

**Third Annual UHC Financing Forum
Greater Equity for Better Health and Financial Protection**

Thinking about Equity in Health Financing: A Framework

*A paper prepared to inform development of the discussion paper for
the Forum*

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This paper is not for quotation. It will be further developed after the Forum to take account of the discussion. Written comments are also welcome. Please send to Kent Ranson at mranson@worldbank.org

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Summary¹

Key Messages

1. Health financing policy, with its components of revenue generation, pooling and purchasing, has multiple objectives in addition to equity, some of which might conflict with the equity objective. Different views of social justice legitimately influence the weight people and countries decide to give to equity in any given decision.
2. Universal Health Coverage (UHC) offers the promise of equity - all people receive affordable health services, or good quality, according to need. However, on the path to UHC, inequalities persist and some health financing policy choices can make them worse and too often health financing policies are developed without a thorough consideration of the consequences on equity.
3. Based largely on the principles of UHC, the following criteria were developed to guide decisions about which of the inequalities in health outcomes, and those associated with each financing function, are unfair, and therefore inequitable:
 - a. **Benefits:** Coverage of health services, of good quality, should be according to need. On the path to UHC, priority is given to cover those with the greatest health needs;
 - b. **Burden:** Financial contributions should be de-linked from service use and based on ability to pay. As part of this, people should be protected from financial hardship associated with OOPs. On the path to UHC, priority is given to financially protecting people with the least ability to pay.
4. After considering the range of other possible objectives of health financing policy, a set of policy options that are regarded as unacceptable because they further exacerbate inequities is derived – reproduced below.

Ten Unacceptable Trade-offs Linked to Health Financing Policies

Financing contributions to the system:	<p>It is unacceptable to:</p> <ol style="list-style-type: none"> 1. Increase out of pocket payments (OOPs) for universally guaranteed personal health services without an exemption system² or compensating mechanisms 2. Raise additional revenues for health in ways that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer final income distribution is not more unequal 3. Raise additional revenues for universally guaranteed personal health services through voluntary, prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors
Benefits from the system:	<ol style="list-style-type: none"> 4. Change per capita allocations (of domestic general government revenue or donor funds) across prepaid and pooled financing schemes that worsen inequities, unless justified by differences in need or the availability of funds from other sources³. 5. Within financing schemes, change per capita allocations from higher to lower

¹ This note draws on presentations made by Christoph Kurowski and Amanda Glassman, as well as the ensuing discussion, at a meeting in Equity of Financing UHC, Oslo, 7-8 September 2017.

² Proof that these systems and mechanisms is critical.

³ This includes changes to requirements for counterpart funding taking domestic resources from relatively under-funded areas to those that are relatively well funded.

	<p>autonomous, administrative units, that worsen inequities, unless justified by differences in need or the availability of funds from other sources</p> <ol style="list-style-type: none"> 6. Within schemes or pools, change allocations of funds across diseases that worsen inequities, unless justified by differences in need or the availability of funds from other sources 7. Introduce high cost, low benefit interventions to a universally guaranteed service package before close to full coverage with low cost, high benefit services is achieved 8. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need 9. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need 10. Expand the availability and quality of key inputs to produce a universally guaranteed set of personal health services in ways that exacerbate existing inequalities unless justified by differences in need
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5. Countries can follow a process of identifying their own unacceptable trade-offs for financing policy based on their own inequities and view of social justice, perhaps using the trade-offs developed here. The process requires three workstreams:
 - a. Making equity concerns fundamental to all health financing policy debates. This will enable countries to identify and redress current inequalities and to avoid inadvertently exacerbating existing inequities as they move forward;
 - b. Developing a system of process fairness and accountability in health financing so that the public trusts the way decisions are made and is involved in them, recognizing that there will not be universal agreement about the outcomes;
 - c. Track progress in a way that the impact on equity can be evaluated regularly. This requires data disaggregated by the socioeconomic characteristics important to a country, but most commonly by income/wealth, gender and place of residence.
6. The global community can help to facilitate this by: systematically introduce equity considerations in all bi- and multi-lateral engagements on health financing policy while assessing the equity implications of their financial support to the health sector to avoid unacceptable choices; use their financial and technical support to build country capacities and institutions to implement the recommended approach; continue to develop the tools, methods and approaches essential to carry out the country workstreams and provide them as global public goods.

Section 1: Introduction

This paper proposes a framework for thinking about equity in health financing. The framework aims to guide health financing policy decisions on the path toward Universal Health Coverage (UHC) and reflects – in addition to concepts of equity and fairness - the values and principles inherent to this globally adopted goal (United Nations 2018). UHC means that all people can use the promotive, preventive, curative, rehabilitative and palliative services they need, with the quality required to be effective, while also ensuring that the use of these services does not expose them to financial hardship (WHO 2010).

The framework builds on a large body of work exploring the meaning of equity and fairness in health financing, fiscal policy, and more recently, UHC (e.g. Wagstaff & Van Doorslaer 2000; Murray et al. 2003; Xu et al. 2007; O'Donnell et al. 2008; Van Doorslaer & O'Donnell 2011; Bastagli, Coady & Gupta 2012; Ottersen & Norheim 2014; WHO 2014; Clements, Gaspar & Gupta 2015; Mulenga & Ataguba 2017; Fleurbaey & Maniquet 2017; Woo et al. 2017). The terms relate to the idea that certain inequalities in both the financial burden of contributing to health systems and in the benefits derived from them are inequitable and unfair. However, beyond that, there is little consensus on the boundaries and content of the terms equity and fairness and whether and how they are different so, following the WHO Consultative Group on Making Fair Choices on the Path to UHC, in this paper the terms are used interchangeably (WHO 2014).

The framework identifies a set of inequalities associated with UHC that are unfair and health financing policy trade-offs that might be encountered on the path towards UHC that are unacceptable from an equity standpoint because they would further exacerbate existing inequities. The paper does so in three-steps. The first is to develop a set of guiding principles of fairness in the distribution of benefits received from health systems and the financial contributions to them (Section B). The second is to identify a set of inequalities associated with health financing decisions. The third is to use the principles of fairness to determine which of these inequalities can be deemed unfair or, in other words, that constitute inequities. Both the second and third step are in Section D, before which is a brief description of the health financing system and the associated decisions that can reduce, or increase, inequities.

Section E then recognizes that reducing inequities is only one of the possible objectives of health financing policy. Some trade-offs between equity and other policy objectives cannot be rejected unilaterally on fairness grounds because they represent different views about the appropriate weight to be given to each objective. On the other hand, there are a set of policy choices on the path to UHC that are unacceptable in that they risk exacerbating existing inequities, presented here as unacceptable trade-offs.

The paper then moves in to the related questions of fairness of process as a complement to fairness in outcomes (Section F) and the need to be able to track progress if equity on the path to UHC is to be improved (Section G). Section H suggests how countries might apply the framework for their own decision-making. The final section, Section I, complements the framework that was developed from a country perspective with some equity considerations for health financing from a global perspective including considerations of fair contributions to health across countries.

