The share of out-of-pocket expenditure in many countries of the Region is over 50% – and close to 80% in some countries.

Large variation in per capita health expenditure and out-of-pocket expenditure is also observed within different socioeconomic groups of countries of the world and the Eastern Mediterranean Region. Differences in household income explain most of the variations observed in household health expenditures. For example, households in the top income decile on average spend much more on health (in some countries, over 15 times more) than households in the lowest income decile. The difference is much more pronounced in countries where the provision of health services by the public sector continues to be weak.

The share of out-of-pocket health expenditure globally is one of the most important indicators that points to the lack of social health protection in countries. Figure 3 shows the percentage of households facing financial catastrophe and impoverished due to out-of-pocket health spending, and the link between the incidence of financial catastrophe and impoverishment. Figure 3 clearly indicates that the incidence of financial catastrophe and impoverishment fall substantially when

the share of out-of-pocket spending is below 20%, as is the case in countries that have achieved universal coverage.




Source: WHO headquarters, Health Financing Policy unit database, unpublished

**Figure 3. Percentage of households facing financial catastrophe and impoverishment due to out-of-pocket spending**

In recent years, many countries around the world, and in the Eastern Mediterranean Region, have initiated steps to reduce the share of out-of-pocket spending and extend social health protection to their population. Some governments have introduced and extended social health insurance schemes. Others have attempted to move towards universal coverage through expanding government programmes, fully, or partially, financed from general government revenues. Table 1 shows the percentage of government budget allocated to ministries of health in the Region. There is large variation in the share of government budget allocated to ministries of health. The observed variation may be partially explained by the large share of government budget from GDP and the different role and functions of ministries of health in different countries. However, the share of government budget allocated to the Ministry of Health in some countries seems to be low. As a result, ministries of health in these countries may not be able to fulfil their role as the leading health development institution in these countries.

Figure 4 shows the trend in per capita government expenditure and per capita out-of-pocket expenditure on health at constant prices for selected countries in the Region. The same trend is observed in all other countries of the Region. These trends suggest that all governments in the Region have increased the amount of budget allocated to health in the past decade. It is also observed that household out-of-pocket expenditure has also increased in all countries in the Region in the same period, with the notable exception of Lebanon [9]. Lebanon has been able to decrease household out-of-pocket expenditure through several measures, including substitution of generic medicines for brand name medicines and the strengthening of primary health care.

