



# UNIVERSAL HEALTH COVERAGE: ANNOTATED BIBLIOGRAPHY 2.0

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## Introduction: the expanding global focus on universal health coverage

As all countries contemplate how to extend health care services to all 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, universal health coverage (UHC) has emerged as an aspirational goal of governments and civil society worldwide.

The UN General Assembly resolution on *The Future We Want* acknowledged “Universal Health Coverage as a key instrument to enhancing health, social cohesion, and sustainable human and economic development.”<sup>1</sup> UHC is the focus of goal 3 - ‘Ensure healthy lives and promote well-being for all at all ages’ - of the post-2015 sustainable development framework. It is also recognized as central to realizing the World Bank goals of ending extreme poverty by 2030 and boosting shared prosperity for the poorest 40% of the population in every developing country. Efforts to achieve the UHC target within the post-2015 SDGs will be informed by the WHO/World Bank Monitoring Framework for UHC.<sup>2</sup>

As resources devoted to health at all levels of governance experience rapid growth, new industries keep entering the health market. Opportunities for cross-sector involvement in UHC are therefore expanding and receiving increasing attention. Crises such as the Ebola outbreak in Western Africa have emphasized that cross-border health threats are real and can potentially lead to devastating public health outcomes. These challenges remind us that there is no substitute for adequate health coverage and for multisector cooperation when dealing with public health issues.

With these thoughts in mind, the Global Health Programme at the Graduate Institute of International and Development Studies in Geneva, the Johns Hopkins Institute for Applied Economics, Global Health, and the Study of Business Enterprise and Rabin Martin, a global health strategy consultancy based in New York, Geneva and London, 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.

1 [http://www.un.org/en/ecosoc/julyhls/pdf13/concept\\_paper-uhc\\_during\\_ecosoc\\_amr.pdf](http://www.un.org/en/ecosoc/julyhls/pdf13/concept_paper-uhc_during_ecosoc_amr.pdf)

2 Ties Boerma et al. Monitoring Progress towards Universal Health Coverage at Country and Global Levels. *PLoS Med* 11, no.8 (September 2014). Available at [bit.ly/BoermaUHC](http://bit.ly/BoermaUHC).

Our starting point is that the health industry itself has become a major sector of the economy. Health-related goods and services constitute 10 percent of the world's global economic output, around US\$ 6.5 trillion. This "health economy" comprises all stakeholders involved in issues related to the values and behaviours that underlie the production and consumption of health and health care and the efficiency and effectiveness with which health services are delivered. The actors involved in the health economy shape population health and health service delivery, while also ensuring linkages with broader macroeconomic, social and political contexts. The health economy is a system that includes both investments in prevention as well as the supply and demand of healthcare products and services. Its impact shapes both population health and its relationship with economic development.

More than half the population in many developing countries and emerging markets depends in many ways on the private sector for their health care needs. As this annotated bibliography illustrates well, there are many ways in which individuals, communities, entrepreneurs, and health businesses large and small, complement the work of the public sector.

### **A second annotated bibliography of universal health coverage**

This annotated bibliography is the second in a series\* of working papers that delves into the policy and practical issues defining the path to universal health coverage. This series aims to inform discussions of UHC and monitor the progress of the global health debate over the next few years. Given the large and growing literature on universal health coverage, this bibliography cannot be comprehensive. We aim to build upon the first in the series and have included publications appearing from April 2014 to January 2015. This publication complements the first bibliography and continues to serve as a guide to the subject.

Similar to the first working paper, this 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 categories reflect the foci of the evolving literature and help to organize the many studies, reports, and commentaries included here.

As we considered the growing literature on UHC, several salient themes emerged across our eight categories. These include issues surrounding sustainability and equity as they relate to health coverage and health services, along with critical challenges that need to be addressed for governments and non-state actors involved in the health sector. Other key topics covered include the importance for UHC beyond 2015 of putting people first and the need to create an

\* The first annotated bibliography was published in May 2014 and launched on the occasion of the World Health Assembly 2014 in Geneva. It is available online at: [graduateinstitute.ch/globalhealth-publications](http://graduateinstitute.ch/globalhealth-publications) or [rabinmartin.com/our-insights/reports](http://rabinmartin.com/our-insights/reports)

enabling policy environment; the importance of a common global framework for monitoring progress; the governance challenges that UHC entails; and the linkages between UHC and a multitude of other agendas, such as gender, human rights and human resources for health, to name only a few.

The case studies note many examples of promising innovations from both the public and private sectors, attesting to the fact that many involved in the health economy are already concerned with and engaged in UHC-related implementation.

### **A living document**

We hope that our readers find this second working paper useful to inform their own discussions on UHC. While we do not 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 do not 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, the health economy 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

Action for Global Health and WaterAid

## **Making Health a Right for All: Universal Health Coverage and Water, Sanitation, and Hygiene**

March 2014. Available at [bit.ly/AfGH-UHC](http://bit.ly/AfGH-UHC)

Clean water and sanitation play vital roles in health, and this discussion paper explores why Water, Sanitation, and Hygiene (WASH) must be included in a comprehensive definition and provision of universal health coverage, and how this can be done. WASH is a crucial element of primary healthcare for the prevention of infections, and has been identified as the most cost-effective intervention for high-burden diseases in low- and middle-income countries. The paper also demonstrates that UHC can improve WASH conditions by embedding the promotion of personal and environmental hygiene and sanitation practices into healthcare delivery, thus maximizing opportunities for disease prevention. WASH can play an important role in preventive health care, in the provision of good quality care, and in the management of disease and disability. Given its stewardship role of safeguarding public health, the health system plays an important role in championing the need for WASH. The health system has a leading role to play in ensuring policy coherence, in leading cross-sectoral action on WASH, as well as in positioning it as an inseparable part of its overall efforts to improve population health.

Rifat Atun et al

## **Health-system reform and universal health coverage in Latin America**

*The Lancet*, Early Online Publication (October 2014).

Available at [bit.ly/Atun2UHC](http://bit.ly/Atun2UHC). DOI: 10.1016/S0140-6736(14)61646-9

Starting in the late 1980s, many Latin American countries began social sector reforms to alleviate poverty, reduce socioeconomic inequalities, improve health outcomes, and provide financial risk protection. In Latin America, health-system reforms have produced a distinct

approach to universal health coverage, underpinned by the principles of equity, solidarity, and collective action to overcome social inequalities. The countries studied developed country-level and regional capacity to learn from country and regional experiences, and used this capacity to refine health-system reforms to develop context-sensitive policies, and the lessons learned here can be applied to other reform efforts.

This article looks at the health system reforms in Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, Peru, Uruguay, and Venezuela. The authors examine the contextual challenges driving change in LAC health systems, and the substance of health systems reforms, including organization and governance, health systems financing, resource management, and service delivery. Based on these findings, the authors outline several key achievements, including expanded coverage of social protection and health insurance, expanded coverage of health services on the basis of comprehensive primary health care, improvements in health outcomes, improvements in financial protection, and improvements in satisfaction. The study notes that in the countries studied, the journey to universal health coverage followed three paths. In the first path, funding from many sources was pooled and an integrated health-care service network was developed to create a unified health system with equal benefits for citizens, as exemplified by Brazil, Costa Rica, and Cuba. The second path, as exemplified by Argentina, Chile, Colombia, Mexico, Peru, Uruguay, and Venezuela, led to the development of parallel insurance and service delivery subsystems for different population groups with differential benefits, leading to segregation by employment status. The third path, followed by all the study countries except Venezuela, made explicit the entitlements of citizens to specific health services.

As with other countries in Latin America, the countries studied face six major future challenges: addressing socioeconomic inequalities in health outcomes, managing decentralized health systems, equalizing persistently inequitable financing, developing services to meet emerging health needs brought on by social and demographic transitions, adapting to rapid urbanization in Latin America, and achieving sustainability of health-system investments.

Elio Borbonovi and Amelia Compagni

## **Sustaining Universal Health Coverage: the Interaction of Social, Political, and Economic Sustainability**

*Value in Health* 16, no. 1, Supplement (January-February 2013), pages S34-38.

Available at [bit.ly/BorbonoviUHC](http://bit.ly/BorbonoviUHC). DOI: 10.1016/j.jval.2012.10.006

Borbonovi and Compagni question the sustainability of UHC. UHC is currently an aspiration not only in emerging markets such as Brazil, China, and India but also in the United States. They emphasize that when most analysts think about sustainability, they are mostly thinking about economic sustainability. It is important to acknowledge, however, that sustainability has political and social dimensions as well. The policy analysis and commentary in this article suggests that economic unsustainability might be used as an argument to undermine social and political sustainability. In the realm of assessing economic sustainability, they argue persuasively that there is a greater role for the analysis of management practices. They observe that UHC can "... generate positive social spillovers (or social value) well beyond health" that contribute to social and political sustainability.

Michael Drummond, Rosanna Tarricone & Aleksandra Torbica

## **Assessing the Added Value of Health Technologies: Reconciling Different Perspectives**

*Value in Health* 16, no. 1, Supplement (January-February 2013), pages S7-13.

Available at [bit.ly/DrummondUHC](http://bit.ly/DrummondUHC). DOI: 10.1016/j.jval.2012.10.007

The article by Drummond, Tarricone, and Torbica addresses the challenges that UHC systems face in trying to provide access to costly innovative technologies. It provides some insights into the relationship between health technology assessment (HTA) and UHC. The authors note the natural tension that exists among the key stakeholders—patients, payers, and manufacturers of innovative technologies. Patients want (via their physician agents) access to new technologies that provide positive net clinical benefit; payers need to manage their budgets and want value for the money spent on behalf of their clients—the taxpayers or plan members; and manufacturers seek rewards that would provide the best return on their substantial investments. If sustainable access to health care is to be maintained in the future, approaches are needed to reconcile these different perspectives. This article explores the approaches, in both

methods and policy, to help bring about this reconciliation. These include rethinking the notion of social value (on the part of payers), aligning manufacturers' research more closely with societal objectives, and increasing patient participation in health technology assessment.

**David Evans, Robert Marten, and Carissa Etienne**

### **Universal health coverage is a development issue**

*The Lancet* 380 (September 2012), pages 864-5. Available at [bit.ly/EvansUHC](http://bit.ly/EvansUHC).

DOI: 10.1016/S0140-6736(12)61483-4

Although social and environmental factors affect health, maintaining and improving health is both a component and determinant of sustainable development, as health improvements contribute directly to human development. Good quality health delivery systems with universal access protect individuals from illness, stimulate economic growth, and fight poverty by keeping people healthy. They also contribute to social harmony by providing assurance to the population that services are available in the event of illness. A prerequisite, therefore, of sustainable development must be to help countries move closer to universal health coverage.

**Julio Frenk**

### **Leading the way towards universal health coverage: a call to action**

*The Lancet*, Early Online Publication (October 2014). Available at [bit.ly/Frenk2UHC](http://bit.ly/Frenk2UHC).

DOI: 10.1016/S0140-6736(14)61467-7

The call to action emphasizes the next steps that could help reach the goal of universal health coverage both in the Latin American region and the rest of the developing world. Lessons from Latin America can be applied to other countries and to broader discussions of global health reform, particularly because of the magnitude and complexity of Latin American challenges, recent policy innovations, and shared health challenges with the developing world.

This call outlines ten specific actions for Latin American countries, applicable to other developing nations: Action 1. Avoid the establishment of separate coverage schemes for different populations groups and, if they already exist, design initiatives to reduce segmentation; Action 2. Continue to implement social protection schemes that reduce the burden of out-of-pocket

payments; Action 3. Increase financing for health and, over time, increase the proportion of universal health coverage financing from general government revenues; Action 4. Design upstream interventions to address the determinants of health and downstream initiatives to deal with both the unfinished agenda and the emerging challenges related to non-communicable diseases, injuries, and mental diseases; Action 5. Establish effective mechanisms to monitor and assure quality of care, both in its technical and its interpersonal dimensions; Action 6. Improve the training, availability, and distribution of human resources for health; Action 7. Strengthen the key health system functions (stewardship, financing, and delivery) to expand choice, increase effectiveness and efficiency, promote equity, and improve accountability for results; Action 8. Design policies to strengthen the role of the state as the key steward of the national health system; Action 9. Invest in information systems, health systems research, and rigorous assessment; Action 10. Promote the introduction of transparency and accountability procedures, and stimulate the participation of civil society organizations in the design, implementation, and monitoring of universal health coverage initiatives.

Louis P. Garrison

### **Universal Health Coverage – Big Thinking Versus Big Data**

*Value in Health* 16, no. 1, Supplement (January-February 2013), pages S1-S3.

Available at [bit.ly/GarrisonUHC](http://bit.ly/GarrisonUHC). DOI: 10.1016/j.jval.2012.10.016

This is the introductory article to an eight-article special issue, illustrating the diversity of the approaches and methods that social scientists use to understand and meet the evolving challenges of an increasingly complex and global health care environment. Overall, the special issue is about the many facets and issues that surround the widely sought goal of UHC. The articles mostly address big thinking based on a limited number of “stylized facts,” that is, generally held propositions about behavior, often based on a broad review of the state of our knowledge. This is juxtaposed with the big data approach, in the form of comparative effectiveness research (CER). The collection of articles aims to help readers identify where they would like to dig more deeply.

Richard Horton

## **Offline: WHO offers a new future for sustainable development**

*The Lancet* 383, no.9932 (May 2014), page 1872.

Available at [bit.ly/HortonUHC](http://bit.ly/HortonUHC). DOI: 10.1016/S0140-6736(14)60889-8

WHO made its definitive statement about the future it envisions for the post-2015 era of sustainable development. At a standing-room only technical briefing during the World Health Assembly, WHO's Director-General, Dr. Margaret Chan, launched the agency's much anticipated position. WHO is seeking a single overarching health goal: "Ensure healthy lives and universal health coverage at all ages." Dr. Chan has said in the past that UHC is the single most important concept in public health today. But her advocacy for UHC has come under severe criticism from several key donors to WHO—the UK and the Gates Foundation to name but two. By placing so much emphasis on UHC post-2015, WHO has responded to an extraordinary demand by countries. Dr. Chan has resisted the conservatism of some donors who see UHC as an ideology, not an implementable program. WHO also sets out four sub-goals. First, to "Achieve the MDGs for newborn, child, and maternal health, and for major communicable diseases." The second sub-goal is to "Address the burden of non-communicable diseases, injuries, and mental illness." The third, to "Achieve universal health coverage, including financial risk protection." And finally, to "Address the social and environmental determinants of health."

Horton reports that Dr. Chan's vision has been received positively overall, albeit with caveats. During the briefing, several concerns were raised, focusing on unanswered questions and omissions from the report. WHO did not define the meaning of "sustainability," making it difficult to judge the value of the sustainable development goals. Reproductive health also appeared to have been downgraded from its universal MDG status, and calls to address climate change and improve health information systems were omitted from the report entirely. Finally, it was noted that WHO did not set out any overarching vision to frame the UHC quest. Going forward, a central understanding of whether health is to be considered negatively—the absence of disease—or positively—the presence of health and wellbeing—must inform goals of sustainable development.

Richard Horton & Pamela Das

## Universal health coverage: not why, what, or when—but how?

*The Lancet*, Early Online Publication (October 2014).

Available at [bit.ly/Horton2UHC](http://bit.ly/Horton2UHC). DOI: 10.1016/S0140-6736(14)61742-6

The argument about universal health coverage (UHC) has been won, and won remarkably quickly, but the task of delivering UHC for countries most in need of resilient health systems has barely started. And it is in this realm of complex policy making that little progress has been made. It is no longer a case of “why, what, or when” UHC. It is now about “how”. The great gap that now exists for countries trying to deliver UHC is access to a library of knowledge—evidence, experience, and resources—to assist with their decision-making. If countries had a reliable and independent source of information about the advantages and disadvantages, benefits and unanticipated harms, of one particular policy over another, each nation might be able to avoid the mistakes of the past.