Box 1: Principles of Fairness

KEY MESSAGES

- UHC holds the promise of equity - all people receive affordable health services, or good quality, according to need - but with two major caveats:
 1. First, for many countries UHC is a distant future and the principles inherent in UHC provide little guidance how to chart an equitable path towards that goal. While there is general consensus about giving priority to the worse off, the extent varies according to views of social justice. Moreover, a policy objective of reducing inequity associated with health financing decisions can conflict with other social objectives such as increasing employment or improving efficiency where views of social justice also influence the relative weight people or countries decide to give to equity.
 2. Second, while UHC is clear about equity in the distribution of health benefits, when it comes to how much people should contribute financially it focuses exclusively on equity in protection from financial hardship linked to the need to make out-of-pocket payments (OOPs) for health services. It is silent about other sources of financing for health such as insurance premiums and taxes. The concern with financial hardship due to OOPs implicitly suggests, however, a mandate for prepaid and pooled financing with contributions according to ability to pay.
- Accordingly, the following principles are used to guide health financing policy choices:
 - **Benefits:** Coverage of health services, of good quality, should be according to need. On the path to UHC, priority is given to cover those with the greatest health needs.
 - **Burden:** Financial contributions should be de-linked from service use and based on ability to pay. As part of this, people should be protected from financial hardship associated with OOPs. On the path to UHC, priority is given to financially protecting people with the least ability to pay.

Section 2: Principles of Equity and Fairness in Health Financing

Considerations about what is equitable in the distribution of the financial burden of contributing to the health system and in the benefits derived from it vary with perceptions of social justice. The two most common in the debate about health financing are probably the egalitarian and the libertarian viewpoints (e.g. Wagstaff and van Doorslaer 2000).⁴ The egalitarian view suggests predominant public financing with health services distributed according to need and financial contributions according to the ability to pay. Coverage with health services is decoupled from the financial contributions.

The extreme of the libertarian view is that health services are privately financed and people receive them according to their ability and willingness to pay. Any transfers to the poor are dependent on individual acts of charity. A less extreme version, sometimes called sufficientarian liberalism, maintains predominant private financing but with limited public involvement that ensures a safety net for the poor. This safety net allows them to obtain a sufficient standard of living including a level of health service coverage.

⁴ A wide variety of other approaches to social justice also exist. These are simply the two most common in the current debates about health financing policy.

Under this form of libertarianism, the involvement of government finance for safety nets implies some decoupling of financial contributions from the right to service utilization though not as much as in the egalitarian view: the poor cannot pay, or cannot pay fully for the services they need, and the rest of society needs to finance a sufficient set of services for them. Beyond that, however, market forces rule.

There is some debate about the metric on which any concern with equity should focus – perhaps health outcomes, the use of services, use given need, or some concept of access to needed services. Here we draw on the principles inherent in the concept of UHC which implies that the focus should be on equity in affordable coverage with needed services. On the benefit side, the UHC concept clearly reflects the egalitarian principle of distribution of health services according to need: and the concern is not only with coverage of these services, but also their effectiveness as a key dimension of their quality – with the two dimensions commonly captured by the concept of effective coverage.⁵

The principle of distribution of services based on need has implications on the burden side as well: most importantly, that revenue generation systems involving out of pocket payments (OOPs) should not deter people who cannot afford them from using health services. However, in other ways the relationship between the UHC concept and egalitarian principles is less explicit and not as straightforward on the burden side. UHC calls simply for protection from financial hardship because of the need to pay out-of-pocket. Financial hardship from out-of-pocket payments (OOPs) has two widely accepted definitions: first, OOPs that push people into poverty or deeper into poverty, and second, OOPs that have catastrophic, but not necessarily impoverishing effects on households. Examples of catastrophic effects include foregone consumption of essential goods and services - such as education, clothing, housing, food, severe depletion of assets or excessive borrowing to meet health care costs. UHC, therefore, implies that no one should suffer financial hardship from out of pocket payments – implying equity in affordable coverage with needed services - but it is silent on questions of equity in other financial contributions to the system such as taxes and insurance premiums.

The practical application of UHC principles, however, has found that moving away from OOPs to protect people from financial hardship hinges on financing arrangements consistent with egalitarian viewpoints. Protection from financial hardship requires decoupling financial contributions from service utilization - given the potentially large direct costs of health products and services, not only for the poor, but most income groups. While decoupling is in principle possible through any form of prepayment and pooling, this has only been achieved at scale – i.e. covering the entire population - through compulsory prepaid and pooled financing.⁶ Given many of the poor will not be able to contribute financially, in practice this means linking financial contributions to ability to pay in some way.⁷

For most countries, UHC remains a distant future and few countries can afford universal coverage with all health interventions that can prolong life or improve its quality while ensuring financial protection for

⁵ The acceptance of UHC as a goal of health system development does not, however, automatically imply people are egalitarian – for example, they might simply think UHC is good for economic growth or for peace and security.

⁶ Compulsory prepayment includes taxes and other government charges, some of which are used to finance health services. It also includes compulsory insurance contributions as in most European systems, paid either by individuals and/or their employers.

⁷ There is some debate about whether attaining the UHC outcome of financial protection should go beyond OOPs and include protection from financial hardship due to other costs associated with service utilization, such as transportation fees or opportunity costs of time, which includes losses of income. This has not traditionally been included in the concept of UHC, so is not discussed further.

all. This raises the question of equity on the path toward UHC. The concept of UHC implies equality in affordable coverage with needed services in the long run, as we have seen, but it is silent on the role of equity on the path to UHC. The general concepts of equity and fairness suggest that some priority be given to the worse-off in terms of both need and ability to pay – i.e. people who are the sickest and those that are poor. Indeed, this is also consistent with the sufficientarian view of providing sufficient health services for the poor, however, with the caveat that UHC obliges governments to progressively move toward the full realization of UHC outcomes (Baltussen et al. 2017).

Drawing on the concepts of equity, fairness and the values and principles inherent to the concept of UHC, the WHO Consultative Group on Making Fair Choices on the Path to UHC proposed a set of principles to determine inequalities and policy choices that are unfair (WHO 2014; Ottersen & Norheim 2014). Based on the earlier arguments, these are refined as:

1. **Benefits:** Effective coverage of services is according to need. On the path to UHC, priority is given to cover those with the greatest health needs.
2. **Burden:** Financial contributions are based on the ability to pay and independent of service use. On the path to UHC, priority is given to cover (under such financing arrangements) those with the least ability to pay.

These principles are also consistent with the idea of progressive universalism which argues that, on the path to UHC, the poorest should benefit at least as much as the rich (Gwatkin & Ergo 2011; Gwatkin 2014; Jamison et al. 2013).

It is important to recognize that these principles are not absolute and require trade-offs with social objectives other than equity and fairness, as discussed subsequently. At the same time, these principles leave room for interpretation. For example, fair contribution based on ability to pay might be interpreted as fair contributions for all health funding from an egalitarian perspective, or for the funding required to cover only the essential health needs of the poor from a sufficientarian perspective.⁸ The principle of contributions according to ability to pay can be interpreted that the rich pay more than the poor, or that the rich pay a higher proportion of their incomes than the poor – typically defined as progressive contributions.⁹ And even when this question is settled, perceptions about how much more the rich should pay will vary.

Moreover, the separation of principles for benefits and burden may also require trade-offs. Should countries give priority to expanding the range of quality services available for those with the greatest health needs, or expanding financial protection to those with the least ability to pay? Or should they do a mix of the two – if so, what weight should be given to each component? And even within each component, policy-makers will face additional trade-offs: for example, in terms of benefits, whether to increase coverage or improve the quality of available services. Answers require an assessment not only of the extent to which policy options will advance progress toward UHC at the aggregate level, that is, across the various dimensions and outcomes of UHC, but also how these alternatives will reduce inequalities deemed unfair.

