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**UNIVERSAL HEALTH COVERAGE:
AN ANNOTATED BIBLIOGRAPHY**

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Universal Health Coverage: An Annotated Bibliography

by Ilona Kickbusch, Jeffrey Sturchio, Tanya Mounier, Michaela Told,
Amanda Fales, Thorsten Behrendt, and Lyndsey Canham

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About the Series

The *Studies in Applied Economics* series is under the general direction of Prof. Steve H. Hanke, Co-Director of the Institute for Applied Economics, Global Health, and the Study of Business Enterprise (hanke@jhu.edu).

About the Annotated Bibliography

This annotated bibliography was originally published in May 2014 under the same title and authors. It is the first of a two-part series, stemming from a two-year collaboration between the Global Health Programme at the Graduate Institute of International and Development Studies in Geneva (globalhealth@graduateinstitute.ch), Rabin Martin (uhc@rabinmartin.com), a global health strategy consultancy based in New York and Geneva, the Johns Hopkins Institute for Applied Economics, Global Health, and the Study of Business Enterprise (iaeghsbe@gmail.com), along with advisors from academia and the public and private sectors. The following authors contributed to the annotated bibliography: Ilona Kickbusch, Jeffrey Sturchio, Tanya Mounier, Michaela Told, Amanda Fales, Thorsten Behrendt, and Lyndsey Canham.

Summary

The debate over universal health coverage has become increasingly central for the global health community and for national economies of all sizes. What are the parameters of universal health coverage, how can differing economies achieve it, and what resources are required? This annotated bibliography is divided into eight thematic sections and includes a series of country case studies intended to illustrate on-the-ground realities faced by different countries.



UNIVERSAL HEALTH COVERAGE: AN ANNOTATED BIBLIOGRAPHY

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Ilona Kickbusch, Jeff Sturchio, Tanya Mounier, Michaela Told, Amanda Fales, Thorsten Behrendt, Lyndsey Canham.

Introduction: the move to universal health coverage

Universal health coverage. This simple phrase has become a central focus of debate in the global health community in recent years as countries large and small, rich and poor, contemplate how to extend health care to more of their citizens in a way that guards against the risk of catastrophic out-of-pocket expenditures, improves health outcomes equitably and uses available resources efficiently. As UN member states contemplate the new agenda around the post-2015 sustainable development goals, universal health coverage has come forward as a proposed goal to capture the degree to which different societies are reaching their ambition to provide equal access to health for all.

Of course, countries will differ in the way they address universal health coverage, based on a wide range of factors – political, economic, social, epidemiological and technical. But the concept is here to stay, and multilateral organizations and their member states are engaged in a lively and critical debate about the meaning of universal health coverage and the mechanisms and resources required to achieve it. Civil society and the private sector are also engaged in dialogue with governments on the subject, which will continue to be on the global health diplomacy agenda for the next several years.

With these thoughts in mind, the Global Health Programme at the Graduate Institute of International and Development Studies in Geneva and Rabin Martin, a global health strategy consultancy based in New York and Geneva, have embarked on a two-year collaboration, together with a working group of advisors from academe, civil society, and the public and private sectors, to explore several critical dimensions of the move to universal health coverage. Our starting point is the insight that health and health care constitute a major economic force in most countries. This “health economy”, as we will call it, is estimated to account for roughly 10% of global GDP. It comprises all stakeholders concerned with and involved in issues related to the efficiency, effectiveness, values and behaviours in the production and consumption of health and health care. The actors involved in the health economy shape population health and health service delivery, while also ensuring linkages with the wider macroeconomic, social and political context. The health economy is a system that includes both investments in prevention as well as the supply and demand of healthcare resources – its impact interfaces both with the health of a population and with economic development.

In the context of this focus on the health economy, we hope to explore and understand the key governance challenges that arise for country governments, donor governments, the private sector and civil society in the move to universal health coverage. Our project will explore key dimensions of universal health coverage, including the equity, innovation and development agendas. It will also take the contribution of international organisations into account.

From the standpoint of **equity**, for instance, we hope to explore how the private sector can contribute to achieving universal health coverage. In many countries, access to affordable health care remains elusive. Yet, it is one of the most important mechanisms of poverty reduction. In these countries with limited resources the major part of health care is provided by the private sector, including informal providers; often this leads households to fall into poverty through out-of-pocket payments. Too many countries face limited capacity to regulate and to govern a public-private mix adequately, with due attention to such factors as market entry, pricing, purchasing and quality. As they expand coverage, too many countries neglect to invest in public health, health promotion and prevention. Chronic disease costs rise as NCDs' control is neglected.

With respect to **innovation**, we will ask what out-of-the-box solutions can the private sector and their partners contribute? Rapid developments in telecommunication, for instance, are making cross-border solutions for health more accessible. MHealth is allowing outreach to populations not thought possible a few years ago – investments in broadband are becoming important investments in health. New forms of social protection (social impact bonds) and social insurance are being developed. These are just some of the areas to be explored in articulating a pragmatic approach to just how countries will reach universal health coverage.

The UHC agenda is no longer just a national challenge: health is global. The global health industry is growing rapidly – presently it is calculated to be worth USD 6.5 trillion per year and predicted to grow to USD 10 trillion in the near future. New industries are entering the health market. Professionals and patients are moving across borders and some countries are investing in health tourism in order to promote national growth. Cross-border health threats are increasing – they include not only infectious diseases but also NCDs and antimicrobial resistance – and need to be controlled through cooperation. As countries invest significantly in expanding coverage, the dangers of corruption and waste can increase if there are no appropriate safeguards. Additionally, while it is recognized that the MDGs have given a powerful anti-poverty push to the world with positive outcomes, much still remains to be done to meet those goals in many countries and to position health strategically in the post-2015 agenda.

An annotated bibliography of universal health coverage

A first fruit of this collaborative project is this annotated bibliography of universal health coverage. This is the first in what we intend as a series of working papers to appear over the course of the next few years. Given the large and growing literature on universal health coverage, this offering cannot be comprehensive. Instead it is intended as an introductory guide to the subject, one that will expand as the debate evolves in the coming months.

The bibliography is organized into eight sections: concepts and considerations; governance; equity and social protection; health systems financing; health systems delivery; health workforce; metrics; and country case studies. These seemed to be natural categories to organize the many studies, reports and commentaries we found to be helpful in working our way along the learning curve. They also reflect the foci of the existing literature. The WHO defines UHC as “ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”¹. This clearly demonstrates that issues surrounding how health care is paid for are of fundamental importance, together with an improved understanding of the need to shape health financing systems to promote UHC, while keeping equity and social protection firmly in mind. No country in the world will achieve UHC without strong political will and recognition of the crucial role that strong governance at local, national and international levels will play in the countries’ journey towards UHC. To achieve UHC, countries need to address the percentage of the population covered, the percentage of the costs prepaid at the point of service and the percentage of interventions that are covered by prepaid schemes. To be able to do this effectively, countries will find that intersectoral cooperation is critical.² As a result, issues around the delivery of services (including preventive services) will be critical. These are just some of the issues that the articles cited below address.

Finally, we included a number of country case studies to illustrate the on-the-ground realities that countries around the world face in their efforts to reach UHC. These case studies clearly demonstrate the many different avenues that countries can take to reach UHC, highlighting the fact that there is no “one-size-fits all” path to UHC. Each country will need to work at its own pace, factoring in the many parameters (e.g. burden of diseases, demographics, political will, state of their health systems, private-public sector mix, financing system, etc.) that relate to their own country when devising their strategy to reach UHC.

1 http://www.who.int/health_financing/universal_coverage_definition/en/

2 http://www.who.int/health_financing/strategy/dimensions/en/

A living document

We hope that our readers find this first working paper useful to inform their own discussions on UHC. While we don't have all the answers yet, we are certain that the lively interest in the concept of UHC and the health economy is likely to continue for some time to come. Please don't hesitate to contact us with citations for future editions of this bibliography – and, more importantly, your thoughts on how we can collectively improve our understanding of UHC and its practical implications for addressing the changing needs of our complex global health systems.

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1. Universal Health Coverage: Concepts and Considerations

Lara Brearley, Robert Marten & Thomas O’Connell

Universal Health Coverage: A Commitment to Close the Gap

Rockefeller Foundation, Save the Children, UNICEF, and WHO, 2013.

Available at bit.ly/BrearleyUHC

Support for universal health coverage (UHC) – ensuring “that all people obtain the health services they need, of good quality, without suffering financial hardship when paying for them” – is fast gaining momentum. The World Health Organization (WHO), the World Bank and many developing and donor countries have already adopted UHC as their top health priority. This report focuses on how and why inequity – unfair and avoidable inequalities – should be prioritized as countries progress on the path towards UHC. It identifies policy options that governments and donors should consider when implementing reforms for UHC and estimates the effect on health outcomes, setting out the implications for the post-2015 sustainable development framework. Research for this report included: a structured literature review to identify lessons from countries; key informant interviews with a range of experts; an econometric analysis to estimate the impact of more equitable health financing on mortality rates; and, a Lives Saved analysis to estimate the impact of eliminating in-country wealth inequities in coverage of maternal and child health services.

Nellie Bristol

Global Action toward Universal Health Coverage

Center for Strategic and International Studies (CSIS). 2013. Available at bit.ly/BristolUHC

This report is a primer on universal health coverage. It examines the history of universal health coverage, the momentum the concept is gathering in countries and at international organizations, the elements needed to move toward expanded coverage, and the obstacles involved. As national incomes have risen across diverse countries—along with the burden of noncommunicable diseases—demand has intensified for quality, affordable health services. Many countries today are actively seeking to bring about universal health coverage—ensuring quality

health services for all at a price that does not create undue financial pressure for individuals seeking care. The effort has stirred expanded interest and guidance from international organizations such as the World Health Organization and the World Bank, and led to new platforms for developing countries to learn from each other. While universal health coverage will provide new funding and opportunities, including for the private sector, there is a need for dynamic, transparent negotiations among all health constituents, to forge enduring, feasible arrangements that ensure quality services reach all populations and make the best use of scarce health resources. Universal health coverage will remain a work in progress for many countries for many years. It will require grappling with considerable uncertainties and risks. It also has the potential to attract greater attention to health spending, health systems, and improved equity, advances that will benefit human development more broadly.

Nellie Bristol

Universal Health Coverage Going Global

A Conference Report of the CSIS Global Health Policy Centre. Center for Strategic and International Studies (CSIS). 2014. Available at bit.ly/Bristol2UHC

Experts from around the world met in Washington, D.C., in early 2014 to discuss the growing momentum toward universal health coverage in a range of countries, especially emerging economies. Topics for the day-long conference included a brief history of the movement, the elements required to establish universal health coverage, and trends evident as countries struggle to meet the challenge. Participants—including Jim Yong Kim, president of the World Bank Group, and Nils Daulaire, assistant secretary for global affairs in the U.S. Department of Health and Human Services—also discussed the role of the private sector and efforts to make the most cost effective use of health care resources. This report summarizes the key messages from the meeting as experts described a trend considered crucial to ensuring social and economic stability in developing countries.

Guy Carrin, Ke Xu & David Evans

Exploring the Features of Universal Coverage

Bulletin of the World Health Organization 86, no. 11 (November 2008), page 818.

Available at bit.ly/Carrin1UHC. DOI: 10.2471/BLT.08.060137

In light of the present general consensus that health financing systems should be shaped to promote universal coverage, authors in this issue of the Bulletin explore UHC financing mechanisms. Drawing lessons from cases in several countries, articles focus on the problematic nature of out-of-pocket payments, a shift toward various prepayment schemes, the potential role of additional funds and external aid, and the value of effective fund transfer.

Kalipso Chalkidou et al

Health Technology Assessment in Universal Health Coverage

The Lancet 382, no. 9910 (December 2013), pages e48-e49.

Available at bit.ly/ChalkidouUHC. DOI: 10.1016/S0140-6736(13)62559-3

First, intergovernmental organizations, such as the WHO, the Pan American Health Organization, and the Association of Southeast Asian Nations, can highlight and build awareness of the contribution of HTA to UHC through global health diplomacy. Second, bilateral institutions, such as DFID, can support the translation of research evidence into policy and practice through strengthening Southern institutions and empowering UK institutions to enter technical cooperation relationships and capacity enhancement, building on the UK's experience of UHC through the National Health Service. Pushing researchers to become advocates for their own research products is not a credible alternative to helping build local capacity for countries' own research needs. Third, national governments have to acknowledge and recognize the need for HTA and help generate and sustain the demand for HTA as they move towards UHC. Finally, national institutions working on HTA, such as the National Institute for Health and Care Excellence (NICE) in the UK and the Health Intervention and Technology Assessment Program (HITAP) in Thailand, should document and share their experiences and evidence to accelerate the transfer of knowledge, and assist others by building networks of expertise in the initiation and evolution of similar institutional capacity.

Margaret Chan

Best Days for Public Health Are Ahead of Us, Says WHO Director-General

Address to the 65th World Health Assembly, Geneva, 21 May 2012. Available at bit.ly/ChanUHC

Following the morning elections of the President and five Vice Presidents of the 65th Assembly, WHO Director-General Margaret Chan took the stage to present on the work of the WHO with special attention to the theme of “Towards universal coverage”.

