

Domestic expenditure on health service delivery in low income settings

Achieving universal health coverage

Member states of the World Health Organization (WHO) have set themselves the target of developing their health financing systems in order to accelerate and sustain progress towards universal health coverage (UHC). UHC is defined as ‘all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them.’^[1]

UHC has three key objectives, regardless of the approach used to achieve it:

1. improving access to health services, particularly for disadvantaged populations
2. improving the health of individuals covered
3. providing financial risk protection.^[2]

Currently, the world is still far from UHC — 46 million births are unattended by skilled personnel and 23 million infants do not receive basic vaccines.^[1] One hundred and fifty million people suffer financial catastrophe each year because they have to pay out-of-pocket for health services that are beyond their means.^[1] The path to universal coverage will involve governments making greater commitments to health, both in terms of the expenditure they commit to and from domestic resources, and the ownership that they take over their health system. Presently, many systems are fragmented and struggle to contain high levels of out-of-pocket spending in a poorly regulated private sector and in light of the changeable trends of the global health donor community.

UHC requires more sustainable, domestically-sourced financial resources. A recent report by Chatham House recommended that all countries ‘should meet their primary responsibility for securing the health of their own people. This involves a responsibility to oversee domestic financing for health and ensure that it is sufficient, efficient, equitable and sustainable.’^[3] It also pointed out, however, that there are profound challenges related to raising and managing domestic financing for health in many low and middle income countries (LMICs). These include:

- insufficient total funds — most countries’ resources fall short of their per capita spending targets, which have been estimated as the minimum required to provide an essential package of care
- overreliance on out-of-pocket payments, particularly those that are catastrophic and impoverishing
- rudimentary mechanisms for mandatory prepayment with pooling of funds – these are not used to their full extent and existing mechanisms are often poorly designed
- problematic priorities and inefficient health spending
- inadequate accountability.

This report aims to summarise existing thinking on:

- how much money is required to fund a basic package of care
- where these funds can be found
- whether tax-based or contributory insurance models are likely to be more effective at reaching UHC.

How much do governments need to spend?

To achieve UHC, spending on health service delivery and health systems strengthening needs to increase, as well as be sustained and well-planned. Countries face two challenges:

1. Their health systems need more and better targeted funding to achieve universal coverage.
2. Donor organisations are keen to reduce their levels of commitment to LMICs' health systems. The rhetoric is increasingly about finding sustainable domestic financing sources for health systems to achieve UHC.^[4]

Levels of government spending on health are reflective of the wealth of a country and its political commitment to its health sector. While there is a correlation between levels of national income and spending on health, some countries spend more than would be expected on health and others less. For instance, Myanmar, an LMIC, spends 2.1 percent of its gross domestic product (GDP) on health, whereas Burundi, a low income country (LIC), spends 13.6 percent.^[5] Similarly, of the 46 countries included in an analysis undertaken by the High Level Taskforce on Innovative Health Financing (HLTF) in 2009, the share of total government spending allocated to health (including external funding flowing through government mechanisms) ranged from one to 23 percent, and was not highly correlated with countries' GDP per capita.^[6] This implies that some countries did not need to wait for their national incomes to grow before they were able to allocate a higher proportion of government revenues to health.

Estimates of required spending

According to the WHO Global Health Observatory, in 2015 annual per capita health expenditure was \$41 (US dollars) in LICs and \$82 in middle income countries (MICs), with out-of-pocket spending contributing 38 percent and 60 percent of those totals respectively.^[7] Just as there is no clear linear relationship between national income levels and spending on health, neither is there a clear linear relationship between spending and achievement of UHC. Indeed, a recent WHO study revealed a great variety of achievement in coverage for the same levels of expenditure.^[8] Nevertheless, a minimum level of funding is clearly required for a health system to develop and function.

Since 2001, a number of estimates of how much countries should spend on health have been put forward (see overleaf) and have helped to advocate for greater investment in the health sector.^[2,3,9-11]

More recently, a World Bank report has estimated that providing two essential packages of care — the Essential Universal Health Coverage (EUHC) package and the



Health worker on a home visit, Mozambique

more restricted High Priority Package (HPP) — will cost approximately \$76 and \$42 per capita respectively in LICs, and \$110 and \$58 per capita respectively in LMICs.^[2] The authors of a related Disease Control Priorities (DCP³) working paper concluded:

'Assuming that the objective of UHC is to successfully crowd out out-of-pocket spending at the point of care through prepayment mechanisms and pooled contributions, these cost estimates suggest that current government and donor spending will need to approximately double or triple to finance the HPP or EUHC packages.'^[2]

Targets for government health spending: per capita estimates

In 2001, the **Commission for Macroeconomics and Health** (CMH) made the first attempt to cost the funding gap for global health.^[10] It estimated that **\$34 per capita** would be required to deliver a key set of basic health interventions. However, this package was limited; it did not include interventions to tackle non-communicable diseases (NCDs), nor the cost of antiretroviral drugs (ARVs). It also did not allow for the investment that would be required to raise the capacity of health systems to sustainably deliver these services at scale.