⁸ The Consultative Group interpreted it as fair contributions to an essential package that would be guaranteed to everyone, and then expanded over time as more resources become available.

⁹ In the taxation literature, the term progressive has been used to describe where the share of total income contributed rises with income. Regressive is the opposite. However, sometimes the terms are used to mean that the poor pay more than the rich in absolute, not necessarily proportional terms. In this paper we use the term in its strict sense.

The separation between benefits and burden also contrasts with some recent work that seeks to assess whether government fiscal policies overall – including, but not restricted to health – improve equity. The focus of that work has been on the impact of fiscal policy on “final” income: the distribution of pre-tax gross income is compared with the distribution of post-tax final household income (e.g. Lustig et al. 2013; Lustig 2016, 2017, 2018; Jellema et al. 2017). Final income subtracts out taxes, social security contributions and charges from gross income and adds in benefits each household receives in cash or kind from the government (e.g. sickness or unemployment benefits, child allowances, the use of subsidized health or education services)¹⁰. Fiscal policies where the poor have a greater share of final income than gross income are considered fairer than those that do not achieve this type of redistribution.

This concept of fairness focuses on the net impact of fiscal policy on individuals and groups of individuals – payments minus benefits. The services received in kind are valued at their cost of provision independent of any assessment of the extent to which people needed to use the services. The concept of UHC is different, however, on the benefit side. It asks whether people who need to use health services receive them, at good quality. Use, contingent on needs, is critical to the idea of UHC, so we maintain the separation of burden and benefits as the basis for our assessment of fairness in health financing, drawing on principles 1 and 2 above.

¹⁰ There is no agreement on whether pensions should be included here, or as part of the pre-tax gross income. Lustig et al. do the calculations both ways.

Section 3: Health Financing Systems

Health financing arrangements influence the ability of health systems to ensure that services people need are available, of quality and affordable: the essence of UHC. Health financing systems typically connect a wide range of health system actors through a complex network of fund flows ([Rechel, Thomson, and Van Ginneken 2010](#)). The system design and performance depend on choices in three inter-linked health financing functions – generating or mobilizing the necessary financial resources, pooling them to spread financial risks associated with illness, and using them to purchase or provide health services (Gottret & Schieber, 2006) (WHO, 2010) (McIntyre & Kutzin, 2016). Purchasing can be divided into two components: what to purchase and how to purchase (Box 2).

Box 2: Health Financing Functions

Revenue generation/mobilization involves raising the financial resources needed to develop and run a health system. Contributions typically come from individuals/households, firms, and sometimes external sources in the form of development assistance for health (DAH). Some contributions are health-specific, and some go into general government revenue at different levels of the government system, part of which is, in turn, allocated to finance health.

Pooling requires decisions about whether and how financial contributions to the health system are spread across individuals to reduce the financial risk associated with unexpected illness and medical expenses. Out-of-pocket payments (OOPs) are one extreme, where individuals or households pay directly (entirely or partly) for the services they obtain. There is no risk sharing with OOPs: the people who use services must pay the cost. The end of the spectrum is in systems where governments fund the bulk of health services through general government revenues, which can be held by national and/or sub-national levels of government. In systems with social health insurance, there can be multiple pools if different population groups are covered from different funds or if funds compete (e.g. Switzerland, the Netherlands), or a single social health insurance fund. In the case of multiple funds, governments frequently transfer resources across the pools as a form of "risk equalization," in order to ensure that funds covering people with a disproportionately high risk of incurring large costs do not suffer financially compared to those that cover disproportionately low risk people. Government revenues typically also supplement social health insurance pool(s).

Purchasing requires decisions about how the available funds should be used to purchase¹ (or provide) health services – personal services (prevention, promotion, treatment, rehabilitation, palliation) and essential public health functions like population-based promotion and prevention, outbreak readiness and response, and health system governance. There are two inter-related decisions: what to purchase and how to purchase. The first involves decisions about rationing and entitlements, including what services should be universally available or available to people covered by the purchaser. The second requires decisions about how to pay providers and suppliers of inputs and services to encourage quality and efficiency.

1. The term "purchase" is used here to capture the purchase of services or the inputs that are used to provide services.

In each of these health financing functions, decisions impact on equity and fairness. There are three important considerations to bear in mind.

First, the ability of the health financing system to transform the revenues raised into needed health services, of quality, with financial protection, depends on a complex interplay between the diverse decisions made about resource generation, pooling and purchasing. Each individual decision matters, but it is the combination of decisions that is crucial for UHC.

Second, rapid progress towards UHC and the maintenance of past gains requires a broad set of health system actions in addition to those related to health financing. Among others, these include activities to

ensure there are: sufficient, motivated health workers; good quality health infrastructure; a range of quality health services; essential medicines and other medical products available when they are needed; health workers, infrastructure, medicines and medical products are available where they are needed; strong leadership and governance; and information that is both relevant and timely enough to influence decisions.

Third, the socioeconomic conditions in a country, and actions taken in other sectors to address them, influence how feasible it is to collect revenues for health, to spread risk and to purchase needed services. For example, raising income taxes in countries where a high proportion of the population works in the informal sector or people are poor may not achieve the desired results. Strategies to increase the rate of formalization or to reduce poverty are important to improve revenue generation, but they are beyond the control of the health sector.

For these reasons, the remainder of this paper uses the term “inequalities associated with health financing” rather than “health financing inequalities”. Moreover, the framework considers health system inequalities, as long as there is a clear link with health financing - even if they are also influenced by other parts of the health system, other sectors and underlying socioeconomic determinants. UHC as a key outcome is one example of this. The availability of resources, the nature of pooling and decisions made about what to purchase clearly impact on the extent of coverage with needed services, their quality and affordability, but there are many other determinants as well. The framework, however, does not extend the focus to considering inequalities beyond UHC to health outcomes, where direct links with health financing are more difficult to trace.

Section 4: Inequalities and Inequities Associated with Health Financing

This section presents types of inequalities associated with health financing, then applies the principles developed in section B to deliberate about which inequalities can be deemed unfair. The section starts with inequalities in UHC outcomes before exploring inequalities associated with decisions made in the three health financing functions - revenue mobilization, pooling and purchasing - that impact on inequalities in UHC outcomes.

To understand inequalities, it is important to specify units of analysis. On the benefits side, inequality analysis typically focuses on individuals/households or groups of people – for example, groups of individuals by income, gender, geographic region, ethnic origin, affiliation with pooling arrangements, legal status of residency, and health problem/disease type. On the contribution side, inequalities relate to firms as well as individuals/households, as discussed subsequently.

UHC Outcomes

Types of inequalities

The two UHC outcomes are effective coverage of needed health services and protection from financial hardship. The units of analysis for considering inequalities in these outcomes are individuals/households or groups of individuals/households.

Effective coverage of health services requires that people not only obtain the health services they need, but that the services are of sufficient quality to be effective. Protection from financial hardship means first and foremost protection from being pushed into poverty from out-of-pocket payments (OOPs) for health products and services but also protection from needing to reallocate budgets from other necessities to pay for health services.

The following inequalities can be observed:

- Differences across people or groups in effective coverage with health services of all types (personal health services, public health (including non-personal health services) and governance functions.¹¹ For example, the poor or people in rural areas typically obtain a more limited range of services, frequently of lower quality, than the rich or people in urban areas.
- Some people or groups are pushed into poverty or further into poverty due to out-of-pocket payments (OOPs) for health services. The incidence of impoverishing OOPs is typically much higher among the near-poor than richer groups.
- Differences across people or groups in the incidence or extent of catastrophic OOPs for health services. This can occur for a number of reasons: variation in the need to use health services; differences in the way user charges are levied (e.g. when women and children are exempted from some user fees but not men); or households with particular characteristics (e.g. those headed by women) have lower capacity to pay than those of other households.

