



# UNIVERSAL HEALTH COVERAGE:

# A COMMITMENT TO CLOSE THE GAP



## ACKNOWLEDGEMENTS

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# TABLE OF CONTENTS

|   |           |   |           |
|---|-----------|---|-----------|
| Acknowledgements  | ii        |   |           |
| Disclaimer  | ii        |   |           |
| <b>FOREWORDS</b>  | <b>2</b>  |   |           |
| <b>EXECUTIVE SUMMARY</b>  | <b>4</b>  |   |           |
| Abbreviations and acronyms  | 9         |   |           |
| <b>1. INTRODUCTION</b>  | <b>10</b> |   |           |
| <b>OUTLINE OF REPORT</b>  | <b>13</b> |   |           |
| <b>METHODOLOGY</b>  | <b>13</b> |   |           |
| <b>2. WHY EQUITY IS IMPORTANT FOR UNIVERSAL HEALTH COVERAGE</b>                         | <b>14</b> |   |           |
| <b>UHC AS A MEANS TO ACHIEVE GREATER EQUITY IN HEALTH AND FINANCIAL RISK PROTECTION</b> | <b>14</b> |   |           |
| Inequities between and within countries   | 16        |   |           |
| Pervasive inequities of health service coverage   | 17        |   |           |
| The social gradient of financial risk protection  | 21        |   |           |
| Weak health systems exacerbate health inequities  | 24        |   |           |
| <b>3. WHAT ARE PROGRESSIVE PATHWAYS TOWARDS UNIVERSALISM?</b>                           | <b>26</b> |   |           |
| <b>A CONCEPTUAL FRAMEWORK FOR ASSESSING EQUITY IN PATHWAYS TOWARDS UHC</b>              | <b>28</b> |   |           |
| Health system goals   | 28        |   |           |
| Applying a systems lens   | 28        |   |           |
| Managing trade-offs   | 28        |   |           |
| Identifying access barriers   | 29        |   |           |
|   |           | <b>KEY LESSONS FOR EQUITABLE PATHWAYS TOWARDS UHC</b>   | <b>30</b> |
|   |           | Financing for equitable pathways towards UHC  | 30        |
|   |           | Taking a whole-systems approach   | 42        |
|   |           | <b>4. THE INVESTMENT CASE FOR EQUITABLE PATHWAYS TOWARDS UHC</b>  | <b>47</b> |
|   |           | A case of moral obligation  | 48        |
|   |           | More health for the money   | 48        |
|   |           | Wider social and economic benefits  | 51        |
|   |           | <b>5. IMPLICATIONS FOR UHC MEASUREMENT AND THE FUTURE DEVELOPMENT FRAMEWORK</b>                         | <b>52</b> |
|   |           | A catalyst for progress   | 55        |
|   |           | <b>6. CONCLUSION AND RECOMMENDATIONS</b>  | <b>58</b> |
|   |           | Recommendations   | 61        |
|   |           | <b>7. APPENDIX</b>  | <b>62</b> |
|   |           | Report methodology  | 62        |
|   |           | <b>EVIDENCE OF SUCCESSFUL STRATEGIES TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH STRUCTURED REVIEW</b> | <b>63</b> |
|   |           | Exclusion criteria  | 65        |
|   |           | Econometric analysis  | 69        |
|   |           | Key informant interviews  | 70        |
|   |           | Lives Saved Tool analysis   | 71        |
|   |           | Endnotes  | 72        |

# FOREWORDS



**Judith Rodin**  
President of the  
Rockefeller Foundation

LESS THAN A DECADE AGO, the idea that most nations in the world would commit to working toward achieving Universal Health Coverage (UHC) was seen as unlikely, and certainly not a priority for the global health community. Today, we face an entirely different landscape. Since the 2010 World Health Report *Health Systems Financing: The Path to Universal Coverage*, more than 70 countries have approached WHO to request technical assistance in moving forward on UHC. A movement has built among global and national actors, leading to the passage of the UN Resolution endorsed by more than 90 countries in December 2012 to make UHC a key global health objective. Commitment is increasing for UHC to be the umbrella health goal in the post-2015 framework.

In the meantime, success stories keep rolling in not only from early adopters such as Mexico, Thailand, Chile, Turkey, and Brazil, but from countries making greater efforts towards UHC more recently, including Ghana, Cambodia, and Turkey. For example, in Rwanda, a vision for moving towards UHC was key to its Vision 2020 health strategy developed in 2000. As a result, 90 percent of the population is now enrolled in the national plan, while 7 percent more are covered by civil, military and private insurance. Over the last ten years, health outcomes in Rwanda have improved dramatically, with infant mortality falling 60 percent, and deaths from HIV, TB, and malaria dropping 80 percent. At the same time, GDP per person has tripled, and Rwanda is the only country on track to meet most of its Millennium Development Goals.

The Rockefeller Foundation is pleased to have been among the early and vocal supporters for UHC as part of our larger goal of transforming health systems, an initiative we launched in 2009. With 150 million individuals paying exorbitant, out-of-pocket costs for health care, and 25 million households plunged into poverty as a result, it was clear to us that measurably improving the health status and financial resilience of the poor required transformation of health financing at the country level. Since then, we have invested \$100 million in pursuit of these outcomes, including the initiation of a Joint Learning Network, which connects low- and middle-income countries to trade best practices and share ideas for implementing universal health coverage.

But the work is far from over. The world's poorest people continue to pay the highest percentages of their wealth for health. While ensuring health care and financial protection for the poorest continues to be a challenge to achieving UHC, it is also an opportunity to leverage the momentum around UHC to promote strategies that not only move us toward universal health coverage, but universal health *equity*, ensuring that all people, regardless of socio-economics, gender, ethnicity or age can access the same quality health care and financial protections. The following report details a number of ways countries can embed more equitable coverage into their health system designs, from pooling health sector resources to increasing financing to improving coordination and building political will.

There is much to celebrate regarding the incredible progress that has been made in advancing UHC, at both an international and national level. But we cannot take our foot off the accelerator – if anything, we must speed up our efforts ten-fold to ensure UHC lives up to its transformative potential. We believe this report in itself is a start, marked by unprecedented collaboration among stakeholders, including two leading UN agencies and a global health nongovernmental organization. We at the Rockefeller Foundation look forward to continuing this work alongside WHO, UNICEF, Save the Children and the growing community to make the UHC dream a reality – and we invite those still on the sidelines to join us in this pursuit.



**Jim Yong Kim**  
President of the  
World Bank Group

**W**E STAND AT A MOMENT of exceptional possibility, when global health and development goals that long seemed unattainable have come within our reach. We have seen dramatic achievements in global health in recent years: the child mortality rate has fallen more than 40 percent since 1990, 10 million people on AIDS treatment since 2003, deaths from measles dropped by more than 70 percent. These advances have been the result of many factors, including science, technology, education, committed health professionals, international aid and government spending. But much health progress also has been made possible – and sustainable - through a growing global movement toward universal health coverage.

To end poverty and boost shared prosperity, all countries need robust, inclusive economic growth. And to drive growth, they need to build human capital through investments in health, education, and social protection for all their citizens. Countries as diverse as Thailand, Turkey, and Mexico are showing how universal health coverage (UHC) programs can serve as vital mechanisms for improving the health and welfare of their citizens, and lay the foundation for national innovation, growth, and competitiveness.

But the goal of UHC must be joined with an unwavering commitment to equity. First, we must make sure that no family is forced into poverty because of health care expenses. Current best estimates are that out-of-pocket health spending forces 100 million people into extreme poverty every year. This is an overwhelming form of affliction for some people, as the anguish of poverty compounds the suffering of illness. Countries can end this injustice by introducing equitable models of health financing along with social protection measures such as cash transfers for vulnerable households.

Second, we must close the gap in access to quality health services for the poorest 40 percent of the population in every country. This requires investing in strong systems that address the barriers to access both in and beyond the health sector, such as roads and transport, clean energy, water and sanitation, good governance and education. Improving health coverage and outcomes among poorer people is critical to building their capabilities and enabling them to compete for the good jobs that will change their lives.

And we must prioritize just-in-time and ongoing knowledge exchange and learning for better delivery - across organizations and sectors, across countries, and across the globe. We must advance the science of delivery, translating the evidence on what does and does not work into cost-effective policies and programs that can operate at scale and produce measurable impact. Reports such as this provide valuable insights for policymakers, donors, and practitioners on how and where to focus their efforts.

We can change history by ensuring that everyone in the world has access to affordable, quality health care in a generation. Let's make it happen.

# EXECUTIVE SUMMARY

**S**UPPORT FOR UNIVERSAL HEALTH coverage (UHC) – ensuring “that all people obtain the health services they need, of good quality, without suffering financial hardship when paying for them”<sup>1</sup> – is fast gaining momentum. The World Health Organization (WHO), the World Bank and many developing and donor countries have already adopted UHC as their top health priority.

This report focuses on how and why inequity – unfair and avoidable inequalities – should be prioritised as countries progress on the path towards UHC. It identifies policy options that governments and donors should consider when implementing reforms for UHC and estimates the effect this could have on health outcomes, setting out the implications for the post-2015 sustainable development framework.

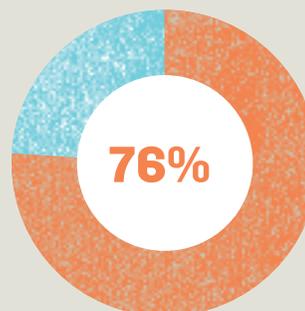
Research for this report included:

- a structured literature review to identify lessons from countries
- key informant interviews with a range of experts
- an econometric analysis to estimate the impact of more equitable health financing on mortality rates
- a Lives Saved analysis to estimate the impact of eliminating in-country wealth inequities in coverage of maternal and child health services.

**MORE EQUITABLE COVERAGE  
COULD PREVENT THE DEATH OF:**

**1.8  
MILLION  
CHILDREN**

**100,000  
MOTHERS**



**IT COULD ALSO  
MEAN A 76%  
INCREASE IN  
THE NUMBER  
OF COUNTRIES  
REACHING MDG 4**

**ADDRESSING INEQUITIES SAVES LIVES  
AND PROVIDES VALUE FOR MONEY**

Investing in equitable pathways towards UHC is the right thing to do from a moral and ethical perspective.<sup>2</sup> But making the needs of poor and vulnerable groups the first priority will also accelerate progress towards global and national aggregate targets.<sup>3,4</sup>

Research commissioned for this report using the Lives Saved Tool (LiST) estimated that the elimination of within-country wealth inequities in coverage of essential maternal and child health interventions would prevent the deaths of 1.8 million children under-five and 100,000 mothers. This would reduce child mortality by one-fifth and maternal mortality by almost one-third.<sup>5</sup>

More equitable health financing produces better value for money.<sup>6</sup> Another piece of research commissioned for this report revealed that, by increasing pooled funding as a share of national health expenditure by 10 percentage points, under-five mortality rates could fall by 15 deaths per 1,000 live births. This effect is amplified in countries where the health system is more equitable.

More equitable health financing through risk pooling could enable 13 countries currently not on track to meet Millennium Development Goal (MDG) 4 – a two-thirds reduction in the number of children dying by their fifth birthday – to achieve their target.<sup>7</sup> This is a 76% increase in the number of countries reaching MDG 4 based on current projections.<sup>8</sup>



Zaria, Nigeria- Midwife Catherine Oluwatoyin Ojo weighs Fatima, 6 months, in the Pepfar Clinic at the Ahmadu Bello University Teaching Hospital in Zaria, Nigeria.

© SAVE THE CHILDREN / JANE HAHN

## UHC: A RIGHT AND AN OBLIGATION

UHC is rooted in the human right to health, which governments are obliged to fulfil.<sup>9,10</sup> It aims to ensure access to good quality health services based on need, not on the ability to pay or other social attributes. It seeks to reduce the financial hardships caused by reliance on ineffectual health systems, the volatility of markets and having to pay fees at the point of use. Those who are poorest and most excluded are not only the most vulnerable to ill-health and premature death, they are also the least likely to have access to good-quality services or protection against financial risk.