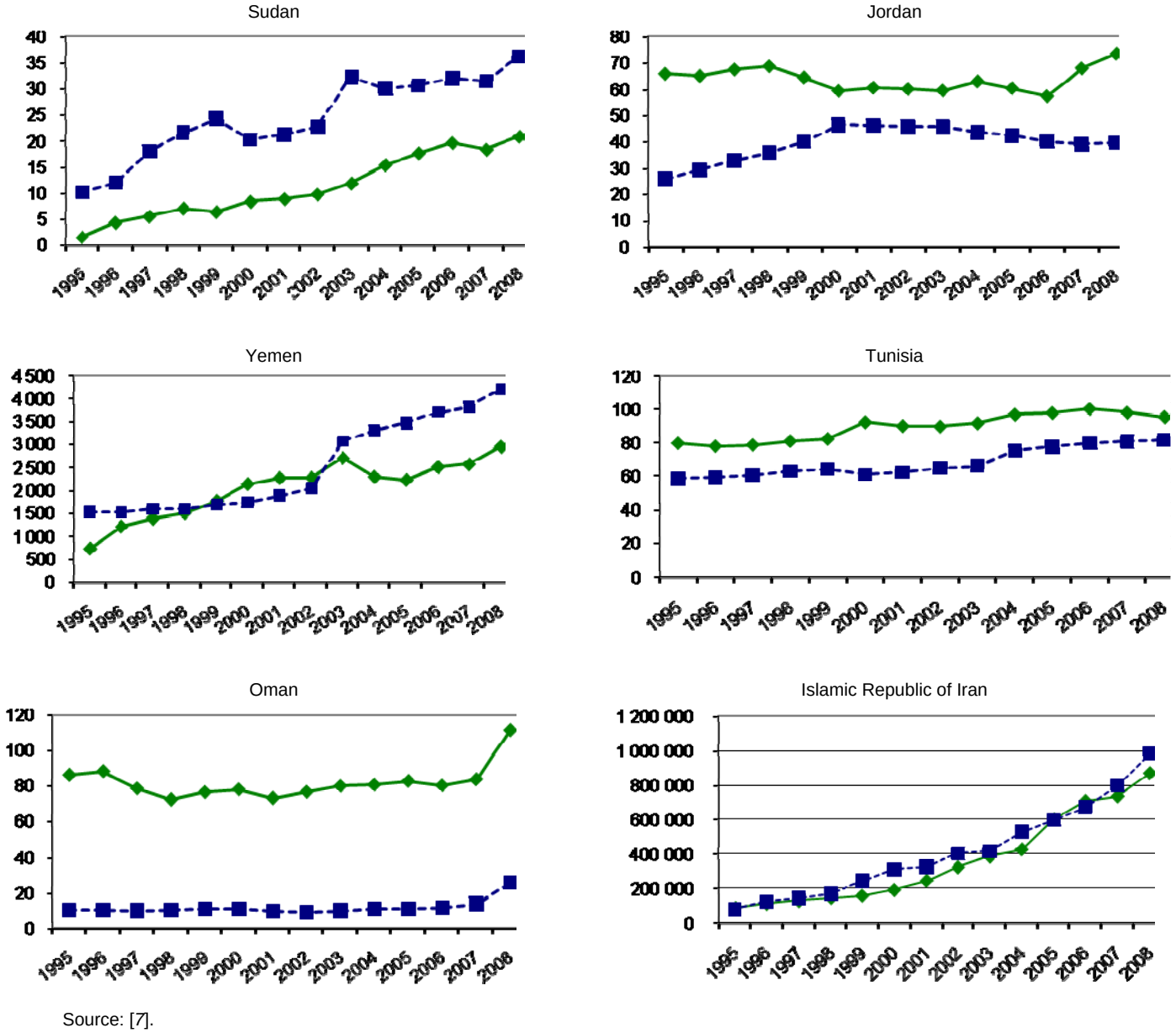
**Table 1. Percentage of government budget allocated to Ministry of Health**

| Country | Ministry of Health budget as % of government budget | Year |
|---|---|---|
| Afghanistan | 5.3 | 2007 |
| Bahrain | 7.8 | 2007 |
| Djibouti | 7.2 | 2003 |
| Egypt | 2.3 | 2007 |
| Iran, Islamic Republic of | 6.0 | 2008 |
| Iraq | 4.4 | 2007 |
| Jordan | 7.0 | 2008 |
| Kuwait | 5.1 | 2008 |
| Lebanon | 3.3 | 2008 |
| Libyan Arab Jamahiriya | 7.5 | 2007 |
| Morocco | 5.0 | 2006 |
| Oman | 4.6 | 2007 |
| Palestine | 11 | 2008 |
| Qatar | 5.1 | 2007 |
| Saudi Arabia | 5.6 | 2008 |
| Sudan | 3.0 | 2006 |
| Syria | 4.1 | 2008 |
| Tunisia | 7.1 | 2006 |
| United Arab Emirates | 7.0 | 2007 |
| Yemen | 4.0 | 2006 |

Source: [8]

In countries where time series data are available, the percentage of households that suffer financial catastrophe has not decreased, despite increases in government per capita health expenditure at constant prices (Regional Office for the Eastern Mediterranean, unpublished data on financial catastrophe and risk of impoverishment from: Egypt, Islamic Republic of Iran, Jordan, Morocco, Palestine and Tunisia, 1997–2006). This is consistent with the observed correlation between government per capita health expenditure and households' per capita out-of-pocket health expenditure, where the increase in government expenditures on health, in many countries, is accompanied with an increase in out-of-pocket spending. Understanding such correlation has important implications for countries' strategies to move towards universal coverage. Increasing government expenditure will not, in itself, necessarily lead to reduction in out-of-pocket expenditure.