Inequalities deemed unfair

¹¹ There has been some debate about whether the concept of UHC includes public health and non-personal health services (Ottersen & Schmidt 2017). We argue that it does. The fact that there are rarely co-payments or charges for these services simply means there is no financial catastrophe or impoverishment associated with them, and effective coverage is more important in this case than financial protection.

Healthy people do not need to use curative health services, so differences in coverage with health services are only unfair if they do not reflect differences in need. On the other hand, equality in coverage can be unfair if there are differences in need. So Table 1 defines when differences in service coverage are unfair.

In terms of OOPs, there is some controversy about when financial catastrophe is unfair. The major point of contention relates to countries, Sri Lanka for example, where richer people choose to opt out of using the services that are universally available from public funds. If, in doing so, they incur health expenditures deemed to be catastrophic, should this be considered unfair? There is no universal agreement, so as a compromise, the framework proposed here considers catastrophic OOPs as unfair when they occur due to lack of access to services guaranteed under compulsory prepaid and pooled financing arrangements or because people need to pay OOP for these guaranteed services.

The logic can also be extended to impoverishing OOPs payments. Where they are incurred because people cannot get access to services that are theoretically guaranteed, or because they pay OOP for those services, is impoverishment due to OOPs considered here as unfair. All inequities (unfair inequalities) in UHC outcomes are summarized in Table 1.

Table 1. Inequities in UHC Outcomes

1. Differences in the effective coverage of health services (including non-personal health services) and governance functions unless justified by differences in health needs. ¹²
2. No differences in effective coverage of health services when there are differences in health needs. ¹³
3. Some people or groups are pushed into poverty, or deeper into poverty due to OOPs because of lack of access to, or in using services guaranteed by compulsory prepaid and pooled financing arrangements.
4. Differences across people and groups in the incidence or extent of catastrophic OOPs because of lack of access to, or in using services guaranteed by compulsory prepaid and pooled financing arrangements.

The next sub-sections consider inequalities linked to decisions in the three health financing functions that can impact inequalities in UHC outcomes.

Revenue Generation/Mobilization

Types of inequalities

There are five principle sources of domestic financing:

- Taxes and charges that are not health-specific and which flow into general government revenues at central or sub-national level;
- Health-specific taxes and charges, most commonly compulsory social health insurance contributions, but including also any taxes and charges that are earmarked for health, such as those on tobacco or alcohol products or mobile phone use;¹⁴

¹² Horizontal equity

¹³ Vertical equity

- Government borrowing, whether health or not health specific, where future generations have to pay for services that are enjoyed by people living today;
- Voluntary health insurance premiums;
- Out-of-pocket payments, whether as forms of cost-sharing or for services not covered at all from any of the sources above.

Development assistance for health (DAH) is not considered in this section on inequity in financial contributions, given that these inequities are more global than domestic. DAH though is discussed as a source of domestic inequalities in who benefits from the available funds, in the sections on pooling and purchasing, while the international perspective on DAH is considered the final section of the paper.

With revenue generation, individuals or households are not the only economic agents. Firms also contribute: they pay taxes and charges that are not health-specific, sometimes contribute to social health insurance on behalf of employees, subsidize voluntary health insurance or pay directly for health services for staff.¹⁵ The public finance literature does not consider firms separately to individuals for equity analysis on the grounds that firms pay incomes to individuals (employees, shareholders) so that, in the end, it is the overall inequality across individuals that is critical. Governments simply choose to tax firms for convenience.

While we accept the logic, we propose to be somewhat heretical by continuing to consider firms separately. The public debate frequently focuses on whether firms pay sufficient taxes compared to individuals, and whether some firms are treated more favourably than others – for example, the Third International Conference on Financing for Development, held in Addis Ababa in August 2015 to herald the beginning of the SDG era, affirmed that countries would seek to “ensure transparency in all financial transactions between governments and companies to relevant tax authorities. We will make sure that all companies, including multinationals, pay taxes to the governments of countries where economic activity occurs and value is created...” (Addis Ababa Action Agenda, 2015, paragraph 23).

Accordingly, for this document the main types of inequalities across sources of funding are:

- Differences across people and groups in the incidence of OOPs for health services
- Differences across people and groups in net contributions to the public finance system (including, but not limited to health)¹⁶
- Differences across firms in their net contributions to the public finance system, perhaps because of tax holidays or exemptions from paying social insurance contributions. Firm may also “transfer” profits to part of the firm that is resident in a country with a low-tax regime.
- Differences across individuals or groups in contributions to voluntary prepaid and pooled financing arrangements.

Inequalities deemed unfair

¹⁴ Taxes on products harmful to health are not always hypothecated for health in which case they fall into type a.

¹⁵ Some sources of finance, such as sovereign wealth funds and state enterprises, contribute to government revenues under a) above, but do not lend themselves to the analysis of inequalities in contributions across either households or firms. Inequalities in who benefits from all government revenues are discussed in subsequent sections.

¹⁶ Net contributions are gross contributions minus transfers received in cash or kind

Turning now to the issue of which of these inequalities can be considered unfair, as discussed in the previous section there is broad agreement that unaffordable out-of-pocket payments for services in a guaranteed package are unfair, whether they prevent some people from using health services when they need them, or push some who use them into poverty, deeper into poverty or result in financial catastrophe.

A number of different viewpoints are possible when it comes to what is unfair in terms of other types of financial contributions. Contributions to health are only one part of the total financial contribution of households and firms to government finances. One view is that it is the fairness of the overall contribution that counts rather than the fairness of each component – one part, say health financing, could be very progressive to balance regressively in another part, say in financing education.¹⁷ Or one method of raising funds might be regressive (perhaps VAT) but is offset by progressivity with other instruments (e.g. income tax). Even then, governments can balance out any unfairness in financial contributions by ensuring that the poor and vulnerable receive fiscal transfers from the funds that are raised to compensate, so fairness is determined by the way that net contributions (cash contributions minus transfers in cash and kind) are distributed across the population.

An alternative view is that inequalities in health financing, or in a component of it such as social health insurance contributions, are important because they can make the entire system even less fair. For this paper, we lean towards the first interpretation and argue that governments need to trade-off a number of objectives when choosing instruments for raising revenues. They include the possible yield (how much is raised) and the costs of collection and enforcement, as well as questions of fairness. Governments can balance these objectives across instruments, and by using the proceeds to compensate, so it is the overall financing system that must be the focus for decisions about fairness. For this reason, we do not consider SHI contributions that are regressive - the rich do not pay a higher proportion of their incomes than the poor often because contributions are capped - as necessarily unfair. Fiscal policy can compensate the poor for this inequality in other ways.

The question of inter-firm fairness in contributions has not much discussed in the health financing literature, nor is the question of the fair division of financing burden between households and firms. We suggest that this is an oversight at least in terms of the way voters think, and that it is possible to use the principle of payment according to capacity to pay outlined earlier to categorize at least one type of inequality relating to firms as unfair. Inter-temporal unfairness between generations, when governments or households borrow to fund their expenditures, including for health, has only just started to be discussed in relation to health financing (e.g. Daniels 2011). It is, in any case, broader than health. It is now being actively considered in the public finance literature and will not be discussed further here (e.g. Kotlikoff 2018).