Julio Frenk & David de Ferranti

Universal Health Coverage: Good Health, Good Economics

The Lancet 380, no. 9845 (September 2012), pages 862-64.

Available at bit.ly/FrenkUHC. DOI: 10.1016/S0140-6736(12)61341-5

Four points are central to the discussion of the transition to UHC: economics, policies, institutions, and costs (EPIC). Case studies from Mexico and Thailand illustrate that successful country transitions to UHC benefit from solid management of these four pillars. When attention to these EPIC factors is combined with momentum for UHC that comes from domestic forces as opposed to external pressure and resources, UHC represents a uniquely promising way to integrate social and economic policy.

Laurie Garrett, A Mushtaque Chowdhury & Ariel Pablos-Méndez

All for Universal Health Coverage

The Lancet 374, no. 9697 (October 2009), pages 1294-99.

Available at bit.ly/GarrettUHC. DOI: 10.1016/S0140-6736(09)61503-8

Successful transitions to UHC—and the complicated health financing systems that enable them—have proven dependent not simply on increased health budgets, but also on years of hard work and innovation in combination with more resources. A national and global advocacy drive is necessary to ensure that governments worldwide see the value in prepaid risk pools and the ways universal health-financing schemes can trigger progress in other social sectors. First steps toward financing mechanisms might include insurance schemes that initially target special groups.

Ursula Giedion, Eduardo Alfonso & Yadira Díaz

The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence

UNICO Studies Series 25. Washington DC: The World Bank, 2013. Available at bit.ly/GiedionUHC

A systematic review of UHC interventions in low- and middle-income countries yields several relevant findings. While these interventions have generally proven to improve access to healthcare, their design, implementation, and context play a large role in determining the extent of their impacts. In addition to this main insight, policy makers can draw four primary lessons from this review: affordability alone does not spell success for a UHC scheme; while targeting the poor is important, effects on the non-poor must be considered; benefits should be closely linked to the needs of target populations; and highly focused interventions are important in blazing a trail for UHC. More broadly, evaluation should be integrated into UHC design and development to allow for better and more regular assessment.

The report builds on an earlier literature review that examines available evidence concerning the impact of health insurance in low- and middle-income countries (see Giedion and Díaz 2008; 2011) and is an update of the earlier work with two noteworthy changes. First, four years of new evidence is included, and second, not only is health insurance reviewed, but so is a wider range of health schemes that fit under the universal health coverage umbrella. These two changes are important because there has been a boom in interest in UHC schemes and an increased interest in high-quality impact evaluations (see, for example, Savedoff, Levine, and Birdsall 2005 and Simon and Barmeier 2010), and, in light of the aforementioned movement to promote universal coverage (UC) within the global health debate, the report goes beyond the consideration of universal insurance schemes to achieve the UHC goal.

Amanda Glassman & Kalipso Chalkidou

Priority-Setting in Health: Building Institutions for Smarter Public Spending

A report of the Center for Global Development's Priority-Setting. Washington DC: Center for Global Development, 2012. Available at bit.ly/GlassmanUHC

In this report, the Center for Global Development's Priority-Setting Institutions for Health Working Group has identified core features of priority-setting processes and institutions worldwide, recommending direct substantive support for creating fair and evidence-based national and global health technology assessment systems that will be applicable in any kind of health system.

David Holmes

Margaret Chan: Committed to Universal Health Coverage

The Lancet 380, no. 9845 (September 2012), page 879. Available at bit.ly/HolmesUHC.
DOI: 10.1016/S0140-6736(12)61493-7

Margaret Chan, World Health Organization Director-General, has drawn on personal and professional experiences to champion UHC. Despite current pushes for austerity, Chan persists in her promotion of UHC and aims to find ways the WHO can help individual countries develop UHC.

Dean Jamison et al

Global Health 2035: A World Converging Within a Generation

The Lancet 382, no. 9908 (December 2013), pages 1898-1955. Available at bit.ly/JamisonUHC.
DOI: 10.1016/S0140-6736(13)62105-4

The returns on investing in health are impressive. Reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured in their national income accounts. However, although these accounts capture the benefits that result from improved economic productivity, they fail to capture the value of better health in

and of itself. This intrinsic value, the value of additional life-years (VLYs), can be inferred from people's willingness to trade off income, pleasure, or convenience for an increase in their life expectancy. A more complete picture of the value of health investments over a time period is given by the growth in a country's "full income"—the income growth measured in national income accounts plus the VLYs gained in that period. Between 2000 and 2011, about 24% of the growth in full income in low-income and middle-income countries resulted from VLYs gained. This more comprehensive understanding of the economic value of health improvements provides a strong rationale for improved resource allocation across sectors. If planning ministries used full income approaches (assessing VLYs) in guiding their investments, they could increase overall returns by increasing their domestic financing of high-priority health and health-related investments. Assessment of VLYs strengthens the case for allocating a higher proportion of official development assistance to development assistance for health.

Jim Yong Kim

Poverty, Health and the Human Future

Address to the 66th World Health Assembly, Geneva, 21 May 2013. Available at bit.ly/Kim1UHC

World Bank Group President Jim Yong Kim called on countries gathered at the 66th World Health Assembly to ensure universal access to quality, affordable health services to help end extreme poverty by 2030 and boost shared prosperity. Worldwide estimates are that out-of-pocket health spending forces 100 million people into extreme poverty every year and inflicts severe financial hardship on another 150 million people.

Jim Yong Kim

Speech by World Bank Group President Jim Yong Kim at the Government of Japan-World Bank Conference on Universal Health Coverage

Speech, Tokyo, 6 Dec. 2013. The World Bank. Available at bit.ly/Kim2UHC

Today, I am pleased to announce that with our Japanese partners we are releasing a synthesis of case study findings from 11 countries that have achieved, or are committed to achieving, universal health coverage. These 11 countries are diverse – geographically, culturally, and

economically. But all of these countries are demonstrating how these programs can improve the health and welfare of their citizens and promote inclusive and sustainable economic growth. The good news is that many low- and middle-income countries are introducing fundamental reforms and achieving remarkable progress. So what are the main lessons from these 11 countries? One, strong national and local political leadership and long-term commitment are required to achieve and sustain universal health coverage. Two, short-term wins are critical to secure public support for reforms as in the case of Turkey where hospitals were outlawed from retaining patients unable to pay for care. Three, economic growth, by itself, is insufficient to ensure equitable coverage—so countries must enact policies that redistribute resources and reduce disparities in access to affordable, quality care. Four, strengthening the quality and availability of health services depends not only on highly skilled professionals but also on community and mid-level workers who constitute the backbone of primary health care. And finally, five, countries need to invest in a robust and resilient primary care system to improve access and manage health care costs.

Brian Latko et al

The Growing Movement for Universal Health Coverage

The Lancet 377, no. 9784 (June 2011), pages 2161-63. Available at bit.ly/LatkoUHC.

DOI: 10.1016/S0140-6736(10)620065

As UHC emerges as a goal for lower- and middle-income countries, global momentum is boosting national and regional efforts, but disagreement over UHC's definition and implications persist. The international community must rally to support the movement toward UHC, since its implementation involves risk and complex challenges. The transition to UHC will vary greatly across countries and regions, but broad experience sharing and technical assistance will contribute to overall progress.

Martin McKee et al

Universal Health Coverage: A Quest for All Countries But under Threat in Some

Value in Health 16, no. 1 (January-February 2013), pages S39-S45.

Available at bit.ly/McKeeUHC. DOI: 10.1016/j.jval.2012.10.001

Over the past 50 years, health care has been making a growing contribution to population health in many countries. Yet its benefits are still denied to many people worldwide. This article describes how many countries, both developed and developing, have pursued the quest to achieve universal health care. This has been an explicitly political process. In Europe, it emerged from a belief in solidarity, a fear of revolution, and a changing view of the role of the state. In developing countries, progress was more erratic, characterized by debates about the affordability of universal health care, until it was realized that functioning health systems were essential to deliver development goals. Throughout, the United States has been an exception. An analysis of progress toward universal health care, combining a review of existing theories and new empirical analysis, identifies five factors as important: the strength of organized labor and left-wing parties, adequate economic resources, absence of societal divisions, weakness of institutions that might oppose it (such as organized medicine), and windows of opportunity. Having noted the substantial benefits accruing from universal health care, the article concludes with an analysis of how universal health care is under threat in some European countries and a warning about the risks posed by current radical austerity policies.

Thomas O'Connell, Kumanan Rasanathan & Mickey Chopra

What does universal health coverage mean?

The Lancet, 2013, 1–3; Viewpoint. Accessed September 15, 2013.

Available at bit.ly/OConnellUHC. DOI: 10.1016/S0140-6736(13)60955-1

The recent UN General Assembly resolution calling for universal health coverage (UHC) was testimony to the continuing high-level political commitment to achievement of global health goals - an achievement that has the potential to transform health systems, especially for the poorest people. Fulfilment of this potential, however, requires a clear definition of the term UHC otherwise it could suffer the same fate of the refrain of Health for All, which received high-level political support but failed to produce sufficiently widespread policy and budgeting changes to realize its aims.

Results for Development

UHC Forward

Accessed January 30, 2014. Available at uhcforward.org

The Results for Development Institute, in partnership with the Rockefeller Foundation, launched UHC Forward, a new website that tracks and consolidates key health coverage information from hundreds of sources into a one-stop portal with feature news, events, and publications related to the growing global universal health coverage (UHC) movement.

Judith Rodin & David de Ferranti

Universal Health Coverage: the Third Global Health Transition?

The Lancet 380, no. 9845 (September 2012), pages 861-62.

Available at bit.ly/RodinUHC. DOI: 10.1016/S0140673-6(12)61340-3

The global movement toward UHC represents the third major shift in recent global health history—following a demographic transition beginning in the 18th century that sparked major public health developments through the 20th century, and an epidemiological transition starting in the 20th century. Historical context highlights broad similarities that link these three transitions, underlining the importance of inter-country collaboration and country-specific solutions; the authors suggest that these approaches are central to the expansion of UHC worldwide.

Jeffrey Sachs

Achieving Universal Health Coverage in Low-Income Settings

The Lancet 380, no. 9845 (September 2012), pages 944-47.

Available at bit.ly/SachsUHC. DOI: 10.1016/S0140-6736(12)61149-0

Although environmental factors play a large role in determining health outcomes, the healthcare system can also significantly affect these outcomes. In light of the complex nature of poverty and healthcare finance, an equitable and efficient healthcare system must rely on public, not private, provision of funds. The increase in healthcare access in low-income countries since the WHO Commission on Macroeconomics and Health (2000—01) and the adoption of the Millennium

Development Goals (2000) illustrates the benefits of public spending on health. Relatively minor additions to aid for health – rather than the proposed cuts, which pose a significant threat to the state of global health – could bring about universal coverage.

William Savedoff, David de Ferranti, Amy Smith & Victoria Fan

Political and Economic Aspects of the Transition to Universal Health Coverage

The Lancet 380, no. 9845 (September 2012), pages 924-32.

Available at bit.ly/SavedoffUHC. DOI: 10.1016/S0140-6736(12)61083-6

This is the second in a Series of three papers about universal health coverage.

Countries have reached universal health coverage by different paths and with varying health systems. Nonetheless, the trajectory toward universal health coverage regularly has three common features. The first is a political process driven by a variety of social forces to create public programs or regulations that expand access to care, improve equity, and pool financial risks. The second is a growth in incomes and a concomitant rise in health spending, which buys more health services for more people. The third is an increase in the share of health spending that is pooled rather than paid out-of-pocket by households. This pooled share is sometimes mobilized as taxes and channeled through governments that provide or subsidize care—in other cases it is mobilized in the form of contributions to mandatory insurance schemes. The predominance of pooled spending is a necessary condition (but not sufficient) for achieving universal health coverage. This paper describes common patterns in countries that have successfully provided universal access to health care and considers how economic growth, demographics, technology, politics, and health spending have intersected to bring about this major development in public health.

The Struggle for Universal Health Coverage

The Lancet 380, no. 9845 (September 2012), page 859. Available at bit.ly/Lancet1-UHC.

Series available at bit.ly/LancetSeries-UHC. DOI: 10.1016/S0140-6736(12)61485-8

This Lancet series lays out the ethical, political, economic, and health arguments for UHC ahead of the UN General Assembly of September 2012. Reports and articles by William Savedoff,

David Evans, Rodrigo Moreno-Serra, Peter Smith, Jeffrey Sachs, Gina Lagomarsino, and their colleagues inform conversations around UHC. When considering these viewpoints, one must remember that effective UHC takes more than policy change alone: new policies should be accompanied by sufficient staff, resources, and a culture of good governance and optimism. Current conversations often neglect the importance of accountability in UHC schemes; a multilateral process is necessary to develop metrics for evaluating progress toward UHC.