Latin America is a laboratory to study the mechanics of implementing UHC. A common enemy for these governments during the past 20 years has been social inequality. Notions of solidarity, civil society activism, and collective action have therefore been important guiding principles for decision makers. Policies directed at achieving equity, combined with economic growth to create fiscal space for investments in health, have seen 60 million people lifted out of poverty. But despite these successes, Latin American health systems face considerable challenges—persistently wide disparities in health outcomes, fragmentation of health systems, inequitable financing, health services poorly adapted to population needs, and sustainability. These challenges are facing other countries struggling to protect and strengthen their advances towards UHC—e.g. China, Thailand, and even Japan. Can the experiences of Latin American nations provide evidence to assist countries facing similar predicaments?

Jim Yong Kim

## Remarks by World Bank Group President Jim Yong Kim at the Toward Universal Health Coverage by 2030 Event

Speech, Washington, D.C., 11 April 2014. The World Bank. Available at [bit.ly/Kim3UHC](http://bit.ly/Kim3UHC)

There are just 629 days until the deadline for the Millennium Development Goals. Yet despite all our best efforts, there will be unfinished business when 2015 ends. We must build on the

progress made through the health MDGs and work together to set goals that are universal and based on the principle of health equity for all. We need a bold health goal for 2030 that encompasses BOTH the health outcomes we want AND the path to get us there. And we also have a growing body of evidence that the most equitable and sustainable way to achieve the health outcomes we all want is through Universal Health Coverage. Let's have a goal that will make it happen by 2030.

Countries like Japan, Thailand, and Turkey have shown the promise of Universal Health Coverage for their people. And a growing number of countries like Myanmar, Nigeria, Peru, Senegal, Kenya, South Africa, and the Philippines have made Universal Health Coverage a top priority. Thanks to our collaboration with WHO, for the first time, we now have two time-bound targets for Universal Health Coverage. These targets will allow us to chart progress, both in scaling up equitable access to essential health services, and in preventing poverty due to out-of-pocket payments for health. These targets can be applied to all countries, rich and poor, as envisioned under the Sustainable Development Goals. Time-bound targets for universal coverage in the post-2015 framework will drive policy and program choices that lead to better health -- such as investing in strong, front-line primary care that is accessible to the poorest and most marginalized communities. We also know...that investments in health deliver great economic returns. Nearly a quarter of the growth in full income in low- and middle-income countries between 2000 and 2011 was due to better health outcomes. Unwavering political commitment, clear progressive goals, and measurable targets drive the change.

**Jim Yong Kim**

### **Speech by World Bank Group President Jim Yong Kim on Universal Health Coverage in Emerging Economies**

Speech, Center for Strategic and International Studies Conference on Universal Health Coverage in Emerging Economies, Washington, D.C., 14 January 2014. The World Bank.  
Available at [bit.ly/Kim4UHC](http://bit.ly/Kim4UHC)

[Excerpts] For us at the World Bank Group, achieving universal health coverage and equity in health are central to reaching the global goals to end extreme poverty by 2030 and boost shared prosperity. Our aims are clear: First, everyone should have access to affordable, quality health services. Second, no one should be forced into poverty, or be kept in poverty, to pay for the health care they need. Third, all countries must harness investments in other sectors

beyond health that provide the essential foundations for a healthy society. The World Bank and WHO have released a joint framework for monitoring progress toward universal health coverage with two targets, one for financial protection and one for service delivery. For financial protection, the proposed target is by 2020 to reduce by half the number of people who are impoverished due to out-of-pocket health care expenses. By 2030, no one should fall into poverty because of out-of-pocket health care expenses. For service delivery, the proposed target is equally ambitious. Today, just 40 percent of the poor in developing countries have access to basic health services. We propose that by 2030 we will double that proportion to 80 percent coverage. In addition, by 2030, 80 percent of the poor will also have access to many other essential health services, such as treatment for high blood pressure, diabetes, mental health and injuries.

Helping countries advance universal health coverage is a strategic priority across the World Bank Group. Through our Bank loans and technical assistance, we are partnering with middle-income countries to design and implement tough health sector reforms and contain costs, while at the same time expanding and sustaining coverage. Through IDA, our fund for the poorest countries, we are supporting the next generation of countries to lay the foundations for universal health coverage. And through the International Finance Corporation, our private sector arm, we are helping both middle and low-income countries harness the resources and innovation of the private sector – while promoting greater collaboration between private and public sector health institutions.

Here are five lessons from country experiences with universal coverage:

- First, strong national and local political leadership and long-term commitment are required to achieve and sustain universal health coverage;
- Second, short-term wins are critical to secure public support for reforms. For example, in Turkey, hospitals were outlawed from retaining patients unable to pay for care;
- Third, economic growth, by itself, is insufficient to ensure equitable coverage. Countries must enact policies that redistribute resources and reduce disparities in access to affordable, quality care;
- Fourth, 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, countries need to invest in a resilient primary health care system to improve access and manage health care costs.

Margaret E. Kruk

## **Universal health coverage: a policy whose time has come**

*BMJ* 347 (October 2013). Available at [bit.ly/KrukUHC](http://bit.ly/KrukUHC). DOI: 10.1136/bmj.f6360

Universal health coverage is the right and the smart thing to do. It puts countries on the path to realizing people's right to health—a global commitment made, but as yet unfulfilled, in many countries. And it is an efficient way to finance healthcare—getting more health from healthcare investments while minimizing patients' financial burden. People in middle- and low-income countries increasingly demand better health services—the top global priority of African and Asian respondents to a recent UN survey. This rising interest comes as economies in low-income countries grow and citizens ask more of their governments, including a stronger social safety net. And governments seem to be listening. After WHO published its report on financing for universal health coverage, more than 70 countries asked for technical help in designing systems to promote such coverage. The move toward universal health coverage is likely to be well worth the effort. Analysis commissioned for the UN has found that countries with a greater reliance on insurance tended to have lower child mortality.

Paradoxically, the gap between rich and poor can be widened by expanding health insurance and services—for example, the introduction of private insurance that only rich people can afford or that covers health services mainly available in cities. To counter this, public insurance must be financed through progressive taxation and charges at the point of care eliminated. To ensure that poor people are not left behind on the road to universal health coverage, insurance must also prioritize coverage for diseases that are common in these populations, such as infectious and maternal and child health conditions, injuries, and, increasingly, chronic diseases. UN reports have thus far paid insufficient attention to quality of care, which is weak in many low-income countries. Poor quality of care—absent or unmotivated providers, poor clinical and interpersonal skills, lack of drugs and equipment—discourages people from using newly insured services or motivates them to seek private or specialized care, undoing the benefits of financial protection. Improvements in quality must go hand in hand with the expansion of access and financial protection.

Akiko Maeda et al

## **Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies**

World Bank. 2014. Available at [bit.ly/MaedaUHC](http://bit.ly/MaedaUHC)

This book synthesizes experiences from 11 countries—Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam—in implementing policies and strategies to achieve and sustain UHC. These countries represent diverse geographic and economic conditions, but all have committed to UHC as a key national aspiration, are approaching it in different ways, and are at different stages in achieving or sustaining it.

The book examines UHC policies for each country based on a common framework that includes three themes: (1) the political economy and policy process for adopting, achieving, and sustaining UHC; (2) health financing policies to enhance health coverage; and (3) human resources for health policies for achieving UHC. The findings from these country studies are intended to provide lessons that can be used, provided they are adapted to local conditions, by countries aspiring to adopt, achieve, and sustain UHC. Although the path to UHC is specific to each country, countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks. Key policy messages emerged from the case studies, including the need for strong national and local political leadership, the need for investments in a robust and resilient primary care system and in public health programs, and the need to coordinate scale-ups of health workforces and other human resources for health.

Martin McKee et al

## **Universal Health Coverage: A Quest for All Countries but Under Threat in Some**

*Value in Health* 16, Issue 1, Supplement (January-February 2013), pages S39-S45.

Available at [bit.ly/McKee2UHC](http://bit.ly/McKee2UHC). DOI: 10.1016/j.jval.2012.10.001

McKee et al. combine previous data analysis with big thinking about historical factors to review the potential fragility of UHC. This article describes how many countries, both developed and developing, have pursued the quest to achieve universal health care. They sift through the data to identify five key factors that enable UHC: the strength of organized labor and the

left-leaning parties that represent them, the availability of resources (including economic growth), the potential for building shared identities and public goals (as seen in more homogeneous societies), path dependency (so that the conditions today impact the possibilities for tomorrow), and windows of opportunity (often created by exogenous events such as financial crises, natural disasters or wars, or political transitions). 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.

**Anne Mills**

## **Health Care Systems in Low- and Middle-Income Countries**

*The New England Journal of Medicine* 370 (February 2014), pages 552-557.  
Available at [bit.ly/Mills2UHC](http://bit.ly/Mills2UHC). DOI: 10.1056/NEJMr1110897

Over the past 10 years, global health debates have paid increasing attention to the importance of health care systems, which encompass the institutions, organizations, and resources (physical, financial, and human) assembled to deliver health care services that meet population needs. It has become especially important to emphasize health care systems in low- and middle-income countries because of the substantial external funding provided for disease-specific programs, especially for drugs and medical supplies, and the relative underfunding of broader health care infrastructures in these countries.

A functioning health care system is fundamental to the achievement of universal coverage for health care, and has been the focus of recent statements by advocacy groups and other organizations around the globe. The key health system issue for low- and middle-income countries is how to provide increased financial protection for households and the key financing question is whether the rest of the population — those who are outside the formal sector of the economy but who are not the very poorest — should be covered by funds raised through general taxation or encouraged to enroll in contributory insurance programs. This issue has been at the core of debates on the financing of universal coverage.

Eduardo Missoni

## **Understanding the Impact of Global Trade Liberalization on Health Systems Pursuing Universal Health Coverage**

*Value in Health* 16, Issue 1, Supplement (January-February 2013), pages S14-S18.

Available at [bit.ly/Missoni2UHC](http://bit.ly/Missoni2UHC). DOI: 10.1016/j.jval.2012.10.002

This article by Missoni is an analytical policy piece that explores the potential impact of global trade liberalization on UHC. The article systematically assesses the possible adverse impacts of global trade on each of WHO's six health system building blocks: service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership and governance. While trade and knowledge spillovers—for example, the availability of low-cost, first-line antiretroviral treatment for HIV disease—can benefit those in developing countries, the article identifies numerous possible adverse effects. These range from the “commercialization” of health care under trade agreements, to the disconnect between drug development and the global burden of disease, to the exportation of unhealthy Western lifestyles and habits, to numerous other examples. Missoni argues for strengthening the role of WHO in promoting “global governance for health” in our increasingly connected world.

Albert Mulley, Tim Evans & Agnes Binagwaho

## **Meeting the Challenges of Providing Universal Health Coverage**

*BMJ* 347 (October 2013). Available at [bit.ly/MulleyUHC](http://bit.ly/MulleyUHC). DOI: 10.1136/bmj.f6485

Equitable and affordable universal health coverage and improvements in people's health cannot be achieved by merely expanding and scaling up existing “one size fits all” healthcare delivery models of today. The 2010 World Health Report estimated that 20-40% of current healthcare spending is wasted. This waste derives both from failure to deliver care efficiently and safely and from overuse of services that exceed what people would want if they were informed of alternatives and the outcomes. Any attempt to build capacity to achieve universal health coverage must therefore go hand in hand with a commitment to ensure the quality, efficiency, and effectiveness of priority health services that are accessible to all.

Shifting the emphasis toward care that is high value rather than high volume will demand innovation in two areas. The first is the adoption of genuinely innovative models for patient

centered healthcare delivery and the second involves rethinking the relationship between health systems and service users. The path toward better and more affordable healthcare starts with redesigning and revitalizing primary care systems that keep patients healthy and reduce the demand for intensive hospital based care. Strategies to improve the quality of services through increased competition and greater patient voice include extending opportunities for patients to choose their service provider and strengthening channels for patients to express views about their care. The next step is to improve systems for recording the informed treatment preferences of engaged patients. When aggregated, these data can provide the guidance needed to invest wisely in capacities to deliver different services and improve delivery models. A formal feedback loop linking informed preferences of patients engaged in their healthcare with the investment decisions made by those responsible for capacity planning and system performance is needed to achieve high value service delivery.

**William Savedoff & Amy Smith**

## **Achieving Universal Health Coverage: Learning from Chile, Japan, Malaysia, and Sweden**

Working Paper, December 2011. Results for Development Institute.  
Available at [bit.ly/Savedoff3UHC](http://bit.ly/Savedoff3UHC)

This paper examines the histories of attaining universal health coverage in four countries – Sweden, Japan, Chile and Malaysia. It shows that domestic pressures for universalizing access to health care are extremely varied, widespread, and persistent. Secondly, universal health coverage is everywhere accompanied by a large role for government, although that role takes many forms. Third, the path to universal health coverage is contingent, emerging from negotiation rather than design. Finally, universal health coverage is attained incrementally and over long periods of time. These commonalities are shared by all four cases despite substantial differences in income, political regimes, cultures, and health sector institutions. Attention to these commonalities will help countries seeking to expand health coverage today.

Larry Temkin

## **Universal Health Coverage: Solution or Siren? Some Preliminary Thoughts**

*Journal of Applied Philosophy* 31, no.1 (February 2014), pages 1-22.

Available at [bit.ly/TemkinUHC](http://bit.ly/TemkinUHC). DOI: 10.1111/japp.12050

This article speaks directly to the growing groundswell of support for the idea that UHC should be provided for everyone, even in the developing world. While the author agrees with the eventual goal of attaining UHC globally as soon as possible, the article expresses Temkin's worries as to "whether the world's rich countries, or institutions like the World Health Organization, should be pushing the world's poorest countries to take whatever steps necessary to achieve that goal." The fear expressed is that universal health coverage in the developing world is an intoxicating, but potentially dangerous, idea whose time may not yet have come. This article's aim is not to settle the question of whether the developing world should be urged, or pushed, to adopt policies of universal health coverage; it is to explore worries about the wisdom of such a task.

## **Universal health coverage post-2015: putting people first**

Editorial. *The Lancet* 384 (December 2014), page 2083. Available at [bit.ly/Lancet3UHC](http://bit.ly/Lancet3UHC). DOI: 10.1016/S0140-6736(14)62355-2

Everyone has the right to demand health, and national universal health coverage plans must incorporate from the outset accountability mechanisms to ensure that providers (private sector included) deliver services fairly. Financial risk protection alone is not enough to ensure quality of care. The evaluation of care quality should include patient experiences. Ensuring equity and including the most vulnerable populations must underpin national health and development planning to address the unfinished MDGs and to ensure the sustainability of the benefits. For these reasons, universal health coverage beyond 2015 must put people first to ensure that strong, responsive systems are built.

## 2. Governance

Amir Attaran & Alexander Capron

### **Universal Health Coverage and Health Laws**

*The Lancet* 383, no.9911 (January 2014), page 25.

Available at [bit.ly/AttaranUHC](http://bit.ly/AttaranUHC). DOI: 10.1016/S0140-6736(13)62724-5

Law reform is an essential precondition for restructuring of the health-care system, especially for universal health coverage. For example, health insurance is a legal contract between insurer and beneficiary; laws are required for it to be created. Unfortunately, no global library of laws relevant to universal health coverage exists, meaning that every parliament that legislates health-system reforms must reinvent the wheel rather than build on the legal best practices of other countries. Such an ad-hoc, evidence-free approach would be intolerable in any other area of medical or public health practice, but is the norm for health legislation.

Attaran and Capron argue that the WHO has contributed to this problem by quietly abandoning its International Digest of Health Legislation, a collection of health laws that began in 1948. Furthermore, the website has been “temporarily” unavailable for months. The authors call on WHO to renew its collection of health laws and to provide targeted advice on legal best practices to attain universal health coverage—tasks for which it has the express duty under the WHO Constitution, and which it has lamentably neglected.