In terms of private insurance, there are debates about whether it is unfair that some people can afford it and others cannot. Here we focus on insurance that charges different premiums according to risk profiles or pre-existing conditions. This is contrary to the principle of separating out payments from the need to use health services outlined in section B, so is unfair.

¹⁷ For example, value added taxes are sometimes regressive in that the poor pay the same absolute amount as the rich. However, it is frequently easier to raise taxes in this way so governments might accept some regressivity here and compensate by additional progressivity in income or company taxes.

The suggestions for the type of inequalities in revenue generation that are unfair are summarized in Table 2. They build on the principle of Section B that people should contribute according to their capacity to pay, but with the proviso that health financing is only part of the fiscal system.

Table 2. Inequities associated with revenue generation/mobilization

1. Some people or groups are pushed into poverty, or deeper into poverty due to OOPs because of lack of access or in using quality services guaranteed by compulsory prepaid and pooled financing arrangements (also part of Table 1, but a component of revenue generation).
2. Differences across people and groups in the incidence or extent of catastrophic OOPs because of lack of access or in using quality services guaranteed by compulsory prepaid and pooled financing arrangements (also part of Table 1).
3. Differences across people and groups in the incidence of OOPs that deter them from using quality services guaranteed by compulsory prepaid and pooled financing arrangements (implicit in Table 1).
4. Revenue generation systems with differences across people and groups in net contributions to the public finance system (including, but not limited to health) which make the post-tax, post-transfer final income distribution less equal than the pre-tax distribution
5. Revenue generation systems with differences across firms in their net contributions to the public finance systems that cannot be justified by some compensating benefit for the economy
6. Differences across individual or groups in contributions to voluntary prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors.

Even though other types of inequality associated with revenue mobilization do not feature in the set of inequities – e.g. the question of whether a VAT is progressive or regressive – it is still important for policy-makers to understand the nature of inequalities associated with each of the different revenue generation instruments. This allows governments to consider how best to balance out the trade-offs between the different objectives – raising sufficient revenue, limiting the costs of collection and enforcement, and ensuring fairness – or to redress other inequalities in revenue generation.

Pooling

Types of inequalities

The impact of pooling on service use and financial protection is the topic of a subsequent section. The focus here is on inequalities in eligibility or ability to benefit from pooled funds and the amount of pooled funding available per person.

Health financing systems often tend to be highly fragmented into different pools through various mechanisms including: government pools financed from consolidated revenues, with lower levels of government receiving transfers from higher levels and sometimes also raising local taxes and other revenues; different types of social health insurance schemes; and private health insurance. In low- and middle-income countries, community-based health insurance is included in private insurance because of its voluntary nature, even though it might still benefit from government subsidies. DAH is also a source of pooled funds in many countries, whether passing through government budgets or administered separately.

Different types of pooling arrangements can lead to different types of inequalities. Some pools might offer “better” coverage than others because they have more money per person adjusted for need. Some people may simply not benefit from any type of financial protection from pooling either because they are not eligible or face other barriers to their participations, while others are eligible to benefit from multiple pools.

The range of inequalities can be summarized as:

- Differences in eligibility across people and groups to participate in any pool or differences in eligibility across people and groups to participate in particular pools
- Differences across people and groups in enrolment with private health insurance including insurance for services not guaranteed by compulsory prepaid and pooled financing arrangements
- Differences in per capita allocations (of domestic general government revenue or donor funds) to prepaid and pooled health financing schemes (including publicly funded health services, social health insurance, voluntary insurance)¹⁸
- Within financing schemes, differences in per capita allocations from higher to lower autonomous, administrative units
- Within schemes or pools, differences in allocations of funds across diseases.

Inequalities deemed unfair

The relevant equity principle from section B is that effective coverage of health services should be according to need, and that on the path to UHC, priority is given to cover people with the greatest needs. In addition, all people should be protection from financial hardship associated with OOPs, with the poor given priority. This requires equality in eligibility to be covered from pooled funds, and in the amount of pooled funding available per person, unless differences can be justified by differences in either health or financial need.¹⁹ Table 3 accounts for differences in need when deriving the types of inequalities in pooling that can be considered unfair.

¹⁸ Health care financing schemes are the main types of financing arrangements through which health services are paid for and obtained by people. Here we refer to pooled schemes rather than to OOPs, including national or sub-national health services funded from government revenues (sometimes with donor funds as well), social health insurance, voluntary insurance (OECD 2011).

¹⁹ Pooling arrangements allow for vertical equity across the people covered by the pool – people who are sick, for example, use pooled funds and those who are healthy do not need to. This allows those in greatest need to get the most benefit.

Table 3. Inequities Associated with Pooling

1. Ineligibility of people and groups to participate in any pool or differences in eligibility across people and groups to participate in specific pools unless justified by differences in need ²⁰
2. Differences across people and groups in enrolment with private health insurance including insurance for services not guaranteed by compulsory prepaid and pooled financing arrangements unless justified by differences in need
3. Differences in per capita allocations (of domestic general government revenue or donor funds) across prepaid and pooled schemes units unless justified by differences in need or the availability of funds from other sources
4. Within financing schemes, differences in per capita allocations from higher to lower autonomous, administrative units unless justified by differences in need or the availability of funds from other sources
5. Within schemes or pools, differences in allocations of funds across diseases that are not justified by differences in need or the availability of funds from other sources

Not all of the unfair inequalities can be addressed by the health financing system alone. For example, the affordability of private health insurance is mediated by income inequalities in society while the targeting of DAH is rarely decided entirely by the host country. As with revenue generation, some of the inequities associated with health financing are broader than the health financing system and require actions elsewhere.

Purchasing

Types of inequalities

As described earlier, purchasing refers to decisions made about what to purchase and how to pay for the services or inputs that are purchased (or provided). Inequalities in coverage with needed services was discussed in the earlier section on inequalities in UHC outcomes. The most obvious form of inequality in purchasing is associated with differences in the range of services purchased from pooled funds of the various types, so there is a direct link to the discussion of inequalities in pooling in the previous section. However, some is also linked to the availability and quality of services that can be purchased out-of-pocket.

Most attention has been focused on inequalities in the availability of, and access to, personal health services (personal prevention, treatment, rehabilitation, palliation), but inequalities in the broader public health functions, including non-personal health services also exist.

The inequalities associated with the purchasing function are summarized below:

- Differences in entitlements of guaranteed service packages, implicit or explicit, across people and groups. Entitlements reflect the services and levels of financial protection to which people are entitled de jure. Whether people receive these entitlements de facto was considered an inequity in UHC outcomes earlier (Table 1);

²⁰ Differences in need include both health and income. Those with lower health need more health services, and those that are poor are less able to pay for needed health services.

- Differences across people or groups in the availability and quality of personal health services. Availability means here that services exist and people can use them. This includes differences across diseases in the availability and quality of services when some are well funded from donor funds and others are chronically underfunded;
- Differences across people and groups in the availability and quality of core public health functions²¹, for example, population-based health promotion, surveillance, outbreak control;
- Differences across people or groups in the availability of key services inputs, for example, health workers, equipment, medicines, and infrastructure.