World Bank

Lessons from 11 Country Case Studies: A Global Synthesis

Presentation at the Global Conference on Universal Health Coverage for Inclusive and Sustainable Growth, Tokyo, Dec. 5–6, 2013. Available at bit.ly/WB2-UHC

There is a growing demand from low- and middle-income countries (LMICs) to understand the conditions and requirements for achieving UHC. Following the occasion of the 50th anniversary of Japan's own achievement of UHC (in 1961), the Japan–World Bank Partnership Program on Universal Health Coverage (the Program) was conceived as a joint effort by the government of Japan and the World Bank to respond to this growing demand from LMICs for technical advice and investment support for designing and implementing UHC policies and strategies. The Program has undertaken detailed studies of Japan's experience with UHC, which aim to identify potential lessons from Japan for LMICs on policies that led to coverage-enhancing (alternatively, coverage-eroding) results. Ten other case-study countries were selected, largely for their commitment to UHC and readiness to explore the key policy questions included in the Program's analytical framework.

World Health Organization

Universal Coverage and Health System Strengthening

Health Financing for Universal Coverage. World Health Organization. Last modified 2014. Available at bit.ly/WHO1-UHC

Strengthening health systems is essential for ensuring progress toward universal coverage (UC). Moving towards UC involves reducing the gap between need and service use, improving quality, and improving financial protection. Health financing policies play a critical role, but

progress on these UC objectives requires coordinated action across health system building blocks such as: health service delivery systems, human resources for health, medicine procurement and distribution mechanisms, health information systems, and governance. Such action is required to address the specific barriers to progress that may exist in any country. This is fully aligned with the primary health care approach, which requires health sector and inter-sectoral reforms that put people's health needs at the center.

2. Governance

Oren Ahoobim et al

The New Global Health Agenda: Universal Health Coverage

Council on Foreign Relations, April 2012. Available at bit.ly/AhoobimUHC

The field of global health is witnessing a shift in focus from disease-driven initiatives to projects aimed at increasing the sustainability and strength of health systems. A crucial component to this is universal health coverage (UHC), which seeks to address financing schemes for health, separate from efforts to provide both adequate numbers of health workers and structures for health-care delivery. UHC may be provided by government or through a combination of private insurance schemes, public-sector planning, and employer-based programs. Countries across the world, from China and India to Rwanda and Mexico, are beginning to implement different universal health coverage schemes, marking a rise in interest and political will for universal health coverage. The authors discuss this rise in support for universal health coverage and the financial benefits that may be reaped by implementing such schemes, and provide examples of models used to date by countries in establishing universal health coverage.

An Appelmans & Luc van Leemput

Universal Health Coverage: A background document developed for the Belgian Development Cooperation

Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgian Department of Public Health, 2013. Available at bit.ly/AppelmansUHC

Universal Health Coverage (UHC) has sparked a lot of debate over the years, both conceptually and in terms of directions on how to move towards achieving it. It continues to do so. Nevertheless, there is now a broad consensus on the objective of UHC in line with previous milestone targets as health and health care for all. UHC entails access to a package of essential qualitative health services for all. There is a crucial role of governance on national and international levels, a world of increasing interdependence, and an urgent need for additional domestic and international funding for health, if one is serious about reaching UHC. Efforts

should be made to identify mechanisms to build effective bridges between local, national and global levels to overcome the gap between the current global rhetoric on universal health coverage and what is actually happening in the field. Belgium has several roles to play in the UHC era: the role of a national steward (UHC in Belgium itself), a donor, a provider of technical assistance and a global actor. Crucially, the Belgian government should further investigate and continue the focus on UHC within a multi-sectoral perspective. It should also emphasize and advocate for national and global social contracts as it has an obvious watchdog and actor position in both.

The Bangkok Statement on Universal Health Coverage

Editorial. *The Lancet* 379 (February 2012), page 494. Available at bit.ly/Lancet2-UHC

The theme of the Prince Mahidol Award Conference in Bangkok, Thailand, on Jan. 24–28, 2012, was “Moving towards universal health coverage: health financing matters.” At the close of the meeting, a 10-point declaration recognized universal health coverage (UHC) as fundamental to the right to health, and marked the commitment by more than 800 delegates to translate the rhetoric of UHC into better, more equitable health outcomes. Similar endorsements of UHC have been made before, including at the World Health Assembly in 2011. What makes the Bangkok Statement any more likely to hasten and widen the implementation of UHC? The conference showed the linkages between health system strengthening, coverage, and quality; and the pragmatism that UHC is an aspiration with many paths and challenges, yet with steps that countries at any stage of socioeconomic development can take to improve care. In addition to political will and sustainable funding, progress towards UHC requires careful outcomes research to guide interventions and health system development. With so many opportunities to improve care, rigorous evaluation of meaningful, common endpoints is essential to share experiences that maximize benefits and avoid replication of unsuccessful interventions.

Pascal Canfin et al

Our Common Vision for the Positioning and Role of Health to Advance the UN Development Agenda Beyond 2015

The Lancet 381, no. 9881 (June 2013), pages 1885 -1886.

Available at bit.ly/CanfinUHC. DOI: 10.1016/S0140-6736(13)60952-6

Universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, and rehabilitative basic health services and essential, safe, affordable, effective, and quality medicines. Universal health coverage is well recognized in the Rio+20 Declaration as “a key instrument to enhancing health, social cohesion and sustainable human and economic development”. The role of health as “a precondition for, an outcome and an indicator of all three dimensions of sustainable development” are now fully recognized. We believe further global health advancement should rely not only on health-related development goals, but also on health indicators that could serve to measure our progress towards sustainable development in other sectors. We therefore call for a global mobilization in favor of strengthening health in the UN development agenda beyond 2015, with universal health coverage as an important element of the future we want.

Carissa Etienne

Universal Health Coverage in the Americas

Pan American Health Organization, 2013. Available at bit.ly/EtienneUHC

UHC is the application of the right to health, equity, and solidarity. UHC is much more than financial protection and should be built through expanding Social Protection in Health (SPH). Strong political will to engage on UHC is needed. Out of Pocket Payments (OOPs) must be reduced, and fees at the moment of seeking health care should be eliminated. Public health investment should be greater than 5% of GDP, and funds should be pooled. Combined top-down with bottom-up strategies with an open-negotiation approach should be privileged.

Harnessing Non-State Actors for Better Health for the Poor

Universal Health Coverage: The Role of the Private Sector

Harnessing Non-State Actors for Better Health for the Poor. Last modified October 3, 2013.
Available at bit.ly/HANSHEP-UHC

The concept of Universal Health Coverage (UHC) has gained momentum on the global development agenda. UHC requires that all people have access to the quality health services they need without the risk of experiencing severe financial hardship in order to pay for them. All countries can take actions to move towards UHC, and it is particularly important that they tap all available resources - both public and private - in order to do so. There is a wide range of actors in the private health sector, which consists of all actors outside government, including for-profit, non-profit, formal and non-formal entities. Although their contribution to health service provision is considerable, it is often overlooked, discounted or not taken into consideration. Often misperceived as primarily catering to the richer part of the population, the actual relevance of the private sector for the provision of health services for the poor remains in some instances underestimated or even unrecognized. In this special symposium, experts from different regions and with different institutional backgrounds will consider similarities and differences in approaches towards private sector engagement in various settings, and discuss problems that have emerged in the process.

Joseph Kutzin

Anything goes on the path to universal health coverage? No

Bulletin of the World Health Organization 90, no. 11 (November 2012), pages 793-868.
Available at bit.ly/Kutzin-UHC. DOI: 10.2471/BLT.12.11- 3654

In its 2010 World Health Report, the World Health Organization noted that there is no single, best path for reforming health financing arrangements to move systems closer to universal health coverage, i.e. to improve access to needed, effective services while protecting users from financial ruin. However, this lack of a blueprint for health financing reforms was not meant to convey the message that “anything goes” on the path to universal health coverage. Indeed, concerns have been raised that some reforms, often implemented in the name of expanding coverage, may actually compromise equity. Theory and country experience yield important lessons on both promising directions and pitfalls to avoid.

Gina Lagomarsino et al

Moving Towards Universal Health Coverage: Health Insurance

The Lancet 380 (2012), pages 933-43. Available at bit.ly/LagomarsinoUHC.

DOI: 10.1016/S0140-6736(12)61147-7

We analyze nine low-income and lower-middle-income countries in Africa and Asia that have implemented national health insurance reforms designed to move towards universal health coverage. Using the functions-of-health-systems framework, we describe these countries' approaches to raising prepaid revenues, pooling risk, and purchasing services. Then, using the coverage-box framework, we assess their progress across three dimensions of coverage: who, what services, and what proportion of health costs are covered. We identify some patterns in the structure of these countries' reforms, such as use of tax revenues to subsidize target populations, steps towards broader risk pools, and emphasis on purchasing services through demand-side financing mechanisms. However, none of the reforms purely conform to common health-system archetypes, nor are they identical to each other. We report some trends in these countries' progress towards universal coverage, such as increasing enrolment in government health insurance, a movement towards expanded benefits packages, and decreasing out-of-pocket spending accompanied by increasing government share of spending on health. Common, comparable indicators of progress towards universal coverage are needed to enable countries undergoing reforms to assess outcomes and make midcourse corrections in policy and implementation.

Anne Mills

Strategies to Achieve Universal Coverage: Are there Lessons from Middle Income Countries? A literature review commissioned by the Health Systems Knowledge Network

March 30, 2007. Available at bit.ly/MillsUHC

A number of reviews have been written on options facing countries in moving towards universal coverage, focusing especially on the role of social health insurance (e.g. Carrin and James 2004, Barnighausen and Sauerborn 2002, Abel-Smith 1986). Less attention has been given to the political dynamics of change, and the attitudes of different stakeholders. This paper responds to the terms of reference from the Health Systems Knowledge Network, and aims

to: 1) review the evidence on strategies to achieve universal coverage, where strategies are interpreted not just as technical strategies but also as strategies for managing the policy process; and 2) generate lessons for senior policy-makers, donors and civil society groupings. By agreement with the Knowledge Network, it focuses on countries which have either recently achieved universal coverage or are close to achieving it, essentially middle income countries, though some limited discussion of the circumstances of low income countries is included. A key issue addressed is the extent to which different strategies promote equity, where the concern is both equity of financing and equity of access to and use of services.

NCD Alliance

Healthy Planet, Healthy People: The NCD Alliance Vision for Health in the post-2015 Development Agenda

Available at bit.ly/NCD-Alliance-UHC

In 2000, world leaders signed the Millennium Declaration and committed to achieve a set of eight international development goals – the Millennium Development Goals (MDGs) – by 2015. With three of the eight goals directly related to improving health outcomes (MDGs 4, 5, and 6), the MDGs are rightfully acknowledged as having contributed to the widespread understanding that health is central to human development. Now, with the expiry date of the current MDGs fast approaching, the global health community has a unique opportunity to shape the framework and priorities for the successor development agenda. Collectively we must ensure that health remains at the heart of the future development agenda, with a framework that accelerates progress towards achieving the current MDGs while fully addressing new health priorities – most notably non-communicable diseases – to realize the vision for a healthy future for all. Non-communicable diseases (NCDs) – mainly cancer, cardiovascular disease, chronic respiratory diseases, and diabetes – are a major challenge to health and development in the 21st century. They are the leading cause of death and disability worldwide, exacting a heavy and growing toll on the physical health and economic security of all countries, particularly low- and middle-income countries (LMICs). Driven in large part by widespread exposure to four common modifiable risk factors – tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol – these conditions perpetuate and entrench poverty within households and communities, and increase inequalities within and between countries. This policy brief sets out the NCD Alliance’s vision for NCDs and health more broadly in the post-2015 development agenda. It provides an analysis of the MDGs from a health perspective; the

rationale for the inclusion of NCDs; a proposed framework for health in post-2015, including goals, targets, and indicators; and key elements of the broader enabling environment for the post-2015 era.

Julia Ravenscroft & Liliana Marcos

Civil Society Organizations and Universal Health Care

The Lancet 380, no. 9845 (September 2012), page 888. Available at bit.ly/RavenscroftUHC. DOI: 10.1016/S0140-6736(12)61506-2

Action for Global Health calls for a mobilization of civil society in support of UHC. Dedicated community groups are essential to developing UHC systems that improve health outcomes of the general population and poor and marginalized groups. Examples in South Africa, Thailand, and Spain demonstrate the potential of civil society movements in bringing about UHC.

Rockefeller Foundation

Catalyzing Change: The System Reform Costs of Universal Health Coverage”

New York, 2010. Available at bit.ly/RockefellerUHC

This report aims to call health leaders’ attention to the importance and enhanced feasibility of establishing the systems and institutions needed to pursue UHC. It also seeks to quantify the transition costs associated with reforming a health system away from one that relies on out-of-pocket payments and towards one in which health expenditures are more evenly distributed.

David Stuckler, Andrea Feigl, Sanjay Basu & Martin McKee

The Political Economy of Universal Health Coverage: Background Paper for the Global Symposium on Health Research

World Health Organization, 2010. Available at bit.ly/StucklerUHC

Considerations of politics and power shape the decision of a country's leaders to commit to UHC. Although much has been written about the mechanics of expanding health care coverage and its consequences for levels and distribution of health and financial contributions, much less has been written on the power and politics behind choices to expand healthcare access. While UHC remains an aspiration for many, there has been little progress in understanding how health ministers and concerned public health advocates should seek to achieve it. This background paper asks a series of basic questions: (1) What do we mean when we talk about Universal Health Care? (2) How do we define a Universal Health Coverage System, and which countries have such a system? (3) Why do some countries have Universal Health Coverage while others do not? (4) What are, if any, the social, economic, and political preconditions for Universal Health Coverage to be a realistic political goal? (5) How have countries in the past achieved UHC, and does their experience offer lessons that apply to low- and middle-income countries today? This background paper does not discuss the mechanisms whereby a country implements UHC and this has been examined in detail elsewhere. Furthermore, readers must bear in mind that every country faces a unique and changing policy context that must be taken into account when applying lessons from elsewhere. However, the extensive work on which this background paper is based, including a systematic review of the literature on UHC, detailed historical case-studies, and an econometric analysis of available data, identifies three main strategies involved in past successes to attain UHC: re-framing the debate, identifying and creating political opportunities, and mobilizing resources.