Giovanni Fattore & Fabrizio Tediosi

### **The Importance of Values in Shaping How Health Systems Governance and Management Can Support Universal Health Coverage**

*Value in Health* 16, Issue 1, Supplement (January-February 2013), pages S19-S23.

Available at [bit.ly/FattoreUHC](http://bit.ly/FattoreUHC). DOI: 10.1016/j.jval.2012.10.008

The article by Fattore and Tediosi on cultural values and their role in governance in relation to UHC is an example of a large conceptual thought piece. They lay out a plausible theory of how

different underlying cultural values can lead societies to select different management and governance structures that are more or less friendly to UHC. They distinguish between “management” and “governance,” the former being more about operational activities and the latter about how policies and regulations are developed and monitored. They emphasize, however, that not only are both management and governance critical to supporting UHC policies, but these solutions and how they are developed are related to underlying cultural values. On the basis of cultural theory, they characterize four cultural archetypes: hierarchist, individualist, fatalist, and egalitarian. These archetypes vary depending on two dimensions in a society: the importance of rules and authority structures, and the group versus individual orientation. The authors argue that it is not clear that any one archetype is most conducive to UHC. Their main conclusion is that implementation can matter as much as the goals implied by cultural values. In other words, both management and governance are important for the implementation and sustainability of UHC, and how they are best used to support a UHC goal will depend on societal cultural values.

Gorik Ooms et al

## **Great expectations for the World Health Organization: a Framework Convention on Global Health to achieve universal health coverage**

*Public Health* 128, no.2 (February 2014), pages 173-178. Available at [bit.ly/OomsUHC](http://bit.ly/OomsUHC).

DOI: 10.1016/j.puhe.2013.06.006

Establishing a reform agenda for the World Health Organization (WHO) requires understanding its role within the wider global health system and the purposes of that wider global health system. In this paper, the focus is on one particular purpose: achieving universal health coverage (UHC). The intention is to describe why achieving UHC requires something like a Framework Convention on Global Health (FCGH) that have been proposed elsewhere, why WHO is in a unique position to usher in an FCGH, and what specific reforms would help enable WHO to assume this role.

## Seven Ministers of Health

### **Universal health coverage and the post-2015 agenda**

*The Lancet* 384, no.9949 (September 2014), pages 1161–1162.

Available at [bit.ly/SevenMoH-UHC](http://bit.ly/SevenMoH-UHC). DOI: 10.1016/S0140-6736(14)61419-7

The global community is working to establish a new international agreement that would commit the world to universal health coverage (UHC). 14 years ago, the leaders of 189 nations signed the Millennium Declaration, committing their countries to fight poverty and promote development by 2015. The Declaration included eight Millennium Development Goals (MDGs) that have since shaped development policies around the globe. Much has been achieved during these years, but there is still much to be done. While countries are committed to the unfinished health development agenda until 2015, global leaders must now produce a new blueprint for the post-2015 development agenda. Health is a precondition, consequence, and indicator of all three dimensions of sustainable development: economic, environmental, and social. Health is also an essential part of people’s lives and a driver of poverty reduction.

On December 12, 2012, the United Nations General Assembly (UNGA) unanimously adopted a landmark resolution endorsing UHC as a global priority for sustainable development. The General Assembly called upon governments to “urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services”. Dozens of countries at all income levels have chosen to pursue UHC to ensure that their citizens are protected and able to contribute to the development of their nations.

A large number of factors outside immediate health services have an impact on population health, including conflict, income levels and distribution, consumption and production patterns, working conditions, sanitation, access to clean energy, environmental conditions, and education. To improve the health of their citizens, governments should work to strengthen performance in all these areas, and measure the impact of all policies on health. However, formal health sectors must also play their part by developing health systems able to meet all citizens’ needs without exception, so that health care is no longer a luxury that the poor cannot afford.

While countries are negotiating to agree on a new set of objectives for the development framework after 2015, the undersigned Ministers of Health from seven countries (France, Germany, Cote D’Ivoire, Malaysia, Mexico, Morocco, Senegal) want to underline that UHC is crucial to increase healthy life expectancy, eradicate poverty, promote equity, and achieve

sustainable development. Moreover, UHC gives people the peace of mind that the health services they might need are available, affordable, and of good quality.

### World Health Organization

## **Health: essential for sustainable development: United Nations resolution on universal health coverage**

6 December 2012. Available at [bit.ly/WHO4-UHC](https://bit.ly/WHO4-UHC)

This resolution, adopted on 12 December 2012, urges the governments of all Member States to move towards providing all people with access to affordable, quality health-care services. The resolution reaffirms WHO's leading role in supporting countries as they respond to the challenges of achieving universal health coverage. It specifically recognizes the role of health in achieving international development goals and calls for more attention from Member States, civil society and international organizations to health as an important cross-cutting policy issue on the international agenda. It notes that health is a precondition and an outcome and an indicator of all three dimensions of sustainable development, and invites Member States to recognize the links between the promotion of UHC and other foreign policy issues, and to place universal health coverage high on the international development agenda. The need for a multisectoral approach in overcoming the obstacles facing health is also noted.

## 3. Equity and Social Protection

Michelle Bachelet

### **Towards universal health coverage: applying a gender lens**

*The Lancet*, Early Online Publication (October 2014). Available at [bit.ly/BacheletUHC](http://bit.ly/BacheletUHC).  
DOI: 10.1016/S0140-6736(14)61781-5

Investment in the health and wellbeing of women and girls is not only the right thing to do from a moral and human rights perspective, but it is also smart, strategic, and cost-effective. Because health is a function not only of the health sector but of government, combined with one's working and living conditions, psychosocial status, and other socioeconomic factors, approaches taken by Latin American governments to address the gender dimensions of health reforms are in some cases overlooked because they lie outside the health sector. Therefore, application of a so-called gender lens, defined as the social and cultural constructs that prescribe men's and women's roles in society, requires looking at the health sector and beyond to examine the range of social reforms that affect health outcomes.

There is no better investment that a country can make to extend democracy, justice, and economic growth than investing in girls and women. In our complex world and in view of unprecedented economic, demographic, and environmental challenges, we can no longer afford to waste the potential of half the world's population. Addressing these challenges will need a health response with a special focus on women.

Carissa Etienne

### **Achieving universal health coverage is a moral imperative**

*The Lancet*, Early Online Publication (October 2014).  
Available at [bit.ly/Etienne2UHC](http://bit.ly/Etienne2UHC). DOI: 10.1016/S0140-6736(14)61679-2

Although many countries have used provisions in their constitutions, global or regional human rights instruments that guarantee the right to health, universal access to quality health care is still a challenge. An increased and intensified effort is required to overcome this challenge.

We must strive for a comprehensive approach to the delivery of health care, ensuring prevention and health promotion, treatment, rehabilitation, and palliation for all. Each country must define its own roadmap towards universal health coverage, taking into consideration its historic, cultural, political, and economic context. National roadmaps should not focus exclusively on the health systems model or on financial reform processes. Instead, health systems must build on what exists and on what has been achieved to improve health outcomes and reduce inequities. These must be predicated on universality in access to comprehensive quality services, and solidarity to ensure financial protection for all.

Christine Goepfel

### **Universal health coverage for elderly people with non-communicable diseases in low-income and middle-income countries: a cross-sectional analysis**

*The Lancet* 384 (October 2014), page S6. Available at [bit.ly/GoepfelUHC](http://bit.ly/GoepfelUHC).

DOI: 10.1016/S0140-6736(14)61869-9

Population ageing and the growing burden of non-communicable diseases are crucial challenges for low-income and middle-income countries, especially because of their effects on the economy and on development and competitiveness indicators. The authors assessed health coverage for elderly people with non-communicable diseases in six low-income and middle-income countries (China, Ghana, India, Mexico, Russia, and South Africa) from the WHO Study on global AGEing and adult health. They found that effective coverage rates ranged from 20.7% of patients in Mexico, to 48.2% of patients in South Africa. In all the countries studied, health insurance was found to be associated with health coverage but it is insufficient to ensure universal health coverage. Differences in effectiveness and equity within and between low-income and middle-income countries relate to the social circumstances in each country, and determine the challenges of achieving universal health coverage.

Ahmad Reza Hosseinpoor et al

## **Equity Oriented Monitoring in the Context of Universal Health Coverage**

*PLOS Med* 11, no.9 (September 2014). Available at [bit.ly/HosseinpoorUHC](http://bit.ly/HosseinpoorUHC).

DOI: [10.1371/journal.pmed.1001727](https://doi.org/10.1371/journal.pmed.1001727)

Monitoring inequalities in health is fundamental to the equitable and progressive realization of universal health coverage (UHC). A successful approach to global inequality monitoring must be intuitive enough for widespread adoption, yet maintain technical credibility. This article discusses methodological considerations for equity-oriented monitoring of UHC, and proposes recommendations for monitoring and target setting. Inequality is multidimensional, such that the extent of inequality may vary considerably across different dimensions such as economic status, education, sex, and urban/rural residence, and inequality spans populations. The authors recommend targets for monitoring across populations and subgroups. Building capacity for health inequality monitoring is timely, relevant, and important. The development of high-quality health information systems, including data collection, analysis, interpretation, and reporting practices that are linked to review and evaluation cycles across health systems, will enable effective global and national health inequality monitoring. These actions will support equity-oriented progressive realization of UHC.

**International Labour Organization**

## **Addressing the Global Health Crisis: Universal Health Protection Policies**

ILO, Social Protection Policy Papers, Paper 13. December 2014.

Available at [bit.ly/ILO2-UHC](http://bit.ly/ILO2-UHC)

This policy paper (i) examines the dimensions of the global health crisis based on severe deficits in health protection and limited access to needed health care; (ii) presents the extent of the health crisis at global, regional and national levels as well as rural/urban divergences within countries and their root causes; (iii) suggests policy options to address the health protection crisis using the framework of national social protection floors by focusing on inclusive legislation and adequate financing as well as making quality services available and providing financial protection; (iv) concludes that progressing towards universal health protection is possible by

developing a three step approach that yields highest rates of returns in terms of sustainability, economic growth and equity. The annexes present global data on total health expenditure, health coverage and skilled health workers for 171 countries.

Knut Lonnroth et al

## **Beyond UHC: Monitoring Health and Social Protection Coverage in the Context of Tuberculosis Care and Prevention**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/LonnrothUHC](http://bit.ly/LonnrothUHC).

DOI: 10.1371/journal.pmed.1001693

In addition to the post-2015 Sustainable Development Goals, WHO has developed a post-2015 Global TB Strategy that emphasizes the necessity of UHC to the improvement of TB care and prevention. This paper discusses indicators and measurement approaches for both UHC and social protection as they relate to tuberculosis. While access to high-quality TB diagnosis and treatment has improved dramatically in recent decades, there is still insufficient coverage, especially for correct diagnosis and treatment of multi-drug resistant TB. The continued and expanded monitoring of effective coverage of TB diagnosis and treatment is needed, for which further improvements to existing surveillance systems are required.

In addition to coverage shortcomings, many households still face severe financial hardship as a result of tuberculosis infection. Out-of-pocket costs for medical care, transport, and food are often high, though income loss remains the largest financial threat for TB-affected households. Consequently, the financial risk protection target in the post-2015 Global TB Strategy is more inclusive than the one conventionally used for Universal Health Coverage – “catastrophic health expenditure” – which concerns only direct medical costs. The post-2015 Global TB Strategy proposes that “no TB affected families experience catastrophic costs due to TB,” encompassing all direct medical costs as well as income loss.

Svetla Loukanova et al

## **Universal Health Coverage for Chronic Diseases – A challenge in Low and Middle-Income Countries**

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, Discussion Papers on Social Protection, Issue no. 22 (April 2014). Available at [bit.ly/LoukanovaUHC](http://bit.ly/LoukanovaUHC)

This paper discusses perspectives and possible prospects regarding universal health coverage, taking into consideration that there is no single model for achieving UHC in the context of a growing chronic disease burden and demographic transition. The central focus is on the financial coverage of services for chronic care provision alongside the other dimensions of quality of UHC services and equity in access. This paper aims to contribute to the discussion on how to cope with these challenges and to show possible ways for a holistic approach to strengthening health systems. It examines the links between UHC and noncommunicable diseases, focusing on the financing and equity agendas as they relate to chronic conditions. Measurement and quality improvement tools are also discussed, particularly in the context of low- and middle-income countries. The paper presents several suggestions for the way forward for LMICs and development cooperation.

Gorik Ooms et al

## **Is Universal Health Coverage the Practical Expression of the Right to Health Care?**

*BMC International Health and Human Rights* 14, no.3 (February 2014).  
Available at [bit.ly/Ooms2UHC](http://bit.ly/Ooms2UHC). DOI: 10.1186/1472-698X-14-3

This article discusses a comparative normative analysis conducted with the aim of validating the WHO contention that universal health coverage is “by definition, a practical expression of the concern for health equity and the right to health.” The authors pose the question: if UHC became the new ‘single overarching’ health goal, with the political normative power the MDGs do seem to have, what can people expect this goal to achieve, and would that outcome really provide the practical or political translation of what people can legitimately expect from the right to health? An overview of authoritative sources regarding the right to health care is provided, followed by a comparison of this right with the right to universal health coverage. In the comparison, the authors find one missing element in the equation of universal health

coverage with the right to health: a straightforward confirmation that international assistance is essential, not optional. In 2013, the United Nations Sustainable Development Solutions Network proposed an understanding of UHC as a “work in progress,” in which all countries achieve universal health coverage at every stage in life, and which sets out a series of global financing targets. Ooms et al. conclude that this proposal for UHC by the UNSDSN can be considered a practical expression of the right to health care.

**Jonathan Quick, Jonathan Jay & Ana Langer**

## **Improving Women’s Health through Universal Health Coverage**

*PLoS Med* 11, no.1 (January 2014). Available at [bit.ly/QuickUHC](http://bit.ly/QuickUHC).

DOI: 10.1371/journal.pmed.1001580

The new post-2015 framework for improving lives must pass the vital test of reducing inequalities, especially gender-related ones, as a critical step towards the improvement of women’s health. Measurably improving women’s health throughout the life course will contribute to other post-2015 goals. Conversely, women’s social empowerment through education, participation in the labor market, and political representation will improve health. As a result the authors argue that the next iteration of the development goals has to embrace women’s health and wellbeing as a key priority, particularly since indicators for women’s health in the current MDGs, including maternal mortality, are among those lagging farthest behind. They further note that on-going policy debates around the post-2015 development agenda provide a unique window of opportunity to advance a comprehensive women’s health agenda. Additionally, in this article the authors analyze the connection between UHC and the women’s health agenda, recommending policy measures that can help to ensure that adoption of UHC, as part of the post-2015 framework and implementation of UHC in national health systems, will directly contribute to improving women’s health.

Kevin Watkins

## Leaving no one behind: an agenda for equity

*The Lancet*, Early Online Publication (May 2014). Available at [bit.ly/WatkinsUHC](http://bit.ly/WatkinsUHC).

DOI: 10.1016/S0140-6736(13)62421-6

Ensuring that no one is left behind from universal health care reforms will require fundamental changes in patterns of growth, linked to changes in how governments allocate resources, deliver services, and respond to the needs of their most marginalized citizens. However, well-designed equity targets could turn the spotlight on the most marginalized sections of society and help policy makers remember what they seem to have forgotten: the face of the poorest people.