There are several plausible explanations for the above observation. First, other factors affecting health expenditure such as: increase in per capita income, introduction of new health technology, and epidemiological and demographic transition, may be driving total health expenditure – including out-of-pocket payments – upward, and the increase in government expenditure only seems to compensate partially for the increase in demand for health care. Second, expansion of government health programmes may induce demand for health services not covered by the existing government-sponsored programmes. For example, introducing a government-funded breast cancer screening programme without any accompanying government-funded treatment programme could lead to increases in out-of-pocket expenditure as women who are diagnosed with breast cancer through the screening programme seek treatment elsewhere and have to pay for it. This example indicates that households have to purchase additional health care services from the private sector, which results in increasing out-of-pocket spending and leads to passive privatization of service provision. In short, public and private provision of health care may be complementary and not simply direct substitutes for each other.




Source: [7].

**Figure 4. General government and out-of-pocket per capita health expenditure in selected countries of the Region, 1995–2008 (2000 constant prices in local currency)**

The analysis suggests that increases in government expenditures on health alone would not lead to universal coverage in all its dimensions (breath, depth, and cost coverage) and to the reduction in the incidence of financial catastrophe and impoverishment. Indeed, increasing public spending for health seems to be a necessary but not sufficient condition. Hence, the move towards universal coverage should be planned as a move to reform all the different building blocks of the health system, and should be based on primary health care for the intended effects to be realized. This indicates that more is expected and needed from ministries of health that are the leading institutions in health sector. In the case of Lebanon, for example, policy reforms and the move towards primary health care reduced both per capita health expenditures and out-of-pocket health expenditures (Box 1).

**Box 1. Reform can be effective: Lebanon's reforms focused on primary health care have contributed to improving health system efficiency and to lowering out-of-pocket spending**

The first round of national health accounts analysis carried out in 1998 showed that Lebanon was allocating 12.4% of GDP to health, the highest in the Eastern Mediterranean Region, with a high proportion of out-of-pocket spending (60%), affecting mainly lower income groups. Medicine was also found to represent the main item for household health expenditure. Since the issue of the first national health accounts report, a series of reforms have been implemented by the Ministry of Health in order to contain health care costs and to improve equity and overall health system efficiency.

The focus of the policy reforms implemented by the Ministry of Health was, and is, on primary health care, as a cost-effective and more equitable arrangement for service provision, in a country dominated by private delivery at various levels of the health system. Policy reforms have focused on reorganizing the primary health care network, on improving access to public hospitals, on developing an accreditation system for hospitals and on improving rational use of medical technology including increased penetration of quality assured generic medicines into the health care system. In parallel, the Ministry of Health has also striven to strengthen its leadership and governance functions through establishment of a well-functioning national regulatory authority for health and biomedical technology.

Health outcomes, as reflected in life expectancy, indicators of morbidity and mortality and utilization of preventive, promotive and curative services, have improved since 1998. The national health accounts in 2005 showed important improvement in the health care financing function. Total spending as a percentage of GDP fell from 12.4% to 8.4% and out-of-pocket spending decreased from 60% to 44%. Access to primary health care services and to public hospital services for the poor has increased.

## 3. Current response and challenges

### 3.1 Current response

Most countries in the Region have been able to take steps to improve social health protection for their population, despite the fact that some countries are facing complex emergencies.

Following Regional Committee resolution EM/RC51/R.6 on the impact of health expenditures on households and options for alternative financing and World Health Assembly resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance, various countries have attempted to move forward with introducing and/or expanding various social health protection measures. For example, most Gulf Cooperation Council countries have taken initiatives to introduce social health protection schemes for expatriates. Egypt, Islamic Republic of Iran, Jordan and Morocco have taken measures to expand coverage through the existing social health protection schemes, including social health insurance, and some are approaching universal coverage. Sudan is attempting to scale up its social health insurance coverage in Khartoum State. Yemen is expected to enact a social health insurance law to cover civil servants and formal sector workers shortly. However, health care systems in low-income countries in the Region continue to be seriously under-funded and dependent to a large extent on donor contributions. In addition, most low-income countries are in complex emergency situations that hinder them from having long-term views for developing social health protection schemes. Today, these countries find that developing and funding a minimum basic benefit package that covers all the population in line with the recommendations of the WHO Commission on Macroeconomics and Health is out of their reach.

