GLOBAL HEALTH 2035

A World Converging within a Generation

POLICY BRIEF

What Steps Are Countries Taking To Implement Pro-Poor Universal Health Coverage?

Key messages from the literature and expert interviews

The June 6–10, 2015 workshop at the Rockefeller Foundation Bellagio Center in Italy on implementing pro-poor universal health coverage was supported by The Rockefeller Foundation and the United States Agency for International Development.

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Background

Universal health coverage (UHC)—ensuring that everyone has access to quality, affordable health services when needed—can be a vehicle for improved equity, health, financial well-being, and economic development. In its 2013 report, *Global Health 2035*: *A World Converging within a Generation*, the Commission on Investing in Health made the case that pro-poor pathways towards UHC, which target the poor from the outset, are the most efficient way to achieve both improved health outcomes and increased financial protection (FP).[i] Countries worldwide are now embarking on health system changes to move closer to achieving UHC, often with a clear pro-poor intent.

Much has been written about what steps countries have taken and are currently taking to: (1) set and expand guaranteed services, (2) develop health financing systems to fund guaranteed services and ensure FP, (3) ensure high-quality service availability and delivery, (4) improve governance and management of the health sector, and (5) strengthen other aspects of health systems to move closer to UHC.[ii] As background for a meeting on UHC implementation, held at the Rockefeller Foundation's Bellagio Center, Italy, from 7–9 July 2015, we reviewed this body of literature, and conducted interviews with global UHC implementers and researchers.[iii] In this short policy brief,[iv] we synthesize the key messages from the literature and interviews.

1. What countries are doing to set and expand guaranteed services

As countries move towards UHC, they are taking a number of different approaches to setting and expanding population coverage and service packages. In setting pathways to expand coverage, countries should consider the ability of selected strategies to meet the health needs of the population, to meet the equity and FP goals of UHC, and to ensure value for money.

- **Determining which populations to cover.** Many countries have begun their path to UHC by offering targeted coverage to a subset of the population. Common strategies used to determine coverage include targeting by employment status (e.g. social health insurance for formal sector employees), and targeting specific population groups, such as by geographic location (Lagarde et al, 2012) or health priority (e.g. pregnant women and/or children under 5 years of age) (Yates 2010). These approaches vary in their ability to provide coverage to poor populations at the outset, and in response, some countries have chosen to gradually expand coverage to poorer populations as more resources become available. A major challenge that several countries face is that of a "coverage wall:" for example, coverage rates stubbornly remain at 60–70% in Indonesia, the Philippines, and Vietnam, and are considerably lower in Ghana (35%) and Nigeria (5%), despite efforts to expand towards universality (Nicholson et al, 2015).

  There are a number of challenges associated with targeted approaches, including concerns about quality of care, fragmentation, and lack of coverage for the informal sector and middle-income populations. To address these, Nicholson and colleagues (2015) suggest that achieving full population coverage from the outset, with a smaller package of services, is preferable to "covering selected population groups with more generous packages of services and leaving some people relatively uncovered."
- **Defining which services to guarantee.** The World Health Organization (2014) outlines three elements to consider when deciding which services to cover: cost-effectiveness, priority for the worst-off, and FP. Nicholson and colleagues (2015) also highlight the importance of reducing inequality when determining service packages, while the World Bank (2014) includes a strong emphasis on public health program investment and primary health care principles. The *Global Health 2035* report made the case that infectious disease control, maternal and child health services, and "best buys" for non-communicable diseases should be prioritized first in pro-poor pathways to UHC because the poor are disproportionately affected by these conditions. There is a growing emphasis on the need for research evidence and country-specific contexts to be taken into consideration in determining service packages, something that many countries are starting to do (Nakhimovsky et al, 2015).

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i See globalhealth2035.org

ii These five buckets categorizing the steps that countries are taking in the path towards UHC closely align with WHO's health system building blocks, namely: delivery of high quality, effective health services; a solid health financing system; strong leadership and governance; and a well-functioning and well-performing health system (where inputs such as human resources and medical products, vaccines, and technologies are available and of high quality and where a strong health information system is available and used).

iii In contrast to the large amount of literature on what steps countries are taking to implement UHC, there is less information published or otherwise easily accessible about the "how" of UHC—how to maximize the chances of successful implementation. "How" questions were the focus of the Bellagio meeting: participants shared their experiences in, and discussed the limited amount of empirical evidence on, tackling a set of key "how" questions. The Bellagio meeting report, and a short practice brief summarizing the main discussion points, are available at globalhealth2035.org.

iv The full background report, which expands on the topics in this brief, is available at http://globalhealth2035.org/sites/default/files/bellagio/background-paper-pro-poor-uhc-evidence.pdf.