## WIDENING INEQUITIES IN HEALTH OUTCOMES AND ACCESS TO CARE

Inequities in life expectancy between and within countries remain vast.<sup>11</sup> Despite falling national rates of child mortality, many countries have seen widening gaps in survival rates between the richest and poorest populations.<sup>12</sup> It is estimated that 1 billion people do not receive the care they need each year.<sup>13</sup>

Those left behind are not a random selection. Systematically, health outcomes and access to health services are based on wealth, education, urban/rural location, gender, ethnicity and age.<sup>14</sup> For instance, 1 million children develop TB annually, with the burden highest in countries with health systems least able

**Morning registration at the inpatient clinic at a comprehensive health centre in northern Nigeria. Save the Children has been running this inpatient clinic since September 2010.**

© SAVE THE CHILDREN/LUCIA ZORO

to treat them. This adds to the inequitable burden of child mortality in countries like Afghanistan, Pakistan, and nations across sub-Saharan Africa.<sup>15,16,17</sup> These inequities are driven by social determinants,<sup>18</sup> which must be tackled both to advance social justice and to meet global and national development targets.

### **IMPOVERISHMENT AND FINANCIAL HARDSHIP FROM ACCESSING CARE**

Each year, 150 million people face financial catastrophe and 100 million are pushed into poverty due to high out-of-pocket spending (OOPS) on healthcare<sup>19</sup> – which is widely acknowledged as the most regressive form of health financing.<sup>20</sup> WHO estimates that the incidence of financial catastrophe becomes negligible only when OOPS is less than 15–20% of national expenditure on health.<sup>21</sup> This burden also falls disproportionately on those who are poor and vulnerable.

Whereas many Asian countries such as India, Bangladesh and Cambodia have high rates of OOPS, other low- and middle-income countries (LMICs) – including Sri Lanka, Thailand and Malaysia – have kept it lower.<sup>22</sup>

### **ADDRESSING INEQUITIES THROUGH UHC**

UHC must be the response to these inequities. Health systems in LMICs are typically underfunded<sup>23</sup> and weak.<sup>24</sup> Within the health system, financing policy reforms are critical to ensure that those who are poor and vulnerable are not left behind. How resources are collected, pooled and spent affect equity in financing of the system, access to essential services, and protection from the risk of financial hardship.<sup>25</sup>



### **LESSONS FOR COUNTRIES**

As countries design health system reforms to progress towards UHC, it is critical that the poor and vulnerable benefit first. This report has identified some of the emerging lessons on how this can be done in LMICs:

- The level and progressivity of funding for the health sector must increase. This will require the elimination of OOPS, at least for vulnerable populations and priority services, with greater reliance on mandatory mechanisms



for prepayment from taxation, whereby contributions are made according to ability to pay and disassociated from healthcare needs.

- Health sector resources must be pooled across the population to allow the redistribution of resources and cross-subsidisation by the healthy and wealthy to cover the costs of care for the poor and sick. Strategic use of resources to tailor the benefit package to meet the needs of poor and vulnerable people, including a minimum of free primary healthcare, and aligning the incentives

of healthcare providers through payment mechanisms, will help to ensure more equitable coverage.

- Quality concerns in service delivery must be addressed. While financing is necessary, it is not sufficient to secure progressive pathways towards UHC. Coordinated reforms across the whole system, and beyond the health sector, are needed to address other barriers to demand and supply.

- The quantity, quality and use of disaggregated data is critical to inform planning process, monitoring, evaluation and accountability. Effective government stewardship is essential for regulation, strategic planning and effective collaboration with other actors. Wider enabling factors include political will, and sufficient, effective support from development partners.

This list is far from exhaustive. Nevertheless, it is indicative of the opportunities for policy reform to reduce coverage gaps – an important step to address inequities in health outcomes.

Identifying an equitable pathway in any country is no easy task. Setting priorities and managing trade-offs is complex and challenging, and must start with the existing context, including: the policy landscape; structures of the health system and public administration; disease burden and distribution of health needs across sub-population groups; fiscal space; strength of key interest groups; and political landscape. The sequencing of reforms will be defined by assessing opportunities and constraints.

### **A CATALYST FOR PROGRESS**

The post-2015 development framework offers a critical opportunity to galvanise more equitable approaches to health, including better data, more accountability and greater political will. Universal birth and death registration systems must be a priority and should capture the country's socio-economic characteristics.<sup>26</sup> In order to measure progress in achieving health equity, coverage must be measured across all segments of society, with targets of both gap reductions and increased national averages set.

The proportion and depth of impoverishment by household characteristics are the best measures of progress for financial risk protection. All countries must undertake household expenditure surveys that include appropriate health questions, which is currently not the case.

Accountability mechanisms at local, national, regional and global levels are essential to ensure that duty bearers deliver on their promises. Donors must honour commitments and practise the principles of effective aid, shifting from a vertical disease-specific preference to horizontal investments to strengthen health systems and build domestic capacities.

### **TIME FOR ACTION**

The means and resources exist to bring an end to preventable mortality and foster healthy lives, eliminating inequities in access to good-quality healthcare. Equitable progress towards UHC must be the health system's response to this challenge. As more and more countries commit to UHC and embark on this journey, it is crucial that addressing inequity is prioritised.

Investing in equitable progress towards UHC will save lives. It will improve health status, increase productivity, and contribute to economic growth and stronger household resilience.

Governments and development partners have the opportunity and the responsibility to make a major difference to those who are poorest and most disadvantaged by prioritising equitable pathways towards UHC. The cost of inaction is high,<sup>27,28,29</sup> and the current momentum must be seized to maximise the opportunity of country commitments to UHC to promote equity.

## **ABBREVIATIONS AND ACRONYMS**

|               |   |
|---------------|---|
| <b>CBHI</b>   | Community-based health insurance            |
| <b>CSDH</b>   | Commission on Social Determinants of Health |
| <b>GNI</b>    | Gross national income                       |
| <b>HLP</b>    | (UN) High Level Panel of Eminent Persons    |
| <b>LMICs</b>  | Low- and middle-income countries            |
| <b>LiST</b>   | Lives Saved Tool                            |
| <b>MDG</b>    | Millennium Development Goal                 |
| <b>OOPS</b>   | Out-of-pocket spending                      |
| <b>SDSN</b>   | Sustainable Development Solutions Network   |
| <b>SHI</b>    | Social health insurance                     |
| <b>UHC</b>    | Universal health coverage                   |
| <b>UNGA</b>   | United Nations General Assembly             |
| <b>UNICEF</b> | United Nations Children's Fund              |
| <b>WHO</b>    | World Health Organization                   |

# 1. INTRODUCTION

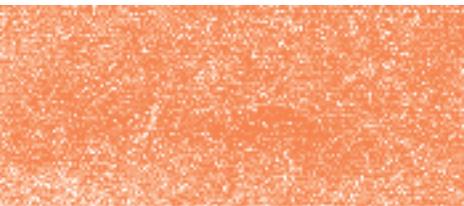




An Anganwadi worker measures blood pressure of a pregnant woman during the awareness-raising session on health and nutrition at Anganwadi centre in Namkum. An Anganwadi worker in every targeted village teams up with a small group of local resource people who are then given a basic training in nutrition, childcare and hygiene. Once trained, the team visits pregnant women and mothers of newborns in their homes to educate them about safe delivery, breastfeeding, immunisation, and other essential care practices during pregnancy and early childhood. UNICEF is prioritising reducing the high malnutrition and child mortality rates in Jharkhand, and reaching out to millions of families here to address these concerns.

© UNICEF / DHIRAJ SINGH

SUPPORT FOR UNIVERSAL health coverage (UHC) is gaining momentum at global, regional and national levels, with both the World Health Organization (WHO) and the World Bank adopting it as their priority. It has also been proposed as an overarching framework for health targets in the sustainable development agenda that will follow the Millennium Development Goals (MDGs), as a means to end preventable deaths and foster healthy lives. More and more countries are making commitments to UHC and it is becoming a rallying call for civil society. It offers a persuasive approach to making the human right to health a practical reality for many more of the world's poorest people.<sup>30</sup> This transformative potential of UHC must be seized.



## ENDING INEQUITY – UNFAIR AND AVOIDABLE INEQUALITIES – IS INHERENT IN THE CONCEPT OF UHC, WITH AN EXPLICIT COMMITMENT TO ENSURE EFFECTIVE COVERAGE, FOR THE WHOLE POPULATION, NOT JUST THE MOST PRIVILEGED.

The WHO has defined UHC as “[ensuring] that all people obtain the health services they need, of good quality, without suffering financial hardship when paying for them”.<sup>31</sup> This means that no one should be impoverished by accessing essential healthcare or denied access because they cannot afford it. Despite many variations in the terminology used and differences in definitions and interpretations,<sup>32,33,34</sup> most agree that UHC is about the convergence of two related priorities: access to healthcare and financial protection.<sup>35,36</sup>

Ending inequity – unfair and avoidable inequalities – is inherent in the concept of UHC,<sup>37</sup> with an explicit commitment to ensure effective coverage<sup>i,38</sup> for the whole population, not just the most privileged.<sup>39</sup> However, the extent to which improving equity is identified as a priority objective within efforts to achieve UHC is not clear and varies between countries. As inequities in health service coverage and financial risk protection widen, it is unacceptable that those who are poorest and most vulnerable are the last to

benefit from efforts to expand coverage. An equitable approach to UHC will both maximise value for money and improve important health outcomes.<sup>ii</sup>

There is no single blueprint for how countries should move towards UHC with equity. However, key lessons are emerging from country experiences. Much of the current research focuses on how health financing systems must be improved.<sup>iii</sup> However, it is clear that other factors – relating to other health system building blocks, as well as non-financial barriers to access and the social determinants of health – must also be addressed.

This report seeks to identify factors that affect equitable progress towards UHC in low- and middle-income countries (LMICs), the potential impact of such approaches on health outcomes, and implications for the post-2015 development framework.

I MEANING THAT ALL PEOPLE WHO NEED SERVICES ARE AWARE OF THEIR NEED AND ABLE TO USE THE SERVICES THEY NEED, AND THAT THOSE SERVICES ARE PROVIDED WITH SUFFICIENT QUALITY TO IMPROVE THE HEALTH OF THOSE WHO USE THEM.

II INEQUITABLE APPROACHES MAY IMPROVE HEALTH OUTCOMES BUT NOT EQUALLY FOR THE POPULATION BASED ON NEED.

III THIS IS BASED ON THE FINDINGS OF THE STRUCTURED REVIEW WHICH INCLUDED PAPERS THAT ANALYSED BOTH THE FINANCIAL RISK PROTECTION AND SERVICE COVERAGE DIMENSIONS OF UHC.

## OUTLINE OF REPORT

Chapter 1 defines UHC and outlines the objectives of this report, which are (a) to identify progressive pathways towards UHC, (b) to estimate the potential impact of more equitable strategies for UHC, and (c) to explore implications for the sustainable development agenda, identifying recommendations for governments and development partners (including bilateral donors, multilateral agencies, civil society and the private sector).

Chapter 2 unpacks what is meant by equity in relation to UHC and calls for governments and other development partners to seize the opportunity of growing political momentum for UHC to accelerate progress on addressing inequities. Pervasive inequities in health service coverage and financial risk protection are presented and linked with health system weaknesses, noting the potential of policy to mitigate some of these inequities.

Chapter 3 provides a conceptual framework for assessing equity in pathways towards UHC, drawing lessons from a structured review based on country experiences.

Chapter 4 presents the investment case for pursuing equitable pathways towards UHC, including the moral imperative, value for money and wider social and economic benefits of addressing inequities. It includes new estimates of the impact on saving lives of addressing inequities in service coverage and investing in more progressive health financing.

Chapter 5 discusses the implications of equity in pathways towards UHC for the measurement of UHC and the future development framework.

The report ends with a brief conclusion of the main findings and recommendations to governments and development partners.

## METHODOLOGY

The following pieces of research were commissioned to provide the evidence basis for the report:

- A structured literature review on the results of strategies for UHC on equity in access to services, financial risk protection or health outcomes in selected countries [page 62]
- Semi-structured key informant interviews on the place of equity in current dialogues on UHC and best paths forward. There were 17 key informants from academia, ministries of health, multilateral and bilateral organisations, and non-governmental organisations [page 70]
- An econometric analysis to estimate the impact of proxies for equitable strategies for UHC<sup>iv</sup> on mortality rates, the marginal cost for lives saved, related to the level of equity in service coverage [page 69]
- A Lives Saved Tool (LiST) analysis<sup>40</sup> to model the potential impact of reaching the entire population with a level of coverage of maternal and child health interventions<sup>41</sup> at the same level as is currently being reached by the highest wealth quintile [page 71].
- These have been supplemented with secondary research, through a scoping review, and quantitative analyses to support specific sections of the report. (“Appendix” on page 62)

IV INCLUDING INCREASED HEALTH EXPENDITURE AND DECREASED RELIANCE ON OUT-OF-POCKET SPENDING (OOPS) IN HEALTH FINANCING, AND HIGH AND EQUITABLE COVERAGE OF SELECTED ESSENTIAL INTERVENTIONS.