United Nations General Assembly, 67th Session. 53rd Meeting

Adopting Consensus Text, General Assembly Encourages Member States to Plan, Pursue Transition of National Health Care Systems Towards Universal Coverage

Available at bit.ly/UNGA67-53-UHC

Recognizing the intrinsic role of health in achieving international development goals, the General Assembly today – through the unanimous adoption of a resolution on global health and foreign policy – encouraged Governments to plan or pursue the transition towards universal access to affordable and quality health-care services. By that text, the Assembly, calling for more attention to health as an important cross-cutting policy issue, urged Member States, civil society and international organizations to incorporate universal health coverage in the international development agenda and in the implementation of the internationally agreed development goals, including the Millennium Development Goals. The Assembly also recognized that improving social protection towards universal coverage “is an investment in people that empowers them to adjust to changes in the economy and the labor market and helps support a transition to a more sustainable, inclusive and equitable economy”. As such, while planning or pursuing the transition towards universal coverage, Member States were encouraged to continue investing in health-delivery systems to increase and safeguard the range and quality of services and meet the health needs of their populations.

Jeanette Vega

Universal Health Coverage: the Post-2015 Development Agenda

The Lancet 381, no. 9862 (January 2013), pages 179-80.

Available at bit.ly/VegaUHC. DOI: 10.1016/S0140-6736(13)60062-8

The UN resolution on UHC illustrates the impressive momentum behind the need to accelerate action towards UHC as a strategy for improving health and ameliorating inequities in health. Using the post-MDG process as a platform to build on the movement that sees health systems as the backbone of a healthy population, we hope to ensure that in another 15 years, all of the world’s people will have access to health at an affordable cost. The time is ripe to be bold. A system-level approach working towards UHC could have a transformative effect in the battle against poverty, hunger, and disease. If we prioritise health as a human right, in addition to

a healthier population, social and economic development will flourish. By focusing on UHC in the post-2015 framework, the international community has an opportunity to endorse a country-driven agenda, as well as build and improve upon the robust legacy of the MDGs.

World Bank

Universal Health Coverage Study Series

Last modified 2014. Available at bit.ly/WB1-UHC

The World Bank supports countries' efforts to achieve universal health coverage, with the aim of providing quality, affordable health care to everyone—ultimately improving health outcomes, reducing financial risks associated with ill health, and increasing equity. Achieving universal health coverage is a path specific to each country, and no single system or model exists to achieve it. The Bank's universal health coverage study series offers knowledge and operational tools to help countries tackle challenges in ways that are fiscally sustainable and that enhance equity and efficiency. Studies from 22 countries and Massachusetts analyze the “nuts and bolts” of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol, studies, and technical papers contribute to discussions about universal health coverage, provide implementers with an expanded toolbox, and inform the universal health coverage movement as it continues to expand worldwide. In 2013, the Bank health team plans to produce a comparative analysis of all 22 countries and Massachusetts. The team will also test the UNICAT, a new universal coverage assessment tool, which they developed based on lessons from the studies. The tool will help countries assess their strengths and weaknesses in implementing universal health coverage.

World Health Organization, World Bank

Report on the Ministerial Level Roundtable on Universal Health Coverage

18-19 Feb. 2013. Available at bit.ly/WHO-WB2-UHC

Health and finance ministers and high-level officials from 27 countries came together with development partners for a two days roundtable convened by the World Health Organization

(WHO) and the World Bank. In her opening remarks, the WHO Director-General (DG), Dr. Margaret Chan, emphasized that interest in and support for Universal Health Coverage (UHC) is gaining momentum not only in ministries of health. She noted that the recent adoption of a UN General Assembly resolution on UHC placed the goal of moving closer to UHC high on the development agenda as well. Country demand for support has increased, with over 70 countries requesting WHO technical assistance to help them move towards UHC in the last year. Tamar Manuelyan Atinc, World Bank (WB) Vice President for Human Development, reported strong interest in UHC in developing countries, with more than 30 middle-income countries implementing programs that should push them down the road toward UHC, and many more low- and middle-income countries considering similar programs. The World Bank is working closely with countries on the path to achieving UHC by helping them build healthier, more equitable societies, as well as improve their fiscal performance and country competitiveness – towards the goals of ending extreme poverty and boosting shared prosperity. The main message in the opening session was that the core idea of UHC, that everyone should have access to good quality health care without incurring financial hardship, offers a way forward for all countries. It was also noted that UHC is as much a journey as a destination, and that all countries start that journey from a different place and face different challenges along the way. However, despite the different challenges faced, the experiences of the many countries that are moving towards UHC indicate that some form of prepayment and pooling of resources, coupled with an emphasis on primary health care and broader health system development, are integral ingredients of successful transitions. The DG ended the opening session by stressing that simply raising more money for health does not guarantee sustainable systems designed to deliver UHC; efficient use of resources and control of costs is also essential.

3. Equity and Social Protection

Ceri Averill

Universal Health Coverage: Why Health Insurance Schemes Are Leaving the Poor Behind

Campaigns. Oxfam International. Last modified October 9, 2013. Available at bit.ly/AverillUHC

Donors and governments should abandon unworkable insurance programs and focus on financing that delivers universal and equitable health care for all. Developing country governments should develop financing systems based on the four 'key ingredients' outlined by WHO. Rather than looking to adapt European-style employment-based social health insurance, build on the lessons from the growing number of low- and middle-income countries that are making progress towards Universal Health Coverage. They should also make equity and universality explicit priorities from the outset and avoid the temptation to start with the 'easiest to reach' in the formal sector. Those living in poverty must benefit at least as much as the better off every step of the way. High-income country governments and multilateral organizations should stop promoting inappropriate approaches in the name of Universal Health Coverage, especially private and community-based voluntary health insurance programs; take action on tax avoidance and tax evasion, which denies poor countries much-needed revenue for universal public services; and provide support for progressive tax reform in poor countries, including technical support to strengthen tax administration capacity.

Davidson Gwatkin & Alex Ergo

Universal Health Coverage: Friend or Foe of Health Equity?

The Lancet 377, no. 9784 (June 2011), pages 2160 - 2161.

Available at bit.ly/GwatkinUHC. DOI: 10.1016/S0140-6736(10)62058-2

Once again, calls for universality are being heard from health advocates and planners. Last time around, such calls were for achieving the health-for-all goal at the 1978 Alma-Ata conference. Now they are re-emerging, as more limited but nonetheless stirring appeals to seek universal coverage or access in a wide range of health-related areas such as HIV/AIDS,

reproductive health, health insurance, and free health services, particularly for women and children. Reflecting such interest, universal coverage will figure as the organizing theme of a large WHO research meeting on Nov 16—19. This quest for universal coverage is often advocated as a way of improving health equity. If fully achieved, it would clearly do so. Everyone—rich and poor, men and women, ethnic or religious majorities and minorities—would enjoy full equal access to the services concerned. Such an achievement would obviate both the stigma thought to accompany use of services designed specifically for people who are poor, and the possibility that such services might be of low quality.

But beware—universal coverage is much more difficult to achieve than to advocate. And people who are poor could well gain little until the final stages of the transition from advocacy to achievement, if that coverage were to display a trickle-down pattern of spread marked by increases first in better-off groups and only later in poorer ones. Should the resulting rise in inequality endure for an extended time—or worse, become permanent as a drive for universal coverage falls short of fully realizing its goal—the result would be to reduce rather than enhance health equity.

International Labor Organization

Social Health Protection: an ILO Strategy towards Universal Access to Health Care

Social Security Department, International Labor Organization, August 2007.
Available at bit.ly/ILO-UHC

In view of the alarming deficit in social health protection coverage in many countries and ILO's long experience in this field, a new strategy has been developed with the aim of contributing to achieve universal coverage at a global level. This strategy reinforces the agreement on social security reached among representatives of governments, workers' and employers' organizations at the International Labour Conference in 2001 to give highest priority to "policies and initiatives which can bring social security to those who are not covered by existing systems". It is part of the Global Campaign on Social Security and Coverage for All. The new strategy responds to the needs of uncovered population groups in many developing countries, the informalization of economies and persisting high rates of unemployment. The approach explicitly recognizes the contribution of all existing forms of social health protection and optimizes their outcomes with a view to achieving universal coverage. This paper aims to set forth some basic notions about the ILO strategy on "Rationalization of the use of pluralistic financing mechanisms." It is based

on the most recent information on social health protection coverage. After a brief introduction to the ILO's concept of social health protection, the paper outlines global patterns of social health protection financing and coverage. Given the lack of data and trends in social health protection coverage. The paper proposes a new indicator aimed at providing, for the first time, some assessment of the global deficit in access to health services. The ILO strategy takes account of the significant gaps revealed by the ILO access deficit indicator and suggests new pragmatic policies to close the gaps, based on a rational and coherent approach.

Jim Yong Kim & Margaret Chan

Poverty, Health, and Societies of the Future

Journal of the American Medical Association 310, no. 9 (September 2013), pages 901-2.
Available at bit.ly/Kim-Chan-UHC. DOI: 10.1001/ja- ma.2013.276910

The relationship between clinician and patient has been the bedrock of the global health equity movement. It was the call for access to basic medical services for patients—and patients demanding empowerment for their community health workers—that drove the Health for All movement in the 1970s. It was the insistence by patients, activists, and clinicians for all people with AIDS to receive treatment that led to the transformation in access starting just 10 years ago in the developing world. That insistence will continue to be the energy and lifeblood of the movement—patients claiming their rights, and physicians supporting their patients—together advocating for a world in which a child born anywhere can have a life of opportunity, dignity, and access to quality health care.

Viktoria Rabovskaja

Universal Health Coverage: Reflections from a development perspective

Discussion Papers on Social protection, GIZ, 2013. Available at bit.ly/RabovskajaUHC

In recent years, the term “Universal Health Coverage” (UHC) has become increasingly visible and prominent on the global and national agendas of numerous countries. But what is meant by UHC and what makes this concept so attractive for countries and development partners? This paper proposes some conceptual clarifications, reflects on discussions at the international level and on how UHC can be implemented and supported.

4. Health Systems Financing

Guy Carrin, Inke Mathauer, Ke Xu & David Evans

Universal Coverage of Health Services: Tailoring Its Implementation

Bulletin of the World Health Organization 86, no. 11 (November 2008), pages 817-908.
Available at bit.ly/Carrin2UHC. DOI: 10.2471/BLT.07.049387

Out-of-pocket payments create financial barriers that prevent millions of people each year from seeking and receiving needed health services. In addition, many of those who do seek and pay for health services are confronted with financial catastrophe and impoverishment. People who do not use health services at all, or who suffer financial catastrophe, are the extreme. Many others might forego only some services, or suffer less severe financial consequences imposed by user charges, but people everywhere, at all income levels, seek protection from the financial risks associated with ill health. A question facing all countries is how their health financing systems can achieve or maintain universal coverage of health services. Recognizing this, in 2005 the Member States of WHO adopted a resolution encouraging countries to develop health financing systems aimed at providing universal coverage. This was defined as securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost. Thus, universal coverage incorporates two complementary dimensions in addition to financial risk protection: the extent of population coverage (e.g. who is covered) and the extent of health service coverage (e.g. what is covered). In some countries it will take many years to achieve universal coverage according to the above-mentioned dimensions. This paper addresses a number of key questions that countries will need to address and considers how the responses can be tailored to the specific country context. In addition, it highlights the critical need to pay attention to the role of institutional arrangements and organizations in implementing universal coverage.

Benedict Clements, David Coady & Sanjeev Gupta (eds)

The Economics of Public Health Care Reform in Advanced and Emerging Economies

Washington DC: International Monetary Fund, 2012. Available at bit.ly/ClementsUHC

Health care reform is a difficult policy issue. It involves complex trade-offs between policy goals, such as ensuring access to high-quality health care and keeping public spending at fiscally affordable levels. Preferences regarding the role of the state in the provision and financing of health care services also vary significantly across countries. Many of these issues go beyond the scope of our work in this area. However, with a combination of cross-country analyses and case studies—and not least based on the stimulating debate within and outside the IMF on these issues—this book identifies potential policy responses to contain public health spending pressures in an efficient and equitable manner. Of course, much remains for us to learn, and the IMF will continue to stay abreast of new developments and insights in this complex area of policy.