Inequalities deemed unfair

As with the pooling function, the fairness principle of coverage with health services according to need is used to determine which of the inequalities are unfair where need includes the health needs and the need for financial protection. Inequalities in the availability of health services are only unfair if the populations covered have equal need, for example. Equality in the availability of services is only fair if people have the same needs. Table 4 suggests how fairness can be brought into the discussion about these inequalities.

Table 4. Inequities Associated with Purchasing

1. Differences in entitlements of guaranteed service packages across people and groups unless justified by differences in need
2. Differences across peoples and groups in the availability and quality of universally guaranteed personal health services unless justified by differences in need.
3. Differences across people and groups in the availability and quality of core public health functions unless justified by need
4. Differences across people or groups in the availability of key inputs to produce a universally guaranteed set of personal health services unless justified by differences in need

Again, the fact that an inequality is judged to be unfair does not mean that it is easy to redress it. For example, despite decades of experiments, it is very difficult to attract and keep highly trained health providers in rural areas. Compared to a counterfactual of having no providers at all, community health workers might be an important improvement. It does not, however, detract from the fact that some people are served largely by relatively untrained community health workers and others by better trained people, something that is unfair. Over time, it would be desirable to increase the range of skills and services available to the population living in rural areas to redress this inequity.

Summary

²¹ Essential public health functions, services or operations are usually defined to include all activities relating to health except the delivery of personal health services. The names for the elements included differ, but can be summarized as: health governance (e.g. developing and enforcing laws, assuring quality, raising funds, developing the workforce, organizational structures and competences), organization and delivery of non-personal health services such as population prevention and health promotion, monitoring and evaluation, health protection including occupational and food safety, outbreak response and control, monitoring and evaluation, and public health research - see, for example, CDC 2018, WHO 2017, WHO 2018.

This step by step summary of the inequalities that can be observed in UHC outcomes, then those related to the three health financing functions of resource generation, pooling and purchasing, is useful for understanding the nature of health financing inequities but is somewhat artificial from a policy perspective. Policy decisions are often interlinked – for example, the decision about who will be covered by a new form of social health insurance (pooling) is rarely made independently of the decision about what services should be covered. The question of what services should be covered requires consideration of the depth of coverage to be offered – i.e. what proportion of the costs will be covered by the health insurance.

It is also important to note that some of the other inequalities that have been identified are not necessarily deemed to be universally unfair based on the principles developed earlier. They should, however, be quantified and understood to help in the policy process. Reducing inequality associated with SHI might, for example, be an option for increasing the equity of contributions to the overall fiscal system, even if it is not possible to argue that inequality in SHI contributions is, by itself, unfair.

The entire set of inequalities and inequities is reproduced in the Annex along with the associated unacceptable policy choices and trade-offs.

Section 4: Unacceptable Trade-offs

The fact that an inequality is designated as unfair is only the first step. Governments have different objectives when developing policy, and reducing inequity is only one. The trade-offs between objectives are slightly different for revenue generation than for decisions about pooling and purchasing made subsequently.

For revenue generation, governments think about the yield of various revenue collection instruments, their costs of administration, collection and enforcement, and the political constraints to their acceptance and implementation in addition to the equity implications. As argued earlier, they may well introduce a new tax because it will have a high yield with low transaction costs, even if it is somewhat regressive. Any bias against the poor and vulnerable could first, be minimized, and second, be offset by how the additional revenue is used.

Another example relates to taxes on products harmful to health. The main role for these taxes is to improve health rather than to generate resources for income redistribution even though they sometimes raise substantial revenues as well. Regressivity in financial contributions, likely in the case of tobacco products for example, is offset by the greatest health benefits accruing to the poor (who use tobacco products more than the rich) and can be further offset by decisions about how to use the revenues of this and other taxes in ways that benefit the poor (Summers 2018).

Governments might also give tax holidays or exempt some firms from paying social security contributions to attract them to invest, and provide employment, in the country. The obvious unfairness that introduces in the contributions of different firms, they might feel, is compensated by the provision of additional income-earning opportunities to the population.

For pooling and purchasing, governments also have multiple objectives. They seek to increase aggregate levels of coverage with needed health services and financial protection, encourage efficiency and quality among providers, be prepared for possible future health emergencies, and reduce inequalities in coverage. These objectives can sometimes compete. For example, ensuring that isolated communities have access to needed health services can be more expensive per person covered than increasing service availability in more populated areas.

The WHO Consultative Group recognized that different societies will legitimately make this type of trade-off in different ways, but nevertheless sought to identify if there are any trade-offs it felt were unacceptable based on the principles of fairness they had developed.

One unacceptable trade-off was linked to revenue generation. It considered the question of what governments should do to replace revenues lost through the abolition or reduction in user-charges as a strategy to improve financial protection and remove barriers to accessing services. This trade-off was:

1. It is unacceptable to reduce OOPs and increase prepayment in a way that makes overall health financing less progressive.

The other unacceptable trade-offs the Group proposed were related to how to define and then expand a package of health services guaranteed to all people through a process that was seen to be procedurally fair. In this, it would be unacceptable to:

2. Expand coverage for low or medium priority services before close to full coverage with high priority services is achieved.
3. Provide high-cost, low-health benefit interventions because they protect people financially, when low-cost, high health-benefit interventions have not been fully implemented.
4. Expand more services to the well-off before the poor are covered for the defined essential services.

For this paper, we argue that the third proposal is applicable probably only at the extreme. In choosing a guaranteed package of benefits, it is likely that decision-makers and the population would be willing to trade-off some decrease in population health levels for increased financial protection. We have also expanded consideration of the fairness of revenue mobilization beyond only the question of OOPs considered by the Consultative Group. Accordingly, we modify and expand these proposals to a larger set of proposed unacceptable trade-offs for broader health financing policy development (Table 5). They are reproduced in Annex 1 in a table that builds up from the identified inequalities, to the associated inequities, and then to the unacceptable trade-offs associated with them.

Table 5. Unacceptable trade-offs linked to health financing policies

Contributions to the system:	<p>It is unacceptable to:</p> <ol style="list-style-type: none"> 1. Increase OOPs for universally guaranteed personal health services without an exemption system²² or compensating mechanisms 2. Raise additional revenues for health in ways that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer final income distribution is not more unequal 3. Raise additional revenues for universally guaranteed personal health services through voluntary, prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors
Benefits from the system:	<ol style="list-style-type: none"> 4. Change per capita allocations (of domestic general government revenue or donor funds) across prepaid and pooled financing schemes that worsen inequities, unless justified by differences in need or the availability of funds from other sources²³. 5. Within financing schemes, change per capita allocations from higher to lower autonomous, administrative units, that worsen inequities, unless justified by differences in need or the availability of funds from other sources 6. Within schemes or pools, change allocations of funds across diseases that worsen inequities, unless justified by differences in need or the availability of funds from other sources 7. Introduce high cost, low benefit interventions to a universally guaranteed service package before close to full coverage with low cost, high benefit services is achieved 8. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need

²² Proof that these systems and mechanisms is critical.

²³ This includes changes to requirements for counterpart funding taking domestic resources from relatively under-funded areas to those that are relatively well funded.

	<p>9. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need</p> <p>10. Expand the availability and quality of key inputs to produce a universally guaranteed set of personal health services in ways that exacerbate existing inequalities unless justified by differences in need</p>
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These propositions are a useful starting point to think about the development of health financing policies in ways that explicitly address inequity and unacceptable trade-offs.