Although there are no simple equity targets for wealth distribution, such targets are both feasible and desirable in other sectors. When it comes to basic life changes – for survival, nutrition, education, and wider opportunities – narrowing gaps should be an explicit policy goal. Three broad principles should guide policy. First, the targets themselves should be understandable and aligned to goals set for 2030. Rather than being viewed as a standalone commitment, they should be seen as a stepping stone that will, if reached, accelerate progress towards ambitious national goals by enhancing equity. Second, the targets should be developed through national debates between governments, civil society, trades unions, health-care workers, education specialists and others, rather than prescribed on a top-down basis, implying a degree of flexibility in design. The aim should be to develop a set of targets and measures through which governments report first and foremost to their own citizens on progress in reducing social and economic disparities in life chance. Third, the targets should be universal and applicable to high-income countries as well as low-income countries. One of the weaknesses of the MDG framework was that it provided a set of targets drawn up by rich countries for the governments of poor countries to report on through the UN. Inequality is a growing concern across countries at all income levels—and well-crafted goals for equity could mobilize a support for universal healthcare reforms in the rich world.

World Health Organization

## **Making fair choices on the path to universal health coverage: final report of the WHO Consultative Group on Equity and Universal Health Coverage**

2014. Available at [bit.ly/WHO5-UHC](http://bit.ly/WHO5-UHC)

Since 2010, more than seventy countries have requested policy support and technical advice for universal health coverage (UHC) reform from the World Health Organization (WHO). As part of the response, WHO set up a Consultative Group on Equity and Universal Health Coverage. This final report by the Consultative Group addresses the key issues of fairness and equity that arise on the path to UHC by clarifying these issues and by offering practical recommendations.

To achieve UHC, countries must advance in at least three dimensions. Countries must expand priority services, include more people, and reduce out-of-pocket payments. Yet in each of these dimensions, countries are faced with a critical choice: Which services to expand first, whom to include first, and how to shift from out-of-pocket payment toward prepayment? A commitment to fairness—and the overlapping concern for equity—and a commitment to respecting individuals' rights to health care must guide countries in making these decisions. The following three-part strategy can be useful for countries seeking fair progressive realization of UHC: 1) Categorize services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to the worse off, and financial risk protection. 2) First expand coverage for high-priority services to everyone. This includes eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds. 3) When doing this, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations.

## 4. Health Systems Financing

Victoria Fan & William Savedoff

### **The health financing transition: a conceptual framework and empirical evidence**

*Social Science & Medicine* 105 (March 2014), pages 112-121.

Available at [bit.ly/FanUHC](http://bit.ly/FanUHC). DOI: 10.1016/j.socscimed.2014.01.014

Almost every country exhibits two important health financing trends: health spending per person rises and the share of out-of-pocket spending on health services declines. The authors describe these trends as a “health financing transition” to provide a conceptual framework for understanding health markets and public policy. Using data over 1995–2009 from 126 countries, this framework examines the various explanations for changes in health spending and its composition. A significant upward trend in health spending is seen – an increase of about 1 per cent annually – which is associated with a combination of changing technology and medical practices, cost pressures and institutions that finance and manage healthcare. The out-of-pocket share of total health spending is not related to income, but is influenced by a country’s capacity to raise general revenues. These results support the existence of a health financing transition and characterize how public policy influences these trends.

Anne Mills

### **Universal Health Coverage: The Holy Grail? 21st Annual Lecture Publication**

Office of Health Economics, Annual Lecture, June 2014. Available at [bit.ly/Mills3UHC](http://bit.ly/Mills3UHC)

Mills examines the three key components of a UHC system: sources of finance, financial intermediaries, and service providers. UHC and these three key components are discussed in the context of low- and middle-income countries with a focus on applying the learnings from the experience of countries already involved in addressing the key challenges in making progress towards UHC. The discussion is further framed around the priorities of different stakeholders involved in the health system, including population/patients, service providers, financial intermediaries, and

governments/professional organizations. Five elements fundamental to the provision of universal health coverage are outlined: 1) the appropriate combination of financing sources, including a core mandatory mechanism; 2) means to extend financial protection, notably to the informal sector and the non-working population; 3) a strong purchasing role encompassing both public and private providers, with emphasis on health promotion and prevention; 4) payment systems with appropriate incentives for cost containment and quality of care; and 5) strong primary-care and local-level infrastructure with geographical access reaching poorer areas. Additionally a number of institutional elements are called out for the implementation of UHC, and include: a robust civil service with sufficient capability, including human and financial resources, to implement health programs and policies; institutions which integrate the voices of disadvantaged or poor populations in policy debates and decisions; a way to resolve the divide between healthcare financing and provision arrangements for the rich and for the rest of the population; and sufficient social solidarity to finance coverage across income groups.

Gorik Ooms et al

### **Beyond Health Aid: would an international equalization scheme for universal health coverage serve the international collective interest?**

*Globalization and Health* 10 (May 2014), page 41. Available at [bit.ly/Ooms3UHC](http://bit.ly/Ooms3UHC).

DOI: 10.1186/1744-8603-10-41

Using the Sustainable Development Solutions Network proposal to finance universal health coverage as a test case, this article examines the hypothesis that national social policies face the threat of a ‘race to the bottom’ due to global economic integration and that this threat could be mitigated through international social protection policies that include international cross-subsidies – a kind of ‘equalization’ at the international level. The investigation finds that the evidence for the race to the bottom theory is inconclusive and that in fact a ‘convergence to the middle’ was instead taking place. Yet, the ‘middle’ where ‘convergence’ of national social policies is likely to occur may not be high enough to keep income inequality in check. The authors highlight that the implementation of the international equalization scheme proposed by the Sustainable Development Solutions Network would serve to ensure universal health coverage at a cost of US\$55 in low income countries-the minimum cost estimated by the World Health Organization, and that the domestic efforts expected from low and middle countries would be far more substantial than the international co-financing efforts expected from high income countries. As a result, this would contribute to ‘convergence’ of national social policies at a higher level, hence that this international

equalization scheme should not be considered as foreign aid, but rather as an international collective effort to protect and promote national social policy in times of global economic integration.

Daniel Titelman, Oscar Cetrangolo & Olga Lucia Acosta

### **Universal health coverage in Latin American countries: how to improve solidarity-based schemes**

*The Lancet*, Early Online Publication (October 2014). Available at [bit.ly/TitelmanUHC](http://bit.ly/TitelmanUHC).  
DOI: 10.1016/S0140-6736(14)61780-3

This article explores the association between the financing structure of health systems and universal health coverage. Latin American health systems encompass a wide range of financial sources, which translate into different solidarity-based schemes that combine contributory (payroll taxes) and non-contributory (general taxes) sources of financing. To move towards universal health coverage, solidarity-based schemes must heavily rely on countries' capacity to increase public expenditure in health. Improvement of solidarity-based schemes will need the expansion of mandatory universal insurance systems and strengthening of the public sector including increased fiscal expenditure. These actions demand a new model to integrate different sources of health-sector financing, including general tax revenue, social security contributions, and private expenditure. The extent of integration achieved among these sources will be the main determinant of solidarity and universal health coverage. The basic challenges for improvement of universal health coverage are not only to spend more on health, but also to reduce the proportion of out-of-pocket spending, which will need increased fiscal resources.

## 5. Health Systems Delivery

Gloria Coe & Joy de Beyer

### **The imperative for health promotion in universal health coverage**

*Global Health: Science and Practice* 2, no.1 (February 2014), pages 10-22.

Available at [bit.ly/CoeUHC](http://bit.ly/CoeUHC). DOI: 10.9745/GHSP-D-13-00164

The authors assert that health promotion should be front and center in universal health coverage efforts. Health promotion and disease prevention have huge impacts on health, yet given low priority, risk being overlooked in universal health coverage efforts. Universal health coverage tends to focus on health “care” and health “services,” often in the context of health “insurance.” That leads to an emphasis on curative care. Ironically, health promotion generally takes a back seat, despite its enormous importance for well-being. And the surging rates of noncommunicable diseases and injuries (NCDIs) in developing countries only strengthen the need for prevention and health promotion. To effectively prioritize promotion and prevention, qualified health professionals are needed with expertise in domains as diverse as legislation and health policy, social and behavior change communication, prevention and community health, health journalism, environmental health, and multisectoral health promotion. This article advocates that national policy and decision-makers should rebalance efforts in the health field to do far more to promote health and prevent disease.

Karen Grepin

### **The role of the private sector in delivering maternal and child health services in low-income and middle-income countries: an observational, longitudinal analysis**

*The Lancet* 384 (October 2014), page S7. Available at [bit.ly/GrepinUHC](http://bit.ly/GrepinUHC).

DOI: 10.1016/S0140-6736(14)61870-5

There is debate about the role of the private sector in the delivery of health services in low-income and middle-income countries (LMICs) and its potential contribution towards achieving universal health coverage. However, the share of health services provided by the private sector

is poorly understood. This study investigated the share and trends of selected health services delivered by the private sector in low-income and middle-income countries from 1990 to 2012. The share of key maternal, child, and reproductive health services (source of treatment of diarrhoea, source of treatment of fever or cough, source of modern family planning methods, location of delivery, and location of antenatal care) that were provided by the private medical sector were calculated and assessed over time. It was found that the private medical sector provided more than half of treatments for diarrhoea (54%) and fever or cough (57%) but substantially less for other health services: family planning (31%), deliveries (13%), and antenatal care (27%). Wealthier, more educated, and urban households were more likely than were other households to use the private sector. It is clear that in LMICs, the private sector plays an important—although not necessarily dominant—part in the provision of health services. It is an important complement to public health services and governments should further engage the private sector as they move towards universal health coverage.

**Luis Gomes Sambo & Joses Muthuri Kirigia**

## **Investing in health systems for universal health coverage in Africa**

*BMC International Health and Human Rights* 14, no.28 (October 2014).

Available at [bit.ly/SamboUHC](http://bit.ly/SamboUHC). DOI: 10.1186/s12914-014-0028-5

This study highlights the current situation of the health systems' components in the African Region and the way they affect the coverage of health MDGs. This study focuses on the 47 Member States of the World Health Organization (WHO) African Region. It examines the health systems' components, analyzes the correlation between the interventions related to the health Millennium Development Goals (MDGs) and some health systems' components, and provides an overview of four major thrusts for progress towards universal health coverage (UHC).

The analysis reveals the existence of substantial deficits in health systems' components and access to health care, of gaps in densities of health personal in the Region, as well as of high rates of household out-of-pocket spending on healthcare. Some of these gaps in health system components were found to be correlated to coverage gaps in interventions for maternal health (MDG 5), child health (MDG 4) and HIV/AIDS, TB and malaria (MDG 6). It is therefore imperative that countries adopt the 2014 Luanda Commitment on UHC in Africa as their long-term vision, and that they back it with sound policies and plans with clearly engrained road maps for strengthening national health systems and addressing the social determinants of health.

## 6. Health Workforce

Andrew Cashin

### **The Challenge of Nurse Innovation in the Australian Context of Universal Health Care Collegian**

April 2014. Available at [bit.ly/CashinUHC](http://bit.ly/CashinUHC). DOI: 10.1016/j.colegn.2014.03.006

Universal health care is a global mission and was the theme of the 2013 Congress of the International Council of Nurses. Universal health care as a concept represents a fundamental shift from the development and funding of discrete interventions or programs, to that of developing and funding entire systems of health care. The three critical elements required are: a clear definition of what is considered health care and funded for who, how the system is financed, and evaluation. Australia has a system of universal health care that addresses all three elements. As nursing pushes further into the realm of primary health care in Australia, the challenges to achieving reasonable federal funding for nursing services need to be considered. This consideration must be underpinned by a comprehensive understanding of the concept of universal health care, how the concept relates to the Australian health care context, and the resultant challenges to innovation in health care service delivery in Australia. While the existing approach to universal health coverage was initially resisted by organized medical practitioners, they have adapted to the current system and now fiercely resist change. These medico-centric attitudes inhibit innovation and pose challenges to sustainability. The article illustrates this innovation challenge, analyzing the implementation of the financial policy that gave Nurse Practitioners access as providers and prescribers for Medicare funded services.

Allison Annette Foster, Kate Tulenko & Edward Broughton

## **Community Health Workers and Universal Health Coverage: Monitoring and accountability platform**

World Health Organization, Global Health Workforce Alliance. October 2013.

Available at [bit.ly/FosterUHC](https://bit.ly/FosterUHC)

This paper is one of three Working Papers commissioned by the Global Health Workforce Alliance to provide a platform for discussion around how better to capture synergies, harmonize support and address knowledge gaps in planning, developing and delivering on Community Health Worker (CHW) programs. Together with the Framework for Partners' Harmonized Support, this paper proposes a complimentary operational frameworks through which national and international partners may align their actions with the collective goal to normalize a cadre of community workers and collaborate toward integrated, harmonized program designs, rather than competitive, siloed, and parallel interventions.

As Ministries of Health and global stakeholders have strengthened health systems toward attaining MDGs 4, 5, and 6, they have seen a growing role for community health workers (CHWs). Particularly for low resource environments, remunerated and volunteer CHWs possessing basic primary service skills have widened access and filled critical care gaps, enabling progress in a wide range of health outcomes. Despite the growing role of CHWs, improvements are needed in the process for developing and managing CHW programs. Although many CHWs are volunteers or receive minimum stipends and/or per diem for their contribution, certain CHW roles have evolved in such a way that formal recognition within the country health systems would be more appropriate. Recognizing this role as an institutionalized component of the primary health care system, countries will soon, if they have not already, adjust their policies to include community health workers as a part of the national human resources for health (HRH). Policies that formally recognize that contribution – in such areas as medicine dispensary and immunizations – will be advantageous to planners as they calculate staffing and resource needs. Such calculations would include considerations on the resources and infrastructure needed for program management and performance support.

As stakeholders further define their individual roles in strengthening the integration and harmonization of CHW programs and the systems in which they work, the indicators proposed here aim to provide a means of benchmarking progress and achievements within countries and across the global community. The indicators proposed in this paper have been selected

according to several criteria: 1) Alignment with the Framework for Partners' Harmonized Support; 2) Coordination and Enhancement of Existing HRH indicators; 3) Feasibility; 4) Systems Strengthening.

### Global Health Workforce Alliance

## **Human Resources for Health: foundation for Universal Health Coverage and the post-2015 development agenda**

Report, Third Global Forum on Human Resources for Health, Recife, Brazil. June 2014.  
Available at [bit.ly/GHWA2-UHC](http://bit.ly/GHWA2-UHC)

The Third Global Forum on Human Resources for Health provided an opportunity for an inclusive dialogue with many stakeholders involved in efforts to develop human resources both in countries and globally. The Forum shed light on what universal health coverage really means in relation to human resources for health. The report summarizes the thematic debates and discussions and various other activities of the Forum. The conference had a dual purpose: a technical one in the form of an event to share new evidence, best practices and lessons learned among experts and planners in human resources for health; and a political one to galvanize the support of policy-makers.

The highlights of the Third Global Forum were the political statements presented in the Recife Political Declaration on Human Resources for Health as well as more than 80 commitments made by WHO Member States and member organizations of the Global Health Workforce Alliance. A holistic agenda on human resources for health, instrumental to attaining universal health coverage will require interconnected efforts at the national and global levels in support of four main areas of action discussed at the conference:

- Anticipating and adapting to new challenges;
- Articulating ambitious targets with a long time horizon (10–15 years), including producing larger number of health workers and establishing benchmarks for the performance of higher education and employment;
- Broadening participation in policy development and response beyond the public health sector by engaging other key constituencies and sectors and creating accountability mechanisms to support and oversee implementation; and
- Innovating through more efficient and rational planning and use of financial and human resources in the health sector and towards more results-focused implementation.

Global Health Workforce Alliance, World Health Organization

## **A Universal Truth: No Health without a Workforce**

Report, Third Global Forum on Human Resources for Health. November 2013.