Most countries have been attempting to make more efficient use of their available resources through the introduction of economic principles and tools, effective management and

strengthening of primary health care. The economic tools include: national health accounts, households expenditure and health utilization surveys, and costing of health services at different levels of care. Some countries have also moved towards introducing performance-based purchasing, using capitation and diagnostic-related groups. Furthermore, in order to reduce expenditures on medicines and enhance quality and efficiency, some countries – most notably the GCC countries – have been using bulk purchasing for medicines and replacing generic medicines for more expensive brand names.

### 3.2 Challenges to achieving universal coverage

All Member States face challenges that hamper their efforts to move towards universal coverage. The main challenges are:

- absence of an effective strategic vision for health care financing in many countries;
- limited capacity of governments in non-oil exporting countries to collect taxes in order to create the necessary fiscal space to provide adequate social health protection to the population;
- fragmented health financing and delivery systems with inadequate coordination among the various national and international stakeholders;
- lack of coordination and collaboration among international partners;
- a growing unregulated private sector, which leads to induced demand by providers;
- persistence of high rates of out-of-pocket payment in most countries despite the efforts made by the governments to reduce it;
- difficulty in extending social health protection to the informal sector, which constitutes a large share of the population in many countries;
- limited capabilities in the rational use of scarce resources, including priority-setting and use of technology;
- complex emergencies prevailing in several countries, which make it difficult to develop the long-term plans required to provide adequate social health protection to their populations.

## 4. Moving towards universal coverage: financing and service delivery based on primary health care

Health financing is composed of three functions: collection, pooling and purchasing.

1. *Collection*: raising sufficient and sustainable revenues in an equitable manner in order to provide all individuals with a range of needed health services and protect them against the risk of financial catastrophe and impoverishment.
2. *Pooling*: managing the revenues collected, in order to equitably and efficiently pool health risks, allowing for subsidies from: rich to poor, healthy to unhealthy, and productive workers to dependents.
3. *Purchasing*: using the pooled revenue to purchase a range of health services in a manner that is efficient and is performance-based, thereby offering incentives to both providers and consumers to behave efficiently. In doing so, the following questions must be answered: what services to buy, for whom to buy, from whom to buy, and how to pay the providers.

Achievement of universal coverage will only be possible if the above functions are satisfactorily governed and fulfilled – a necessary but not sufficient requirement, as noted in section 2. The move towards universal coverage is a move to reorganize the health system and all its building blocks, focusing on financing and how the system is managed and health services are delivered.

There are various models for financing universal coverage (e.g. government revenue-funded, social health insurance, etc.) and for delivering health services (e.g. family practice based on primary health care). However, health financing and service delivery models are interlinked and the interface between these two components of the health system is crucial for the successful move towards universal coverage.

The institutional split between health financing and service provision is possible and in some cases even recommended. For example, the health system could be financed by the public sector in order to allow for solidarity and broader risk pooling, while health services could be provided by public and private sectors and nongovernmental organizations, in order to allow for competition among providers and offer choices to consumers. However, the institutional split between health financing and service provision, when it exists, does not mean the health financing functions and the health service delivery are independent. Development and implementation of the purchasing function is where these two building blocks of the health system interface and hence must be synchronized.

## 5. Strategic directions to improve health care financing and expedite the move towards universal coverage

The objective of health financing is to achieve universal coverage and protect against the risk of financial catastrophe and impoverishment. This requires sufficient funds to be equitably mobilized and efficiently utilized. Furthermore, there should be no financial or physical barriers to access needed health services for all. In addition the system should be sustainable and flexible enough to respond to new challenges.

There is no unique pathway towards universal coverage that is appropriate for all countries in the Region. It should be noted that according to the World Health Report 2002, up to 70% of disease burden can be prevented through provision of primary prevention and health promotion services and programmes. These services and programmes (also called population-based services or non-personal services), generate measurable external benefits, and include such public goods as clean water and sanitation, and services such as health promotion and immunization. Hence, the financing and provision of population-based services remains the sole responsibility of the government regardless of the choice of health financing and service delivery options.

In addition, governments' responsibilities to ensure that poor and vulnerable groups receive quality health services, through a well-functioning primary health care network, should not be undermined. These programmes are financed by the government through taxes and other sources of revenue and are, often but not always, provided through state-owned facilities or contracted out to national and international nongovernmental organizations.