## 2. WHY EQUITY IS IMPORTANT FOR UNIVERSAL HEALTH COVERAGE

### UHC AS A MEANS TO ACHIEVE GREATER EQUITY IN HEALTH AND FINANCIAL RISK PROTECTION

Universal health coverage (UHC) is essentially about basing access to health services on need rather than on ability to pay or other socio-cultural attributes. The term ‘coverage’ is used to denote access that is realised, going beyond legislative entitlement to effective coverage.<sup>v,42,43</sup> It also includes the quality of health services received (preventive, promotive, curative, rehabilitative and palliative), social equity, and the financial risk protection that has been obtained.<sup>44</sup> It is a political concept as it goes to the heart of the entitlements that a citizen can expect from the state.<sup>45</sup>

UHC is far from a new concept, and was recently described as “old wine in a new bottle”.<sup>46</sup> Following World War II, the principles embodied in UHC emerged from deliberate efforts to foster social

cohesion in Europe and human security<sup>vi,47</sup> in Japan. UHC is firmly rooted in the right to health,<sup>48,49</sup> which was enshrined in the Constitution of WHO in 1946,<sup>50</sup> and included in the Universal Declaration of Human Rights two years later.<sup>51</sup> The right to health re-emerged in 1978 at the heart of the Alma Ata Declaration on Primary Healthcare.<sup>52,53</sup> Every country has now signed up to at least one treaty that acknowledges the right to health and many countries’ constitutions echo this entitlement.<sup>54</sup> The new focus on UHC has allowed countries to act on and operationalise existing constitutional guarantees of equitable access or the right to health and health services.

Growing global and country-level momentum on UHC (Box 1) offers huge potential for realisation of the right to health for those most in need if efforts to achieve UHC prioritise the needs of those who are poorest and most vulnerable.<sup>vii</sup> This could have transformative

V DEFINED AS “THE PROPORTION OF THE POPULATION IN NEED OF AN INTERVENTION WHO HAVE RECEIVED AN EFFECTIVE INTERVENTION”, WITH EFFECTIVE SERVICES DEFINED AS THE MINIMUM AMOUNT OF INPUTS AND PROCESSES REQUIRED “TO PRODUCE DESIRED HEALTH EFFECTS”.

VI HUMAN SECURITY IS DEFINED AS A PEOPLE-CENTRED, COMPREHENSIVE, PREVENTION-ORIENTED CONCEPT THAT ENABLES INDIVIDUALS TO FULLY DEVELOP THEIR HUMAN POTENTIAL THROUGH THEIR PROTECTION AND EMPOWERMENT, AS PER UNGA RESOLUTION A/RES/66/290 FOLLOW-UP TO PARAGRAPH 143 ON HUMAN SECURITY OF THE 2005 WORLD SUMMIT OUTCOME. THE JAPANESE GOVERNMENT HAS PRIORITISED GLOBAL HEALTH IN ITS FOREIGN POLICY AS INDISPENSABLE TO ACHIEVE HUMAN SECURITY, AND THIS IS CHANNELLED THROUGH THE PROMOTION OF UHC.

VII IN THIS REPORT, PRIORITISING THE NEEDS OF POOR PEOPLE IS CONSIDERED WITHIN EFFORTS TO MEET THE NEEDS OF THE WHOLE POPULATION, AS THE OBJECTIVE IS UHC.

## BOX 1 SEIZING THE MOMENTUM

Since WHO published its 2010 World Health Report on *Health systems financing: the path to universal coverage*,<sup>55</sup> UHC has gained prominence as a global health priority. WHO's Director-General, Margaret Chan, has declared, "Universal health coverage is the single most powerful concept that public health has to offer."<sup>56</sup>

This momentum has continued through many international meetings, conferences and declarations. At the World Health Assembly in May 2011, a resolution mandated WHO's Director General to request a session on UHC at the United Nations General Assembly (UNGA).<sup>57</sup> Since early 2012, the Foreign Policy and Global Health Group (France, Norway, Indonesia, Brazil, South Africa, Senegal and Thailand) has embraced UHC.<sup>58</sup> In January 2012, the Prince Mahidol Annual Conference in Bangkok led to a ministerial declaration recognising UHC as fundamental to the right to health, and emphasising the importance of translating the

rhetoric of UHC into better, more equitable health outcomes.<sup>59</sup> In April 2012, Mexico hosted an international forum on UHC ending with a Mexico City Political Declaration on UHC.<sup>60</sup> In July 2012, there was a Tunis Declaration from Ministers of Health and Finance focused on helping African countries achieve UHC,<sup>61</sup> and in September 2012, Ministers of Health from the East African Community released a statement on UHC and long-term harmonisation of social health protection.<sup>62</sup>

All these efforts culminated in UNGA unanimously adopting a resolution on UHC in late 2012.<sup>63</sup> This coincided with a timely interim report on the importance of sufficient and equitable financing for health in realisation of the right to health for all from the UN Special Rapporteur on the Right to Health.<sup>64</sup> UHC is widely considered a health priority for the post-2015 agenda – as is reflected in reports of the High Level Panel of Eminent Persons,<sup>65</sup> the UN Global Compact,<sup>66</sup> and the Sustainable Development Solutions Network<sup>67</sup> – and is likely to remain prominent in ongoing post-2015 discussions.

At the country level, political commitment to UHC has grown in rich and poor countries alike.<sup>1,68</sup> India, China, Ghana, Rwanda, Sierra Leone, South Africa and Vietnam are among the growing number of countries undergoing reforms towards UHC. In the United States, President Obama's recently-passed Patient Protection and Affordable Care Act will extend coverage to millions of US citizens, moving the country closer to UHC.<sup>69</sup>

The global financial crisis has presented new challenges of how to maintain and improve coverage in times of austerity.<sup>70,71,72</sup> These developments at the country level are reinforcing interest in UHC as a global health agenda.

IN THE MY WORLD SURVEY – A GLOBAL SURVEY FOR CITIZENS INITIATED BY THE UNITED NATIONS TO CAPTURE PEOPLE'S PRIORITIES, VIEWS AND VOICES ON THE FUTURE DEVELOPMENT GOALS – BETTER HEALTH IS THE SECOND HIGHEST PRIORITY IDENTIFIED BY RESPONDENTS GLOBALLY, AS WELL AS IN LOW- AND MIDDLE-INCOME COUNTRIES. THE DEFINITION OF BETTER HEALTH INCLUDES THE AVAILABILITY OF GOOD-QUALITY HEALTH SERVICES TO EVERYONE WHEN THEY NEED TREATMENT, WHICH IS CONSISTENT WITH THE GOAL OF UHC. SEE [HTTP://WWW.MYWORLD2015.ORG/](http://WWW.MYWORLD2015.ORG/)

potential in addressing health inequities and accelerating progress towards global and national health targets.

UHC is inherently related to debates about equity, but this critical component has received inadequate attention in discussions about UHC. Health inequities are defined as the unfair and avoidable inequalities in health status between populations.<sup>73,74,75</sup> Within health systems, equity applies to the goals of improved health outcomes, equity in finance, financial risk protection and responsiveness, as well as the objectives of good quality and utilisation based on need.<sup>76</sup> These are consistent with the core objectives of UHC: coverage of services according to need, and financial contribution based on ability to pay.<sup>77</sup> If this is achieved, UHC

policies will be implicitly redistributive.

If UHC were achieved tomorrow, equity would not be an issue, since everyone in a given country would have access to healthcare. However, as resources increase, efficiencies improve or technologies evolve, the gap between need and coverage across different sub-populations often gets wider, with poor and other vulnerable groups the last to see their access improve. It has therefore been argued that UHC is "a direction, not a destination", towards which all countries can progress.<sup>78</sup>

On the pathway towards UHC, complex, often political, questions arise regarding how resources are allocated and who benefits from such investments. Should a

country first expand the population covered with a more basic package, or increase the entitlements for existing beneficiaries? In such decisions, there is a risk that gaps between need and use of services are addressed very slowly and that poor and other vulnerable groups are often the last to see their access improve.<sup>79</sup> Those currently excluded from using services tend to have the highest concentrations of ill-health, risk factors and, consequently, the remaining burden of disease in the population.<sup>80</sup> In the short term, therefore, UHC policies that do not prioritise reducing inequities from the start might actually exacerbate inequities rather than resolve them.<sup>81</sup> Countries that decide to take a pro-equity approach towards UHC must start with the needs of the most excluded first and aim to accelerate the pace at which vulnerable populations rise to the same standards of health enjoyed by the more privileged in that society.

Financing is a central and transformative component of health systems, particularly in relation to UHC and equity. Indeed, as a key informant stated, “A core goal of financing is to effect a financial transfer from healthy and wealthy to sick and poor, enabling the latter groups to secure access to services they otherwise could not afford.” This is the very heart of equity which must come with UHC.

An equally critical component of achieving UHC is related to overcoming and dismantling non-monetary barriers to access.<sup>82,83</sup> These must be addressed concurrently for the equalising effects of any financial transfer to be fully realised. Exploring how to achieve this is beyond the remit of this report, but it clearly warrants additional research and attention.

## **PERVASIVE INEQUITIES IN HEALTH STATUS**

The world has made substantial progress in improving health outcomes at the aggregate level, with far fewer women and children dying from preventable causes. At the global level, under-five mortality went down by 41% between 1990 and 2011.<sup>84</sup> Yet it is estimated that 1 billion people do not receive the health services they need each year.<sup>85</sup> For those who do access care, 150 million people face financial catastrophe from having to pay for healthcare, propelling an estimated

100 million people into poverty every year.<sup>viii,86</sup> Since the indirect and opportunity costs of seeking care – such as transportation and time away from productive labour – are excluded from these estimates, the true incidence of catastrophic expenditure and impoverishment from accessing healthcare is likely to be higher.

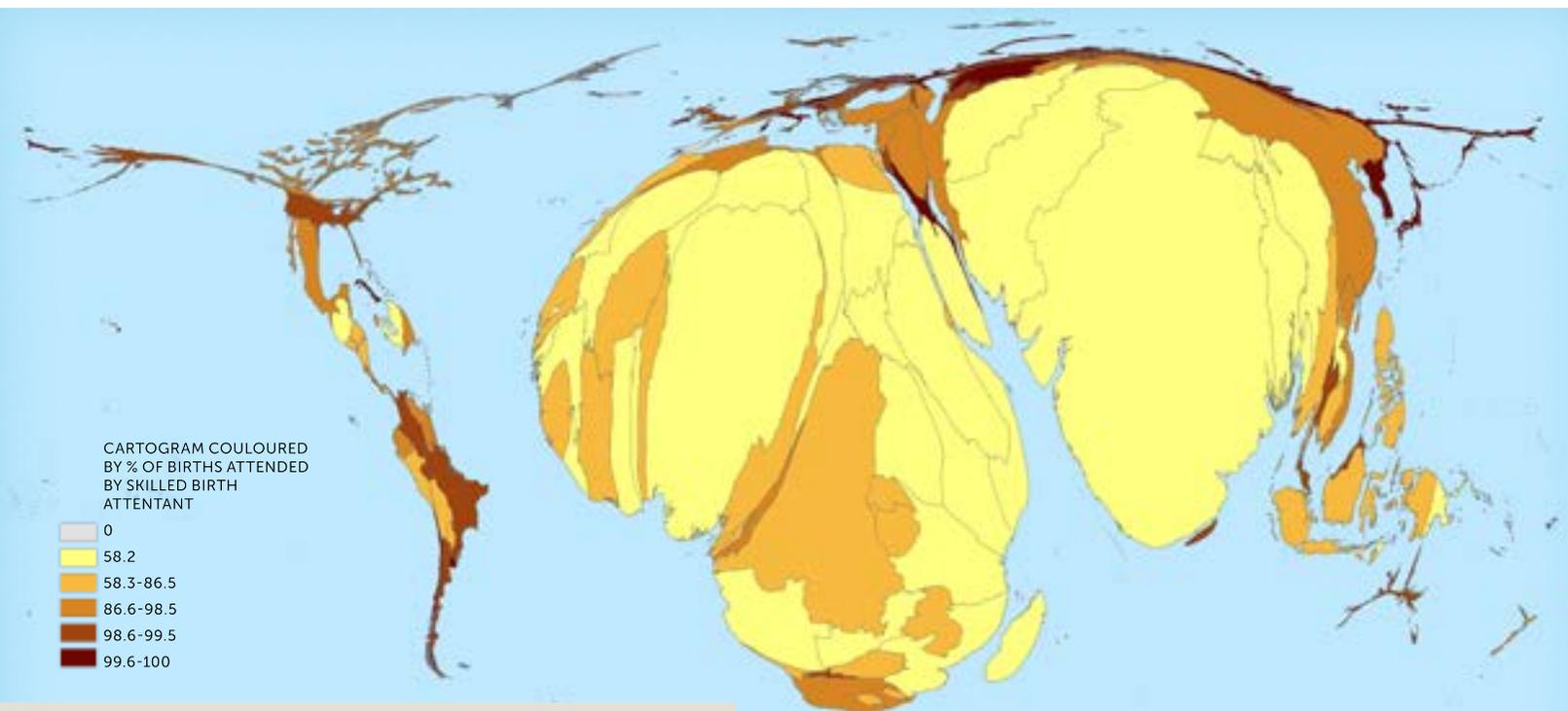
## **INEQUITIES BETWEEN AND WITHIN COUNTRIES**