- **Ensuring value for money using cost-effectiveness analysis (CEA) and extended CEA.** As countries expand coverage, it is increasingly important to ensure the impact and cost-effectiveness of UHC programs. There is general consensus that good value for money can be achieved by emphasizing primary care and community-based services, as well as some district hospital services (Jamison et al, 2013; Nicholson et al, 2015). Examples of the former include Ethiopia's community-health worker scheme (Crowe, 2013), and China's barefoot doctors (Weiyuan, 2008), both of which contributed to impressive population health gains at relatively low cost.

  Cost-effectiveness analysis—which compares the costs and outcomes of alternative interventions—is one important tool for improving the efficiency of health service delivery, although it should not be used in isolation from considerations about priority for the poor and equity. However CEA does not assess an intervention's impact on FP. A newer tool, extended cost-effectiveness analysis (ECEA), measures both the health and FP benefits of alternative interventions (Jamison et al, 2013) and can help decision-makers by showing the financial versus mortality trade-offs between investing in different interventions. While many countries are beginning to use CEA and ECEA in determining service packages (Nakhimovsky et al, 2015), this information is not always incorporated into decision-making where there is political pressure to the contrary (Giedion et al, 2014; Kapiriri, 2012). In addition to focusing on specific interventions, new information on the cost-effectiveness of different types of delivery platforms, such as clinic-, hospital-, community- or outreach-based strategies, will be needed to help countries determine which service delivery strategies are likely to have the greatest reach and impact at the lowest cost.

- **Differing populations may be guaranteed different services.** We use the term "universalism" somewhat loosely to mean "everyone covered." This does not necessarily mean that all people are in the same pool, paying the same premiums and co-payments, and accessing the same services. Instead, the reality in several countries that have made great progress towards UHC, including Mexico and Thailand, is "fragmentation." For historical reasons, different populations are covered by different schemes, contribute different amounts (nothing for the poor except through general taxation), and are guaranteed a different set of health services.

  Such fragmented systems may be more costly, and can be inequitable. Nonetheless, providing the poor with coverage through at least one mechanism is a move towards improving equity, enabling them to access essential services with out-of-pocket payments (OOPs) even if they do not have access to as extensive a service package as wealthier populations.

  Some countries have a longer-term vision to reduce or eliminate fragmentation, and with it, inequality. Thailand, for example, has a goal of merging its three existing health insurance schemes—the social security scheme, the civil servants' medical benefit scheme, and the universal coverage scheme (Evans et al, 2012). However, to date this has been politically challenging. It is also possible for governments to play a risk-equalization role between the different schemes, effectively ensuring greater government subsidies go to the scheme covering the poor.

2. What countries are doing to develop health financing systems

To achieve UHC, countries must develop health financing strategies and systems that (i) provide adequate resources to guarantee and expand coverage over time and (ii) incentivize the efficient use of resources, provision of high quality care, and equitable distribution of health coverage across populations.

- **Raising funds:** Countries have many options for raising additional domestic funds for health (see Box 1). In selecting among these options, it is important to evaluate the ability of these fund sources to provide sustainable finance, and to ensure the FP of poor populations.

  There is broad agreement that the poor should have free or very low cost payments for services. In most low-income countries (LICs) and middle-income countries (MICs), where a priority is to increase FP, OOPs should not be used as the main mechanism for revenue generation as they are regressive and inequitable, they deter use of health services, and they are a common cause of impoverishment. Decreasing the reliance on forms of direct payments, including OOPs, requires increasing the amount of revenue from forms of prepayment, such as through insurance premiums. Currently, no national health insurance system relies solely on wage-related deductions or contributions; even in high-income countries, general government revenue is required to supplement the cost of assuring coverage.

Box 1. Sources of domestic funds for health

Out-of-pocket payments
Payment for service delivery by individuals at the point of care

Health insurance premiums
Paid by individuals directly or through wage deductions, by companies through employer contributions, or by governments

Taxes and charges
Options include income and company taxes, indirect taxes such as value added tax (VAT), and taxes on specific items such as alcohol, tobacco, imports, and exports.

Contributions from charitable organizations and external development partners

There are many options for raising additional government revenues, including various tax strategies, at least some of which can be used for health. However, ensuring the earmarking or allocation of these revenue sources towards health, and UHC specifically, remains a challenge in many countries. Many counties could also increase the share of government funding currently allocated to health. While there is no clear evidence on exactly what proportion of government spending should be directed to health, in 2001 the heads of state of the African Union in the Abuja Declaration determined that 15% was an appropriate level. However, in most LICs and lower MICs, government allocations to health remain well below this target.