Finally, the private sector, in all countries of the Region, must be regulated but must also be regarded as a partner that has the potential to contribute to and improve the performance of the health system. The role and size of the private sector depends on the extent to which the public sector fails to provide the necessary coverage at an acceptable level of quality.

Six strategic directions and corresponding actions are presented here. It should be noted that all strategic directions are applicable to all countries in the Region regardless of their level of development. However, some recommended actions may be more imperative in one country compared to another country.

#### Strategic direction 1: Mobilizing sufficient resources for universal coverage

Governments together with their development partners need to make a case for investing in health and its high rate of economic return as was recommended by the Commission on Macroeconomics and Health. It should be noted that the Members of the Organization of African

Unity (OAU) pledged to set a target of allocating at least 15% of their annual government budget to the improvement of the health sector in the Abuja Declaration 2000. However, the share of government budget allocated to health in most members of the OAU still falls short of the target.

*Recommended actions*

- Advocate health as a human right.
- Promote the potential impact of health on economic growth, based on available evidence.
- Improve policy dialogue with the Ministry of Finance, Ministry of Planning and Parliament.
- Propose targets for allocation of government resources for health, including 8% allocation for the Ministry of Health.
- Introduce earmarked and sin taxes for health, such as tobacco or alcohol taxes.

#### Strategic direction 2: Developing prepayment schemes

Out-of-pocket payment was identified as a main culprit for risks of financial catastrophe and impoverishment. In order to protect households, especially the poor and vulnerable, resources for health must be pooled to allow for cross-subsidies from rich, healthy and productive individuals to the poor, unhealthy and dependent.

*Recommended actions*

- Articulate various options for development and implementation of prepayment schemes (government revenue-funded schemes, social health insurance schemes, private health insurance, etc.).
- Support feasibility and actuarial studies for development of prepayment schemes.
- Work to promote a culture of health insurance including social/private and community-based schemes.
- Reduce administrative costs associated with collection, pooling and purchasing through efficient management.
- Strengthen, and reduce the administrative costs of introducing different forms of health insurance schemes, particularly community-based health insurance.

#### Strategic direction 3: Promoting and supporting strategic purchasing

Purchasing remains the least developed health care financing function in the Eastern Mediterranean Region. Available resources need to be allocated efficiently. Priorities should be set for selection of suitable interventions, and selected interventions need to be produced at the lowest possible cost. Appropriate incentives should be built into the system to change the behaviour of both providers and consumers to make the most rational use of health resources [*10*].

*Recommended actions*

- Develop and cost the benefit package in line with countries' needs and capacities to fund and deliver.
- Support the development and management of contracting for purchasing health services.
- Assure appropriate allocation of resources between the different levels of primary, secondary and tertiary care in a manner to maximize health gains.
- Promote appropriate provider payment mechanisms and introduce appropriate incentives for providers and patients to modify their behaviour.

- Strengthen the health information system including utilization indicators in order to design and monitor the adopted provider payment mechanisms.
- Develop clinical guidelines to direct providers' practices.
- Advocate a cost-containment strategy, for example, in the area of medicines, bulk purchasing, substitution of generic medicines for more expensive brand name medicines, and rational use of medicines.
- Promotion of health technology assessment and cost-effectiveness studies for selection, use and evaluation of medical devices.

**Strategic direction 4: Promoting, supporting and generating knowledge for evidence-based health financing policies and achievement of universal coverage.**

Policies need to be evidence-based. Consequently, appropriate information should be gathered and analysed to inform the decision-making process.

*Recommended actions*

- Promote the use of household expenditure and utilization analysis to assist the decision-making process.
- Promote the use of equity studies.
- Institutionalize and use national health accounts for policy development.
- Promote the use of health economics and health financing principles in analysing and developing health policies.
- Strengthen the capacity of Ministry of Health staff in health financing policy development and implementation.
- Develop and strengthen the capacities of academic institutions in the area of health economics and health care financing.

**Strategic direction 5: Coordinating national and international partners and improving aid effectiveness**

Many international partners are present in low-income countries and in countries facing complex emergencies. Therefore, the coordination of national and international partners for the move towards universal coverage remains crucial.