Joseph Kutzin

Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy

Bulletin of the World Health Organization 91, no. 8 (2013), pages 602-11.
Available at bit.ly/KutzinUHC. DOI: 10.2471/BLT.12.113985

Unless the concept is clearly understood, “universal coverage” (or universal health coverage, UHC) can be used to justify practically any health financing reform or scheme. This paper unpacks the definition of health financing for universal coverage as used in the World Health Organization’s World Health Report 2010 to show how UHC embodies specific health system goals and intermediate objectives and, broadly, how health financing reforms can influence these. All countries seek to improve equity in the use of health services, service quality and financial protection for their populations. Hence, the pursuit of UHC is relevant to every country. Health financing policy is an integral part of efforts to move towards UHC, but for health financing policy to be aligned with the pursuit of UHC, health system reforms need to be aimed explicitly at improving coverage and the intermediate objectives linked to it, namely, efficiency, equity in health resource distribution and transparency and accountability. The unit of analysis

for goals and objectives must be the population and health system as a whole. What matters is not how a particular financing scheme affects its individual members, but rather, how it influences progress towards UHC at the population level. Concern only with specific schemes is incompatible with a universal coverage approach and may even undermine UHC, particularly in terms of equity. Conversely, if a scheme is fully oriented towards system-level goals and objectives, it can further progress towards UHC. Policy and policy analysis need to shift from the scheme to the system level.

Ministers of Finance and Ministers of Health of Africa

Tunis Declaration on Value for Money Sustainability and Accountability in the Health Sector: A Joint Declaration by the Ministers of Finance and Ministers of Health of Africa

5 July 2012. Available at bit.ly/UNAIDS-UHC

The Ministers of Finance and Ministers of Health of Africa recommend to national governments that they: (1) intensify dialogue and collaboration between our respective ministries and with technical and financial partners; (2) take concrete measures in respective countries in order to enhance value for money, sustainability and accountability in the health sector for reaching the objective of universal health coverage; (3) integrate socio-economic, demographic and health factors into broader development strategies and policies in an effective manner especially in the formulation of medium term strategic plans; (4) design effective investments in the health sector, based on evidence-based strategies leading to the prioritization of high impact interventions, which lead to results; (5) promote equitable investment in the health sector; ensure that health financing is pro-poor benefiting disadvantaged areas; (6) lay out the path to universal health coverage for each country, in particular establishing mechanisms to ensure equitable access to essential health services; (7) improve efficiency in health systems, including equitable access to skilled health workers and the introduction of measures such as results based financing and incentives to enhance transparency and performance and reduce waste; (8) solidify sustainable health financing systems that build on and coordinate the diversity of sources of finance, including institutional health financing and better coordination and predictability of external resources, to ensure that all have access to good quality essential health services; (9) strengthen accountability mechanisms that align all relevant partners, build on the growing citizens' voice and ensure the highest possible level of results for the money spent; (10) increase domestic resources for health through enhanced revenue collection

and allocation, re-prioritization where relevant and innovative financing, giving priority to immunizations, non-communicable diseases, AIDS, Tuberculosis and malaria, as well as reproductive, maternal and child health in national budgets.

William D. Savedoff

Transitions in Health Financing and Policies for Universal Health Coverage: Final Report of the Transitions in Health Financing Project

Results for Development. August 24, 2012. Available at bit.ly/Savedoff2UHC

Discussions of economic trends associated with health are typically fragmented. Studies that address the growth in health spending are mostly concerned with efforts to contain costs and/or improve cost-effectiveness. Studies that address the rising share of pooled funding typically focus on institutional issues, debating the relative merits of public and private provision, public and private insurance, or public health services in contrast to social insurance. Other studies focus on out-of-pocket spending, looking at the effects of public policies like user fees and community health insurance or measuring the impact of out-of-pocket expenditures on the risks of impoverishment. Still other studies try to disentangle causality, asking whether rising incomes are responsible for improved health or if improvements in health have driven economic growth. The Transitions in Health Financing project looked at these questions together and sought a broad vision for how these different pieces relate. By looking at trends over long periods of time, conducting literature reviews, and contributing additional evidence and analysis, the resulting papers explore the nexus between economics and health within a framework that highlights the general trends that make up this transition.

United Nations General Assembly, 67th Session

Resolution A/67/L.36 [Global Health and Foreign Policy]

6 December 2012. Available at bit.ly/UNGA67-UHC

The General Assembly of the United Nations (GA) reaffirms that health is a key cross-cutting policy issue that should remain a priority in many types of international dialogue. It calls upon Members States (MS) to strive for UHC or improved UHC schemes, based on country-specific contexts, and with special consideration of the poorest communities. The GA also brings

attention to the importance of transparent and equitable decision-making and collaboration among governments, civil society organizations and international organizations in order to achieve functional health financing systems to support UHC. To support these efforts, the GA calls on the Secretary-General to compile a report showcasing experiences of MS that have already implemented UHC.

World Health Assembly, 64th Assembly

WHA64.9: Sustainable Health Financing Structures and Universal Coverage

May 2011. Available at bit.ly/WHA-UHC

The World Health Assembly Resolution urges Member States to focus on improving health-financing systems, strengthening health delivery systems, and sharing experiences in order to accelerate progress toward UHC. It also requests that the Director-General offer support and guidance to facilitate the transition to UHC.

World Health Organization

Arguing for Universal Health Coverage

2013. Available at bit.ly/WHO3-UHC

This report includes basic principles on health financing, country examples and evidence-based arguments to support Civil Society Organizations advocating for health funding policies that promote equity, efficiency and effectiveness, and ensure that the rights of the most vulnerable are not forgotten.

World Health Organization

The World Health Report: Health Systems Financing: the Path to Universal Coverage

Geneva, 2010. Available at bit.ly/WH02-UHC

In this report, WHO outlines how countries can modify their financing systems to move more quickly towards universal coverage and to sustain those achievements. The report synthesizes new research and lessons learnt from experience into a set of possible actions that countries at all stages of development can consider and adapt to their own needs. It suggests ways the international community can support efforts in low-income countries to achieve universal coverage.

World Health Organization, 58th World Health Assembly

Resolution WHA58.33 [Sustainable Health Financing, Universal Coverage and Social Health Insurance]

16-25 May 2005. Available at bit.ly/WH058WHA-UHC

The World Health Assembly (WHA) urges member states to think critically about various elements of their healthcare financing, specifically promoting careful management of funds for healthcare, investment in healthcare infrastructure to provide equitable and high quality services, a transition to UHC with attention to country-specific contexts, public-private collaboration, and information sharing. The WHA requests that the Director-General provide member states with technical support, opportunities for information sharing, and support for evaluation as they move to improve healthcare financing and develop UHC schemes.

5. Health Systems Delivery

Action Against Hunger (ACF) International, Global Health Advocates, Terre des hommes

Making Health a Right for All: Universal Health Coverage (UHC) and Nutrition

Action Against Hunger (ACF) International, Global Health Advocates, Terre des hommes. Accessed 2013. Available at bit.ly/ACF-UHC

Addressing nutrition is critical to fulfil the right to health. Globally, regardless of the level of development, national governments already engaged in health system reforms need to take into account the links between nutrition and health. Under nutrition remains a major threat to the survival, growth and development of children. Globally, 165 million children under five are estimated to be stunted and 45% of child deaths are attributable to under nutrition. Obesity and diabetes are growing problems in both developed and developing countries, leading to a double burden of malnutrition in which some individuals are chronically undernourished, while others are chronically overweight. Yet nutrition is still a neglected area in public health. Above all, under nutrition disproportionally affects the poorest in society, and perpetuates generational poverty. Current debates on UHC must recognize that exclusion and equity gaps are often not accidental but the result of a range of factors. These include neglect or political apathy towards a particular group or groups; deliberate exclusion as an expression of discrimination, and attempts to achieve other policy objectives. The setting up and implementation of UHC policies in many developing countries, combined with the increasing interest from UN agencies and donor(s) towards this approach, represents an important opportunity for nutrition to be part of national health policies. In low income countries in particular, government needs to decide what interventions should be prioritized when defining universal health coverage policies, how will they be delivered and how they will be financed from their often very limited health budgets. These debates are taking place at the national level by ministries of health and finance and at the global level by UN agencies and governments. This briefing paper explores how UHC can deliver on nutrition, and addresses in particular maternal and child under nutrition.

Bruno Meessen, Belma Malanda & for the Community of Practice “Health Service Delivery”

No universal health coverage without strong local health systems

Bulletin of the World Health Organization 92:78-78A (2014).

Available at bit.ly/MeessenUHC. DOI: 10.2471/BLT.14.135228

Despite the current global and national momentum, universal health coverage could remain an empty promise unless it is focused on the provision of quality essential services to everyone. And this, in turn, will not happen without strengthening local health systems.

Rodrigo Moreno-Serra & Peter Smith

Does Progress Towards Universal Health Coverage Improve Population Health?

The Lancet 380, no. 9845 (September 2012), pages 917-23.

Available at bit.ly/Moreno-SerraUHC. DOI: 10.1016/S0140-6736(12)61039-3

Many commentators, including WHO, have advocated progress towards universal health coverage on the grounds that it leads to improvements in population health. In this report we review the most robust cross-country empirical evidence on the links between expansions in coverage and population health outcomes, with a focus on the health effects of extended risk pooling and prepayment as key indicators of progress towards universal coverage across health systems. The evidence suggests that broader health coverage generally leads to better access to necessary care and improved population health, particularly for poor people. However, the available evidence base is limited by data and methodological constraints, and further research is needed to understand better the ways in which the effectiveness of extended health coverage can be maximized, including the effects of factors such as the quality of institutions and governance.

6. Health Workforce

Agnes Binagwaho et al

The Human Resources for Health Program in Rwanda – A New Partnership

The New England Journal of Medicine 369 (November 2013), pages 2054-59.
Available at bit.ly/BinagwahoUHC. DOI: 10.1056/NEJMs1302176

A global shortage of 4.3 million health professionals poses a major bottleneck to poor people worldwide with regard to benefiting from the fruits of modern medicine. Among existing health professionals, there are also staggering inequities in skill levels and geographic distribution. Unsurprisingly, the deepest national gaps in human resources for health run parallel to poor population-level health outcomes. Sub-Saharan Africa bears 24% of the global burden of disease but is served by only 4% of the global health workforce. The health graduate schools in the region face overwhelming financial, infrastructural, and personnel constraints, limiting their ability to address the shortage.

J Campbell et al.

Human Resources for Health and Universal Health Coverage: Fostering Equity and Effective Coverage

Bulletin of the World Health Organization 91, no. 11 (November 2013), pages 853-63.
Available at bit.ly/CampbellUHC. DOI: 10.2471/BLT.13.118729

Achieving universal health coverage (UHC) involves distributing resources, especially human resources for health (HRH), to match population needs. This paper explores the policy lessons on HRH from four countries that have achieved sustained improvements in UHC: Brazil, Ghana, Mexico and Thailand. Its purpose is to inform global policy and financial commitments on HRH in support of UHC. The paper reports on country experiences using an analytical framework that examines effective coverage in relation to the availability, accessibility, acceptability and quality (AAAQ) of HRH. The AAAQ dimensions make it possible to perform tracing analysis on HRH policy actions since 1990 in the four countries of interest in relation to national trends in

workforce numbers and population mortality rates. The findings inform key principles for evidence-based decision-making on HRH in support of UHC. First, HRH are critical to the expansion of health service coverage and the package of benefits; second, HRH strategies in each of the AAAQ dimensions collectively support achievements in effective coverage; and third, success is achieved through partnerships involving health and non-health actors. Facing the unprecedented health and development challenges that affect all countries and transforming HRH evidence into policy and practice must be at the heart of UHC and the post-2015 development agenda. It is a political imperative requiring national commitment and leadership to maximize the impact of available financial and human resources, and improve healthy life expectancy, with the recognition that improvements in health care are enabled by a health workforce that is fit for purpose.

Lawrence Loh, Cesar Ugarte-Gil & Kwame Darko

Private Sector Contributions and Their Effect on Physician Emigration in the Developing World

Bulletin of the World Health Organization 91 (2013), pages 227-33.
Available at bit.ly/Loh-UHC. DOI: 10.2471/BLT.12.110791

There has been considerable academic interest in the growth of the private sector in the delivery and financing of health care in developing countries. In a recent editorial, Forsberg et al. drew attention to the “major role in financing and provision” that the private sector plays in low- and middle-income countries, and went on to state that “private health sector research has moved beyond classifying and counting providers and users, to the assessment of mechanisms for harnessing the private sector and identifying conditions for their successful application”. In the developing world in particular, research on health care is often hampered by a lack of standard definitions. For example, only clinicians with medical degrees are categorized as physicians in some studies, but traditional healers are also considered physicians in other investigations. Despite such problems with definitions, a growing body of literature now links private health-care financing and delivery in low- and middle-income countries with quality of care, drug availability, patient access and equity, provider training and provider knowledge, and changes in public-sector health care delivery in the same settings. Various interventions may further improve private health care provision in low- and middle-income countries. The private sector is making a growing contribution to health care in much of the developing world. In an analysis of data from 26 African countries by the World Bank, nearly half of the sick

children from the poorest income quintile were found to have made use of private providers. Most (nearly 87%) of India's health care is now privately funded and out-of-pocket payments from patients have been found to represent 40–70% of the gross domestic product spent on medical care in 20 developing countries. Various factors, including the traditional counterbalance between supply and demand, heavily influence the growth of private health care in the developing world and whether physicians choose to practice in the private sector, the public sector or both sectors and to stay in their home country or to emigrate. Physicians in low- and middle-income countries often emigrate because of the poor incomes and inadequate resources available in their home countries and the better professional prospects and higher standards of living available to them abroad. There is considerable recruitment of such physicians by high-income countries. Of the physicians working in Australia in 1999, Canada in 2002, the United Kingdom of Great Britain and Northern Ireland in 2002 and the United States of America in 2004, 23–28% were immigrants, mostly from Asia, the Caribbean and sub-Saharan Africa; India alone accounted for nearly 60 000 of the physicians. The emigration of physicians from numerous low- and middle-income countries drains skilled personnel from already weak health systems and reduces the success of existing primary care and public health activities. In an attempt to determine if countries with relatively large private health care sectors have relatively low rates of physician emigration, the relevant data from three countries with emerging economies were collected together and analyzed.