- **Pooling to spread risk:** Pooling mechanisms enable costs to be subsidized across populations, while also minimizing the financial risk of the insurers. Contributions from a larger population (either by households directly or through third-party government or employer contributions) effectively enable the healthy to subsidize the costs for the sick. Most pooling schemes also develop progressive contribution systems such that the rich subsidize the poor. Government revenues, some of which are used to provide or fund health services, and health insurance funds serve the same purpose as prepayment and pooling.
- **Using funds more efficiently:** The 2010 World Health Report estimated that between 20% and 40% of health resources were typically wasted through various forms of inefficiency (WHO, 2010). Countries seeking to reduce this inefficiency use two primary strategies: (i) conducting active or "strategic" purchasing, and (ii) introducing forms of results- or outputs-based payments. Strategic purchasing requires that countries explicitly consider: the costs and benefits of alternative packages of health services; where services should be made available; who delivers them; and the costs and incentives for efficiency and quality that exist in the alternative payment mechanisms potentially available. Changing payment from historical line item budgets that do nothing to encourage efficiency to forms of paying for results or outputs can be difficult and requires good administrative capacities, but is a strategy that is increasingly being pursued in several countries around the world.
- **Considering equity in health finance arrangements:** Countries must explicitly consider the equity implications of decisions about all three health financing functions—raising funds, pooling them, and using them to provide or purchase services. Decisions about raising funds impact who pays and how much they pay. With pooling, critical questions such as who is eligible to receive benefits emerge. For example, should it only be individuals (i.e. the policyholder)? Or should it be individuals and their families (and what is the limit on the number of family members who can be covered)? In terms of purchasing, equity considerations are related to the question of what services are purchased or provided, and if these services meet the health needs of poor and vulnerable populations.

3. What countries are doing to ensure high-quality service availability and delivery

- **Ensuring service availability and use.** There are many steps that countries can take to improve service availability and use, such as (i) seeking to involve all of the "vertical" health programs in development, review, and modification of national health plans and policies, and (ii) using planning tools, such as the OneHealth Cost and Impact Tool, which estimates costs and impacts of scaling up disease-specific programs and health systems. It is important that countries engage a variety of actors in these discussions, from external partners to civil society. Countries should also ensure that plans to improve FP go hand-in-hand with plans to improve the availability and quality of needed health services.
- **Ensuring continuity of care.** Countries are developing strategies to provide and link services across the continuum of health needs, from promotion and prevention, to treatment, rehabilitation and palliation; throughout the life course; and across the various levels of care (e.g.

primary care to tertiary hospitals, and between public and private providers). Organized provider networks with clear and appropriate referral systems are important, as are decisions about integration across delivery platforms.

- **Overcoming barriers to service access.** It can be very helpful for countries to conduct reviews to determine population service access barriers. Financial barriers are common, including those linked to OOPs, transport, accommodation, food, and lost work time. Barriers can also be linked to gender, ethnicity, and social or educational status. Countries should develop appropriate responses based on the best available international experiences, adapted to the local setting. If health services are already known to be of such poor quality that people avoid them except when absolutely necessary, improving quality is an important first step.
- **Balancing the role and integration of non-governmental sector service provision.** Countries must balance the appropriate role for the public sector and non-governmental sectors (NGOs, faith-based organizations, private non-profits, and private for-profits) in service delivery, including in health promotion and non-personal services such as laboratories, medical products, and cleaning and catering services. Quality in the non-government sector ranges widely, from state of the art facilities to unlicensed medicine vendors. In many settings government regulatory capacity is weak. Many governments must expand their capacity to legislate, regulate, and set and enforce quality standards within the non-government sector, which has commonly expanded more rapidly than government's capacity to oversee and monitor. Countries that have moved most successfully towards UHC have taken a pragmatic approach to expanding service availability by assessing what mix of government and non-government services makes most sense in their settings, and ensuring government has the capacity to set, incentivize, and enforce quality standards everywhere.

4. How countries are improving health sector governance and management

Governance includes the process and rules through which health systems are administered and managed, including policy formulation and implementation, how responsibility and accountability are assigned to actors, and the incentive structures that shape the relationships between these actors (Brinkerhoff and Bossert, 2008; Kaufmann and Kraay, 2008; Savedoff, 2011; Barbazza and Tello, 2014).

Common governance challenges that governments face in moving towards UHC include: (1) identifying an appropriate role for the private sector and regulating this sector accordingly; (2) establishing adequate leadership and technical capacity within the health system; (3) instituting mechanisms for accountability and transparency in financing and delivery decisions; (4) ensuring participation in these decisions; (5) controlling corruption; and (6) maintaining regulatory strength and enforcement capacity for financers and providers of health services.