Available at [bit.ly/GHWA-UHC](http://bit.ly/GHWA-UHC)

This flagship report was commissioned by the Global Health Workforce Alliance Secretariat and the World Health Organization to consolidate the latest information available on human resources for health and provide recommendations to the global community on how to attain, sustain and accelerate progress on universal health coverage. The report was launched at the Third Global Forum on Human Resources for Health, informing discussions at this landmark event. Following requests for clarification on the report and a further quality check on the human resources for health (HRH) data used for the analysis, the initial Report was updated to provide a more explicit and detailed breakdown of the HRH estimates in each of the country profile.

Adam Koon & Susannah Mayhew

## **Strengthening the health workforce and rolling out universal health coverage: The need for policy analysis**

*Global Health Action* 6 (July 2013), page 21852. Available at [bit.ly/KoonUHC](http://bit.ly/KoonUHC).

DOI: 10.3402/gha.v6i0.21852

This article opens a debate about how to think about moving forward with the emerging twin movements of human resources for health (HRH) and universal health coverage (UHC). There is sufficient evidence to warrant these movements, but actors and the policy process significantly affect which policies are adopted and how they are implemented. How exactly this occurs in low- and middle-income countries (LMICs) is not very well understood, and it is not clear whether actors will mobilize for or against the emergent HRH and UHC agendas. The authors argue that not only should the movement for UHC be paired with current efforts to address the human resources crisis, but also, for both to succeed, that more needs to be known about how health policy works in LMICs.

Angelica Sousa et al

## **Health labour market policies in support of universal health coverage: a comprehensive analysis in four African countries**

*Human Resources for Health* 12, no.55 (September 2014). Available at [bit.ly/Sousa2UHC](https://bit.ly/Sousa2UHC). DOI: 10.1186/1478-4491-12-55

Progress toward universal health coverage in many low- and middle-income countries is hindered by the lack of an adequate health workforce that can deliver quality services accessible to the entire population. This study used a health labor market framework to investigate the key indicators of the dynamics of the health labor market in Cameroon, Kenya, Sudan, and Zambia, and identified the main policies implemented in these countries in the past ten years to address shortages and maldistribution of health workers. The investigation found that despite increased availability of health workers in the four countries, major shortages and maldistribution persist. Several factors aggravate these problems, including migration, an aging workforce, and imbalances in skill mix composition. The authors provide new evidence that partial health workforce policies are not sufficient to address planning in low- and middle-income countries.

## 7. Metrics

Ties Boerma et al

### **Monitoring Progress towards Universal Health Coverage at Country and Global Levels**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/BoermaUHC](http://bit.ly/BoermaUHC).

DOI: 10.1371/journal.pmed.1001731

This paper summarizes the findings from 13 country case studies and five technical reviews, which were conducted as part of the development of a global framework for monitoring progress towards UHC. The case studies show the relevance and feasibility of focusing UHC monitoring on two discrete components of health system performance: levels of coverage with health services and financial protection, with a focus on equity. These components link directly to the definition of UHC and measure the direct results of strategies and policies for UHC. The summary report notes that most countries do not have an explicit framework for UHC monitoring, though the monitoring of UHC is often partially embedded in regular overall health sector progress and performance reviews. Major gaps in the availability and quality of data required for monitoring progress towards UHC exist, leading countries to mostly rely on international survey programs or national surveys to obtain disaggregated data on coverage and financial protection indicators. While these are often complemented by health facility data, the frequency and contents of these surveys are insufficient to meet countries' information needs. Overall, monitoring progress towards the two components of UHC will be complementary and critical to achieving desirable health outcome goals.

Ties Boerma, Carla AbouZahr, David Evans & Tim Evans

### **Monitoring Intervention Coverage in the Context of Universal Health Coverage**

*PLoS Med* 11, no.9 (September 2014), page e1001728. Available at [bit.ly/Boerma2UHC](http://bit.ly/Boerma2UHC). DOI:

10.1371/journal.pmed.1001728

Monitoring universal health coverage is integral to overall tracking of health progress and performance, and should focus on indicators of financial protection and coverage, with a

strong equity focus. A few measurable and understandable indicators to monitor progress can be a powerful way of galvanizing efforts to move towards UHC. A comprehensive core set of country specific indicators should be monitored on a regular basis as part of health progress and systems performance assessment for all countries. UHC monitoring should be embedded in a broad results framework at the country level, but also include indicators related to coverage of services that most directly reflect UHC investments and strategies in each country. Countries should not limit themselves to tracking a small set of indicators that are included in internationally agreed development goals but should also work to progressively include additional indicators that are locally important.

Several steps are recommended for country monitoring of UHC, including ensuring that there is a fully developed regular system of health progress reviews and systems performance assessment of the national health sector strategic plan, including annual health sector reviews; embedding UHC monitoring within the overall monitoring and review system; selecting a set of tracer indicators for financial protection and coverage, divided into promotion and prevention, and treatment, that address the main intervention areas; ensuring special attention for the quality dimension of the interventions; and investing in data sources that should include timely, accurate, complete facility data, and a regular health examination survey that collects information on all priority health topics.

Carlos Dora et al

## **Indicators Linking Health and Sustainability in the post-2015 Development Agenda**

*The Lancet*, Early Online Publication (June 2014). Available at [bit.ly/DoraUHC](http://bit.ly/DoraUHC).

DOI: 10.1016/S0140-6736(14)60605-X

The UN-led discussion about the post-2015 sustainable development agenda provides an opportunity to develop indicators and targets that show the importance of health as a pre-condition for and an outcome of policies to promote sustainable development. This article presents a rationale and methods for the selection of health-related indicators to measure progress of post-2015 development goals in non-health sectors. The proposed indicators show the ancillary benefits to health and health equity (co-benefits) of sustainable development policies, particularly those to reduce greenhouse gas emissions and increase resilience to environmental change. The authors use illustrative examples from four thematic areas: cities, food and agriculture, energy, and water and sanitation.

Some proposed indicators can be used to monitor progress in more than one development area, and the potential indicators covered in this review are examples that connect development policies, determinants of health, and health outcomes. Indicators showing such linkages can support better governance, improve accountability, and facilitate communication with communities, civil society, and the private sector. They constitute a key guide for the health sector to support implementation of Health in All Policies, and a contribution to the OWG deliberations. Embedding a range of health-related indicators in the post-2015 goals can help to raise awareness of the probable health gains from sustainable development policies, thus making them more attractive to decision makers and more likely to be implemented than before.

**Andrea Feigl & Eric Ding**

### **Evidenced Formal Coverage Index and Universal healthcare enactment: A prospective longitudinal study of economic, social, and political predictors of 194 countries**

*Health Policy Journal* 113, no.1-2 (November 2013) pages 50-60.

Available at [bit.ly/FeiglUHC](http://bit.ly/FeiglUHC). DOI: 10.1016/j.healthpol.2013.06.009

Determinants of universal healthcare (UHC) are poorly empirically understood. The authors undertook a comprehensive study of UHC development using a novel Evidenced Formal Coverage (EFC) index that combines three key UHC elements: legal framework, population coverage, and accessibility. Applying the EFC index measures (legislation,  $\geq 90\%$  skilled birth attendance,  $\geq 85\%$  formal coverage) to 194 countries, aggregating time-varying data from 1880–2008, this study investigates which macro-economic, political, and social indicators are major longitudinal predictors of developing EFC globally. The novel EFC index and this longitudinal prospective study together indicate that investments in economic growth and in education should both be seen as equally important for the development of UHC. The findings help to understand the social and political drivers of universal healthcare, especially for transitioning countries.

Overall, 75 of 194 countries implemented legal-text UHC legislation, of which 51 achieved EFC. In an analysis of EFC prediction, higher GDP-per-capita, higher primary school completion, and higher adult literacy were significantly associated with achieving EFC. Results also identify a minimum level GDP-per-capita for development of EFC. GDP-per-capita and education were each

robust UHC predictors in middle-income countries, and education remained a significant predictor for UHC even after controlling for GDP growth over time. For income-inequality, the GINI coefficient was suggestive in its role in predicting EFC: for each doubling of the GINI coefficient (greater inequality), the likelihood of universal health care development decreased by 72%.

For social and political indicators, a greater degree of ethnic fractionalization, non-proportional electoral systems, and dictatorships were further negatively associated with EFC. Both democracy and proportional political representation were major factors in determining whether or not a country was likely to achieve universal health care. If a country had proportional representation, it was nearly three times as likely to have universal health care as countries without such a system; if a country was a democracy as opposed to a dictatorship, the likelihood jumped 10-fold. Further, for each 25% increase in ethnic fractionalization in a country, the likelihood of achieving universal health care dropped by 49%.

Marie Ng et al

## **Effective Coverage - a Metric for Monitoring Universal Health Coverage**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/NgUHC](http://bit.ly/NgUHC).

DOI: 10.1371/journal.pmed.1001730

A major challenge in monitoring universal health coverage (UHC) is the identification of an indicator that can adequately capture the multiple components underlying UHC. This paper reviews the concept of effective coverage and outlines three components of a metric for monitoring effective coverage — need, use, and quality — using several examples. Further, it describes how the metric can be used for monitoring interventions at both local and global levels and discusses the ways that current health information systems can support generating estimates of effective coverage.

The recommendations for tracking effective UHC include first, reviewing existing evidence on disease burden, affordable interventions and social priorities; second, developing strategies to measure needs, use, and quality; and third, building system capacity for measuring coverage. Among these considerations, building capacity for data collection and use remains the most substantial hurdle in achieving broad rates of effective coverage. Without further developing the strength and use of routine health information systems, tracking national and

subnational progress towards health goals, such as UHC, is likely to be more resource-intensive and prone to suboptimal accuracy. By harnessing existing health information systems and expanding their capacity, countries can ensure that effective coverage aligns with their specific UHC needs and more accurately monitor progress towards their UHC goals.

Priyanka Saksena, Justine Hsu & David Evans

## **Financial Risk Protection and Universal Health Coverage: Evidence and Measurement Challenges**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/SaksenaUHC](http://bit.ly/SaksenaUHC).

DOI: [10.1371/journal.pmed.1001701](https://doi.org/10.1371/journal.pmed.1001701)

Financial risk protection is a key component of universal health coverage (UHC), which is described as access to all needed quality health services without financial hardship. The aim of this paper is to examine and to compare and contrast existing measures of financial risk protection. The paper presents the rationale behind the methodologies for measuring financial risk protection and how this relates to UHC as well as some empirical examples of the types of measures. Three key recommendations for measuring financial risk protection as a component of UHC schemes are presented. First, at the country level, routinely measure the incidence of financial catastrophe and impoverishment and associated inequalities to understand if the situation is improving. Second, where possible, measure the catastrophic overshoot and the difference in the poverty gap for further insights. Finally, where possible, standardize survey instruments and data on the use of health services. This paper also presents the specific challenges related to monitoring inequalities in financial risk protection. An examination and documentation of the practical challenges associated with measurement of financial risk protection contextualizes the recommendations.

Kirstin Scott & Ashish Jha

## Putting Quality on the Global Health Agenda

*The New England Journal of Medicine* (July 2014), pages 3-5. Available at [bit.ly/ScottUHC](http://bit.ly/ScottUHC). DOI: 10.1056/NEJMp1402157

This article cites Janani Suraksha Yojana (JSY), a conditional cash-transfer program in India, as evidence that increases in access to health care services does not necessarily have any effect on patient outcomes. This critical lesson must inform Universal Health Coverage expansions, as simply augmenting access will not be enough to improve the health of the world's population. The essay outlines how and why reforms must ensure that the care provided under UHC schemes is of high quality, based on the Institute of Medicine's description of safe, effective, patient-centered, efficient, timely, and equitable care. Of these six features of quality care, there is evidence of substantial deficiencies in the first three: safe, effective, and patient-centered. The major challenges to improving these features of quality care include a lack of metrics, lack of data, and resistance to change.

The authors argue that, at its core, the agenda for quality could focus on systematic measurement of performance, and the resulting data could be fed back to both providers and policymakers. Without a basic understanding of the current level of quality of care, it will be difficult to improve. Policymakers might consider additional strategies beyond measurement, such as promoting transparency, financially incentivizing high-quality care, and investing in health information and communications technologies. Although each of these strategies holds promise, focusing on robust and timely collection of data on meaningful quality metrics is foundational.

World Health Organization, World Bank

## Monitoring progress towards universal health coverage at country and global levels: Framework, measures and targets

May 2014. Available at [bit.ly/WHO-WB3-UHC](http://bit.ly/WHO-WB3-UHC)

This paper proposes a framework for tracking country and global progress towards UHC; its aim is to inform and guide these discussions and assessment of both aggregate and equitable coverage of essential health services as well as financial protection. Monitoring progress

towards these two components of UHC will be complementary and critical to achieving desirable health outcome goals, such as ending preventable deaths and promoting healthy life expectancy and also reducing poverty and protecting household incomes.

This paper was written jointly by the World Health Organization (WHO) and The World Bank Group on the basis of consultations and discussions with country representatives, technical experts and global health and development partners. A draft was posted online and circulated widely for consultation between December 2013 and February 2014. Nearly 70 submissions were received from countries, development partners, civil society, academics and other interested stakeholders. The feedback was synthesized and reviewed at a meeting of country and global experts in Bellagio, Italy, in March 2014. The paper was modified to reflect the views emerging from these consultations.

The framework proposes the goal of achieving UHC, with all people obtaining the good-quality essential health services that they need without enduring financial hardship. As targets towards this goal, the framework suggests that by 2030, all populations, independent of household income, expenditure or wealth, place of residence or gender, have at least 80% essential health services coverage; and by 2030, everyone has 100% financial protection from out-of-pocket payments for health services. Specific indicators are also outlined for health services coverage and financial protection coverage.

## 8. Country Case Studies

Gilbert Abihiro, Grace Mbera & Manuela de Allegri

### **Gaps in universal health coverage in Malawi: a qualitative study in rural communities**

*BMC Health Services Research* 14, no. 234 (May 2014). Available at [bit.ly/AbihiroUHC](https://bit.ly/AbihiroUHC).

DOI: 10.1186/1472-6963-14-234

In sub-Saharan Africa, universal health coverage (UHC) reforms have often adopted a technocratic top-down approach, with little attention paid to the rural communities' perspective in identifying context-specific gaps to guide reforms. This approach might result in reforms that are not sufficiently responsive to local needs. This study explored how rural communities experience and define gaps in universal health coverage in Malawi, a country which endorses free access to an Essential Health Package (EHP) as a means towards universal health coverage.

A qualitative cross-sectional study was conducted in six rural communities in Malawi, and results showed that the EHP has created a universal sense of entitlement to free health care at the point of use. However, respondents reported uneven distribution of health facilities and poor implementation of public-private service level agreements, which have led to geographic inequities in population coverage and financial protection. Most respondents reported affordability of treatment at private facilities and transport costs as the main barriers to universal financial protection. From the perspective of rural Malawians, gaps in financial protection are mainly triggered by supply-side access-related barriers in the public health sector such as: shortages of medicines, emergency services, shortage of health personnel and facilities, poor health workers' attitudes, distance and transportation difficulties, and perceived poor quality of health services. Moving towards UHC in Malawi, therefore, requires the introduction of appropriate interventions to address the gaps in financial protection found in the study. Reforms must address context specific gaps and operational bottlenecks.

Alayne Adams et al

## **Innovation for universal health coverage in Bangladesh: a call to action**

*The Lancet* 382, no.9910 (December 2013), pages 2014-2111.