*Recommended actions*

- Develop a national health strategy to move towards universal coverage that will facilitate coordination, harmonization and alignment between nationals and various donors and international partners as articulated in the Paris Declaration in 2005 and Accra Declaration in 2008.
- Enhance the role of civil society in promoting access to health care services for all, as a basic human right.
- Initiate steps to improve transparency and accountability to reassure donors and international partners about the effectiveness of their contributions.
- Work together with international partners to reduce administrative formalities and transaction costs of international development assistance.
- Work together with international partners to reduce the volatility of international development assistance.

**Strategic direction 6: Monitoring and evaluating equity and universal coverage**

Moving towards universal coverage in its three dimensions (breadth, depth and cost coverage) calls for reorganization of the health system, and introduction of new policies. In order to monitor the progress made towards universal coverage indicators must be developed and measured.

*Recommended actions*

- Institutionalize the practice of monitoring and evaluation and make it an integral part of the health information system.
- Develop appropriate instruments and indicators, including equity and access indicators, for measuring and monitoring the move to universal coverage.
- Allocate sufficient resources to monitor and evaluate the move towards universal coverage.

## 6. Conclusion

Policy-makers in all countries need to enhance access to needed health care by dismantling existing barriers. These barriers are in many cases financial, associated with having to pay out-of-pocket for needed health care, resulting in higher risks of financial catastrophe and impoverishment. Therefore, instituting universal coverage will provide the necessary social health protection for all.

Achieving universal coverage, in turn, requires reorganizing the health care system to focus on financing and how the system is managed and health services are delivered. Countries need to develop a vision, have clear objectives, set priorities in view of limited resources, and develop strategies for reorganizing their health care systems in order to expedite the move towards universal coverage. Moving towards universal coverage requires building institutional and human capacities, and generating evidence to guide and monitor the progress made. Policy-makers need to coordinate efforts with all national stakeholders, including civil society organizations. Countries also need to learn from other countries experiences and collaborate with international organizations.

Based on per capita income, the countries of the Region can be divided into three groups: low-income, middle-income and high-income countries. The optimal health path towards universal coverage depends on availability of resources and the health profile of each country. Nevertheless, all countries, regardless of the level of income, can take actions in order to expedite the move towards universal coverage.

**For low-income countries**, in addition to population-based services and programmes, a free basic primary health care package for all, financed by government general revenue and donors is the only viable alternative at present. Health services that are provided through a network of state-owned facilities or contracted out to nongovernmental organizations represent the basic structure of the system. Community-based health insurance can supplement the basic coverage to the extent that communities can be organized efficiently to play their part. A limited number of disease control and management programmes can be targeted for government financial support to the extent that public resources permit.

**For middle-income countries**, a comprehensive primary health care package financed by government general revenue with minimal user fees for some services and medicines, to curb over-utilization, should be made available to all. Health care that is provided through a network of state-owned facilities or contracted out to nongovernmental organizations represents the basic structure of the system. Compulsory social health insurance should be launched to provide comprehensive coverage for civil servants, formal sector workers, workers in large institutions, and their family members. Special schemes need to be supported by governments to provide coverage for poor and vulnerable groups, and to target selected diseases for all. Private health

insurance organizations could offer coverage, including supplementary financing, to cater for the gap not covered by social health insurance. Over time, social health insurance coverage should become compulsory for all and social health insurance schemes need to be consolidated. The government needs to pay the premium for the poor and vulnerable groups out of general government revenue.

**For high-income countries**, the existing government-funded programmes have been providing comprehensive coverage for all citizens and some expatriates. However, in the move towards development of compulsory health insurance schemes for expatriates, countries need to adhere to the principles of fairness and equity. Moreover, the administrative cost of launching a new system to cover nationals and its impact on the existing system needs to be studied carefully.

The private sector in all countries of the Region must be regulated but also regarded as a partner that has the potential to improve the performance of the health system. The role and size of the private sector depends on the extent to which the public sector fails to provide the necessary coverage at an acceptable level of quality.

There is no unique pathway to move towards universal coverage that is appropriate to all countries in the Region. The transition towards universal coverage takes time. However, recent experiences have shown that some countries have achieved universal coverage within a period that is much shorter than countries that did so during the last century.

## 7. References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