In 2009, the **HLTF** built on the work of the CMH, including a broader set of services and some costs for health systems strengthening in its calculations.^[11] The HLTF estimated that by 2015, LICs would need to spend an annual average of **\$60 per capita** on health to ensure coverage with a relatively limited set of key health services that would help attain the health-related Millennium Development Goals (MDGs). This figure included the costs associated with strengthening health systems, as well as of the interventions themselves. However, the target should be viewed as the very minimum necessary; it was based on the assumption that the entire sum would be spent only on a core set of interventions, which themselves included very few elements of care and prevention for NCDs.

In 2014, the **Chatham House Shared Responsibilities for Health working group** increased this figure to **\$86 per capita** as a recommended minimum level of spending.^[3,9] It also advised that governments should spend a minimum of five percent of GDP on their health sectors. In cases where such a percentage would not equate to \$86 per capita, the international community would need to step in and fill the gap.

In 2018, DCP³ (a World Bank report) estimated that two basic essential packages of care would cost **between \$42 and \$110 per capita** depending on the package chosen and the country in which it were to be delivered.^[2]

Targets for government health spending: relative targets

In 2001, the **Abuja declaration** called for all African governments to spend a minimum of 15 percent of government expenditure on health. By 2011, only one country had reached this target; a further 26 had increased the proportion of government expenditure they allocate to health, 11 had reduced it, and nine exhibited no obvious upward or downward trend.^[12] As of 2018, the target has been met by three countries: Liberia, Rwanda and Tanzania.

In 2013, an analysis of health spending in the 46 countries that were included in the HLTF's analysis found that increasing health expenditure to 15 percent of government expenditure would raise available health revenues by \$26 billion (or \$17 per capita), using 2010 as the base year.^[6] If the 15 percent threshold had been maintained to 2017, government health spending would have grown by \$48 billion — assuming International Monetary Fund GDP growth rates. However, there would have been considerable variation across countries. Nigeria would have contributed \$16 billion to this total, allowing it to increase government health expenditure by a massive \$63 per capita through the combined effect of economic growth and increased priority to health in public spending.

An alternative is to specify **a target of spending relative to the whole economy**, that is, GDP. However, even looking simply at the government expenditure to GDP ratio does not reveal the whole picture of the availability of resources. In absolute terms, in 38 of the 46 HLTF countries, government expenditure per capita is still below \$300. It also remains below \$300 in six of the eight countries that have a government expenditure to GDP ratio of 35 percent or more. This money has to be distributed across all sectors, not just health. Even if these countries allocated 15 percent to health (as suggested in the Abuja Declaration), they would spend only \$45 per capita on health on average, showing the limits imposed on these countries by the low absolute levels of national income.^[6]



Seasonal malaria chemoprevention medication, Burkina Faso

How can more resources for health be found?

Option one — a larger slice for health

The Abuja target is an example of attempts to get a greater focus on health spending within existing government budgets. That very few countries have reached this target, or even made much progress towards it, suggests that a larger share of government spending being dedicated to health is unlikely to be a source of increased revenue for the sector in many countries. This may be due to the following factors:

- **Competing interests:** health is often not the only ministry to have a spending target.^[13] Ministries of Finance have to balance competing calls from various sectors and health is only one ministry that has a strong claim for more investment.
- **Absorptive capacity:** some ministries fail to spend what is allocated to them. A 2010 WHO report cited examples from Kenya, India and Uganda where Ministries of Health returned funds due to an inability to spend these on programmes.^[12] This, arguably, undermines arguments in favour of increasing allocations to health.
- **Lack of conviction that spending more money will solve the problem:** it is often argued that until the health sector can resolve inefficiencies and problems of quality, more money will not resolve the issues presented. Indeed, Ministries of Finance are frequently reluctant to commit more money in the absence of demonstrated value.^[14]