Available at [bit.ly/AdamsUHC](http://bit.ly/AdamsUHC). DOI: 10.1016/S0140-6736(13)62150-9

A post-Millennium Development Goals agenda for health in Bangladesh should be defined to encourage a second generation of health-system innovations under the clarion call of universal health coverage. This agenda should draw on the experience of the first generation of innovations that underlie the country's impressive health achievements and creatively address future health challenges. Central to the reform process will be the development of a multipronged strategic approach that: responds to existing demands in a way that assures affordable, equitable, high-quality health care from a pluralistic health system; anticipates health-care needs in a period of rapid health and social transition; and addresses underlying structural issues that otherwise might hamper progress. A pragmatic reform agenda for achieving universal health coverage in Bangladesh should include development of a long-term national human resources policy and action plan, establishment of a national insurance system, building of an interoperable electronic health information system, investment to strengthen the capacity of the Ministry of Health and Family Welfare, and creation of a supraministerial council on health. Greater political, financial, and technical investment to implement this reform agenda offers the prospect of a stronger, more resilient, sustainable, and equitable health system. This is the sixth in a Series of six papers about innovation for universal health coverage in Bangladesh.

Anju Aggarwal

## **National standards of care quality would help India enable health coverage for all**

*BMJ* 348 (May 2014). Available at [bit.ly/AggarwalUHC](http://bit.ly/AggarwalUHC). DOI: 10.1136/bmj.g3056

The next central government in India should better coordinate existing state led schemes and set national care standards to encourage universal healthcare coverage. By focusing on coordination and oversight, the government has an unprecedented opportunity to reduce medical costs, improve provider quality, and—most importantly—prevent illness in the first place. Propelled by the 2014 elections, the national parties have issued manifestos outlining their

visions for the future of health in India. The details of each vision vary, but the manifestos and many commentators share one key idea—the essential role of universal health coverage. There is a clear path to improve health for the next central government that is consistent among the different party platforms and points of view: support promising state led health initiatives by better coordinating policies and introducing clear national standards for care.

The growing emphasis on improving health is heartening, and whichever party leads the next central government has a valuable opportunity to build on promising efforts that have struggled in implementation without abandoning them altogether. Additional money, training, and infrastructure would all be valuable inputs to healthcare throughout India. However, most important is for central government to take full advantage of its ability to align initiatives and incentives—thanks to its central position, relatively robust budget, access to data, and specialized departments with a mandate to invest in health—to develop guidelines for the best possible performance at every level. The new government should take on these challenges to empower states to make better use of public funding through better designed and more efficiently implemented healthcare financing and delivery programs, and public health interventions.

Successful implementation of policies often depends on states' ability to manage programs. By coordinating policies and providing strong regulatory oversight, central government can help states implement and integrate healthcare financing and delivery initiatives effectively and efficiently. Another opportunity for central government to improve health is through the introduction of standards. State governments have shown the ability to expand healthcare coverage through various programs, but without clear guidelines to ensure high quality of care they have struggled to improve health outcomes. Similarly, the government can support improved quality of care by providing evidence based clinical pathways.

Ximena Aguilera et al

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Chile**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/AguileraUHC](http://bit.ly/AguileraUHC).

DOI: [10.1371/journal.pmed.1001676](https://doi.org/10.1371/journal.pmed.1001676)

With the establishment of the social security system in 1924, Chile started the path towards UHC. A key milestone was the creation of the National Health System in 1952, which offered

public subsidized coverage for the poor. Currently, after the partial privatization of social security in 1981, the health system is mixed, both in insurance and in service provision, and health insurance reaches 98% of the population, with 77% of this coverage by the public health insurance. Regardless of this encouraging figure and a relatively good health situation, a significant burden of out-of-pocket (OOP) payment exists and the access to care has been described as noticeably inequitable between the public and private sectors. Defining UHC as a situation where all people obtain the health services they need without risking financial hardship from unaffordable out-of-pocket payments, this article reviews the case of Chile, with the aim of identifying indicators to monitor and evaluate UHC.

Inequality still remains one of the main challenges faced by the country. In an attempt to tackle health inequities and to increase financial protection, in 2005 the Chilean government implemented an innovative health reform, with the central focus of the recognition of the right to health. However, public spending on health in Chile remains one of the lowest among OECD countries and OOP payments are the highest. System fragmentation, at health insurance and provision levels, results in two realities: an underfunded and overwhelmed public sector and an elitist and increasingly expensive private sector. Increasing resources available for health-care, establishing solidarity among public and private sectors, and improving quality of care to expand effective coverage are key components towards achieving UHC in Chile.

**Abebe Alebachew, Laurel Hatt & Matthew Kukla**

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Ethiopia**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/AlebachewUHC](http://bit.ly/AlebachewUHC).

DOI: [10.1371/journal.pmed.1001696](https://doi.org/10.1371/journal.pmed.1001696)

This paper documents the availability of globally proposed UHC indicators in Ethiopia, seeks feedback from selected key informants on these indicators' relevance and feasibility, reviews the country's overall capacity to collect and use UHC indicators, and compiles existing estimates for proposed UHC indicators. The paper also aims to inform the Ethiopian government as it develops its own UHC strategy and eventually implements such policies. Ethiopia has not yet officially defined UHC, although numerous strategies, policies, and guidelines are being implemented to achieve universal access to primary health care and reduce impoverishment due to health spending. Existing strategies remain fragmented across health care services and financing mechanisms.

Some of the WHO's proposed UHC measurement indicators may not yet be applicable or feasible in a low-income context like Ethiopia, particularly those requiring frequent, large population-based household surveys as well as those related to chronic conditions. Local stakeholders expressed a preference for indicators that are more relevant to their context and less resource-intensive to collect. Involving country representatives in selecting these indicators would harness political commitment towards UHC implementation. Countries such as Ethiopia should be assisted in defining and developing UHC strategies. Technical support should also be given to build their capacity to collect, analyze, and use routine and survey-based information.

**Luiz Andrade**

### **Social determinants of health, universal health coverage, and sustainable development: case studies from Latin American countries**

*The Lancet*, Early Online Publication (October 2014). Available at [bit.ly/AndradeUHC](http://bit.ly/AndradeUHC).  
DOI: 10.1016/S0140-6736(14)61494-X

This article presents case studies from four Latin American countries – Brazil, Chile, Colombia, and Cuba – to show the design and implementation of health programs that have reached national scale to effectively address social determinants of health, improve health outcomes, and reduce health inequities. The paper examines intersectoral action and social participation to address social determinants of health and achieve universal health care, highlighting the challenges faced when addressing health inequities. These challenges are not only rooted in inherent societal inequities, but also in the institutional organization of government sectors that hinder cross-sector cooperation.

The country cases show that although meaningful cooperation and coordination between different sectors exists, in practice, real integration of policies and programming with joint design, programming, implementation, and assessment is challenging. Latin American countries can improve on how they coordinate actions between social, biological, and environmental determinants of health, and build health systems with greater emphasis on primary health-care to show how governments can orient their actions to improve health, welfare and prosperity for all, and not just a select few.

John Ataguba & Candy Day

## **Monitoring and Evaluating Progress towards Universal Health Coverage in South Africa**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/AtagubaUHC](http://bit.ly/AtagubaUHC).

DOI: 10.1371/journal.pmed.1001686

In 2011, the policies required to move towards universal health coverage (UHC) in South Africa were mapped out over a 15-year period. In the first phase, the planning emphasis is on investing in improving access to, and the management and quality of, public sector health services, particularly at the primary health care level. A range of activities has been initiated, driven by the very active leadership of the current minister of health. The second phase is intended to introduce a strategic purchasing mechanism, by establishing a semi-autonomous National Health Insurance Fund (NHIF). It is envisaged that the NHIF will create a universal entitlement to comprehensive health services, to be accessed through primary health care (PHC) gatekeepers and following referral routes. It is important for South Africa to develop an explicit UHC monitoring and evaluation system to support the refinement of reforms over time. Given its inheritance of pervasive inequalities, reducing inequalities should be emphasized while moving toward UHC.

Mauricio Barreto et al

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Brazil**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/BarretoUHC](http://bit.ly/BarretoUHC).

DOI: 10.1371/journal.pmed.1001692

Universal health coverage is a fundamental principle of the Brazilian Unified Health System (SUS), targeted to implement the constitutional right (established by the Constitution of 1988) to health for all Brazilian citizens. Since 1988, Brazil has been making efforts to develop the SUS, aiming at providing comprehensive and universal care, at the preventive and curative level, through decentralized management and provision of health services. The SUS has made advances in management processes, involving committees and negotiation mechanisms between federal, state, and municipal stakeholders for decision making on different managerial and funding aspects. The country has adopted a model of monitoring and evaluation (M&E)

linked to the guidelines of the National Health Plan (NHP) to support the implementation of priority health policies. The chronic underfunding of the system imposes serious limitations on the overall expansion of the SUS, particularly at the secondary and tertiary levels. Continued monitoring of UHC indicators is recommended, with the goal of subsidizing policies to promote greater equity in health care provision and in the decrease of health determinants and risks.

**M. E. Bonilla-Chacin & Nelly Aguilera**

## **The Mexican Social Protection System in Health**

Universal Health Coverage (UNICO) studies series: no. 1. World Bank. 2013.

Available at [bit.ly/Bonilla-ChacinUHC](http://bit.ly/Bonilla-ChacinUHC)

This case study assesses key features and achievements of Mexico's Social Protection System in Health (Sistema de Protección Social en Salud, SPSS). The SPSS was created in 2003 with as objectives to: (a) increase funds to the public health system and decrease the inequities in public expenditures across public insurance schemes and states; (b) improve health outcomes, reduce out-of-pocket payments for health services, and provide protection against catastrophic health expenditure; and (c) reform the organization and functioning of the state health systems. This case study analyzes the contribution of this policy to the establishment and implementation of universal health coverage in the country. Mexico is a large, upper-middle-income country that has benefited from sustained economic growth in the last decade, but where poverty and socioeconomic inequalities remain an important challenge. Indeed, in the early 2000s, a large percentage of the population did not have access to health insurance, which is mostly provided by social security schemes.

**Mohamed Kouni Chahed & Chokri Arfa**

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Tunisia**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/ChahedUHC](http://bit.ly/ChahedUHC).

DOI: 10.1371/journal.pmed.1001729

Currently, health care in Tunisia is delivered both by an extensive public health care facilities network and a growing private sector. Over the past 30 years, Tunisia has made particular

efforts at developing the health workforce and rehabilitating facilities. However, the remaining gap in access to health services between poor populations and areas, and those with better living conditions, contributed to the emergence of the 2011 revolution. Since 2011, the population and civil society have demanded new health policies and approaches to track remaining gaps and to ensure equity.

Tunisia has made substantial progress toward achieving UHC, and the government is implementing a two-tiered social protection system with health insurance and subsidized or free care with the aim of securing financial risk protection. However, the Tunisian health system currently faces some obstacles: the remaining gap in access to health services between poor populations and those with better living conditions; the emergence of chronic and non-communicable diseases that require growing resources to make needed treatments available; the unbalanced development of the health system with a growing private sector contrasting with a less efficient institutional public health sector; and the remaining high level of out-of-pocket expenses. Although a large amount of data and sources of data are available and may be used to assess and evaluate progress towards UHC in Tunisia, there is no comprehensive means within the health information system for its monitoring since no UHC-related core indicators have been defined. Tunisia needs to implement specific UHC in-country monitoring mechanisms including relevant tools to measure progress in equity and financial risk protection.

**Sarbani Chakraborty**

### **Philippines government sponsored health coverage program for poor households**

Universal Health Coverage (UNICO) studies series: no. 22. World Bank. 2013.  
Available at [bit.ly/ChakrabortyUHC](http://bit.ly/ChakrabortyUHC)

This is a nuts and bolts case study of the implementation of the government-financed health coverage program (HCP) for poor households in the Philippines. The data and information in this case study largely draws upon the 2011 World Bank Report “Transforming the Philippine Health Sector: Challenges and Future Directions” (Chakraborty et al. 2011), and technical work undertaken for World Bank support to the Government of the Philippines (GOP) for universal health coverage (UHC) in the Philippines. The aim of the case study is to understand how the HCP was implemented, what worked and did not work, and how it impacted expected results

under the HCP. In 1996, similarly to many low- and middle-income countries, the Philippines introduced a demand-side program for poor households (the Sponsored Program). The objective was to improve access of poor households to needed health services without experiencing a financial burden. Unlike many countries, where such programs are stand alone, in the case of the Philippines it was integrated into the National Health Insurance Program (NHIP). This is a sound design feature from the perspective of providing optimal risk pooling and redistribution, and the Philippines is a model for other countries implementing similar schemes for poor households.

**Shiyao Chao**

### **Jamaica's effort in improving universal access within fiscal constraints**

Universal Health Coverage (UNICO) studies series: no. 6. World Bank. 2013.  
Available at [bit.ly/ChaoUHC](http://bit.ly/ChaoUHC)

Jamaica's primary health care system was a model for the Caribbean region in the 1990s. Because of it, Jamaicans enjoy relatively better health status than people in other countries of similar income level in the Caribbean region. However, Jamaica's health system is being severely challenged by persistent and reemerging infectious diseases and by the rapid increase in noncommunicable diseases (NCDs) and injuries. At the same time, the country has suffered from low economic growth and carries a high debt burden, which leaves limited fiscal space for improving health care. The Government of Jamaica has been trying to sustain the gain in health outcomes and improve access to health care for its population in an environment of constrained resources during the last decade. With the establishment of the Jamaica National Health Fund (NHF) in 2003 and the abolition of user fees at public facilities in 2008, the Government of Jamaica has taken steps toward achieving universal coverage. This study reviews the achievements and challenges in expanding universal access in Jamaica and assesses the impact of the NHF's drug-subsidy programs and the abolition of user fees on universal access, and discusses policy options for achieving universal coverage.

Narayanan Devadasan et al

## **Monitoring and Evaluating Progress towards Universal Health Coverage in India**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/DevadasanUHC](http://bit.ly/DevadasanUHC).

DOI: 10.1371/journal.pmed.1001697

India has pledged to achieve UHC by 2022, but while the population is reasonably covered by preventive and curative health services, financial coverage is lacking for most services. The Indian Ministry of Health (MoH) has a digitized health management information system (HMIS) that collects data every month from all government health facilities across the country. However, the HMIS has a major weakness: it does not collect information from the private health sector. Since the private sector is the main provider of many health services in India, the HMIS reports are incomplete. Thus, policy makers and managers are unable to determine the true health status of the citizens of the country.

For India to move towards UHC, the first step should be to provide financial protection against medical expenses. Although there are currently many subsidized health insurance schemes for poor people, they do not address the main source of OOP payments, which is ambulatory care and medicines. One of the measures that the government of India could take to improve coverage would be to provide access to free medicines for all individuals seeking care, which would reduce OOP payments considerably. The second measure would be to extend existing services to the most vulnerable sections of the population.

Antonio Duran, Joseph Kutzin & Nata Menabde

## **Universal Coverage Challenges Require Health System Approaches; the Case of India**

*Health Policy* 114, no.2 (February 2014), pages 269-277. Available at [bit.ly/DuranUHC](http://bit.ly/DuranUHC).

DOI: 10.1016/j.healthpol.2013.11.009

This paper uses the case of India to demonstrate that Universal Health Coverage is about more than simply health financing. Personal and population services production issues, stewardship of the health system, and the generation of necessary resources and inputs are essential accompaniments to the health financing proposals. The authors advocate for the use of the

WHO framework and extensions developed in the 2000 World Health Report to address UHC in India, but assert that simply more public money will not be enough for UHC to succeed. Increased financing will need to be supplemented with broad interventions at various system levels, and the paper analyses the most important issues in relation to the functions of: service production, generation of inputs, and necessary stewardship. The analysis also discusses reform implementation, and emphasizes the need to accompany implementation with policy analysis. Strengthening “evidence-to-policy” links and the intelligence dimension of stewardship/leadership as well as accountability during implementation are considered paramount. Countries facing similar challenges to those faced by India can also benefit from the approaches to UHC implementation outlined in the article.

Therese Fitzgerald et al

### **Women and Health Reform: How National Health Care Can Enhance Coverage, Affordability and Access for Women (Examples from Massachusetts)**

*Women's Health Issues* 24, no.1 (January-February 2014) pages e5-e10.