Angelica Sousa, Richard Scheffler, Jennifer Nyoni & Ties Boerma

A Comprehensive Health Labor Market Framework for Universal Health Coverage

Bulletin of the World Health Organization 91, no. 11 (November 2013), pages 797-896.
Available at bit.ly/SousaUHC. DOI: 10.2471/BLT.13.118927

A large and appropriately trained health workforce is instrumental to a successful UHC scheme in countries of all income levels. Inadequate workforces may result from poor worker distribution or migration, insufficient training or supervision, among other factors. Budget cuts for social services and ageing populations put further pressure on health systems. In response to the intensifying call for UHC worldwide, nations should recognize that developing comprehensive health workforce policies is an important strategy to accelerate progress toward UHC.

World Health Assembly, 66th Assembly. Side Event

Universal Health Coverage for Workers

22 May 2013. Available at bit.ly/WHA66-UHC

The links between health, sustainable development and poverty eradication become striking when we look at the world of work. Workers in poor communities are much more likely to be exposed to occupational hazards and to suffer work-related diseases and injuries. The resulting disabilities affect their working capacity and income earning potential. Furthermore, global health threats such as HIV/AIDS, tuberculosis (TB), malaria and the growing burden of non-communicable diseases and mental ill health additionally reduce working capacity and labor force participation. Access of workers to health protection and preventive services is still limited mostly to workers in large enterprises in the formal sector with decent jobs and social protection benefits. The working poor and informal sector workers do not have social protection and insurance for occupational injuries. The WHO global survey on workers' health carried out in 2008/2009 among 120 countries found that two thirds of countries still had very low coverage of workers with occupational health services and one fourth of countries did not even know their actual coverage level. In 2007 with Resolution 60.26 "Workers' Health: Global Plan of Action" the 60th World Health Assembly of the World Health Organization urged Member States to work towards full coverage of all workers, particularly those in the informal sector, agriculture, small enterprises and migrant workers with essential interventions and basic health services for the prevention and control of occupational and work-related diseases and injuries. Furthermore, the 12th General Program of Work proposed universal health coverage as one of the five leadership priorities to guide the work of WHO for the period 2014–2019. Universal health coverage combines access to services needed to achieve good health (promotion, prevention, treatment and rehabilitation, including those that address health determinants) with the financial protection that prevents ill health leading to poverty. It provides a powerful unifying concept to guide health and development and to advance health equity in coming years.

7. Metrics

Christopher Dye et al

Research for Universal Health Coverage

The World Health Report 2013. Geneva: World Health Organization, 2013.
Available at bit.ly/DyeUHC

The 2013 World Health Organization report focuses on three key messages. One, universal health coverage, with full access to high-quality services for health promotion, prevention, treatment, rehabilitation, palliation and financial risk protection, cannot be achieved without evidence from research. Research has the power to address a wide range of questions about how we can reach universal coverage, providing answers to improve human health, well-being and development. Two, all nations should be producers of research as well as consumers. The creativity and skills of researchers should be used to strengthen investigations not only in academic centers but also in public health programs, close to the supply of and demand for health services. Three, research for universal health coverage requires national and international backing. To make the best use of limited resources, systems are needed to develop national research agendas, to raise funds, to strengthen research capacity, and to make appropriate and effective use of research findings.

Measurement of Trends and Equity in Coverage of Health Interventions in the Context of Universal Health Coverage

Meeting report, Rockefeller Foundation Center, Bellagio, 17—21 Sept. 2012.
Available at bit.ly/MeetingReportUHC

This report documents the discussion of health experts during a meeting on the measurement of trends and equity in coverage of health interventions in the context of universal health coverage (UHC) at the Rockefeller Foundation's Bellagio Center from September 17-21, 2012. Universal health coverage has been defined as all people who need health care receive it, without incurring financial hardship (World Health Report 2010). It consists of two inter-related components: coverage with needed health services and coverage with financial risk protection,

for everyone. The former captures the aspiration that all people obtain the health services they need, while the latter aims to ensure that they do not suffer financial hardship linked to paying for these services. People value the fact that good quality health services are available and that they do not have to fear suffering severe economic consequences should they need to use them. The level and distribution of coverage of interventions and financial risk protection have been proposed as the focus of monitoring progress towards universal health coverage (UHC). The meeting focused on the measurement of health intervention coverage, with a focus on equity, in the context of UHC, guided by a background paper.

World Health Organization, World Bank

Monitoring Progress Towards Universal Health Coverage at Country and Global Levels: A Framework

December 2013. Available at bit.ly/WHO-WB1-UHC

In recent years, there has been a growing movement across the globe for universal health coverage (UHC) – ensuring that everyone who needs health services is able to get them, without undue financial hardship. This has led to a sharp increase in the demand for expertise, evidence, and measures of progress towards UHC and a push for UHC as one of the possible goals of the post-2015 development agenda. This discussion paper proposes a framework for tracking country progress towards UHC, assessing both the aggregate and equitable coverage of health services, as well as financial risk protection. This paper has been developed jointly by the World Health Organization (WHO) and the World Bank Group (WBG), building upon a series of discussions with country representatives, technical experts, and global health and development partners. WHO and the WBG are seeking feedback on the proposed UHC monitoring framework herein from countries, development partners, civil society, academics, and other interested stakeholders. This feedback will inform the further development and refinement of a common framework for monitoring progress towards UHC at country and global levels.

World Health Organization, World Bank, Ministry of Health Singapore

**Summary Report of the Technical Meeting:
Measurement and Monitoring of Universal Health Coverage**

17-18 Sept. 2013. Available at bit.ly/WHO-WB-MOHSingapore-UHC

Universal Health Coverage (UHC) is defined as the ability of all persons to access quality care when they need it, without facing financial impoverishment. Since the World Health Report 2010, UHC has gained universal acceptance in the global development discourse as both a means to the high level goal of improved health as well as a desirable end in itself. At the same time, it is clear that there is much that is not known about how UHC can be achieved in practice, given the diversity of country levels of economic development, health system organization and epidemiological challenges. The World Health Report 2013 identified the need for research and sharing of country experiences in order to operationalize UHC. It also noted that if UHC is to become a reality, it is essential to develop sound definitions and metrics to measure progress. Without these, it will be impossible to put in place the accountability systems to make sure people's needs are addressed and their rights fulfilled.

8. Country Case Studies

Shinzo Abe

Japan's Strategy for Global Health Diplomacy: Why It Matters

The Lancet 382, no. 9896 (September 2013), pages 915-16.
Available at bit.ly/AbeUHC. DOI: 10.1016/S0140-6736(13)61639-6

Global health is standing at a crossroads. The past decade has been a glorious period for global health because aid to the health sector has surged, and newly formed public—private partnerships have increased the effectiveness of development assistance. Japan has played a significant part, for example by leading discussions at the G8 Kyushu-Okinawa Summit in 2000 and by helping in the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, countries now face changing disease structures, and non-communicable diseases are a global threat. If the world follows the existing disease-focused vertical pathway for development assistance in the coming years, the disparity between resource allocation and actual disease burdens will widen. The disease-specific approach is straightforward, but the importance of tackling health in general is clear. At the G8 Hokkaido Toyako Summit in 2008, Japan proposed a comprehensive approach to health, inclusive of health system strengthening, to complement a vertical approach. A working group led by Keizo Takemi supported the work of the G8 Health Experts Group by recommending actions. Unfortunately, because of the financial crisis that began in 2008, there have been difficulties in sustaining the amount of aid for health.

Carrie Arnold

Vermont Attempts Single-Payer Health Care

The Lancet 380, no. 9845 (September 2012), page 873.
Available at bit.ly/ArnoldUHC. DOI: 10.1016/S0140-6736(12)61488-3

Vermont has pioneered state legislation to implement a single-payer healthcare system. An independent commission of health economists decided that abandoning the existing multi-payer system would promote access to improved healthcare for all Vermont residents.

Rifat Atun et al

Universal Health Coverage in Turkey: Enhancement of Equity

The Lancet 382, no. 9886 (July 2013), pages 65-99.

Available at bit.ly/AtunUHC. DOI: 10.1016/S0140-6736(13)61051-X

Turkey has successfully introduced health system changes and provided its citizens with the right to health to achieve universal health coverage, which helped to address inequities in financing, health service access, and health outcomes. We trace the trajectory of health system reforms in Turkey, with a particular emphasis on 2003—13, which coincides with the Health Transformation Program (HTP). The HTP rapidly expanded health insurance coverage and access to health-care services for all citizens, especially the poorest population groups, to achieve universal health coverage. We analyse the contextual drivers that shaped the transformations in the health system, explore the design and implementation of the HTP, identify the factors that enabled its success, and investigate its effects. Our findings suggest that the HTP was instrumental in achieving universal health coverage to enhance equity substantially, and led to quantifiable and beneficial effects on all health system goals, with an improved level and distribution of health, greater fairness in financing with better financial protection, and notably increased user satisfaction. After the HTP, five health insurance schemes were consolidated to create a unified General Health Insurance scheme with harmonized and expanded benefits. Insurance coverage for the poorest population groups in Turkey increased from 2.4 million people in 2003, to 10.2 million in 2011. Health service access increased across the country—in particular, access and use of key maternal and child health services improved to help to greatly reduce the maternal mortality ratio, and under-5, infant, and neonatal mortality, especially in socioeconomically disadvantaged groups. Several factors helped to achieve universal health coverage and improve outcomes. These factors include economic growth, political stability, a comprehensive transformation strategy led by a transformation team, rapid policy translation, flexible implementation with continuous learning, and simultaneous improvements in the health system, on both the demand side (increased health insurance coverage, expanded benefits, and reduced cost-sharing) and the supply side (expansion of infrastructure, health human resources, and health services).

Ricardo Bitran

Explicit health guarantees for Chileans: the AUGE benefits package

Universal Health Coverage (UNICO) studies series; no. 21. World Bank. 2013.

Available at bit.ly/BitranUHC

This paper focuses on recent and significant health reform implemented in 2005, known as Universal Access with explicit guarantees (Acceso Universal con Garantías Explícitas - AUGE or GES), which mandated SHI insurers to adopt a broad benefits package defined via explicit legal guarantees for all beneficiaries. This innovative reform is a policy reaction to that which previously existed in Chile and which is widespread in many developing countries, whereby the health rights of citizens remain largely undefined or implicit. Limited public resources imply in those countries that access to health care is rationed through queues, patient deflection, legal or under-the-table user fees, and low-quality care. This paper describes the AUGE reform, its implementation, and the functioning of AUGE for the poor and for non-poor citizens. This paper is organized as: section two provides a brief historic overview of health coverage in Chile's SHI system. Section three describes the SHI system in existence today. Section four describes the services offered and mechanisms in place to cover the poor under SHI, while section five spells out the benefits of SHI. Section six introduces the AUGE health reform of 2005, which sought to broaden and make explicit the rights of all SHI beneficiaries. Section seven offers information about the flows and magnitudes of health financing in SHI. Section eight focuses on the system used by Fonasa to target the poor. Section nine explains how Fonasa manages AUGE. Section ten comments on the information environment of AUGE. Section eleven addresses the equity and fiscal implications of expanding the AUGE benefits. Finally, section twelve proposes a pending policy agenda related to the coverage of the poor under SHI and the definition and management of benefits.

Rafael Cortez & Daniela Romero

Argentina - Increasing utilization of health care services among the uninsured population: the Plan Nacer program

Universal Health Coverage (UNICO) studies series; no.12. World Bank. 2013.

Available at bit.ly/CortezUHC

This paper describes the functioning and performance of Argentina's Provincial Maternal and Child Health Investment Program, commonly referred to as Plan Nacer. The program is aimed

at increasing access - for uninsured pregnant women and children under six years old - to a basic set of health services known to effectively address the main causes of maternal and child mortality, while improving the effectiveness and efficiency of the health system. The program supports the development and implementation of publicly funded provincial maternal and child health insurance and the introduction of highly innovative results-based financing mechanisms at the national, provincial, and provider levels. This document is organized as follows. Section 2 provides an overview of the Argentine health care system, including a description of public health, primary care, and supply-side efforts, to put in context the implementation of Plan Nacer. Section 3 presents a detailed description of the main features of the program, including the institutional architecture; the targeting, identification, and enrolment of beneficiaries; the management of the program's funds and benefits package; and the information environment of Plan Nacer. Section 4 provides a discussion of the highly innovative results-based financing mechanisms included in the design of the program. Section 5 draws some conclusions on the pending agenda and challenges ahead.