Option two — bring in external resources

While funding for global health has increased substantially in recent decades (from \$5.8 billion in 1990 to \$31.3 billion in 2013), domestic finance is still the main provider of health spending in all but a few LICs.^[3] In 2007, the average contribution to LICs' health budgets from external sources was below 25 percent, and in 2012, domestic financing accounted for an average of 70 and 86 percent of total health financing in LICs and MICs respectively.^[3,5] In recent years, external financing for health has slowed down.^[3,15] The financial crisis of 2008 destabilised sources of funding and the current turbulent political environment of increasing nationalism and populism may further threaten the commitment of the international community to global health spending.^[16]

Development spending on health is also not always helpful for the achievement of strong health systems in recipient countries. Financing from donors is frequently not directed to where the need is greatest, focusing on some diseases at the expense of others — for example, only two percent of donors' health-related funding in 2017 was allocated to tackling pneumonia, despite the disease accounting for 16 percent of under-five

deaths globally.^[17,18] It can also be unpredictable; despite donors' health-related funding growing rapidly 2000–2009, only a small proportion was distributed to the poorest 26 countries.^[13] Moreover, a considerable proportion of the funds donors have disbursed may in fact be spent before it even enters the country,^[13] for instance on procurement of consultants or supplies that are sourced in richer countries. In such instances, it is hard for national governments to make the long-term investments necessary to build resilient health systems.

Option three — raise more resources

If the share of government spending devoted to the health sector is likely to remain stable within government budgets and external resources are not likely to meet the gap, are there ways in which governments can raise more money domestically, thereby increasing the size of the resource envelope?

A 2013 Chatham House working paper suggested the following possibilities:^[6]

Increase tax collection

Several governments have started to look at innovative ways to raise more money, often specifically for health. Frequently, these new approaches involve simplifying the tax system to make enforcement and collection of taxes more straightforward.

- Since January 2010, Sierra Leone has been implementing a series of reforms of tax mechanisms and structures, including the introduction of a goods and services tax (GST). The GST is applied at a single rate of 15 percent on most goods and services, replacing indirect taxes on imports, goods and services. During the first year of implementation, government revenues rose from 11.7 percent to 13.3 percent of GDP, with revenue from the GST representing 3.2 percent of GDP. Furthermore, the GST reform continued to be a major driver of increased government revenues, which were projected to rise to 14.9 percent of GDP in 2011.
- Vietnam has implemented a series of tax reforms during the last 20 years, focusing on a unified tax system, tax administration improvements and increasing the tax base. These, together with rising revenues from oil exports, pushed government revenue to an annual average of 23.7 and 28 percent of GDP in 2005–2008 and 2010 respectively.
- Ghana has raised money specifically for its national health insurance programme by adding 2.5 percent to value added tax (VAT).
- Chile has taken similar action, adding one percent to VAT for its *Acceso Universal con Garantías Explícitas* (Regime of Explicit Health Guarantees) programme.
- Since 1999, Zimbabwe has added three percent to income tax within the formal sector to fund ARVs.

Natural resource levies

Twenty of the 45 countries in sub-Saharan Africa are now significant exporters of natural resources. Ten of these already collect more public revenues from natural resources than from all other sources together. Volatility in the prices of natural resources means that it is not possible to protect government revenues derived from these in the long term. Nevertheless, carefully thought-out levies can increase government revenues substantially.

- In Papua New Guinea (PNG), the proceeds from the country's biggest mine (the OK Tedi copper and gold mine in the Western Province) are collected in a specific fund (the PNG Sustainable Development Program), which is used for diverse development programmes, including those focusing on health.
- The Lao People's Democratic Republic levies taxes on the sale of electricity to neighbouring countries from the Nam Theun 2 Hydropower Project. Around \$5.6 million (\$0.88 per capita) was collected in 2010 and it is projected that revenues will rise to \$80 million per year over a 25-year period.

Mobile phone taxes and levies

A levy on mobile phone use is an example of a resource-raising mechanism that is based on high-frequency transactions; it is, thus, constructed around a very small unitary levy. As long ago as 2009, the HLTF estimated that a voluntary levy on mobile phone use had, at the global level, the potential to raise between \$260 million and \$1.69 billion annually. With 79 cellular subscriptions for every 100 inhabitants in the world, there would also, therefore, be scope for raising large amounts domestically (i.e. via a small levy on each call).