Section 5: Accountability and Fairness of Process

The previous section argued that people can reasonably disagree about the relative value to give to the different policy objectives linked to each decision and how they should be balanced, partly reflecting different views of social justice (WHO 2014). Recognizing this, a growing body of literature suggests that key policy decisions should be made through a process that all people see as legitimate. One example is the Accountability for Reasonableness framework which has been applied largely to decisions about which health services should be made available for the available pooled funds – i.e. the rationing part of the purchasing function (Daniels 2000; Daniels 2008; Daniels and Sabin 2008; Daniels 2016; WHO 2014; Petricca & Bekele 2017).

Under the framework, four conditions contribute to the legitimacy of the process of choosing interventions.

1. *Publicity*: Details of decisions made on how to ration health resources need to be readily available to the public, along with the justification for those decisions – e.g. why a new technology or medicine was, or was not, accepted for public subsidy;
2. *Relevance*: The organization or authority making the decision about the use of scarce resources must provide a *reasonable* explanation of the criteria it uses to make decisions that provide “value for money” in meeting the varied health needs of the population for the resource constraints;
3. *Revision and appeals*: Mechanisms for challenge and appeal need to be available with opportunities to modify decisions over time if new evidence becomes available;
4. *Regulation*: Formal rules are needed to ensure the first three conditions are fulfilled.

The relevance condition was developed because, while fair minded people may reasonably disagree on the relative weights to give to different criteria that could be used in allocating resources, they should be able to agree on the criteria which need to be clearly enunciated and explained. The use of the term “value for money” as a criterion in the relevance condition, however, has led to some debate about the whole Accountability for Reasonableness framework: for example, whether this biases the decision-making process in a way that gives too much weight to cost-effectiveness analysis at the expense of equity considerations, and whether additional criteria (to cost-effectiveness and equity) need to be introduced as well to fully inform rationing decisions (e.g. WHO 2014; Baltussen et al. 2017; Badano 2018).

Despite this, the approach has been explored in a variety of priority-setting environments, and a frequent recommendation is that some organization or body needs to be established to ensure fairness in the process of taking decisions about which health interventions and technologies should be funded for the available resources. For example, the WHO Consultative Group argued that one option would be to establish a “standing national committee on priority setting to handle particularly difficult cases” (WHO 2014).

The Accountability for Reasonableness approach can be seen as response to the broader concept of ensuring government accountability. Answerability and enforceability are fundamental to accountability, under which individuals and institutions making decisions affecting the population’s wellbeing must provide information about the decisions they make, justify them, and face censure or sanctions for any misconduct (Schedler 1999; WHO 2014). The most common motivation for why accountability is required derives from the human rights framework, which sees the State as acting on behalf of its citizens (Yamin 2000; Farmer 2003). Policy decisions that affect people’s rights need to be justified to the people affected by them and subject to public scrutiny through a fair process, perhaps

backed up by the judiciary (Gruskin & Daniels 2008; Rumbold et al. 2017; Yamin 2017). Informed public scrutiny in turn requires a functioning monitoring system, transparency and access to information, and meaningful public participation in processes (Yamin 2008).

Most attention in applying these principles to health has focussed on ways to involve the public in decisions before they are made. Specific one-off decisions have been debated by the public in consensus conferences, town meetings, or citizen's juries or panels, for example (Rowe & Frewer 2005; Abelson et al. 2008; Mitton et al. 2009; WHO 2014). Civil society inputs to longer term decision making have, in some countries, been formalized through representation on bodies such as hospital boards, local government health authorities, priority setting committees or institutions, or the boards of health insurance funds (Sabik & Lie 2008; Glassman & Chalkidou 2008; Stewart et al. 2016; Byskov et al. 2017; Giedion & Guzman 2017; Simonet 2017).

These processes tend to have been applied to purchasing decisions: how to use the available funds. Further upstream in the financing function, forms of participatory budgeting have also been developed to engage citizens in formal decisions about how to allocate government budgets across competing needs, in settings as diverse as Brazil, Cameroon, Europe, Peru, Sri Lanka and New York City (WHO 2014; Kasdan & Markman 2017). This type of approach can influence how much government money is allocated to health, for example. Citizen engagement has, however, been generally limited to budget decisions by lower levels of government – e.g. municipalities – and usually restricted to a relatively small proportion of the budget (Shapiro & Talmon 2017). There is also limited evidence on its impact, either in terms of the extent of public debate that this facilitates or the outcomes that result from it (Campbell, Craig & Escobar 2017). Less direct have been efforts by civil society organizations such as the African Health Budget Network to influence government allocations to health through advocacy or to encourage African governments to adhere to the agreement made in Abuja Declaration of 2001 to allocate 15% of their budgets to health (Africa Health Budget Network 2018).

The principles behind the Accountability for Reasonableness criteria, combined with affords to ensure public debate and involvement, could be applied to any of the key health financing decisions around revenue generation, pooling or purchasing: public information about the decisions that are made and their motivation, the direct involvement of the public in reaching decisions, a process of appeal and review and clear criteria that set out what factors should influence the decisions. Criteria for reasonableness would differ depending on the question. For example, questions relating to contracting – which health services or inputs should be purchased and at what price – would need to consider factors such as efficiency, the costs of administration and enforcement, incentives for quality, the risk of fraud etc. The extent to which the public could feasibly be engaged in each type of decision would need to be determined on a case-by-case basis, but broad public debate would be warranted.

The question of overall tax policy - decisions about how much to raise, who should contribute and when – requires, perhaps, more consideration. These decisions are usually made in parliaments, as representatives of the interests of citizens. Changes to tax policy are usually the subject of wide public debate, as well as debate in parliament. There will be different views about whether this is a sufficient process to ensure accountability and fairness in processes. On the one hand, it could be argued that the costs of adding an additional layer of complexity to re-enforce process fairness cannot be justified when the purpose of a parliament is to represent the people. On the other hand, it could be argued that in many countries, parliamentarians are relatively well remunerated and a majority come from the more affluent parts of society. They have a conflict of interest when it comes to raising more taxes or making

a tax system more equal, so other ways of influencing these decisions need to be found. This debate and options for re-enforcing accountability in this area will be explored further at the Forum.

Section 6: Tracking Progress

Fair decisions on the path to UHC cannot be made if policy-makers do not know who misses out on needed services, and who suffers severe financial hardship because they have to pay for the health services they receive out of pocket. Moreover, policy makers cannot adjust their policies over time unless they know if things are getting better or worse. This requires measuring levels and inequalities in coverage and tracking progress over time.

It also requires drilling down to the components of the health financing system that influence inequalities in UHC outcomes, described earlier, to see if the inequities associated with revenue generation, pooling and purchasing are being reduced. Inequities in the distribution of health workers and other inputs such as essential medicines also need to be monitored as part of the purchasing function because they influence whether the services people need are available close to them, and of good quality.

Accordingly, part of the process of supporting fairness and equity on the path to UHC is to ensure the necessary data are available, in a timely fashion, that they are analysed appropriately and transmitted to policy makers in a way that they can understand and act on (see Hosseinpoor et al 2018). Part of fairness of process is to also ensure that data are shared with the public and other stakeholders in a way they can digest.

This requires a change in the way countries routinely monitor and evaluate progress in their health systems, largely through routine records of attendance and treatment at health facilities, supplemented by other sources such as cancer registries that vary across countries in number and quality. This generally does not provide information on the baseline – who needs services – or on quality, or on financial protection.