Bernard Couttolenc & Tania Dmytraczenko

Brazil - Brazil's primary care strategy

Universal Health Coverage (UNICO) studies series; no. 2. World Bank. 2013.
Available at bit.ly/CouttolencUHC

This case study summarizes the responses to the questionnaire on The Nuts and Bolts of the Program Expanding Health Coverage to the Poor, developed within the framework of the World Bank's UNICO - Universal Challenge Program. By so doing, it assesses the key features and the achievements and challenges of Brazil's Primary Care Strategy (PCS) and analyzes the contribution of this strategy to the establishment and implementation of universal coverage. Section 2 provides context for the discussion by summarizing key reforms and the impact of the PCS and describes Brazil's health care delivery and financing system. The institutional architecture and interaction of the health care program (HCP), in this case the PCS, is discussed in section 3. Sections 4 through 8 outline the main features of the strategy, including the identification and targeting of beneficiaries, management of public funds, services covered, and the information environment. The case study concludes with a discussion of lessons learned (section 9) and the pending agenda (section 10).

Pamela Das & Richard Horton

Bangladesh: Innovating for Health

The Lancet 382, no. 9906 (November 2013), pages 1681-82.
Available at bit.ly/DasUHC. DOI: 10.1016/S0140-6736(13)62294-1

Bangladesh's health success has been mainly driven by four factors: history; research; equity; and, international cooperation. Mobilization of communities, gender equity, and a commitment to universal health coverage could make a big difference elsewhere. Much of Bangladesh's success has centered on progress towards the Millennium Development Goals. However, less successful have been improvements in maternal and child malnutrition and access to primary care. The final paper in this Series sets out a plan to create a second wave of innovation in health, one that could steer Bangladesh towards universal health coverage. As national elections approach in January 2014, the country's vulnerability to climate change, rapid urbanization, persistence of poverty and inequality, and low quality of life and income levels will be major political challenges. Bangladeshis have shown enormous creativity, resilience, and energy in the past. They will need to continue to do so again in the future.

Pedro Francke

Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage

Universal Health Coverage Studies Series (UNICO) No. 11. World Bank 2013.
Available at bit.ly/FranckeUHC

In the last two decades, Peru has made significant progress in improving maternal and child health, although health inequities remain in rural areas and among indigenous populations. The epidemiological transition toward non-communicable diseases poses challenges, as well. Peru's health system is segmented, and it is comprised of public facilities administered by the decentralized Ministry of Health (Ministerio de Salud, MOH), the social security system, and the private sector, which accounts for 40 percent of spending. Established 10 years ago in parallel—although uncoordinated—with the country's decentralization reforms, the Comprehensive Health Insurance (Seguro Integral de Salud, SIS) has been Peru's major effort to expand health coverage. The SIS aims to reduce economic barriers through the elimination of user fees for a package of services. Although its budget has been low, the SIS has played

an important role in the reduction of maternal and child mortality. However, the improvements expected to the overall health system have not materialized. Meanwhile, when the decentralization process transferred funds and authority to the regions, it did so in a context of weak management capabilities, and it failed to clearly define the relationship between the national and regional governments.

Patricia Frenz, Iris Delgado, Jay Kaufman & Sam Harper

Achieving Effective Universal Health Coverage with Equity: Evidence from Chile

Health Policy Plan, August 2013. Available at bit.ly/FrenzUHC. DOI:10.10-93/heapol/czt054

Chile's 'health guarantees' approach to providing universal and equitable coverage for quality healthcare in a dual public-private health system has generated global interest. The program, called AUGE, defines legally enforceable rights to explicit healthcare benefits for priority health conditions, which incrementally covered 56 problems representing 75% of the disease burden between 2005 and 2009. It was accompanied by other health reform measures to increase public financing and public sector planning to secure the guarantees nationwide, as well as the state's stewardship role. We analyzed data from household surveys conducted before and after the AUGE reform to estimate changes in levels of unmet health need, defined as the lack of a healthcare visit for a health problem occurring in the last 30 days, by age, sex, income, education, health insurance, residence and ethnicity; fitting logistic regression models and using predictive margins. The overall prevalence of unmet health need was much lower in 2009 (17.6%, 95% CI: 16.5%, 18.6%) than in 2000 (30.0%, 95% CI: 28.3%, 31.7%). Differences by income and education extremes and rural-urban residence disappeared. In 2009, people who had been in treatment for a condition covered by AUGE in the past year had a lower adjusted prevalence of unmet need for their recent problem (11.7%, 95% CI: 10.5%, 13.2%) than who had not (21.0%, 95% CI: 19.6%, 22.4%). Despite limitations including cross-sectional and self-reported data, our findings suggest that the Chilean health system has become more equitable and responsive to need. While these changes cannot be directly attributed to AUGE, they were coincident with the AUGE reforms. However, healthcare equity concerns are still present, relating to quality of care, health system barriers and differential access for health conditions that are not covered by AUGE.

Government of Japan

Japan's Strategy on Global Health Diplomacy

June 2013. Available at bit.ly/JapanUHC

Domestically and globally, UHC has long been a priority for Japan. In light of its commitment to UHC, Japan is uniquely positioned to advocate for UHC worldwide and to articulate concrete actions that promote it. Japan pledges to push to include UHC in the post-2015 development agenda, to share its experiences and offer strategic support, to call for global partnerships, and to shape human resources systems that promote health. Based on the belief that progress toward the Millennium Development Goals in Africa is a key first step toward UHC worldwide, Japan also commits to focus on improving healthcare in African countries.

Emily Gustafsson-Wright & Onno Schellekens

Achieving Universal Health Coverage in Nigeria One State at a Time: A Public-Private Partnership Community-Based Health Insurance Model

Working paper, June 2013. Available at bit.ly/Gustafsson-WrightUHC

In this paper, we discuss UHC in the context of Nigeria, a middle-income country that nevertheless is facing enormous health challenges. We discuss the constraints that have prevented Nigeria from attaining UHC to date. We then present promising evidence from large and small-scale insurance interventions in other parts of the developing world. Next, we describe a public-private partnership model of community-based health insurance currently operating in Nigeria and other parts of Africa and show evidence of the program's ability to increase health care utilization, provide financial protection and improve health status in target communities. We contend that UHC in Nigeria can only be achieved by addressing both supply and demand-side constraints simultaneously. The solution must also include building on existing public and private institutions and informal networks, leveraging existing capital, and empowering clients and local communities. An innovative model such as the one presented here that has been implemented successfully in one Nigerian state, could be replicated in others; tackling this challenge one state at a time, to eventually achieve the goal of access to health care and financial protection for all.

Pandu Harimurti, Eko Pambudi, Anna Pigazzini & Ajay Tandon

The nuts and bolts of Jamkesmas - Indonesia's government-financed health coverage program for the poor and near-poor

Universal Health Coverage (UNICO) studies series; no. 8. World Bank. 2013.
Available at bit.ly/HarimurtiUHC

This case study describes and assesses Jamkesmas, Indonesia's government-financed health coverage program for the poor and near-poor. It provides a detailed description of the scope, depth, and breadth of coverage provided under Jamkesmas, and highlights ways in which the program interacts with the rest of Indonesia's health system. It also summarizes and discusses evidence on whether Jamkesmas is attaining its stated objectives of removing financial barriers and improving access to health care by the poor and near-poor, what could be improved, and what lessons can be learned from the experience of Jamkesmas that could help inform Indonesia's quest for universal coverage. The primary theme underlying the study is that supply-side constraints and supply-side subsidies have not been leveraged to increase the effectiveness of the Jamkesmas program. There are significant geographic deficiencies in the availability and quality of the basic benefits package, especially for those living in relatively remote and rural locations of the country, and this limits the effective availability of benefits for many Jamkesmas beneficiaries. The remainder of the case study is organized as follows. Section two provides general background and information on health system outcomes in Indonesia. Section three is an overview of health care financing and delivery. Section four describes the institutional architecture of Jamkesmas. Section five highlights the process of targeting, identification, and enrolment of beneficiaries under the program. Section six focuses on the role of public financing. Section seven outlines the basic benefits package. Section eight provides an overview of the information environment of Jamkesmas. Section nine discusses the special theme of supply-side constraints and supply-side subsidies that dilute the effectiveness of the Jamkesmas program. Section ten discusses the pending agenda around some of the architectural and operational features of Jamkesmas in the context of universal coverage.

Rob Hunter

Turkey's Health Care Reform: the 2023 Challenge

Turkish Policy Quarterly 12, no. 2 (Summer 2013), pages 91-100. Available at bit.ly/HunterUHC

Turkey is at the vanguard of a global trend of implementing universal health coverage. Building on that leadership position, Prime Minister Erdoğan has set a goal for Turkey to become a global leader in the delivery of health services over the next decade. A key element of developing the health care market in Turkey is expanding the country's biopharmaceutical sector. For Turkey to meet its health care objectives, it needs to maintain a public policy environment that ensures adequate resources for health care and fosters innovation and investment in the biopharmaceutical sector. Too often, the government's short-term cost containment policies have conflicted with its aspirations for ensuring Turkish citizens have access to needed innovative therapies and growing a biopharmaceutical sector.

Naoki Ikegami et al

Japanese Universal Health Coverage: Evolution, Achievements, and Challenges

The Lancet 378, no. 9796 (September 2011), pages 1106-15.
Available at bit.ly/IkegamiUHC. DOI: 10.1016/S0140-6736(11)60828-3

Japan shows the advantages and limitations of pursuing universal health coverage by establishment of employee-based and community-based social health insurance. On the positive side, almost everyone came to be insured in 1961; the enforcement of the same fee schedule for all plans and almost all providers has maintained equity and contained costs; and the co-payment rate has become the same for all, except for elderly people and children. This equity has been achieved by provision of subsidies from general revenues to plans that enroll people with low incomes, and enforcement of cross-subsidization among the plans to finance the costs of health care for elderly people. On the negative side, the fragmentation of enrolment into 3500 plans has led to a more than a threefold difference in the proportion of income paid as premiums, and the emerging issue of the uninsured population. We advocate consolidation of all plans within prefectures to maintain universal and equitable coverage in view of the ageing society and changes in employment patterns. Countries planning to achieve universal coverage by social health insurance based on employment and residential status should be aware of the limitations of such plans. This is the second in a series of six papers about Japan's universal health care at 50 years.

Joint Learning Network for Universal Health Coverage

Joint Learning Update

2013. Available at bit.ly/JointLearningUHC

Governments around the world are struggling to navigate the legal, financial, and political frameworks of their countries to determine the best path toward universal health coverage (UHC) reforms. These countries face a multitude of design and implementation challenges due to the adaptation required, political challenges, and the complexity of reform. Through a unique and very practical collaborative model for joint problem solving including multilateral workshops, country learning exchanges and virtual dialogue, Joint Learning Network for Universal Health Coverage (JLN) members build on real experience to experiment and produce useful new knowledge and tools to expand coverage to the more than three billion people globally, many of them in the poorest half of the world's population, that lack access to quality, essential health care with financial protection.

Felicia Knaul et al

The Quest for Universal Health Coverage: Achieving Social Protection for all in Mexico

The Lancet 380, no. 9840 (August 2012), pages 1259-79.
Available at bit.ly/KnaulUHC. DOI: 10.1016/S0140-6736(12)61068-X

Mexico is reaching universal health coverage in 2012. A national health insurance program called Seguro Popular, introduced in 2003, is providing access to a package of comprehensive health services with financial protection for more than 50 million Mexicans previously excluded from insurance. Universal coverage in Mexico is synonymous with social protection of health. This report analyzes the road to universal coverage along three dimensions of protection: against health risks, for patients through quality assurance of health care, and against the financial consequences of disease and injury. We present a conceptual discussion of the transition from labor-based social security to social protection of health, which implies access to effective health care as a universal right based on citizenship, the ethical basis of the Mexican reform. We discuss the conditions that prompted the reform, as well as its design and inception, and we describe the 9-year, evidence-driven implementation process, including updates and improvements to the original program. The core of the report concentrates on

the effects and impacts of the reform, based on analysis of all published and publically available scientific literature and new data. Evidence indicates that Seguro Popular is improving access to health services and reducing the prevalence of catastrophic and impoverishing health expenditures, especially for the poor. Recent studies also show improvement in effective coverage. This research then addresses persistent challenges, including the need to translate financial resources into more effective, equitable and responsive health services. A next generation of reforms will be required and these include systemic measures to complete the reorganization of the health system by functions. The paper concludes with a discussion of the implications of the Mexican quest to achieve universal health coverage and its relevance for other low-income and middle-income countries.

Lilin Liang & John C Langenbrunner

The long march to universal coverage: lessons from China

Universal Health Coverage (UNICO) studies series; no. 9. World Bank. 2013.