- The Philippines is considering a \$0.01-0.02 tax on every text message sent. This is projected to raise \$1.4 billion annually, which is currently earmarked for education.
- Uganda is levying a tax on mobile phone use and on handset sales. This currently provides 9.5 percent of the country's total tax revenue.
- Gabon, Ghana, the Republic of Congo and Senegal are all taxing inbound international calls.
- Gabon has also introduced a 10 percent levy on mobile phone companies' turnover.

Sin taxes: taxing unhealthy habits and products

These are interesting from a health perspective as they simultaneously reduce the consumption of health-damaging products or practices, while raising money for governments. Many countries still apply very low rates of taxation on tobacco and alcohol, and there is considerable scope to increase revenues and improve health.

- Egypt has greatly increased tobacco taxation recently and may earmark some of this revenue to the health sector.
- A 2010 WHO report calculated that if all LMICs increased their tax rates on tobacco by 50 percent, this would generate an additional \$1.42 billion each year. If governments allocated all these funds to health, spending on health would increase by 25 percent.
- Alcohol taxation is being increased in countries such as Thailand and the Philippines.
- As the burden of disease from NCDs grows, LMICs may follow the lead of countries such as Australia, Canada, Finland, France and Norway in imposing taxes on soft drinks and salty snacks.
- Other suggestions to raise money for health include introducing a carbon tax or cutting fossil fuel subsidies, and then redirecting the revenue to health spending.^[15,16]

Option four — expand health insurance

Countries are taking different paths towards UHC.

- The Philippines and Vietnam have expanded financial protection by encouraging voluntary enrolment in social health insurance programmes (SHI), whereas Thailand has used funds from general taxation to fund increased health coverage.
- Rwanda has achieved high voluntary insurance coverage, although the types of services covered are limited and there is still insufficient financial protection for the poorest groups.^[19]
- Ghana introduced a National Health Insurance Programme with compulsory enrolment for the formal sector and voluntary enrolment for the informal sector. However, it is experiencing problems making the premiums affordable and maintaining voluntary enrolment.^[19] In reality, VAT remains one of the largest sources of funding for this programme.
- The insurance scheme in Thailand — a strong example of successful progress towards UHC — is mainly based on tax funding.

A key health financing question facing policy makers in LMICs is how to cater for those who fall between the two extremes of being able to afford their own insurance and needing to be subsidised.^[19] Should low earners and their dependants be covered by funds raised by general taxation or should they be encouraged to enrol in contributory programmes? A recent international review found that there is no conclusive evidence that introducing compulsory health insurance reduces or increases available revenue for the health sector.^[20] This may

be because Ministries of Finance reduce other sources of funding for health when new forms of taxation are specified for health. Nevertheless, health insurance is attracting more and more attention in LMICs as a means for improving healthcare utilisation and protecting households against impoverishing out-of-pocket expenditures, and WHO still considers it a promising means for achieving UHC.^[5,20]

Table 1: Extent to which the conditions for successful SHI are met in LICs and LMICs

Enabling environment for successful SHI	Are these conditions met in LICs & LMICs?
 High formal sector employment, which simplifies administrative functions and collection of premiums via payroll taxes	No. These countries have dominant informal sector employment.
 High wages and salaries, which reduce the economic burden of higher payroll taxes on employees and pave the way to broader social services	No. Wages and salaries tend to be low, and imposing a payroll tax on a small formal sector is likely to discourage formal sector growth.
 Low poverty rate, which reduces the need for the public sector to subsidize poor families	No. Any successful SHI program will require substantial subsidies.
 Small family and household size, which reduces the need for large payroll deductions	No. Family size in LICs and LMICs remains large, making it hard to sustain SHI programs through payroll deductions.
 Efficiently functioning provider networks structured to control costs, improve quality and access, and provide choice	No. Health service provision in LICs and LMICs is dominated by an underfunded public sector and a fragmented, poorly regulated private sector.
 Strong human resource capacities, needed for managing SHI systems	For the most part, No.
 Strong administrative support for banking, accounting, actuarial, and legal activities	No. Rarely are banking and financial systems well developed in low-income countries.
 Governmental capacity to regulate	For the most part, No.

Source: content adapted from 'Hsaio W, Shaw P. Social Health Insurance in Developing Nations. Washington DC: The International Bank for Reconstruction and Development/The World Bank; 2007. Available from: <http://bit.ly/HsaioShaw> by Yazbeck A. Bismarck's Miraculous and Unfortunate Re-emergence. Medium. 9 February 2018 [cited August 2018]. Available from: <http://bit.ly/Yazbeck>.