- **Strengthening governance:** Strategies used to improve the governance function of health systems include methods of control (e.g. laws and contracts), coordination (e.g. joint strategic planning, cost-sharing or resource pooling), collaboration (e.g. partnerships with civil society, inter-ministerial committees), and communication (e.g. satisfaction surveys, and publicly available budgetary information) (Barbazza and Tello, 2014). In some cases, strong leadership has translated into publicly-announced commitments to moving towards UHC. Tools that support the development and maintenance of strategic direction in policy development (such as creation of a national health plan), and implementation (such as operational guidelines and protocols) can be very helpful in improving transparency. Tools can also support knowledge generation (such as periodic audits or public expenditure performance reviews), improved accountability (such as performance-based payment, licensing, and accreditation) and monitoring and controlling corruption (such as through routine auditing). Finally, a handful of tools—such as open meetings, public workshops and national fora—can increase public engagement and collaboration across stakeholders.
- **Measuring governance:** Governments and health system leaders require information about governance in order to improve governance systems and ensure the desired outcomes of quality, equity, and efficiency. Governance evaluation tools and indicators are commonly divided into four areas:[v] (i) *governance inputs or determinants* (existence of policies and institutions that make up and influence the health system), (ii) *governance processes and performance* (implementation of the policies and systems in place to understand the gaps between expected and actual practice), (iii) *governance outcomes* (determining how well health system policies result in the desired health system goals), and (iv) *contextual factors* (external factors that impact the type of governance structures that need to be in place and their enforcement).

v See Baez-Camargo and Jacobs, 2011 and Savedoff, 2011.

5. Other health system strengthening steps that countries are taking to move closer to UHC

- **Strengthening human resources.** The primary strategy countries are using to strengthen human resources is health workforce training. Pre-service training essentially increases the numbers (and quality) of providers while in-service training either increases provider skills or prevents these from deteriorating over time. Training efforts can target expansion into (i) particular service areas (such as building a primary care workforce through the use of community health worker programs to expand access in rural and underserved areas), or (ii) geographic areas (such as expanding the rural health workforce by increasing the recruitment of rural populations into the health professions). Other strategies being used are (i) development and review of comprehensive national health plans and strategies to strengthen in-service training, and (ii) task sharing that enables existing cadres of health workers to take on new service areas or creates new cadres of health workers that require less training, which can expand the accessibility of high need services in underserved areas.

  Countries are also implementing recruitment and retention policies—including the use of financial and educational incentives and regulatory policies—that seek to improve the motivation, skills mix, and geographic distribution of the health workforce. At the global level, the international community is working to support health worker retention through policies to discourage health worker migration from countries with health workforce shortages.

- **Ensure essential infrastructure, medicines, and health technologies.** In addition to human resources, health systems require additional inputs—such as high-quality diagnostics, medicines, health technologies, and health delivery infrastructure—to ensure effective and efficient health care delivery. Countries worldwide are implementing strategies to improve the selection, procurement, distribution, and use of medicines, to ensure that populations access and appropriately use high-quality appropriate low-price quality medicines and technologies (such as diagnostics).

- **Seek quality improvement.** Health service quality is a key objective of a health system and is often considered a third goal of UHC (alongside improved health outcomes and increased FP) (Kruk, 2013). Nonetheless, the quality of care in many LICs and MICs remains very low (Berendes et al, 2011). It is critical that services are safe and of good quality—and perceived by the population to be so. Strategies that countries are using to improve quality of care include: (i) approaches at the policy and/or regulatory level (e.g. setting licensing and accreditation standards or implementing performance-based financial incentives); (ii) facility and/or provider level strategies to motivate better practices (e.g. educational inputs, or audit and feedback); and (iii) demand-side strategies that seek to change social norms and care-seeking behavior (e.g. vouchers and other demand-side performance-based financial incentives) (Mate et al, 2013).

6. Moving forward

As countries continue forward on the path towards UHC, it is critical to continue to capture and document their different experiences—both positive and those that are less positive. The expanding evidence base on what works best with regards to service definition, financing, and delivery, and on ensuring effective health sector governance and strengthened health systems, is a rich resource for country leaders, researchers, and donors alike. These stakeholders can learn from this resource, and take it into consideration when considering possible next steps forward.

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The authors declare that there are no competing interests.