Health inequities between and within countries persist and in many cases are widening.<sup>87,88,89</sup> In 2011, global average life expectancy at birth was 70 years. In high-income countries the average was 20 years older (80 years) than the average in low-income countries (60 years). African regional average life expectancy – at 56 years – was 20 years lower than that in Europe, the Americas and the Western Pacific (76 years). Between individual countries, these gaps are even wider. While in Sierra Leone life expectancy at birth was just 47 years, in Japan it was as high as 83 years.<sup>49</sup> Mortality trends for women, newborn babies and children under five years of age follow a similar pattern of wide variation between regions and countries, with high rates of mortality concentrated primarily in LMICs.<sup>50</sup>

These mortality trends are inversely associated with coverage of essential health services. In the regions and countries with the highest mortality rates, access to services is typically low (Figure 1).

For instance, 1 million children develop TB annually, with the burden highest in countries with health systems least able to treat these children, adding to the inequitable burden of child mortality. This has been the case in Afghanistan, Pakistan, and nations in sub-Saharan Africa.<sup>52,53,54</sup> In Europe, the Americas and the Western Pacific regions, over 90% of women had a skilled attendant when they gave birth between 2005 and 2012. This was true for under half of women

VIII IN THIS ESTIMATE, OOPS MADE DIRECTLY TO A HEALTHCARE PROVIDER FOR RECEIVING SERVICES IS INCLUDED. THIS TYPICALLY INCLUDES CONSULTATION FEES, LABORATORY AND DIAGNOSTIC TESTS, PRESCRIPTIONS AND HOSPITAL BILLS. INSURANCE REIMBURSEMENTS HAVE BEEN DEDUCTED. TRANSPORT AND OPPORTUNITY COSTS ARE NOT INCLUDED AS THESE ARE NOT TYPICALLY AVAILABLE FROM HOUSEHOLD SURVEYS AND LOST PRODUCTIVITY AFFECTS HOUSEHOLD INCOME RATHER THAN THE FINANCIAL IMPACT OF SEEKING CARE.



**FIGURE 1**  
**COUNTRIES' SIZES ACCORDING TO CHILD MORTALITY AND SHADING BY COVERAGE OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL**<sup>92</sup>

in Africa, and fewer than one in ten women in Somalia. In addition, reductions in mortality have been slowest in the countries with higher levels of mortality.<sup>96</sup>

Such inequities can be even more pronounced *within* countries (Figure 2).<sup>97</sup> The gaps between richest and poorest households have widened in over half the countries that have experienced declines in child mortality at national level.<sup>98</sup>

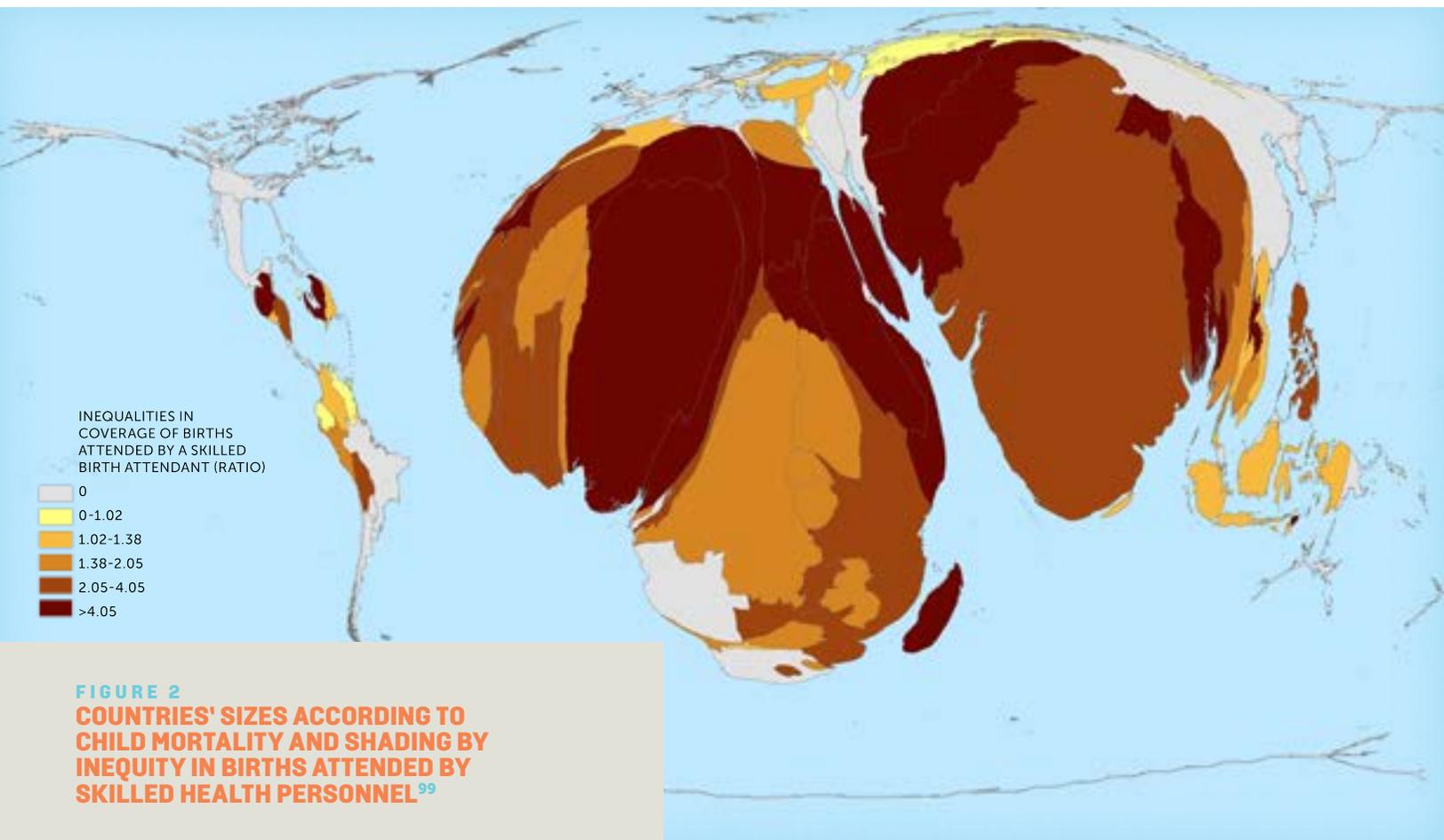
Of the key informants who mentioned the MDGs (63%), all shared a concern that the national average targets have been detrimental to equity as they mask socially stratifying factors.<sup>100</sup> Quoting one key informant: “In most countries, MDG advances are failures from the point of view of inequities. If you look at the distribution, we have decreased maternal mortality, we have increased life expectancy – we have increased almost all outcome indicators – but in none of them has there been a decrease in the inequities.”

Identifying those who have not been reached is crucial to understand why they have been missed or excluded, and to find ways to overcome the underlying barriers.

### **PERVASIVE INEQUITIES OF HEALTH SERVICE COVERAGE**

The inequities that determine health status are not random. There are social determinants of health that lead certain sub-populations to “systematically experience worse health or greater health risks than more advantaged social groups”.<sup>101</sup> These inequities are shaped by social and economic characteristics, and the distribution of resources and power at global, country and local levels.<sup>102,103</sup>

A country’s health system can widen inequities by preventing access to healthcare. This trend has been referred to as the ‘inverse equity’<sup>104</sup> principle, whereby



improvements in healthcare access and use, and thus in health outcomes, often benefit those who are more privileged first.<sup>105</sup> A key informant noted: “The focus is usually on meeting aggregate targets of service coverage and not consideration for who is being covered first, or indeed who is left behind.”

Individual or group characteristics that often affect health service coverage include household wealth, education, geographic location, urban versus rural residence, gender, ethnicity and age.<sup>106</sup> For instance, a child from a wealthy family in Nigeria is more than eight times likely to receive three doses of the diphtheria, tetanus and pertussis containing vaccine than a child from a poor family. In Bangladesh, a woman from a wealthy household is ten times more likely to have a skilled attendant when giving birth, compared to a woman from a poorer family. For urban and rural women in Bangladesh, this ratio is 3:1. In both Bangladesh and India, a woman from a wealthy

household is six times more likely to have at least four antenatal visits.<sup>107</sup>

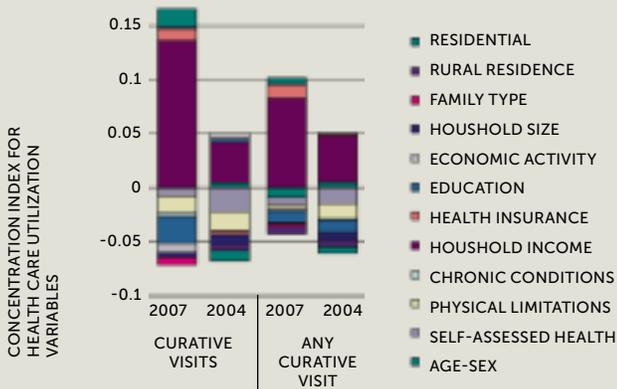
Refugee or migrant status and working in the informal sector can also be significant characteristics of low coverage. Other barriers may be important but difficult to quantify, such as inadequate provision of information or knowledge gaps on the value of healthcare that build on existing beliefs and values,<sup>108</sup> or perceptions about the quality of care.<sup>109</sup> This might be associated with supply-side factors, such as discrimination and mistreatment by service providers. Depending on the country’s health financing arrangements, having health insurance can also be a strong determinant of access, such as in Brazil and Mexico.<sup>110,111</sup>

Understanding these characteristics is restricted by limited data and the lack of standardised measures

## BOX 2

### CHARACTERISTICS OF INEQUITY IN HEALTH SERVICE UTILISATION IN JAMAICA, 2004-07

An analysis of health service use in Jamaica between 2004 and 2007 reveals pro-rich health service coverage. Inequities in access also worsened during the same period, widening the coverage gap. Health insurance coverage and urban residence further exacerbated the effect of income-based inequities, encouraging pro-rich utilisation.<sup>118</sup>



of inequity in access and outcomes.<sup>ix</sup> Various efforts have been made to conceptualise access<sup>x,112</sup> in order to better understand the barriers that are at play, such as distinguishing between availability, affordability and acceptability.<sup>113</sup> Barriers can also be differentiated according to demand and supply, preventive and curative interventions, or by service delivery platforms (eg, facility-based services versus those delivered through outreach or campaigns), to name a few. The relative importance of diverse financial and non-financial factors that mediate access – as well as how these factors interact to enable or constrain access and utilisation of services – may vary substantially across all of these groupings (Box 2).<sup>114</sup> The value of

IX WHILE STANDARDISATION IS IMPORTANT FOR COMPARATIVE ANALYSIS, METRICS MUST BE SENSITIVE TO LOCAL CHARACTERISTICS TO CAPTURE THE MOST RELEVANT STRATIFIERS.