Insurance-based systems, as opposed to tax-based systems, need to take into consideration issues of enrolment and their effect on utilisation. If the objective is universal coverage, the question of whether poorer or more vulnerable groups can manage to enter the scheme and access services is key. There are also questions related to the quality of care offered by national insurance systems and to whether the packages they offer provide effective cover against catastrophic expenditures.

For example, there is a vocal body of thought that argues that the conditions required for SHI to contribute to UHC in most LMICs are simply not met (see Table 1).^[19,21,22] Indeed, most insurance schemes in Africa are being supported by payments that are not contributory (e.g. VAT in Ghana, and donor payments and government budget in Rwanda). Likewise, a 2010 WHO review of community health insurance revealed large heterogeneity in institutional designs and organisational models, and enormous variation in population coverage, services covered and costs savings achieved.^[23]

Different paths to UHC

This section provides some brief snapshots of the situation and progress towards UHC (and with insurance coverage) in several countries that are often talked about as 'success stories'. It is noteworthy that most of these models are, in fact, hybrids of tax funding and insurance and, as such, have encountered challenges of scale, breadth of coverage and affordability. None have identified a magic bullet to the obvious dilemmas of UHC.

Rwanda

In Rwanda, the government commits 19.5 percent of its total annual spending to health. On a low per capita national income, it manages to provide basic services for just \$37 per person.^[24]

Rwanda's Community Based Health Insurance (CBHI) scheme, commonly known as *mutuelles de santé* is one of the largest public health insurance schemes in sub-Saharan Africa. CBHI schemes can be broadly defined as voluntary prepayment plans for healthcare that operate at a community level; in the case of Rwanda, CBHI is a national-level scheme. The Government of Rwanda first scaled up its CBHI policy in 2004, after initial pilots in 1999, to cover patient costs for curative services. Today, it is heralded as one of the most successful in Africa, having expanded coverage from less than seven percent of the population in 2003 to 91 percent in 2010.^[24]

The CBHI scheme is funded 50 percent from annual member premiums and 50 percent from government and/or donor funding. It has a system of co-payments, although these have been controlled at 10 percent of hospital budget and \$0.36 as co-payment for outpatient care since 2006. Currently, more than 90 percent of households are covered — a very high rate compared to other countries in Africa.^[24] As coverage has grown since 2000, so has healthcare utilisation. Those enrolled in the scheme report significantly higher rates of healthcare utilisation than those not enrolled, and coverage has been found to have a positive and significant effect on child and maternal care coverage after adjusting for possible confounders.^[25]



Health worker using a mid-upper arm circumference tape to check whether this child is malnourished, Myanmar

Nonetheless, problems still require ironing out. Specifically, not all health centres offer a comprehensive package of services — vaccination, medical consultation, medical surgery, dental care and surgery, medical radiology and scanning, laboratory tests, physiotherapy, hospitalisation, drugs based on a list accepted by individual *mutuelles*, prenatal, perinatal and postnatal care, reimbursement of ambulance transportation fees, prostheses and orthoses not exceeding a value approved by the fund — it is estimated now that only 30 percent do so.^[26] Also, until 2010, payments for enrolment were standardised and now a new system of stratification of payments has been introduced.^[24]

Thailand

Thailand has become internationally known for its success with UHC. Since the 1970s, successive Thai governments have built up a strong district-level, public sector dominated health system. They introduced several schemes that partially covered different segments of the population: the Medical Welfare Scheme (MWS) — also known as the Low Income Card Scheme for the poor (1975) — the Civil Servant Medical Benefit Scheme (CSMBS) for government employees (1980), the Voluntary Health Card Scheme (VHCS) — a community-based health insurance scheme inaugurated in 1983 — and a Social Security Scheme (SSS) for formal sector employees (1990).^[27] The CSMBS and the SSS targeted people in the formal employment sector, whereas the MWS and VHCS targeted those in the informal employment sector. These schemes all had different benefit packages and purchasing methods.

However, by 2001, 30 percent of the population was still uninsured.^[28] Operational challenges had limited the coverage

of MWS and VHCS. Difficulties encountered when assessing the income of those working in the informal employment sector had led to mis-targeting under the MWS, while adverse selection had enabled high-risk members to purchase insurance at a lower premium than their disease risk would imply under the VHCS.