Available at bit.ly/LiangUHC

The march to Universal Health Coverage (UHC) in China is unparalleled. Since the establishment of the State Council Medical Reform team in 2006, the basic objective of China's health reforms has been to provide the whole nation with basic medical and health care, while ensuring equal access to, and affordability of, health services. The Chinese government announced the national three-year reform plan in 2009, after which the country has made remarkable progress toward achieving nearly universal health coverage. The recent health reform initiatives under the 12th Five-Year Plan (2011-2015) continue to center on five areas. Building on recent experience, more effort is directed toward a structural change of the health system and building an environment that will facilitate policy implementation. This includes optimizing resource distribution, encouraging hospital competition, strengthening regulation and accountability, and enhancing human resources and information technology. While China has successfully extended the breadth of Health Coverage to the Poor (HCP), its scope (the comprehensiveness of services covered) and depth (the degree of financial risk protection) appear to be insufficient. Hospital admissions have increased significantly; suggesting improved access, up to 50 percent of current admissions may be amenable to more cost-effective outpatient care. Thus, it is critical to look into problems beyond the HCP program design, such as institutional arrangements, intergovernmental transfers, and supply constraints. This case study concludes with a discussion of the impacts of HCP and the needed next steps to advance HCP as an intermediate objective to the country's longer-term goals of equitable access and high quality of services.

Chunling Lu et al

Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years

PLoS ONE 7, no. 6 (2012). Available at bit.ly/LuUHC. DOI: 10.1371/journal.pone.0039282

We conducted a quantitative impact evaluation of Mutuelles between 2000 and 2008 using nationally-representative surveys. At the national and provincial levels, we traced the evolution of Mutuelles coverage and its impact on child and maternal care coverage from 2000 to 2008, as well as household catastrophic health payments from 2000 to 2006. At the individual level, we investigated the impact of Mutuelles' coverage on enrollees' medical care utilization using logistic regression. We focused on three target populations: the general population, under-five children, and women with delivery. At the household level, we used logistic regression to study the relationship between Mutuelles coverage and the probability of incurring catastrophic health spending. The main limitation was that due to insufficient data, we are not able to study the impact of Mutuelles on health outcomes, such as child and maternal mortalities, directly. The findings show that Mutuelles improved medical care utilization and protected households from catastrophic health spending. Among Mutuelles enrollees, those in the poorest expenditure quintile had a significantly lower rate of utilization and higher rate of catastrophic health spending. The findings are robust to various estimation methods and datasets. Rwanda's experience suggests that community-based health insurance schemes can be effective tools for achieving universal health coverage even in the poorest settings. We suggest a future study on how eliminating Mutuelles co-payments for the poorest will improve their healthcare utilization, lower their catastrophic health spending, and affect the finances of health care providers.

Diane McIntyre et al

Beyond Fragmentation and Towards Universal Coverage: Insights from Ghana, South Africa and the United Republic of Tanzania

Bulletin of the World Health Organization 86, no. 11 (November 2008), pages 817-908.
Available at bit.ly/McIntyreUHC. DOI: 10.24-71/BLT.08.053413

The aim of this analysis is to explore the extent of fragmentation within the health systems of three African countries (Ghana, South Africa and the United Republic of Tanzania); how this developed; how each country has attempted to address the equity challenges arising from

this fragmentation and what remains to be done to promote universal coverage. This paper draws on the results of the first phase of a three-year project analyzing equity in the finance and delivery of health care in Ghana, South Africa and United Republic of Tanzania.

Joanne McManus

Thailand's Universal Coverage Scheme: Achievements and Challenges

Nonthaburi, Thailand: Health Insurance System Research Office, 2012. An independent assessment of the first 10 years (2001-2010). Available at bit.ly/McManusUHC

After four decades of health infrastructure development and three decades of designing and implementing a number of different financial risk protection schemes, Thailand achieved universal health coverage in 2002. This meant that all Thais were covered by health insurance guaranteeing them access to a comprehensive package of health services. Although many factors contributed to this achievement, the most significant was an ambitious reform known as the Universal Coverage Scheme (UCS). Within one year of its launch in 2001, the UCS covered 47 million people: 75% of the Thai population, including 18 million people previously uninsured. The other 25% of the population were government employees, retirees and dependants, who remained under the Civil Servant Medical Benefit Scheme (CSBMS), and private-sector employees, who continued to have their health-care costs paid for by the contributory Social Security Scheme (SSS). The UCS was remarkable not only for the speed of its implementation, but also because it was pursued in the aftermath of the 1997 Asian financial crisis when gross national income was only US\$ 1,900 per capita, and against the advice of some external experts who believed the scheme was not financially viable.

Eduardo Missoni & Solimano Giorgio

Towards Universal Health Coverage: the Chilean Experience

World Health Report Background Paper 4. World Health Organization.
Last modified 2010. Available at bit.ly/MissoniUHC

Notwithstanding good average health indicators, Chile has a poor ranking in terms of economic equality. In the last decades the epidemiological profile has changed substantially posing new

challenges to the healthcare system. As a result of reforms introduced during the military regime, the Chilean healthcare system is structurally segmented with low-income, high-risk populations being served mainly by the public sector and high-income, low-risk populations generally being treated in the private sector. A drastic intervention of public health policies was required. With the return to democracy, initial interventions were directed to capital investments in the health sector, improvement of primary care and tighter regulation of the private sector. Beginning in 2000, a new set of reforms was proposed focusing on patients' rights and guarantees and increased equity in the financing system. The main result of the new legislation was the introduction of the AUGE Plan, a regime of explicit guarantees (access to treatment, opportunity, quality and financial protection) applied to a list of prioritized conditions progressively increased from 25 to 66. The identification of pathologies to be included was done through an ad hoc defined algorithm including criteria such as magnitude of the problem, effectiveness of available medical treatment, capacity of the healthcare system, costs and social consensus. The AUGE plan benefited both the subscribers of the public as well as the private systems. To cover the cost of the reform additional resources were identified, mainly in the form of a temporary increase in the consumer tax. The reform had to face numerous challenges during the parliamentary debate and was finally approved with some significant compromises. Several unresolved issues have been identified by scholars and social actors, and represent future challenges from ethical, methodological, organizational, quality-related, financial, as well as social and political perspectives. Solutions, however, may now lead away from the solidarity perspective at a moment in which Chile is facing a significant political transition led by a center-right coalition.

Fernando Montenegro Torres & Oscar Bernal Acevedo

Colombia case study: the subsidized regime of Colombia's national health insurance system

Universal Health Coverage (UNICO) studies series; no.15. World Bank. 2013.
Available at bit.ly/MontenegroTorres1UHC

This case study provides an overview of the contribution of Colombia's compulsory health insurance, particularly its Subsidized Regime (SR), to universal health care coverage in the country, and the current challenges the SR faces. The case study is based on discussions with stakeholders from academia and the public and private sectors. The report is divided into four sections: (1) country context and health outcomes; (2) the SR within the institutional architecture

of the national health insurance system; (3) the subsidized regime: considerations on equity in the context of the public debate on the right to health care in Colombia; and (4) policy decisions and key areas of the agenda for the short and medium term.

Fernando Montenegro Torres

Costa Rica case study: Primary health care achievements and challenges within the framework of the social health insurance

Universal Health Coverage (UNICO) studies series; no. 14. World Bank. 2013.

Available at bit.ly/MontenegroTorres2UHC

The objective of this paper is to assess the key interventions Costa Rica has developed to expand health coverage for the poor and other vulnerable groups, with an emphasis on its approach to primary health care. Universal health coverage in Costa Rica is provided through a single national health insurance program. This program, which protects the poor without the pitfalls of a fragmented system, and the sustained policies that have enabled the building of a solid primary health care system, is broadly recognized as a success story. At the same time, new challenges are emerging to sustaining the success of Costa Rica's universal health coverage. Social Security of Costa Rica (Caja Costarricense de Seguridad Social, CCSS) faces increased production costs and demographic and epidemiological changes in a rapidly aging population. This report is divided into three broad sections: (1) objective of the case study and health system overview; (2) primary health care and the organization of health services within CCSS; and (3) agenda of key policy decisions for a renewed primary health care approach as part of a more responsive and sustainable health insurance system.

Christine Lao Pena

Guatemala - Improving Access to Health Care Services through the Expansion of Coverage Program (PEC): The Case of Guatemala

Universal Health Coverage (UNICO) studies series; no. 19. World Bank. 2013.

Available at bit.ly/PenaUHC

Since the signing of the 1996 Peace Accords, Guatemala has made efforts to establish economic and political stability, and to improve its social indicators. The country's Constitution states

that access to health care is a basic right of all Guatemalans. In practice, however, it has been challenging for the Government of Guatemala to guarantee this right using public facilities. As a result, it has been trying to improve access to health services using both Ministry of Public Health and Social Assistance (MOH) facilities and staff, and alternative health service providers, particularly nongovernmental organizations (NGOs). This case study reviews the experience implementing the Expansion of Coverage Program (Programa de Extension de Cobertura, PEC) that was established by the Government of Guatemala in 1997 to improve coverage of health and nutrition services to poor, rural, and largely indigenous areas by contracting NGOs. It describes its origins; its package of services; contracting, financing, monitoring, and supervision mechanisms; and its contributions to improving access and strengthening primary health care services in Guatemala. It also discusses opportunities and challenges that need to be addressed to continue to improve health services coverage in the country.

Somil Nagpal

Expanding health coverage for vulnerable groups in India

Universal Health Coverage (UNICO) studies series; no. 13. World Bank. 2013.
Available at bit.ly/NagpalUHC

India's health sector continues to be challenged by overall low levels of public financing, entrenched accountability issues in the public delivery system, and the persistent dominance of out-of-pocket spending. In this context, this case study describes three recent initiatives introduced by the central and state governments in India, aimed at addressing some of these challenges and improving the availability of and access to health services, particularly for the poor and vulnerable groups in the country. This includes two federal schemes introduced by the Government of India—the National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare and the Rashtriya Swasthya Bima Yojana (RSBY) of the Ministry of Labor and Employment—and the Rajiv Aarogyasri scheme launched by the state government of Andhra Pradesh. The three schemes discussed in this case study were designed and implemented by different agencies almost in parallel, over the same time period, and used different financing and delivery approaches. A discussion of the mechanics and operational features of these programs has been undertaken to unravel the underlying complexities, interactions, and interdependencies of these programs within the country's health system.

Gandham NV Ramana, Rose Chepkoech & Netsanet Walelign Workie

Kenya - Improving universal primary health care by Kenya: a case study of the Health Sector Services Fund

Universal Health Coverage (UNICO) studies series; no. 5. World Bank. 2013.

Available at bit.ly/RamanaUHC

This case study describes the Government of Kenya's initiative to expand the supply of health care and strengthen primary health care through implementation of the Health Sector Services Fund (HSSF), which provides direct cash transfers to primary health facilities. This initiative, launched in 2010, is a direct response to challenges identified by the Public Expenditure Tracking Surveys in making funds for operation and maintenance available to the health facilities, and builds on lessons from initiatives supported by the Danish International Development Agency (DANIDA) in the Coastal Region.

Srinath Reddy et al

High Level Expert Group Report on Universal Health Coverage for India

Instituted by the Planning Commission of India (2013). Available at bit.ly/ReddyUHC

The High Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission of India in October 2010, with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians. While financial protection was the principal objective of this initiative, it was recognized that the delivery of UHC also requires the availability of adequate healthcare infrastructure, skilled health workforce and access to affordable drugs and technologies to ensure the entitled level and quality of care given to every citizen. Further, the design and delivery of health programmes and services call for efficient management systems as well as active engagement of empowered communities. The original terms of reference directed the HLEG to address all of these needs of UHC. Since the social determinants of health have a profound influence not only on the health of populations but also on the ability of individuals to access healthcare, the HLEG decided to include a clear reference to them, though such determinants are conventionally regarded as falling in the domain of non-health sectors.

Kenji Shimazak

The Path to Universal Health Coverage: Experiences and Lessons from Japan for Policy Actions

June 2013. Available at bit.ly/ShimazakUHC

Japan's universal health insurance coverage has been receiving great interest from other countries. However, how and why Japan achieved universal health insurance coverage about half a century ago has not been unravelled. This paper aims to analyse Japan's path to universal health insurance coverage from various perspectives and draw policy lessons for developing countries striving to attain universal coverage.

Owen Smith

Georgia's medical insurance program for the poor

Universal Health Coverage (UNICO) studies series; no. 16. World Bank. 2013.
Available at bit.ly/SmithUHC

Georgia launched its Medical Insurance Program (MIP) for the poor in 2006. This program draws from general tax revenues to provide comprehensive, means-tested health insurance to the poorest 20 percent of the population as identified by a proxy means test. The government contracts private insurance companies who serve as financial risk carriers and purchasing agents for the program. MIP is well targeted to the poor and has had a major impact on improving financial protection of its beneficiaries. It has also served as a launching pad for significant investments in hospitals and information technology (IT) systems. In brief, MIP is a program funded through general taxation that provides a fairly comprehensive benefits package of health services to the poorest 20 percent of the population as identified via a proxy means test. There are no copayments for services. Although run by a state purchaser during the first two years, since 2008 its key feature has been that private insurance companies are contracted by the Ministry of Health to bear financial risk and to purchase services from both public and private providers on behalf of poor beneficiaries. The government sets policy, pays a per capita premium per beneficiary to private insurers, and conducts program oversight. This case study provides an overview of how MIP is designed, its achievements to date, and challenges for the future. A key theme discussed in further detail, and of potential interest to other countries contemplating a push toward the achievement of universal health coverage, is the contracting

of private insurance companies to purchase services on behalf of the poor. Some attention is also given to MIP's targeting approach.

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