X AN ACCESS BARRIER HAS BEEN DEFINED AS "A MANIFESTATION OF A LACK OF FIT BETWEEN A POTENTIAL HEALTHCARE NEED AND THE ACTUAL SERVICE DESIGNED TO ADDRESS THAT NEED. THE RELATIVE SIGNIFICANCE OF AN ACCESS BARRIER DEPENDS ON THE SOCIO-ECONOMIC AND SOCIO-CULTURAL POSITION OF THE INDIVIDUAL, THE HOUSEHOLD AND THE COMMUNITY."

## BOX 3

### ETHNICITY IN VIETNAM<sup>122</sup>

In Vietnam, ethnicity is a strong determinant of the uptake of health services. Women and children from minority ethnic groups consistently have lower coverage of essential services, as compared to Kinh, the dominant ethnic group. Kinh women, for example, are nearly four times more likely than those from minority ethnic groups to give birth at health facilities,<sup>123</sup> and more than twice as likely to seek healthcare for a child with diarrhoea.<sup>125</sup>

For many minority ethnic groups, ethnicity may be associated with social and political marginalisation and thereby contributes to a multitude of deprivations. Residence in remote and often mountainous areas, distance and lack of transportation further discourage access.<sup>126</sup> As health workers are typically Kinh, language barriers further discourage minority ethnic communities from seeking care. Communication may be difficult and discrimination anticipated,<sup>127</sup> as some minority groups fear being misunderstood and seen as 'backward'. Utilisation of services also varies due to cultural differences, as some groups have been shown to favour traditional practices over conventional medicine. For instance, the Red Dao, who reside in the highlands, seek spiritual treatment for childhood diarrhoea before, or in parallel to, treatment from a health facility,<sup>128</sup> while the Hmong, from northern Vietnam, prefer home births due to important rituals related to delivery.<sup>129</sup>

local qualitative research in understanding barriers and bottlenecks to service coverage is fundamental to designing pro-equity and feasible UHC policies.<sup>115,116</sup> Quoting a key informant, "That's the way it's got to go: context specific – not just district specific, but community specific."<sup>117</sup>

Characteristics of non-coverage of health services are complex and often coincide, varying in pattern and magnitude depending on the context and the intervention being studied.<sup>119</sup> The multiplicity and overlap of deprivations can magnify inequities in both the potential coverage as well as the actual utilisation of available services.<sup>120</sup> Where these characteristics overlap, inequities may be compounded. For instance, ethnicity was found to be associated with poverty

#### BOX 4 SOCIAL DETERMINANTS OF HEALTH AND UHC

While many health disparities result from a lack of available health services, structural determinants and people's living conditions also play a critical role.<sup>140</sup> These are the social determinants of health, defined as the "conditions in which people are born, grow, live, work and age".<sup>141</sup> These conditions are largely shaped by such factors as the unequal distribution of wealth, resources and influence both across and within countries, coupled with poor social policies and programmes to address this.<sup>142</sup> Many social determinants can lead to poor and inequitable health access and outcomes.

Therefore, while UHC is crucial to improving health equity and outcomes, addressing social determinants must be part of this. Overcoming socially defined barriers can help countries move towards UHC and complement and mutually reinforce UHC efforts.

In recognition of the importance of social determinants to health equity and outcomes, WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to support countries and global partners in addressing barriers to achieving UHC.<sup>1</sup> Three main recommendations emerged from the Commission's work, including the need to:<sup>143</sup>

1. Improve people's daily living conditions – eg, by improving early child development and education for girls and boys; developing supporting social protection policy; improving living and working conditions;
2. Tackle structural causes of these conditions – eg, by building a strong and well-financed public sector; improving governance with a commitment towards equity at all levels;
3. Measure and understand the problem and assess the impact of action – eg, by setting up health equity surveillance systems;

I THE RIO POLITICAL DECLARATION ON SOCIAL DETERMINANTS OF HEALTH WAS SUBSEQUENTLY ADOPTED IN 2011, AND A RESOLUTION ON THIS ENDORSED AT THE 65TH WORLD HEALTH ASSEMBLY IN 2012.

evaluating health equity impacts of policy and action; training policy makers and practitioners; building public understanding of social determinants.

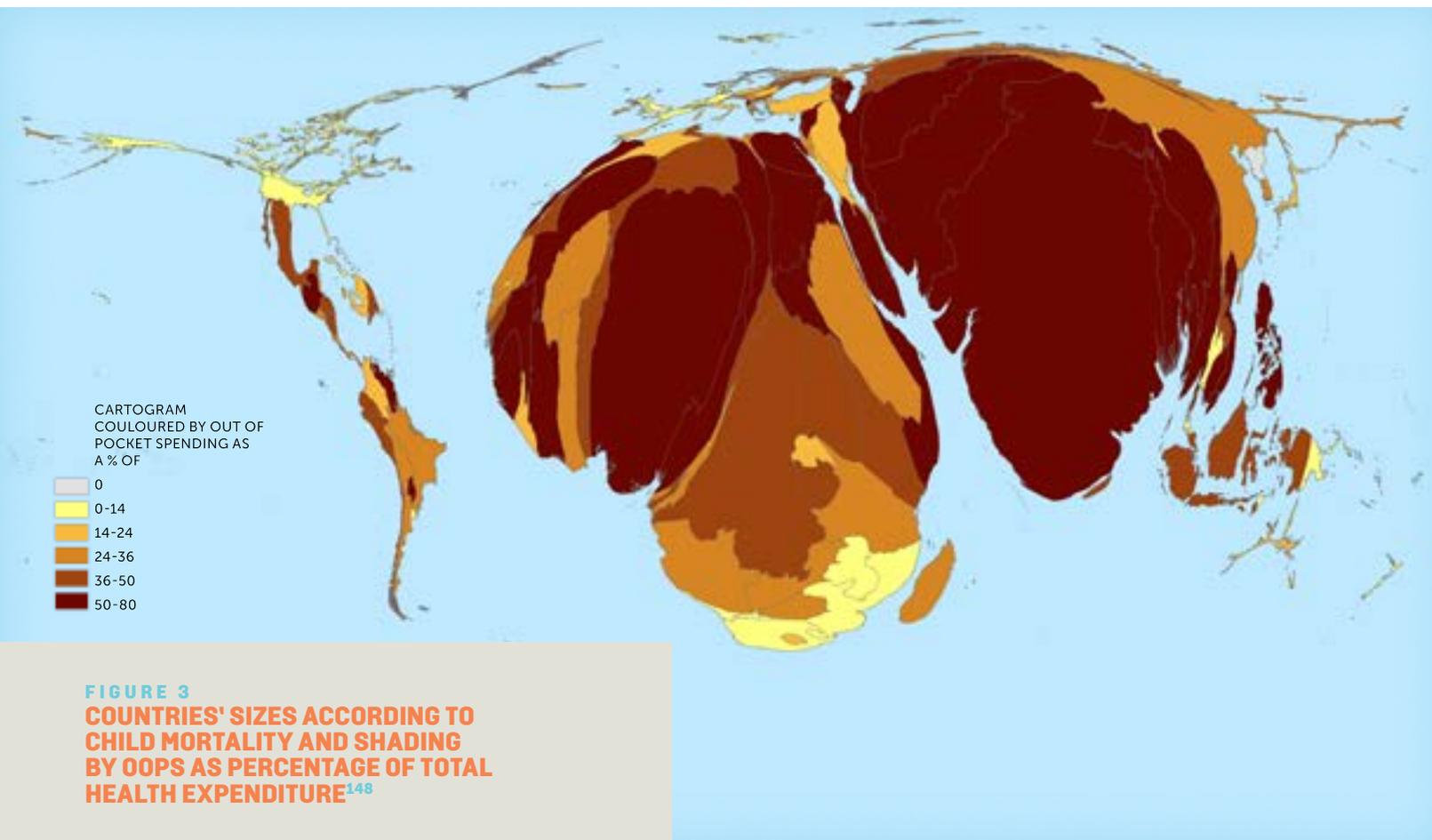
Several countries have also shown political commitment and taken national action on social determinants in order to improve health equity.<sup>144</sup> For example, Brazil has invested in research to better understand social determinants and health equity in the country. It has also reviewed relevant national systems, and developed joint policy and plans to address barriers. Building on previous initiatives, Chile is coordinating work across national partners to address issues around children's and workers' health, including monitoring and revising National Health Equity Targets, integrating social determinants and equity into health sector planning and monitoring, and integrating relevant policies and programmes into the wider social protection system. Through these efforts, Chile is ensuring that addressing social determinants and equity are central to the goals and strategies of key health programmes.

and informal sector occupation in the Americas, exacerbating inequity in access to health services for indigenous people and those of African descent.<sup>121</sup> In Vietnam, people from minority ethnic groups have consistently lower coverage of essential interventions, which is associated with other related determinants of access such as language, distance and traditional practices (Box 3).

Health services that require more sophisticated care through more skilled providers tend to be more inequitably distributed than routine services provided within the community.<sup>130,131,132</sup> For instance, in Mali, inequity in household wealth accounted for at least two-thirds of the national coverage gap in skilled birth attendance but just one-third of the gap in measles vaccination coverage.<sup>133</sup>

As these structural characteristics reveal, social privilege trumps vulnerability and need when it comes to both health status and coverage of essential healthcare.<sup>xi</sup> The conditions in which people are born, grow, live, work and age define health inequities.<sup>134</sup> Broader contextual factors also play a role, such as historical legacies, political agendas and conflict situations.<sup>135</sup> Few social determinants are measured systematically, and few are within the sole control of the health sector. As Hosseinpoor and colleagues state, "Poverty and inequality remain the world's greatest killers."<sup>136</sup>

XI THE AUTHORS ACKNOWLEDGE THAT THERE ARE SOME INTERVENTIONS AND COUNTRIES WHERE COVERAGE IS MORE EQUITABLY DISTRIBUTED.



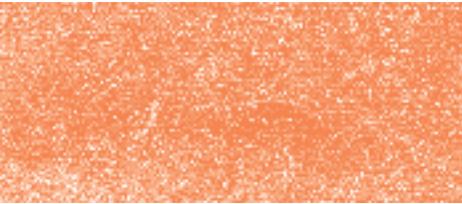
In 2005, WHO convened the Commission on the Social Determinants of Health to report on the structural causes of health inequities and make policy recommendations (Box 4). Addressing these underlying factors is critical to overcoming health inequities and to sustaining the gains made.<sup>137,138</sup> Health systems have a critical role to play in either exacerbating or mitigating such inequities.<sup>139</sup>

### THE SOCIAL GRADIENT OF FINANCIAL RISK PROTECTION

In the absence of effective health systems financing that can deliver equitable progress towards UHC, the unpredictability of need for healthcare and its associated costs exacerbate both the incidence

and extent of poverty endured by less fortunate households.<sup>145</sup> While it is an incomplete measure as it only assesses actual utilisation of the health service, out-of-pocket spending (OOPS) is often used as an indicator to measure financial protection. It is widely acknowledged that OOPS, such as user fees,<sup>xii</sup> is the most regressive form of health sector financing, placing a disproportionate burden on the poorest and most vulnerable communities.<sup>146</sup> High OOPS discourages poor people from seeking care, thus reducing access and widening coverage gaps. However, many countries with a high burden of preventable mortality continue to rely on OOPS for a large share of total health system resources (Figure 3).<sup>147</sup>

XII OOPS INCLUDES DIRECT PAYMENTS AT THE POINT OF USE, BUT ALSO INDIRECT AND OPPORTUNITY COSTS, SUCH AS THE COSTS OF TRAVEL AND TIME AWAY FROM WORK WHEN ACCESSING HEALTHCARE.



## SCRUTINISING THE DISTRIBUTION OF THE FINANCIAL BURDEN OF HEALTHCARE COSTS WITHIN COUNTRIES – IE, WHO IS PAYING FOR HEALTHCARE – IS CRITICAL TO ANALYSE EQUITY IN FINANCING AND FINANCIAL RISK PROTECTION.