References

Baez-Camargo C, Jacobs E. A Framework to Assess Governance of Health Systems in Low Income Countries. Basel: Basel Institute on Governance, 2011 (Working Paper Series No. 11). Available at: https://www.baselgovernance.org/publications/385.

Barbazza E, Tello JE. A review of health governance: definitions, dimensions and tools to govern. *Health Policy*. 2014;116:1–11.

Berendes S, Heywood P, Oliver S, Garner P. Quality of private and public ambulatory health care in low and middle income countries: systematic review of comparative studies. *PLOS Med* 2011;8(4).

Brinkerhoff D, Bossert T. Health Governance: Concepts, Experience, and Programming Options. Washington DC: USAID Health Systems 20/20, 2008. Available at: https://www.hfgproject.org/wp-content/uploads/2015/02/Health-Governance-Concepts-Experience-and-Programming-Options.pdf.

Crowe S. 2013 Progress Report on Committing to Child Survival: A Promise Renewed. New York: United National Children's Fund (UNICEF), 2013. Available at: www.unicef.org/infobycountry/ethiopia_70372.html.

Elovainio R, Evans DB. Raising and Spending Domestic Money for Health. London: Chatham House, 2013 (Centre on Global Health Security Working Group Paper Number 2). Available at: www.chathamhouse.org/publications/papers/view/191335.

Evans TG, Chowdhury AMR, Evans DB, et al. Thailand's Universal Coverage Scheme: Achievements and Challenges. An Independent Assessment of the First 10 Years (2001–2010). Thailand: Health Insurance System Research Office, 2012. Available at: http://www.jointlearningnetwork.org/uploads/files/resources/book018.pdf.

Giedion U, Beltrán R, and Tristao I (eds.). Health Benefits Plans in Latin America. Washington DC: Inter American Development Bank, May 2014. Available at: https://publications.iadb.org/bitstream/handle/11319/6484/Health-Benefit-Plans.pdf.

Jamison DT, Summers LH, Alleyne G et al. Global Health 2035: a world converging within a generation. *Lancet* 2013;382:1898-955.

Kapiriri L. Priority setting in low-income countries: the roles and legitimacy of development assistance partners. *Public Health Ethics* 2012;5:67–80.

Kaufmann D, Kraay A. Governance indicators: where are we, where should we be going? *World Bank Res Obs.* 2008;23:1–30.

Kruk M. Universal health coverage: a policy whose time has come. *BMJ* 2013;347:f6360.

LaGarde M, Barroy H, Palmer N. Assessing the effects of removing user fees in Zambia and Niger. *Journal of Health Services Research and Policy* 2012;17(1):30–6.

Mate KS, Sifrim Z, Chalkidou K, et al. Improving health system quality in low- and middle-income countries that are expanding health coverage: a framework for insurance. *International Journal for Quality in Health Care*, 2013;25:497–504.

Nakhimovsky S, Peterson L, Holtz J, et al. Using Evidence to Design Health Benefits Plans for Stronger Health Systems: Lessons from 25 Countries. Washington DC: USAID and Health Finance and Governance Project, June 30, 2015. At https://www.hfgproject.org/using-evidence-to-design-health-benefit-plans-for-stronger-health-systems-lessons-from-25-countries.

Nicholson D, Yates R, Warburton W, Fontana G. Delivering Universal Health Coverage: A Guide for Policymakers. Report of the WISH Universal Health Coverage Forum 2015. London: WISH, 2015. Available at: http://wish-qatar.org/summit/2015-summit/forumsandpanels/universal-healthcare-coverage/universal-healthcare-coverage.

Savedoff WD. Governance in the Health Sector: A Strategy for Measuring Determinants and Performance. Rochester, NY: Social Science Research Network; 2011 May. Report No.: ID 1837205. Available at: http://papers.ssrn.com/abstract=1837205.

Weiyuan C. China's village doctors take great strides. *Bull World Health Organ* 2008;86(12):909–988.

World Bank/World Health Organization. Monitoring Progress Towards Universal Health Coverage at Country and Global Level. Framework, Measures and Targets. Geneva: WHO, 2014. Available at: http://apps.who.int/iris/bitstream/10665/112824/1/WHO_HIS_HIA_14.1_eng.pdf.

World Health Organization. Health Systems Financing: The Path to Universal Coverage. Geneva: WHO, 2010. Available at: http://www.who.int/whr/2010/en.

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. Geneva: WHO, 2014. Available at: www.who.int/choice/documents/making_fair_choices/en.

Yates R. Women and children first: An appropriate first step towards universal coverage. *Bull World Health Organ* 2010;88:474–475.

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The Bellagio workshop was funded by The Rockefeller Foundation and the United States Agency for International Development (USAID).