Available at [bit.ly/FitzgeraldUHC](http://bit.ly/FitzgeraldUHC). DOI: 10.1016/j.whi.2013.11.006

The authors study women in Massachusetts, as Massachusetts women have the highest rates of health insurance coverage in the nation and women's access to care has improved across all demographic groups. However, important challenges persist for this group. As national health reform implementation moves forward under the Affordable Care Act (ACA), states will likely encounter many of the same women's health challenges experienced in Massachusetts over the past 7 years. The study presents a review of the literature and data analyses comparing health care services access, utilization, and cost, and health outcomes from Massachusetts pre- and post-2006 health care reform, and identified two key challenges in women's continuity of coverage and affordability: the continuity of coverage, and the affordability of coverage. The authors discuss how crucial it is for state and national policymakers to consider these two challenges as they work to reform UHC at various levels.

Ursula Giedion, Ricardo Bitran & Ignez Tirstao (eds)

## **Health Benefit Plans in Latin America: a regional comparison**

Inter-American Development Bank. May 2014. Available at [bit.ly/Giedion2UHC](http://bit.ly/Giedion2UHC)

In the face of scarcity and unlimited demand for healthcare resources, some countries have adopted health benefit plans to explicitly define the services to be covered by public funds. These explicit benefit plans may well be regarded as a realization of the right to health. Explicit and enforceable health plans are seen as an instrument to address funding problems and coverage inequities. The scope of services offered by health systems is one of the three dimensions used to measure progress towards universal health coverage; a benefit plan can give an idea of the depth of coverage, provided that it is effective. Explicit benefit plans are not limited to lists of prioritized services, and they require significant, systematic and continuous methodological efforts from robust institutions and, last but not least, a sustained political commitment to turn priorities into reality.

In 2011, the Inter-American Development Bank implemented a regional knowledge-transfer project on explicit health benefit plans, including methodologies for priority setting, costing, budgetary impact assessment and monitoring, as well as lessons on the processes and institutions necessary for the plans to be technically and politically viable. Within the framework of this project, the IDB organized an international workshop on benefit plans in Santiago, Chile in October 2010. The interest demonstrated by participating countries exceeded all expectations and highlighted potential synergies and the need for knowledge at the regional level. The seminar was also a starting point for a regional study in which seven Latin American countries analyzed their experiences with explicit benefit plans under a single methodology. Its results are summarized in the introduction of this book. Each of the seven subsequent chapters outlines the case studies in Chile of explicit health guarantees, Colombia's compulsory health plan, Uruguay's comprehensive health care plan, the universal list of essential health services in Mexico and that country's catastrophic health expenditure fund, the essential health insurance plan in Peru, Argentina's Plan Nacer, and the basic health package in Honduras.

Antonia Guiffrida, Melitta Jakan & Elina M. Dale

## **Toward universal coverage in health: the case of the state guaranteed benefit package of the Kyrgyz Republic**

Universal Health Coverage (UNICO) studies series: no. 17. World Bank. 2013.  
Available at [bit.ly/GuiffridaUHC](http://bit.ly/GuiffridaUHC)

The Kyrgyz State Guaranteed Benefits Package (SGBP) represents a successful strategy to move toward universal health coverage in a low-income transition economy. In this case study the authors describe the evolution of the Kyrgyz health care system and discuss challenges in ensuring universal access to basic health care services. Section 1 provides an overview of the Kyrgyz health system and of the national health care reform programs that started in 2001 with Manas (2001–2005) and which have been continued with Manas Taalimi (2006–2011), and the recently adopted Den Sooluk (2012–2016). Section 2 provides a detailed discussion of the SGBP that follows a universal approach as it applies to all citizens, and describes the management of public funds and the dissemination of information about the SGBP. Section 3 draws lessons from Kyrgyz national health reforms for universal health coverage for other countries with very limited public resources, widespread poverty, and high levels of corruption. Section 4 discusses the remaining challenges for universal health coverage for the poor and how the provision of good-quality care forms an important part of the agenda for the recently adopted Den Sooluk program.

Juan Pablo Gutierrez et al

## **Effective Access to Health Care in Mexico**

*BMC Health Services Research* 14, no.186 (April 2014). Available at [bit.ly/GutierrezUHC](http://bit.ly/GutierrezUHC). DOI: 10.1186/1472-6963-14-186

This study was developed to propose and estimate an indicator for effective access to health-care services in Mexico. Effective access is used as an operational measure of universal health coverage. Effective access encompasses three dimensions of universal health care: use of needed services, service quality, and financial protection. The survey takes the use (or willingness to use) of private outpatient services by the financially protected population as a proxy to measure the limitations of public services and therefore the extent of universal health coverage. Data from the 2006 and 2012 National Health and Nutrition Surveys (ENSANUT) show

that levels of effective access increased from 2006 to 2012, with just over half of the Mexican population having effective access to healthcare services in 2012. Just over half of the lack of effective access was a result of the absence of financial protection, and the remainder was due to limitations or barriers to public healthcare services.

Piya Hanvoravongchai

### **Thailand - Health financing reform in Thailand: toward universal coverage under fiscal constraints**

Universal Health Coverage (UNICO) studies series: no. 20. World Bank. 2013.  
Available at [bit.ly/HanvoravongchaiUHC](http://bit.ly/HanvoravongchaiUHC)

Thailand's model of health financing and its ability to rapidly expand health insurance coverage to its entire population presents an interesting case study. Even though it is still a middle-income country with limited fiscal resources, the country managed to reach universal health insurance coverage through three main public schemes: the Universal Coverage Scheme (UCS), the Social Security Scheme (SSS), and the Civil Servant Medical Benefit Scheme (CSMBS). The UCS, which is the largest and most instrumental scheme in the expansion of coverage to the poor and to those in the informal sector, is the focus of this chapter.

It may not be feasible or affordable for a country without major health insurance schemes to design a comprehensive universal coverage scheme for the entire population, to be implemented all at once. The Thai experience described in this case study shows that it is important to ensure, from the beginning, that all emerging schemes share a "game plan" and a similar vision of a harmonized health financing system to achieve universal coverage. Also instrumental in the universal coverage movement is having committed policy champions to drive the movement on both the technical and political fronts.

Tanvir Huda

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Bangladesh**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/HudaUHC](http://bit.ly/HudaUHC)

The first ever health financing strategy for Bangladesh was developed and approved in 2012, with a roadmap to achieve UHC by 2032. Despite this apparent momentum, there has been remarkably little implementation of any UHC initiatives on the ground. The country has established an annual process to assess the progress of its Health, Population and Nutrition Sector Development Programme (HPNSDP) on the basis of a results framework, but Bangladesh still needs to assess progress through a well-defined monitoring and evaluation framework to move towards UHC.

The country needs to continue investing substantially in strengthening the capacity of its weak health system to make UHC a reality. The government should continue to measure coverage of priority public-health interventions and include those for non-communicable diseases for all ages and gender. Bangladesh will also need continuous feedback about whether efforts towards achieving UHC are contributing to the progressive realization of equity goals, and to do this, national information sources must be strengthened. Among the major information sources, the routine health information system represents perhaps the most pressing area for improvement, as it is likely the most crucial component of the successful monitoring and evaluation of both the health sector program and UHC. Strengthening the civil vital registration system is almost as urgent as the need to strengthen the routine health information system.

Noaki Ikegami (ed)

## **UHC for Inclusive and Sustainable Development: Lessons from Japan**

World Bank. 2014. Available at [bit.ly/Ikegami2UHC](http://bit.ly/Ikegami2UHC)

This book offers an overview of the political, historical, and macroeconomic context for UHC, and examines challenges of maintaining UHC in Japan in the face of an aging population. The book comprises 10 in-depth studies on different aspects of Japan's experience with UHC. It

serves to help other countries identify elements of success and failure that could inform their own universal health coverage strategies. In addition, the book explores factors determining the allocation of physicians in rural and urban sectors in Japan, and the critical role of licensed practical nurses in addressing nursing shortages, and different perspectives on deploying these categories of health workers.

Japan's commitment to UHC played a key role in the country's economic recovery in the post–World War II period, and it helped to develop a vibrant middle class and secure social stability by ensuring that the benefits of economic growth were shared equitably across the population. Japan's fee schedule, which is applied to all programs and virtually all providers, has played a key role in containing costs and pursuing policy objectives by setting a de facto global budget and by making item-by-item revisions.

**Robert Janett**

### **Massachusetts health reform: approaching universal health coverage**

Universal Health Coverage (UNICO) studies series: no. 7. World Bank. 2013.  
Available at [bit.ly/JanettUHC](http://bit.ly/JanettUHC)

The Commonwealth of Massachusetts, one of the 50 states in the United States of America, has achieved near universal health coverage of its 6.6 million residents after a landmark reform made health insurance mandatory for all residents in 2006. The program has received widespread popular support, and it served as a model for the design of the Patient Protection and Affordable Care Act, which established a plan for mandatory coverage on a national basis for the first time in the United States. This report briefly describes the Massachusetts reform and its context, but focuses for simplicity purposes on the operational details of the MassHealth program of health insurance for the poor. A discussion of the administration and management of MassHealth can offer a glimpse into the inner workings of all other insurance plans in the Commonwealth. MassHealth, private insurance, and Commonwealth Care share similar tools, controls, and strategies.

Constance Johnson

## Indonesia: Universal Health Care Program Implemented

Global Legal Monitor, Law Library of Congress (January 2014).

Available at [bit.ly/JohnsonUHC](http://bit.ly/JohnsonUHC)

On 1 January 2014, Indonesia's government began implementing a universal health care program that will eventually cover all citizens and foreigners residing in the country for more than six months. The government will fully cover health costs for those unable to pay for a minimal level of care, and those covered will be able to obtain medical attention anywhere in the country. It is estimated that more than 86 million Indonesians, out of a total population of roughly 251 million, will be eligible for assistance with the insurance premium payments. Those able to pay for insurance will have fees on a sliding scale, based on whether they are fully employed and the level of coverage they choose. For those working in the private sector, the fee will be 5% of monthly income; as of 2015, employers will have to cover 4% of the costs and employees will pay the last 1\$. The goal is to include 140 million people in the program by the end of January 2014, with the entire country to be covered by 2019. The online system for registering individuals is already in place and more than 111 million people were already signed up by 10 December 2013.

Criticisms of the plan note that different government departments have made widely different estimates of the number of people who would be eligible for government assistance, and questions have been raised regarding whether the funding available for insurance premium subsidies will be adequate. Opposition parties also suggest insufficient preparation of the program on behalf of the government, including a lack of information disseminated to health workers and the public. More generally, the UHC scheme has sparked discussion regarding the general quality and availability of health care in Indonesia, including the number of specialists and facilities available.

Taufique Joarder & Malabika Sarker

## **Achieving universal health coverage through community empowerment: a proposition for Bangladesh**

*Indian Journal of Community Medicine* 39, no.3 (July 2014), pages 129-131.

Available at [bit.ly/JoarderUHC](http://bit.ly/JoarderUHC). DOI: 10.4103/0970-0218.137143

Bangladesh is one of the countries with highest out of pocket (OOP) payment, where 96.52% of the private health expenditure is OOP. This paper argues that a community empowerment approach is useful and should be used to establish UHC in Bangladesh. Findings from current research on Comprehensive Primary Health Care (CPHC) in the context of Bangladesh, which aims to introduce a culturally sensitive and demand driven Primary Health Care (PHC) model, suggested a model that emphasizes empowering communities. Therefore, adoption of CPHC (based on the research) will not only equip the Bangladeshi health system with an improved PHC delivery mechanism, but also pave the way for policy makers to achieve UHC by generating public demand.

Olga Khazan

## **What the U.S. Can Learn From Brazil's Healthcare Mess: Here's what it looks like when a sprawling, diverse nation tries to cover everybody**

The Atlantic (May 2014). Available at [bit.ly/KhazanUHC](http://bit.ly/KhazanUHC)

Since 1988, Brazil's Sistema Unico de Saude – or SUS – has promised free public healthcare to every citizen and has led to huge health gains in the country. The SUS is cherished as a protection against steep medical bills. This article discusses Brazil's healthcare system with an eye towards the changes to be implemented in the United States after the enactment of the Affordable Care Act. The author outlines the strengths and weaknesses of Brazil's universal coverage scheme, noting that "Brazil has the lowest rate of catastrophic health expenditures (2.2 percent) of nearly any other country in the region... That is a higher level of financial protection than Chile, Mexico, and certainly the U.S. have achieved." Brazil also spends just 9 percent of GDP on healthcare to the U.S.'s 18 percent. However, according to the article, "universal healthcare looks very different in Brazil than it does in, say, Scandinavia." Khazan discusses the lack of physicians, medical resources, and overall development that lead to

disparities in care and outcomes in Brazil. The article's thesis claims that, "Obamacare will give millions of Americans better access to doctors, and that's where Brazil provides a true cautionary tale."

Taavi Lai, Triin Habicht & Maris Jesse

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Estonia**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/LaiUHC](http://bit.ly/LaiUHC).

DOI: [10.1371/journal.pmed.1001677](https://doi.org/10.1371/journal.pmed.1001677)

Since regaining its independence in 1991, Estonia has conducted radical health system reforms. The Estonian health system is based on mandatory, solidarity-based insurance and universal access to health services made available by providers operating under private law with primary health care (PHC) playing a central role. The financing of health care is mainly organized through the semi-autonomous Estonian Health Insurance Fund (EHIF), which covers about 70% of total health expenditure in the country. Currently, the main health policy is the National Health Plan (NHP) 2009–2020, which contains a wide set of measurable targets with specific indicators that are reported annually with outcome reviews every second year.

Estonia has been successful in achieving UHC, though work remains in extending insurance coverage, reducing the share of OOP payments, and addressing health inequalities. The Estonian experience has shown that comprehensive policy monitoring and assessment enables the monitoring of UHC even in the absence of a dedicated framework. In particular, UHC monitoring can be facilitated if extensive routine data sources are developed, linked, and integrated through comprehensive IT solutions. However, a specific focus on UHC and creating a dedicated monitoring framework within the existing system would target existing data gaps and move UHC into strong policy focus for systematic policy development.

Robert Marten et al

## **An assessment of progress towards universal health coverage in Brazil, Russia, India, China, and South Africa (BRICS)**

*The Lancet*, Early Online Publication (April 2014).

Available at [bit.ly/MartenUHC](http://bit.ly/MartenUHC). DOI: 10.1016/s0140-6736(14)60075

Brazil, Russia, India, China, and South Africa (BRICS) represent almost half the world's population, and all five national governments recently committed to work nationally, regionally, and globally to ensure that universal health coverage (UHC) is achieved. This analysis reviews national efforts to achieve UHC. With a broad range of health indicators, life expectancy (ranging from 53 years to 73 years), and mortality rate in children younger than 5 years (ranging from 10.3 to 44.6 deaths per 1000 livebirths), a review of progress in each of the BRICS countries shows that each has some way to go before achieving UHC. The BRICS countries show substantial, and often similar, challenges in moving towards UHC. On the basis of a review of each country, the most pressing problems are: raising insufficient public spending; stewarding mixed private and public health systems; ensuring equity; meeting the demands for more human resources; managing changing demographics and disease burdens; and addressing the social determinants of health. Increases in public funding can be used to show how BRICS health ministries could accelerate progress to achieve UHC. Although all the BRICS countries have devoted increased resources to health, the biggest increase has been in China, which was probably facilitated by China's rapid economic growth. However, the BRICS country with the second highest economic growth, India, has had the least improvement in public funding for health. The article concludes with a call for future research to understand the causes of the different levels of prioritization of the health sector in the BRICS countries. Further exploration is also needed to understand the role of strategic purchasing in working with private sectors, the effects of federal structures, and the implications of investment in primary health care as a foundation for UHC.