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Generally speaking, the higher OOPS is as a share of total health expenditure in a country, the greater the incidence of catastrophic spending<sup>xiii,149</sup> and consequent impoverishment due to healthcare payments. High costs of care also deter patients from accessing needed services.<sup>150</sup> WHO has estimated that the incidence of financial catastrophe and impoverishment from OOPS only becomes negligible when direct OOPS is limited to 15–20% of total health expenditures.<sup>151</sup> In many countries, greater income inequality is also associated with higher catastrophic expenditure faced by poor people.<sup>152</sup>

An analysis of Asian countries found that OOPS was particularly high in Bangladesh, Cambodia, China, India and Vietnam, with high levels of catastrophic expenditure and consequent impoverishment due to healthcare payments. In Cambodia, households spend 5.6% of their overall budget on health, one of the highest proportions in the region, pushing 4% of families below the poverty line due to health expenditures each month.<sup>153</sup> In contrast, despite its low-income status at the time of the study,<sup>xiv</sup> Sri Lanka maintained OOPS

below 50% of total health expenditures with only a modest impact on catastrophic spending and poverty (Box 12). At higher income levels, Thailand's and Malaysia's capacity to contain the catastrophic and impoverishing consequences of OOPS is impressive, though non-citizen inhabitants – such as refugees and, in some contexts, minority ethnic groups – do not have the same level of protection and fall through existing safety nets.<sup>154</sup>

Scrutinising the distribution of the financial burden of healthcare costs within countries – ie, who is paying for healthcare – is critical to analyse equity in financing and financial risk protection.<sup>xv,155</sup> A study that disaggregated OOPS by socio-economic status found that in all 51 countries studied, the burden falls disproportionately on the poorest communities.<sup>156</sup> Consistent with inequalities in health service utilisation, in addition to poverty, rural residents and households with a female or less educated head also face a bigger burden from OOPS.<sup>157</sup>

XIII CATASTROPHIC HEALTH EXPENDITURES ARE DEFINED AS DIRECT PAYMENTS ON HEALTHCARE THAT ARE GREATER THAN OR EQUAL TO 40% OF HOUSEHOLD INCOME AFTER BASIC NEEDS HAVE BEEN MET.

XIV NOTE THAT SRI LANKA WAS ELEVATED TO MIDDLE-INCOME STATUS IN 2010: [HTTP://WWW.WORLDBANK.ORG/EN/COUNTRY/SRI LANKA/OVERVIEW](http://www.worldbank.org/en/country/srilanka/overview)

XV HIGH OOPS IS OFTEN USED AS A PROXY FOR EQUITY IN HEALTH FINANCING. HOWEVER, IN SOME COUNTRIES WHERE OOPS AS A SHARE OF TOTAL HEALTH SPENDING IS HIGH, CATASTROPHIC EXPENDITURE MAY BE LOW. THIS TENDS TO BE ASSOCIATED WITH HIGH UTILISATION OF PRIVATE PROVIDERS. FOR INSTANCE, IN SRI LANKA, HIGHER-INCOME HOUSEHOLDS ARE SELF-SELECTING PRIVATE OUTPATIENT CARE ON AN OUT-OF-POCKET BASIS, WHILE LOWER-INCOME PEOPLE USE THE FREE PUBLIC SERVICES. THIS REINFORCES THE IMPORTANCE OF DISAGGREGATING DATA TO EXPLORE WHO BEARS THE BURDEN OF OOPS.

So what are poor people spending their scarce resources on when they seek health services? Medicines and supplies tend to comprise the majority of OOPS for poor people.<sup>158,159,xvi</sup> For example, medicines and drugs are estimated to account for 70% of OOPS in India,<sup>160</sup> pushing more than 40 million people into poverty each year.<sup>161</sup> The rapid increase in drug prices, estimated to have doubled or even tripled annually in recent years, has magnified this already significant burden,<sup>162</sup> which is likely to also be compounded by the rising burden of non-communicable diseases.<sup>163</sup>

Another typical trigger for catastrophic spending and impoverishment is where more complicated healthcare needs are not foreseen – for instance, complicated deliveries and emergency obstetric care.<sup>xvii,164</sup> For many households in African and Asian countries, even normal facility-based deliveries can be extremely burdensome on the household purse.<sup>165</sup>

Catastrophic expenditures tend to be higher for families with elderly members or children under five years of

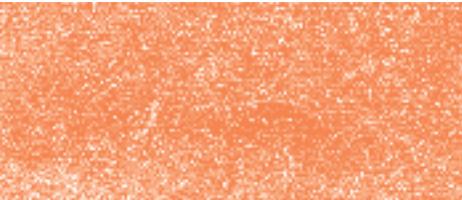
age. Payments for inpatient care are found to be less consistently regressive than outpatient care, which may be due to low levels of utilisation of such services among poorer and more vulnerable groups. However, where people are incurring OOPS for inpatient care, the chance of catastrophic expenditures from inpatient services is high. One study estimated that this affected at least 25% of households in half of the countries analysed.<sup>166</sup>

For poor households, choice of healthcare provider is largely informed by associated costs. Although poor people are more dependent on public care, inadequate supplies of drugs at public health facilities discourages utilisation of government-run facilities, for example in Bangladesh.<sup>167</sup> Even in countries where certain services are free in law, if low wages or inadequate oversight exists, providers may charge patients significant informal fees.<sup>168</sup> In the face of the high cost implications of seeking professional care, poor people are more likely than rich people to refrain from seeking care, or to use informal unqualified healthcare providers.<sup>169</sup>

The burden on households is not limited to direct payments. Indirect costs – such as transport and the opportunity costs of time away from work – can be high and may deter poor households from seeking care.<sup>170</sup> Further, as a consequence of high OOPS, poor families

XVI THIS MAY BE EXACERBATED BY IRRATIONAL USE OF MEDICINES. SEE [HTTP://APPS.WHO.INT/MEDICINEDOCS/PDF/H3011E/H3011E.PDF](http://apps.who.int/medicinedocs/pdf/h3011e/h3011e.pdf)

XVII WHERE OBSTETRIC CARE IS INCLUDED IN THE BENEFIT PACKAGE WITHOUT USER FEES, THE INCIDENCE OF CATASTROPHIC EXPENDITURES AND IMPOVERISHMENT WILL BE SIGNIFICANTLY REDUCED. INDIRECT AND OPPORTUNITY COSTS MAY REMAIN SUBSTANTIAL, ESPECIALLY FOR POOR HOUSEHOLDS.



## INADEQUATE, INEFFICIENT AND INEQUITABLE FINANCING UNDERMINES EFFORTS TO ACHIEVE UHC.

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may employ coping strategies, such as borrowing at high interest rates or selling productive assets, which exacerbate and extend their period of suffering.<sup>171</sup> Impoverishment caused by healthcare costs can span generations.<sup>172</sup> These are rarely captured in estimates of the impact of healthcare costs on households, which may underestimate the actual burden. Nor is the impact on household income of foregoing essential care due to high out-of-pocket cost.

### **WEAK HEALTH SYSTEMS EXACERBATE HEALTH INEQUITIES**

As mentioned above, one of the main determinants of health is the health system itself.<sup>173</sup> Despite the clear association between increases in a country's wealth and improvements in the average health of households, there are many outliers to this trend. This signifies the power of policy to mitigate some of the inequitable impacts of the wider social determinants.<sup>174,175</sup> As Margaret Chan, Director General of WHO said, "Health systems will not *naturally* gravitate towards equity."<sup>176</sup> How a health system is designed will determine whether it compensates for or exacerbates these underlying inequalities.<sup>177</sup> Through policy and its implementation, a health system has the potential to promote health equity and act as an equaliser.<sup>178</sup>

As a health system concept, efforts to achieve UHC must prioritise the equity objective. Financial risk protection, for instance, can reduce the vulnerabilities of poor people and strengthen household resilience if the overall system is adequately funded and sufficiently redistributive.<sup>179</sup>

Inadequate, inefficient and inequitable financing undermines efforts to achieve UHC. Primary healthcare systems in LMICs are often underfunded, and the resources they do receive may not be optimally utilised.<sup>180</sup> Minimum thresholds set by the high-level Taskforce on Innovative International Financing for Health Systems in 2009 estimated that providing a basic package of essential services would cost just over US\$60 per capita by 2015.<sup>181</sup> But spending on health in low-income countries still falls far below this target. In 2011, the average total spending per capita in low-income countries was just US\$31, and only 40% of this came from government sources.<sup>182</sup> Donors' failure to honour pledges and comply with the principles of effective aid has exacerbated this shortfall.<sup>183</sup>

The failure to achieve UHC is also the product of weaknesses across and between the building blocks of the health system. Blockages in the health system – referred to by Sania Nishtar, founder and director of the Pakistani think-tank, Heartfile, as "choked pipes"<sup>184</sup>

## BOX 5 UHC AND SOCIAL PROTECTION

The goal of social protection is to ensure “an integrated set of social policies designed to guarantee *income security* and access to *essential social services* for all, paying particular attention to vulnerable groups”.<sup>190</sup> Income security requires that people know they will have sufficient income over their lifetimes regardless of their employment status. This is usually assured through cash transfers,<sup>191</sup> such as child and maternity allowances, unemployment benefits and old-age pensions. The other part of social protection is access to at least a basic level of *all* services essential to human wellbeing – water and sanitation, education, food security, housing and health.

Social protection initiatives therefore aim to prevent, reduce and eliminate social and economic vulnerabilities, poverty and social exclusion, helping to promote a decent standard of living for all

people.<sup>192</sup> For health, this means ensuring access to needed health services and the transfers associated with addressing barriers to care.

In many countries, people face a range of economic and social barriers to accessing health services. In addition to direct financial barriers (eg, user fees), travel costs, the time implications of visiting a clinic, and additional opportunity costs such as loss of labour for food production or income may prevent individuals from accessing a healthcare facility.

Empirical evidence suggests that integrated social protection interventions can help increase the use of health services through the reduction of financial barriers and the provision of social support and information that enables beneficiaries to access health services.<sup>193</sup> For example, the provision of cash or in-kind transfer programmes that help poor households access adequate nutrition can be an inherent part of ensuring good health, given the

clear complementarities between nutrition and effective medical treatment (for diarrhoea, HIV, tuberculosis, etc). Similarly, a cash transfer that covers transportation costs to and from clinics may mean that poor families are more likely to take advantage of their right to healthcare.

UHC is therefore an important component of integrated social health protection in addressing service availability and quality, and overcoming the financial barriers linked to payment at the point of service. Meanwhile, broader social protection systems can support UHC by removing other barriers that entrench social exclusion or make households less likely to benefit from healthcare. As such, the equitable and effective implementation of UHC has much to gain from the complementary and parallel provision of other forms of social protection.<sup>194</sup>

– lead to inefficient and ineffective coverage.<sup>185</sup> These include the critical shortages of health workers who are appropriately skilled, supported, equipped, motivated and geographically distributed. These shortages leave many of the most vulnerable populations beyond the reach of the health system. Weak procurement and supply systems mean facilities may often be out of stock of essential medicines and supplies, reducing patient confidence in the quality of care provided and increasing OOPS as people turn to private providers.<sup>186</sup> Bad governance and corruption further plague many health systems in LMICs.<sup>187</sup> Coordinated efforts to strengthen the system as a whole must be undertaken to achieve UHC.<sup>188,189</sup>

There are multiple barriers to achieving UHC that must be addressed concurrently. However, they are

not equally amenable to health policy action, and some fall beyond the remit of the health system, such as legal constraints on services offered to refugees. Multi-sectoral efforts are therefore required. The opportunity of complementary initiatives, such as broader social protection mechanisms, must also be pursued (Box 5).

This report focuses on the contribution of the health system – and in particular health financing – in promoting equity in health outcomes through progressive pathways towards UHC. The health sector also has a role to play in influencing broader political and policy agendas, and strengthening community participation and empowerment<sup>195</sup> by making visible the social and individual costs of exclusion on the health of poor and marginalised people.<sup>196</sup>

# 3. WHAT ARE PROGRESSIVE PATHWAYS TOWARDS UNIVERSALISM?





Patients wait to be seen by the nurse at a Save the Children supported clinic in Tenegar, Montserrado county, Liberia.

© SAVE THE CHILDREN / JONATHAN HYAMS

ACHIEVING UHC requires much more than action on health financing. It is critical that an integrated approach is taken to strengthening the capacity of health systems to provide UHC, while also addressing the social determinants of health.