Thailand's Universal Coverage Scheme (UCS) was established in 2002 to cover those previously insured by the MWS and the VHCS, as well as the 30 percent of the population who were not insured. Today, UHC is comprised by the CSMBS (9 percent), the SSS (16 percent) and the UCS (75 percent).^[27] Although there are some differences in their benefit packages and design features, UHC was a political decision at heart. Its success has been attributed to a big-bang policy reform led by a populist government and to the established institutional capacity mobilised by technocratic reformists in the MOPH [Ministry of Public Health] who influenced political decisions through evidence-based knowledge, previous practical experience and institutional networks.^[28] Thailand's UHC package costs \$136 per capita.^[5]

Indonesia

Indonesia is following a route to UHC similar to Thailand's, unifying a number of existing schemes and trying to reach out and provide government-subsidised coverage to poorer groups. In 2014, it introduced Jaminan Kesehatan Nasional (National Health Insurance) (JKN): a unified, contribution-financed SHI scheme.^[29] Contributions for the poor and near poor are paid for by the government. In 2014, 86 million people were eligible for this assistance and the Government of Indonesia spent the

equivalent of \$1.43 billion funding their cover. JKN promotes equity by providing the same services to all population groups.

However, there are concerns over the scheme's financial sustainability and its ability to control costs. An actuarial analysis of the first year's enrolment levels and costs concluded that there were issues with sustainability unless JKN increased its contribution rates.^[30] Issues have also been raised over the capacity of the Indonesian healthcare system to provide services in all the areas that enrollees require.

Ghana

The Government of Ghana has been implementing a National Health Insurance Scheme (NHIS) since 2003. Studies have shown that the scheme is positively correlated with increased use of health services and positive health outcomes, but it is struggling both to maintain enrolment and to ensure that lower income quintiles have equal access.^[31,32] While it is recognised that coverage for MDG-related interventions in Ghana is high, concerns exist regarding how much progress is being made to

widen coverage and how sustainable the scheme is; coverage is not as high as was predicted or planned.^[31,33]

NHIS is also less of an insurance programme, and more a hybrid between tax funding and insurance. In 2012, over 70 percent of its financial inflow came from the National Insurance Levy (a form of VAT); given that more than 60 percent of those enrolled in the scheme are exempt from the levy, this poses a serious challenge. Indeed, a 2016 review highlighted that the following issues threaten the NHIS financially and operationally: cost escalation, supply side weaknesses, a broad benefits package, and a large exemption group, as well as poor quality services decreasing confidence in the scheme and thus enrolment rates.^[31]

Ghana provides a good example of both the benefits of wider insurance coverage and the difficulties of providing insurance on a national scale in countries whose health systems and economies are stretched by the demands that UHC places on them.



Health worker explains the screening process for people who have recently been in areas at high risk of malaria, Cambodia



SMC health worker distributing medication, Burkina Faso

The domestic financing conundrum

The above analysis highlights these key findings:

- Governments that make political and technical commitments to providing a long-term, stable flow of funds to their health systems are the most likely to make headway in achieving true UHC. This brief has highlighted some of the options available in terms of increasing the domestic resources raised for health, such as introducing new taxes.
- There have been several costings of hypothetical packages of care. They all suggest financial commitments that are beyond what LICs are managing to spend on their health sectors, even with donor assistance. A recent DCP³ working paper concluded: 'assuming that the objective of UHC is to successfully crowd out out-of-pocket spending at the point of care through prepayment mechanisms and pooled contributions, these cost estimates suggest that current government and donor spending will need to approximately double or triple to finance the highest priority package or essential UHC packages'.^[2] There should be some guidance on what options exist to do this in the short to medium term.
- Recent decades have seen a steep increase in the levels of spending on global health by donor countries and organisations, but this is unlikely to continue over the next few decades. Donors, such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, are increasingly emphasising a domestic financing and sustainability agenda. This should be strongly encouraged in LICs with a reasonable and growing income base, but might be more difficult in those with a lower income base.
- The UHC movement has very clearly articulated what countries need to do to their health systems to achieve UHC, but has thus far failed to address the overall chronic shortage of funding demonstrated by the second point above.
- There is evidence from many countries that insurance coverage will increase utilisation of important health services by those covered. The challenge is how to fund insurance for those who cannot afford to contribute and where these resources can come from. Insurance is often seen as a solution to this lack of funds, but does not automatically bring more resources into the health sector.
- The donor community can assist by providing longer term, reliable assistance to a specific and realistic package of care for countries most in need of additional finance in their health sectors.

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