Chris McCall

## East Timor striving for universal access to health care

*The Lancet* 384, no.9953 (October 2014), pages 1491-1492.

Available at [bit.ly/McCallUHC](http://bit.ly/McCallUHC). DOI: 10.1016/S0140-6736(08)61345-8

More than a decade after gaining independence, East Timor has made gains in health but still faces an uphill battle to achieve universal health coverage and access. Much of the government's new money has gone into building up the health system and results are starting to show. East Timor now has a medical school, a nursing school, and a midwifery school. The medical school has adopted a Cuban model of health education that is strong on public health, but less strong on basic clinical skills like suturing. In Cuba, where there is a highly structured health system, this is less of an issue than in East Timor, where many clinics are isolated. Distance, time, and infrastructure are issues across the country, and foreign health workers report that the country has also been held back by widespread superstitions and lack of information. The most insidious problems, however, are malnutrition and lack of access.

Qingyue Meng & Ling Xu

## Monitoring and Evaluating Progress towards Universal Health Coverage in China

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/MengUHC](http://bit.ly/MengUHC).

DOI: 10.1371/journal.pmed.1001694

Inequity in health has arisen as a large concern for Chinese society. A new round of health system reforms was initiated by the government in early 2009, aiming to establish a health system in which all people can access basic health care through an equitable, efficient, affordable, and effective health system. The reforms initiated in 2009 have focused on improving social health insurance schemes in both rural and urban areas, strengthening the primary health care system, supporting delivery of essential public health programs, removing drug markups from the financing of the primary health providers, and reforming the public hospital sector. All these reform areas are closely linked with improving access to affordable and quality health care for all.

A number of challenges must be addressed to accelerate UHC in China. Equity and quality of health care need continuous improvement, and the cost escalation of medical care should be

appropriately contained. Finally, the concept of Health in All policies (the inclusion of health considerations in policy making across different sectors that influence health) needs to be operationalized.

**Rekha Menon, Salih Mollahaliloqlu & Iryna Postolovska**

### **Toward universal coverage: Turkey's green card program for the poor**

Universal Health Coverage (UNICO) studies series: no. 18. World Bank. 2013.  
Available at [bit.ly/MenonUHC](http://bit.ly/MenonUHC)

In 2003, Turkey launched a comprehensive health reform effort called the "Health Transformation Program" (HTP), with a key objective of increasing access to services and eliminating fragmentation in financing by merging the then existing five health insurance schemes (including the Green Card program) into a Universal Health Insurance (UHI) scheme to be managed by the newly created Social Security Institution (SSI). This case study unravels Turkey's path to universal coverage. It outlines both the transformation of the health system and the performance of the Green Card program. The gradual steps taken to expand coverage, improve targeting, and expand benefits of the Green Card program, combined with the improvements in service delivery within a comprehensive reform of the health sector, have made Turkey a unique example of universal coverage providing quality health services.

**Gemini Mtei, Suzan Makawia & Honorati Masanja**

### **Monitoring and Evaluating Progress towards Universal Health Coverage in Tanzania**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/MteiUHC](http://bit.ly/MteiUHC).  
DOI: 10.1371/journal.pmed.1001698

Tanzania has been making efforts towards UHC starting with the abolition of user fees soon after independence in 1967, before their reintroduction in the early 1990s, and the introduction of health insurance schemes in early 2000. Currently, the government is in the process of developing its first National Health Financing Strategy (HFS), which stipulates the intention

of developing a health financing system that will guarantee access to needed care for all and provide financial protection against payments for health care.

The burden of OOP payments is significant among the poorest segment of the population, with only 15% of the population covered by health insurance schemes. To achieve the goal of UHC, it is important for Tanzania to expand health insurance coverage through mandatory contributions to health insurance pools. Expansion of health insurance coverage will enhance financial protection among those who use services and also increase access to needed services, thereby translating into improved health status.

Frank Nyonator et al

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Ghana**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/NyonatorUHC](http://bit.ly/NyonatorUHC).

DOI: 10.1371/journal.pmed.1001691

To achieve UHC in Ghana, increases in health sector resources should correspond to targeted investments in preventative, curative services and community-based care. The impediments to achieving UHC are two-fold: First, the poorly understood concept of cost containment in UHC and second, the lack of a mechanism for determining the basic package of services and how these reflect population needs over time.

With expected progress on expansion of pro-poor strategies, there is an urgent need to synergize both national strategies to achieve UHC and its desired impact. In-country monitoring mechanisms and relevant evaluation tools in Ghana are inadequate. There are significant gaps in quantifying equity and financial risk protection among different wealth quintiles, and in addressing the spread and control of non-communicable diseases and other chronic conditions. National monitoring and evaluation frameworks should incorporate relevant global-level indicators that define and track country effective coverage for meaningful comparisons among countries of similar socio-economic and demographic characteristics.

Ijeoma Okoronkwo, Obinna Onwujekwe & Francis Ani

## **The long walk to universal health coverage: patterns of inequities in the use of primary healthcare services in Enugu, Southeast Nigeria**

*BMC Health Services Research* 14, no. 132 (March 2014).

Available at [bit.ly/OkoronkwoUHC](http://bit.ly/OkoronkwoUHC). DOI: 10.1186/1472-6963-14-132

Knowledge and understanding of health service usage are necessary for health resource allocation, planning and monitoring the achievement of universal coverage (UHC). There is limited information on patterns of utilization among adult users of primary health care (PHC) services. Lack of understanding of current and past utilization patterns of health services often hinders the improvement of future Primary Health Care (PHC) delivery in the remote areas of developing countries. This paper presents new knowledge on the patterns of utilization of PHC services among adults in Enugu metropolis southeast Nigeria.

A cross-sectional study was conducted in 15 PHC facilities of Enugu North Local Government Area (LGA) from June to July 2012. Out of the 360 respondents, 46.9% utilized PHC services regularly. The components of PHC mostly utilized by respondents were immunization, treatment of common ailments, and maternal and child health. The least poor SES group utilized PHC services the most while the very poor and poor SES groups used PHC services least. Most adult users in this study did not utilize the health facilities regularly and there were gender, educational and SES inequities in the use of PHC services. These inequities will negate the achievement of universal health coverage with PHC services and should be remedied using appropriate interventions.

Michael Palmer

## **Inequalities in Universal Health Coverage: Evidence from Vietnam**

*World Development* 64 (December 2014), pages 384-394.

Available at [bit.ly/PalmerUHC](http://bit.ly/PalmerUHC). DOI: 10.1016/j.worlddev.2014.06.008

Exploiting a window of opportunity in Vietnam, this paper examines the impact of social health insurance on target population groups. Significant inequalities in the coverage of service utilization and financial protection are found across groups. Persons with disabilities, and retirees to a lesser extent, experienced relatively high rates of service utilization and were

most at risk of health care-induced poverty. A higher level of targeting in the design of benefit packages is recommended.

Krishna Rao et al

### **Progress towards universal health coverage in BRICS: translating economic growth into better health**

*Bulletin of the World Health Organization* 92, no.6 (June 2014), pages 429-435.  
Available at [bit.ly/Rao2UHC](http://bit.ly/Rao2UHC)

Over the last two decades, Brazil, the Russian Federation, India, China and South Africa (BRICS) have undertaken health-system reforms to make progress towards universal health coverage. This paper discusses three key aspects of these reforms: the role of government in financing health; the underlying motivation behind the reforms; and the value of the lessons learnt for non-BRICS countries. Although national governments have played a prominent role in the reforms, private financing constitutes a major share of health spending in BRICS. There is a reliance on direct expenditures in China and India and a substantial presence of private insurance in Brazil and South Africa. Brazilian health reforms resulted from a political movement that made health a constitutional right, whereas those in China, India, the Russian Federation and South Africa were an attempt to improve the performance of the public system and reduce inequities in access. The move towards universal health coverage has been slow. In China and India, the reforms have not adequately addressed the issue of out-of-pocket payments. Negotiations between national and subnational entities have often been challenging but Brazil has been able to achieve good coordination between federal and state entities via a constitutional delineation of responsibility. In the Russian Federation, poor coordination has led to the fragmented pooling and inefficient use of resources. BRICS are diverse in many ways but united by their common experience of high economic growth and an aspiration to improve the health of their citizens. The motivations for recent health reform in each country differ and each country has set out on its own – different – path toward UHC. Notably, all BRICS countries have increased government spending on health and have provided subsidies for the poor. However, such improvements will not guarantee universal coverage in the absence of efficiency and accountability. For BRICS, the biggest challenge remains the effective translation of new wealth into better health.

Shadi Saleh et al

## **The path towards universal health coverage in the Arab uprising countries Tunisia, Egypt, Libya, and Yemen**

*The Lancet* 383, no.9914 (January 2014), pages 368-381. Available at [bit.ly/SalehUHC](http://bit.ly/SalehUHC).  
DOI: 10.1016/S0140-6736(13)62339-9

This report is part of the 'Health in the Arab World' Series in *The Lancet*, and has three overarching objectives regarding UHC in Arab uprising countries. First, the report presents selected experiences of countries that faced similar social and political changes, evaluating how these events affected their paths towards UHC. Second, the authors present a brief overview of the development of healthcare systems in the Arab world, focusing on coverage and financing in Egypt, Libya, Tunisia, and Yemen. Third, the report integrates historical lessons with present contexts in a roadmap for action that addresses challenges and opportunities for progression towards UHC.

The report is particularly timely, as the constitutions of many countries in the Arab world clearly highlight the role of governments in guaranteeing provision of health care as a right for all citizens. However, citizens still face inequitable health-care systems. One component of such inequity relates to restricted financial access to health-care services. The recent uprisings in the Arab world, commonly referred to as the Arab spring, created a sociopolitical momentum that should be used to achieve universal health coverage (UHC). At present, many countries of the Arab spring are considering health coverage as a priority in dialogues for new constitutions and national policy agendas. UHC is also the focus of advocacy campaigns of a number of non-governmental organisations and media outlets.

Aparnaa Somanathan, Huong Lan Dao & Tran Van Tien

## **Vietnam - Integrating the poor into universal health coverage in Vietnam**

Universal Health Coverage (UNICO) studies series: no. 24. World Bank. 2013.  
Available at [bit.ly/SomanathanUHC](http://bit.ly/SomanathanUHC)

This case study aims to provide a descriptive assessment of the key features of Vietnam's Social Health Insurance (SHI), focusing on the impediments to integrating the poor into universal

coverage. The trajectory of SHI in Vietnam is similar to that of many other countries in the East Asia and Pacific region. The poor were covered under a separate Health Care Fund for the Poor to begin with. The 2009 Law on Health Insurance merged all of the different programs into one. Health insurance premiums for the poor were fully subsidized by the government and enrolment became mandatory, resulting in almost complete enrolment of the poor by 2011. Vietnam has combined elements of contributory social health insurance with substantial levels of tax financing to provide coverage for the poor and informal sector.

Kelvin Bryan Tan et al

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Singapore**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/Tan2UHC](http://bit.ly/Tan2UHC).

DOI: [10.1371/journal.pmed.1001695](https://doi.org/10.1371/journal.pmed.1001695)

Promoting UHC has been an important part of Singapore's overall development strategy, with a strong policy focus on the promotion, prevention, and treatment of non-communicable diseases (NCDs). The example of Singapore illustrates that even for a country with an extensive health care system, monitoring of service coverage and financial protection remains highly important. Singapore's experience also shows that the choice of appropriate indicators must evolve as countries go through different phases of socioeconomic development and epidemiological change. Moving ahead, the key challenge that Singapore will face involves ensuring that good health outcomes continue to be achieved with an ageing population and projected increases in chronic conditions.

Viroj Tangcharoensathien et al

## **Monitoring and Evaluating Progress towards Universal Health Coverage in Thailand**

*PLoS Med* 11, no.9 (September 2014). Available at [bit.ly/TangcharoensathienUHC](http://bit.ly/TangcharoensathienUHC).

DOI: [10.1371/journal.pmed.1001726](https://doi.org/10.1371/journal.pmed.1001726)

With the advent of the Universal Coverage Scheme (UCS) that combined a medical welfare low-income card scheme and a government-subsidized voluntary health card scheme with a

coverage extension to the remaining uninsured, Thailand achieved the status of universal health coverage (UHC) in 2002 in terms of insurance entitlement. Despite the achievement of UHC, challenges remain. Cost pressures on all schemes from increasing demands for long-term treatments and increasing burdens from NCDs have shifted policy attention towards effective primary, secondary, and tertiary preventions of priority NCDs, which address the social determinants of unhealthy lifestyles.

The main features of the Thai UHC experience are locally initiated and financed UHC schemes, and the continual improvement of monitoring and evaluation systems that are used for policy decisions. These features ensure sustainability and keep policy in line with national interests. Factors contributing to these features are: institutional capacities to generate evidence and influence policies, monitoring and evaluation systems with effective feedback for adjustment, economic growth and improved fiscal space, political and financial commitments, implementation capacities, and supply-side resilience to accommodate significant increases in service utilization.

Laksono Trisnantoro

### **Universal health coverage and medical industry in 3 Southeast Asian countries**

*BMC Public Health* 14, Supplement 1 (2014), page I3.

Available at [bit.ly/TrisnantoroUHC](http://bit.ly/TrisnantoroUHC). DOI: 10.1186/1471-2458-14-S1-I3

Invited speaker presentation, from 7th Postgraduate Forum on Health Systems and Policies, Phitsanulok, Thailand, 24-25 June 2013. The presentation focuses on the changes in government expenditure on health in Indonesia, Malaysia, and Thailand. In Indonesia and Thailand, there was a move to more public financing. These countries did not have a history of universal coverage, but the governments had political motive for universal coverage. The case of Malaysia provides a contrast: some members of affluent communities were not satisfied with certain services, and demanded better health service using private financing. The policy issue explored was: how does the government policy for achieving universal health care also manage health services as an industry? This analysis shows: (1) universal coverage will put fiscal pressure on governments; (2) private medical services will be "a good safety valve" in reducing the burden of public financing for health; (3) medical industry policy should support the development of private medical services, but consider equity issues. The impact of universal coverage and

medical industry policies are: more segmented hospitals based on technology and economy status; more diverse sources of health financing (public and private); and more mechanisms of funding: fee-for-service, indemnity in commercial health insurance, managed care, and others. These impacts need a carefully crafted health policy to fit within broader social and economic/industrial policy.

**Jeanette Vega & Patricia Frenz**

## **Latin America: priorities for universal health coverage**

*The Lancet*, Early Online Publication (October 2014). Available at [bit.ly/Vega2UHC](http://bit.ly/Vega2UHC).

DOI: 10.1016/S0140-6736(14)61635-4

To achieve universal health coverage, decisions must be made regarding how to best prioritize political and health resources. However, this issue is often neglected or is an afterthought in the debate about universal health coverage, as explicit priority setting is contentious, politically charged, and technically challenging, and it is rarely studied and poorly understood. In this realm, lessons from Latin America are especially relevant, as more than any other part of the world, countries in this region have introduced explicit priority setting to define their health benefit plans.

The lessons from the region are three-fold. First, benefit plans can take different shapes and sizes, and are not restricted to a list of essential services for societies with severe resource constraints. The scope ranges from broad to narrow, in terms of types of technologies used, disease control priorities, and eligible populations. Second, large institutional capacities are needed to define and regularly update benefit plans. Institutions find fulfilling their promise very resource intensive; sustained political, financial, and technical leadership backed by legal underpinnings are required. Third, though benefit plans and their definition processes continue to evolve in Latin American countries, improved monitoring and assessment at national levels are urgently needed to establish whether plans have effectively translated into improved health and health equity and more satisfied citizens.

Worldwide, a forward-looking research and competency development agenda on priority setting is needed to disseminate what is known more widely, investigate what is not known, and support capacity building to do what has to be done to accelerate action on universal health coverage. Learning more from Latin America is a starting point.





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