However, financing policy levers are pivotal in *managing the system*,<sup>197</sup> with the potential to affect more equitable access through: alleviating important barriers; improving the quality of care; and expanding financial risk protection. Countries are increasingly moving away from orthodox historic classifications of health financing models – notably the Beveridge and Bismarck models referred to as tax-financed and social health insurance respectively – towards mixed-models. Moving away from such models, this chapter explores the health system functions at play to identify lessons that might be applicable across contexts.<sup>198</sup>

# A CONCEPTUAL FRAMEWORK FOR ASSESSING EQUITY IN PATHWAYS TOWARDS UHC

## HEALTH SYSTEM GOALS

An analysis of policy levers to affect equitable pathways towards UHC should start with the common goals and objectives of all health systems: improved health status and equity in health outcomes; financial protection and equity in financing and non-discriminatory responsiveness, with intermediary objectives of utilisation based on need, quality and efficiency (Figure 4).<sup>199,200</sup> The relative priority attributed to these objectives and goals is a choice informed by a country's context and values.<sup>201,202</sup>

## APPLYING A SYSTEMS LENS

Reforms in the direction of UHC should be assessed by their effect on vulnerable groups within the whole population and the overall system (Box 6).<sup>204</sup> Partial approaches – such as small schemes for specific population groups – can be effective in promoting coverage for their target population. However, this may be at the expense of other populations and the wider goal of strengthening the health system. Policy and regulation provide opportunities for the government to effectively steward the system to ensure that schemes complement and contribute to the desired goals.<sup>205</sup>

## MANAGING TRADE-OFFS

Limited resources for health policy reforms mean that difficult decisions on how to ration and how to manage trade-offs are inevitable (Box 7).<sup>211</sup> It is critical that policy makers are aware of the social, economic and political implications of potential trade-offs to ensure that progress towards health system goals are maximised.<sup>212</sup>

### BOX 6

#### APPLYING A HEALTH SYSTEM LENS

A health system is defined as all the people, institutions, resources, policies and activities whose primary purpose is to promote and/or maintain health, protecting the population against the cost of ill-health.<sup>206,207</sup>

WHO has identified six core components, or building blocks, of a health system: leadership and governance, service delivery, health workforce, health information system, medical products, vaccines and technologies and health system financing. These functions are dynamic and interrelated: "Every intervention, from the simplest to the most complex, has an effect on the overall system, and the overall system has an effect on every intervention."<sup>209</sup>

It is critical that any reform for UHC should be considered within this framework, with the objective to strengthen the system and deliver on its goals and objectives (Figure 4). Applying a health systems lens – or systems thinking – means maximising the synergies across the building blocks and mitigating potential negative impacts.<sup>210</sup>

Focusing on cost-effectiveness alone can be distortive and detrimental to other health system goals.<sup>213</sup> For instance, the relationship between cost-effectiveness and equity is unpredictable and determined by contextual factors. Investments to improve health status can be cost-effective when they reach the most wealthy as well as when they reach the poorest.<sup>214</sup> While the objective of efforts to scale up coverage should aim to be both cost-effective and equitable,<sup>215</sup> progress towards the equity goal of the health system should be prioritised.

On the other hand, increasing efficiencies in the system not only advance the efficiency objective of health reform itself but, by freeing up resources, can also lessen the impact of trade-offs where it may cost more to promote equity in efforts to scale-up coverage.<sup>216</sup> Moreover, due to the social gradient in health, reaching the poorest and most marginalised can thereby be more cost-effective while still providing equitable and good-quality coverage.<sup>217</sup>

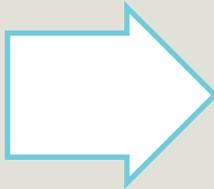
**FIGURE 4**  
**HEALTH SYSTEM FUNCTIONS, OBJECTIVES AND GOALS** <sup>203</sup>

**FUNCTIONS/BUILDING BLOCKS (ACTIONS)**

- Leadership/Governance
- Information
- Health Workforce
- Medical products & technologies (Resource creation)
- Service delivery (Personal and population-based)
- Financing (collecting, pooling and purchasing)

**EFFECTIVE COVERAGE**

UTILISATION  
NEED  
QUALITY



EFFICIENCY

**GOALS/OUTCOMES ALL SYSTEMS STRIVE FOR**

- Health (level and equity)
- Responsiveness (to people's non-medical expectations)
- FINANCIAL PROTECTION** and equity in financing

ADAPTED FROM P. TRAVIS AND WHO 2007

The cube presented in the World Health Report 2010 is a useful, simplified framework to explore the design of healthcare benefits and consider potential trade-offs (Figure 5).<sup>218</sup>

**IDENTIFYING ACCESS BARRIERS**

Whether effective coverage is achieved depends on the interaction of the complex array of interrelated factors that affect access and determine the 'fit' between supply and demand (Figure 6).<sup>226</sup>

A lack of 'fit' contributes to problems in the equity of access. This Tanahashi-based framework (Box 8) helps to identify key bottlenecks to effective coverage.<sup>228</sup> This has also been the basis of the UNICEF framework to identify and address bottlenecks to access at the district level. A range of interventions are required to address these barriers – both on the demand and supply side.<sup>xviii</sup> Financing policy interventions are a

key way of addressing health system problems that contribute to ineffective coverage.

**FINANCING POLICY INSTRUMENTS**

The three financing functions of the health system are revenue collection, pooling, and purchasing (Figure 7).<sup>xix,234</sup> These aspects, along with policies on benefit design and rationing – and of course others across the health system building blocks – can determine the extent to which health system goals and objectives are achieved. Strong governance is critical to coordinate a multitude of complementary policy levers to achieve these goals.<sup>235,236</sup>

The extent to which financing policy facilitates effective access and financial risk protection across the social gradient – and particularly for the most poor and vulnerable – is contingent on the policy design.<sup>238</sup>

XIX REVENUE COLLECTIONS DESCRIBES HOW REVENUES ARE COLLECTED FROM THE SYSTEM AND THE SOURCE OF FUNDS, WHILE POOLING TELLS US HOW PREPAID REVENUES ARE COMBINED ACROSS POPULATIONS, AND PURCHASING DETAILS HOW RESOURCES ARE ALLOCATED TO SERVICE PROVIDERS.

XVIII AS WELL AS BROADER SOCIAL PROTECTION CONTEXT, SEE BOX 5.

**BOX 7**  
**CONSIDERING TRADE-OFFS IN BENEFIT DESIGN USING THE UHC CUBE**

The World Health Report 2010 presents a cube to help policy makers think about the potential trade-offs in benefit design for UHC with the following three dimensions:

- who benefits from pooled resources?
- for what services?
- at what cost at the point of use?<sup>219</sup>

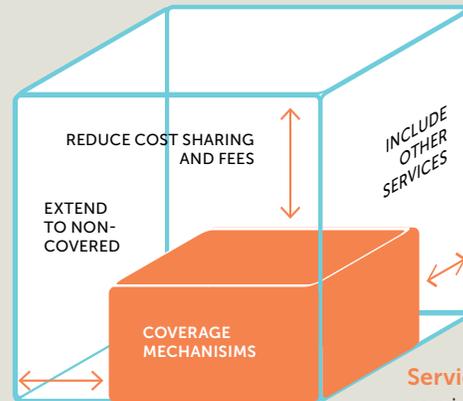
Policy makers are forced to address the challenging moral, ethical and practical questions of whether to include more people, expand the benefit package or reduce direct payments.<sup>220,221</sup>

For effective coverage, the axis on service coverage must be defined in terms of needed and effective services of good quality. The cost axis should reflect relative ability to pay in order to assess affordability of care across the social gradient.<sup>222</sup> This could also include the indirect and opportunity costs incurred to better capture financial burden. Benefit design must be considered within wider health financing policy reforms.

There are different pathways towards UHC. There are also different ways in which this cube may be filled. A progressive pathway towards UHC means ensuring that the needs of the poorest and most vulnerable are effectively covered first and at affordable cost (Figure 2), which will have implications for policy design.

**FIGURE 5**  
**APPLYING AN EQUITY LENS TO THE UHC CUBE<sup>223</sup>**

UNIVERSAL HEALTH COVERAGE



**Cost:** Reduced out-of-pocket spending, considering the differential needs of disadvantaged groups

**Population:** starting with poor and vulnerable people first

**Services:** good-quality services based on burden and distribution of disease and prioritising the needs of the most vulnerable

SOURCE ADAPTED FROM [WWW.BE-CAUSEHEALTH.BE](http://WWW.BE-CAUSEHEALTH.BE)

A more complex interpretation of the cube is required for monitoring progress towards UHC.<sup>224,225</sup>

**KEY LESSONS FOR EQUITABLE PATHWAYS TOWARDS UHC**

A structured literature review, key informant interviews, case studies and a desk review for this report identified potential lessons for the design of health policies to improve equity in pathways towards UHC (see page 47). These lessons are presented according to the financing function, followed by other building blocks and wider factors, as reflected in the evidence reviewed.

The evidence presented is by no means comprehensive, and is limited by the research methodologies undertaken, as well as the quantity and quality of studies available. It is important to note the paucity of studies that analyse a country's progress towards UHC. The evidence is still skewed to studies that analyse specific schemes in isolation.

**FINANCING FOR EQUITABLE PATHWAYS TOWARDS UHC**

Financing policy directly affects equity. Increasing the share of total funding derived from compulsory prepaid sources, and reducing fragmentation in how these are pooled, facilitates broader cross-subsidisation from the wealthy and healthy to the poor and sick.<sup>239,240</sup> Health financing policy also contributes to the concept of equal use for equal need and whether services are provided in line with population needs. Transparency, efficiency, and equity in resource distribution are the intermediate objectives that financing can influence. But depending on design, this influence may be positive or negative.<sup>241</sup>

## BOX 8 TAKING A DIAGNOSTIC APPROACH AT DISTRICT LEVEL<sup>229</sup>

The 1978 work by Tanahashi to clarify the concept of effective health service coverage and to propose an approach to coverage evaluation through assessment of health system weaknesses forms the basis of UNICEF's conceptual model and approach to conducting bottleneck analyses.<sup>230</sup> The Tanahashi framework incorporates the notion that there are five critical implementation bottlenecks that compromise the capacity of the health system to deliver the full effect of interventions. These are: availability; accessibility; acceptability; contact coverage/utilisation; and effectiveness of coverage.<sup>231</sup>

UNICEF has incorporated this model into much of its programming work over the past decade. For example, in 2002, in collaboration with the World Bank and WHO, UNICEF developed tools based on the Tanahashi approach to identify and analyse critical bottlenecks in the health system through the use of costs and effects simulations. It has also been used to assess bottlenecks to, and opportunities for, scaling up newborn care in several countries, as well as to

compare the cost-effectiveness (in terms of child deaths and stunting events averted) between an equity-focused approach to health programming that prioritises the most deprived communities in 14 countries and one province, and a mainstream approach that is representative of current health programming strategies.<sup>232</sup>

Lessons learned over the past ten years have been incorporated into the One Health Tool,<sup>233</sup> which helps identify and prioritise national health system bottlenecks across a wide range of interventions. As with the original approach, the modified model is based on the notion that certain health system bottlenecks and barriers, both financial and non-financial,<sup>1</sup> prevent individuals and households from benefitting from essential interventions and services.

Resolving inequities requires local knowledge of deprivation and coverage patterns. Recognising that national analyses can overlook intra-country patterns of inequities, in 2010 UNICEF and its global, national and local partners began testing a modified version of the Tanahashi model appropriate for use at district

1 NON-FINANCIAL BARRIERS INCLUDE VARIANCES IN ACCESS TO AND UTILISATION OF INTERVENTIONS DUE TO GENDER, ETHNICITY, POLITICAL AFFILIATION OR OTHER SOCIO-CULTURAL AND POLITICAL ATTRIBUTES.

level, particularly to identify and understand critical bottlenecks that lead to inequities in the coverage and effectiveness of maternal, newborn and child health service delivery across different regions and sub-populations. As a result, UNICEF is partnering with ministries of health, district health management teams and their partners to enhance district performance for equitable health programming for women and children.

This sub-national application of the bottleneck analysis by UNICEF has formed the basis for the District Health Systems Strengthening (DHSS) approach being used, which is flexible, outcome-based, and includes four steps (diagnose, intervene, verify and adjust) to understand inequities, and identify and respond to health system supply and demand-side bottlenecks that are amenable to actions taken at the district level. These four steps aim to build on existing processes within the district planning cycle to improve health outcomes by being more responsive to the specific needs of marginalised groups.

To date, UNICEF has conducted sub-national bottleneck analyses within the DHSS approach in Botswana, Democratic Republic of Congo (DRC), Malawi, Nigeria, Sierra Leone, Uganda and Zambia.