Regular collection of **disaggregated data** that allow the health financing-related inequities to be measured and tracked over time is one important element of bringing equity into health financing policy making. At a minimum, data need to be disaggregated by income/expenditure/wealth, gender and geographical location (e.g. rural/urban). Countries can add on other determinants that are important to them, perhaps ethnicity, age structure of families, type of health problem, depending on their problems and capacities.

Methods for undertaking the required analysis are also critical, but many have already been developed. For example, there is a long history of identifying inequities in key health outcomes such as adult, maternal and child mortality (e.g. Marmot et al 1991; Mackenback et al. 1997; Gwatkin 2000; Victora 2003; Moser et al. 2005; Barros et al. 2010; Bendavid 2014; Wagstaff, Bredenkamp & Buisman 2014; Gwatkin 2017). More recently attention has moved to developing the techniques to measure and analyse progress in increasing coverage and reducing inequalities in coverage with core health interventions, largely focused on the diseases that were the target of the MDGs (e.g. Rao et al. 2014; Alkenbrack et al. 2015; Restrepo-Méndez et al. 2016; Hogan et al. 2017; WHO & World Bank 2017; Wong et al. 2017; Victora et al. 2017).

The incidence of financial catastrophe and impoverishment due to OOPs, and an understanding of which people suffer the most, has also been increasingly documented and a number of methods for doing this have been developed (e.g. Xu et al. 2003 & 2006; Wagstaff & Lindelow 2014; Bredenkamp & Buisman

2016; Khan, Ahmed & Evans 2017; Wagstaff et al. 2017a and b; Ghimire et al. 2018). There are, however, disagreements about which of the methods is the most appropriate, so some studies report results using multiple methods (e.g. WHO and World Bank 2017).

Building on all this work, an overall approach to tracking progress towards UHC that takes into account the levels and distribution across population groups in service coverage and financial protection has been developed, although it does not drill down to all of the inequalities associated with the health financing function that were identified earlier (e.g. Boerma et al. 2014; WHO and World Bank 2017). Some of these methods have, however, been developed. For example those relating to:

- the question of whether fiscal policy is pro-poor, taking into account the amount people pay in and receive in the way of subsequent transfers in cash or kind from those funds (e.g. Lustig 2016 & 2017; Jellema et al. 2017; Lustig 2018).
- inequalities in the availability of services and in key inputs such as health workers (e.g. O'Neill et al. 2013; WHO 2015; Speybroeck et al. 2012).

Tools to help country analysts undertake this work are also now available. Methodological guidance is on: how to estimate various indicators of the absence of financial protection and inequalities in them (Wagstaff et al. 2007; Wagstaff 2008; Saksena, Hsu & Evans 2014; Wagstaff & Eozenou 2014; World Bank 2018a) and; how to analyse inequalities in health outcomes and in health service coverage (Hosseinpoor 2016 & 2018; World Bank 2018a.)

The World Bank also provides a tool as part of its ADePT Resource Center that country analysts can use to upload their household expenditure survey data and produce most indicators of the lack of financial protection and inequalities in them (World Bank 2018a). Approaches to rapidly assess the availability and readiness of key health services, which can also be used to track geographic inequalities, have been developed including the Service Availability and Readiness Tool (WHO 2018b).

Finally, many of the current ways of obtaining data, particularly for coverage with key services and with financial protection, require representative household surveys. They are time consuming and relatively expensive. The World Bank has developed a Swift Survey approach as a low cost, rapid way of measuring incomes and tracking progress in reducing poverty (World Bank 2018b). Approaches such as these offer hope of lower cost, more timely ways of obtaining the necessary data for tracking progress in reducing the health financing associated inequities as well.

Section 7: Some Global Considerations

Many low- and lower-middle income countries receive a substantial share of their health resources from DAH, yet there are many inequalities in how DAH is raised and used globally. For example, the contributions of rich countries differ substantially, both per capita and as a share of gross national income (GNI). The way DAH is channelled also favours some people at the expense of others: some middle-income countries receive substantially more per capita than a number of low-income countries; more populous countries receive less per capita than less populous countries; while most DAH is targeted at younger rather than older people (Pietschmann 2014; Vassall et al. 2014; Martinson et al. 2017; Skirbekk et al. 2017). DAH has also been very heavily oriented towards the MDG conditions of reproductive, maternal, neonatal and child health, and a set of communicable diseases. HIV/AIDS has received a substantially higher share than would be expected from its relative disease burden (Chima & Franzini 2015; Steele 2017).

More recently, there has been a debate about when it is appropriate for recipient countries to transition from DAH, with some external funders reducing or eliminating funding as countries reach a target level of national income per capita (Ottersen et al. 2017). At the same time, the majority of the world's poor no longer lives in low-income countries, raising ethical and political questions about how the international community should react if countries which have the financial means to improve health among their poor, do not (Chaumont et al. 2017; Ottersen, Moon & Røttingen 2017).

Views about which of these inequalities are unfair require a view of global social justice and here views diverge at least as much as for domestic health financing policy. We do not seek to take a view in this paper which has focused largely on inequality at the domestic level, but the global questions are important, controversial, and worthy of further consideration.

Section 8: Applying the Framework

Countries

In the search for progress towards UHC, as well as in protecting gains made in the past, countries cannot afford to consider only the overall percentage of the population covered with quality health services and financial protection. A **first step** in applying the framework is to make equity concerns fundamental to all their health financing policy debates. This will enable them to identify and redress current inequalities and to avoid inadvertently exacerbating existing inequities as they move forward.

Given the variation in beliefs about social justice, countries will need to chart their own way taking into account current inequities, the institutions governing their policy-making processes and public policy priorities in addition to reducing inequity. They will need to identify unacceptable policy choices or trade-offs along the lines described in this document, and countries may want to build on the set proposed in this report. In addition, they will need to identify critical inequalities in financing UHC that contribute to inequalities in UHC outcomes, build consensus on what is considered fair and unfair, and determine the weight they want to attach to equity compared to other policy objectives. Some countries might need support in strengthening their capacities to do this.

It is not possible to ensure that no one disagrees with the resulting decisions, but a **second step** is to ensure fair processes for decision-making that the public trusts. Fair processes require an engaged public aware of the criteria that are used for decision-making, what decisions are made and why, and how this affects their wellbeing. It also requires a decision appeals process with regularly reviews of procedures, and a regulatory or legislative framework that sets the rules of the game for fair processes.

Fair processes can be embedded in strong structures and processes to ensure the government is accountable for the health financing decisions that are made. Accountability requires not only that there are fair processes, but that the decisions affecting public wellbeing are transparent and justified with sanctions for misuse of public funds and trust.

The **third step** is to ensure there is a way to track progress and make any necessary policy adjustments rapidly using some of the tools and methods described earlier.

The three steps should be undertaken in parallel. They complement each other, but each has a value independently. For example, fair processes benefit from monitoring impact, yet poor data should not be an excuse to delay efforts to strengthen public involvement and the transparency and accountability of health financing decision-making processes.

The Global Community

The global community can help to facilitate this shift, also in a three-pronged approach. The **first** is, like countries, to systematically introduce equity considerations in all bi- and multi-lateral engagements on health financing policy. This allows external partners to assess the equity implications of their financial support to the health sector and to avoid unacceptable policy choices. The **second** is to use their financial and technical support to build country capacities and institutions to apply the three steps described above. The **third** is to continue to develop the tools, methods and approaches essential to carry out these workstreams and provide them as global public goods. The global community can also further the body of evidence of what works to reduce inequities associated with health financing, but that is beyond the scope of this report.

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