## EQUITABLE AND ADEQUATE GOVERNMENT INVESTMENT IN HEALTH

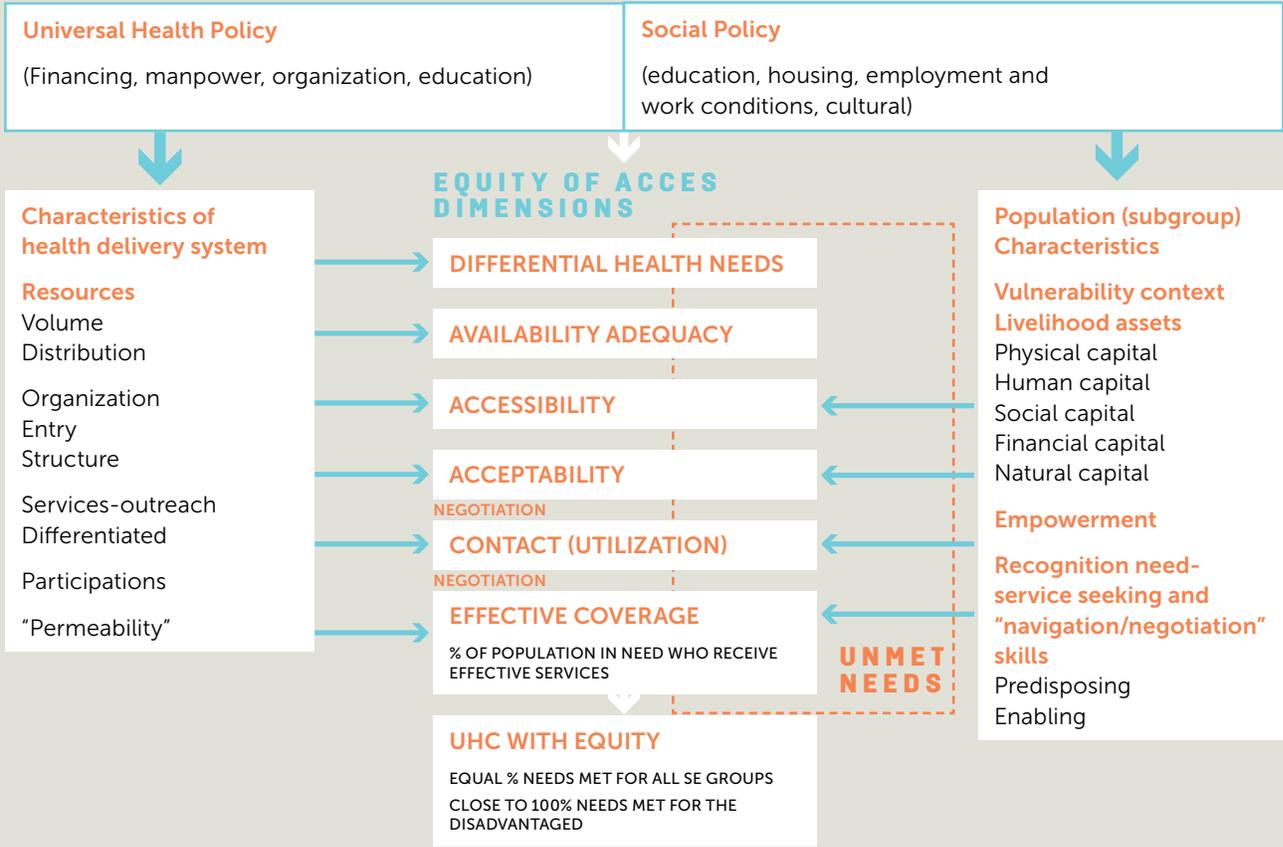
Both the source and volume of revenues for health are important to achieve the health system goals of equity in finance and financial risk protection.

### INCREASING EQUITABLE FUNDING FOR THE HEALTH SYSTEM

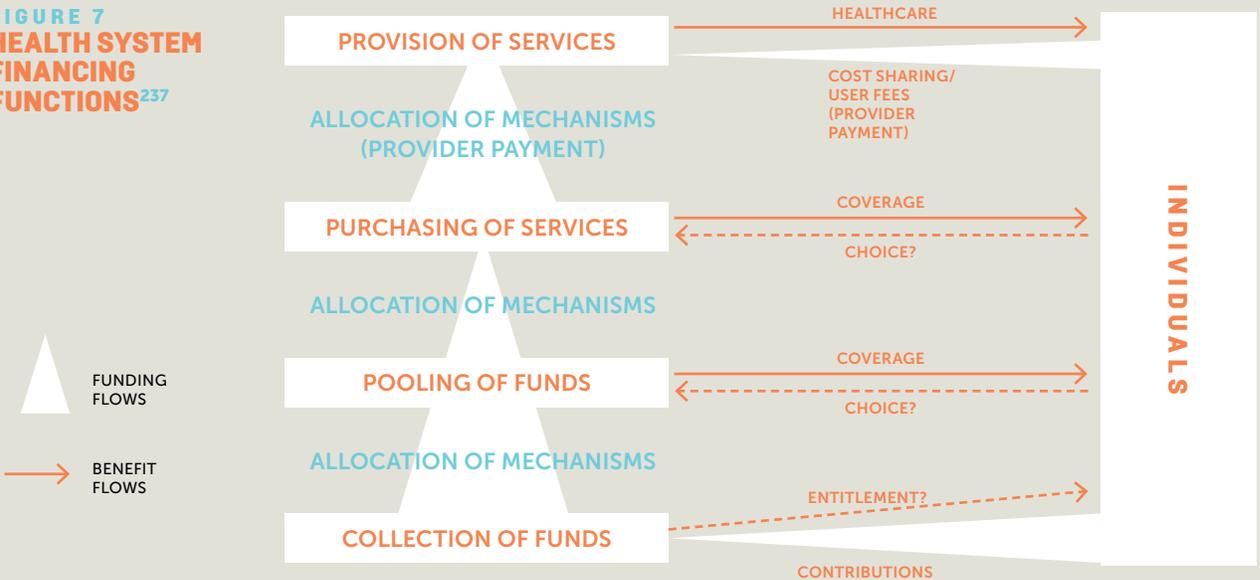
In place of private financing (voluntary prepayment or OOPS), reliance on compulsory or public financing is

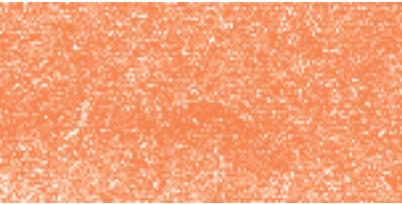
critical to attaining equity of financing in UHC.<sup>242</sup> In order to facilitate access determined by need, public revenues must subsidise the costs of care, particularly for the poorest and most vulnerable. To do this, there must be sufficient quantity of government resources allocated to health. This has been acknowledged in global and regional forums, with commitments to increase public resource allocation to health. For instance, in the Abuja Declaration of 2001, African governments promised to allocate at least 15% of the public purse to health.<sup>243</sup>

**FIGURE 6**  
**EQUITY OF ACCESS THROUGH SUPPLY AND DEMAND 'FIT'<sup>227</sup>**



**FIGURE 7**  
**HEALTH SYSTEM FINANCING FUNCTIONS<sup>237</sup>**





## WITHOUT ADEQUATE RESOURCES, EFFORTS TO ALLEVIATE FINANCIAL BARRIERS CAN FAIL.

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Additional government resource allocation is associated with equitable progress in various studies from the structured review – in Colombia,<sup>244</sup> Mexico<sup>245</sup> and Rwanda.<sup>246</sup> For instance, with the introduction of health reforms to address inequities in both service utilisation and financial risk protection in Mexico, public health spending increased by 5.2% on average per year between 2000 and 2006 in real terms.<sup>247</sup>

In such contexts, donors may have a particularly important role in facilitating increased public investment in health. This was acknowledged as an important factor contributing to implementation of reforms in Rwanda that led to improved equity in health service utilisation and financial risk protection.<sup>248</sup>

Raising and sustaining progressive resources for health can be particularly challenging in LMICs (Box 9).<sup>xx,249</sup> Without adequate resources, efforts to alleviate financial barriers can fail. Insufficient public funding for health was identified as a contributing factor to the ineffectiveness of fee reduction, exemption and insurance initiatives for poor people in Vietnam in the late 1990s.<sup>250</sup>

### ELIMINATING PRIVATE OOPS FOR VULNERABLE POPULATIONS WITH POOLED FINANCING

Evidence from countries confirms the growing consensus that OOPS is regressive, with many articles demonstrating the disproportionate burden on the poorest and most vulnerable caused by OOPS, exacerbating inequities. At the 66th World Health Assembly, the President of the World Bank reaffirmed this position, calling user fees a “potentially fatal bind” for poor people. He asserted that health system financing that relies on OOPS is “unjust and unnecessary”, adding that the “elimination or sharp reduction of point-of-service payments is a common feature of all systems that have successfully achieved universal health coverage”.<sup>260</sup> The ability of financial risk protection systems to sufficiently protect the poor and vulnerable from financial hardship and to encourage needs-based utilisation depends on the extent to which pooled resources cover the costs of care.

Some studies find insurance coverage to be associated with increased financial protection for the poorest and most vulnerable. For example, in Vietnam the insured population were found to transition from private to public providers, and to higher levels of care, addressing healthcare needs that were formerly unmet, while also reducing OOPS.<sup>261</sup> This effect was most pronounced for poor patients.<sup>262</sup> In China, the poorest households enrolled in the Urban Resident

XX INDEED, RAISING SUFFICIENT RESOURCES AND SUSTAINING SUCH LEVELS OF ALLOCATION TO HEALTH IS A PERPETUAL CHALLENGE FOR COUNTRIES AT ALL INCOME LEVELS, WHILE ADAPTING THE HEALTH SYSTEM TO TECHNOLOGICAL ADVANCES AND RESPONDING TO THE COMPLEX POPULATION NEEDS OF COMMUNICABLE, NON-COMMUNICABLE ILLNESS AS WELL AS POPULATION AGING.

## BOX 9 PROGRESSIVE TAXATION FOR HEALTH

Public financing is critical for achieving UHC. When exploring options to increase public revenues, the progressivity of these sources must be assessed, and any implications carefully considered with efforts to mitigate negative impacts on those who are poor and vulnerable. It is also crucial that health systems have fairly stable and predictable sources of revenue. This can be helped by diversifying revenue sources.<sup>251</sup>

One of the most progressive ways to fund a health system is income tax through general revenues, which divorces contributions from entitlements. In many LMICs, efforts must be made to improve the capacities for tax collection. Another form of direct tax is a payroll tax, which tends to be proportional.<sup>252</sup>

Additional revenues may be raised from indirect consumption taxes, which are also hypothecated (ie, earmarked). For instance, value added

tax (VAT) and 'sin taxes' on products that harm health, such as tobacco, alcohol and saturated fats.<sup>253</sup> The progressivity of these taxes depends on the products to which they are applied and the consumption patterns in the country. Sin taxes can also serve an important public health function by sending a price signal to the population, particularly if coupled with public health promotion efforts. Their regressivity may also be countered if poorer people's consumption of the harmful products decreases more in response to the higher prices. Untapped taxes on the wealthy through a land tax, on big corporations such as extractive industries, and on financial transaction, may all be opportunities for complementary sources of revenue for the health sector.<sup>254</sup>

When exploring opportunities for taxation, a key consideration is the country's fiscal space,<sup>i,255,256</sup>

i DEFINED AS THE AVAILABILITY OF BUDGETARY ROOM FOR INCREASING PUBLIC SPENDING FOR HEALTH WITHOUT JEOPARDISING MACRO-ECONOMIC STABILITY.

such as the capacity for taxation, level and distribution of income, growth rates, and labour market structure.<sup>257</sup> Historical legacies, social values and the political landscape will also influence the space for such reforms.<sup>258</sup>

How much a country decides to spend on health is primarily a political choice. Evidence that investments in the health system are translating into progress on health outcomes helps defend investment in the sector. Addressing inefficiencies in the health system can also strengthen this investment case, while also freeing up resources for re-allocation.

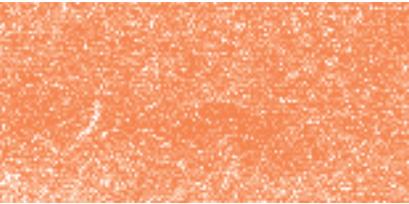
Civil society engagement through health budget advocacy – holding the government accountable for their commitments on allocations to health and how these are spent – can help generate political will for investing the sector.<sup>259</sup>

Basic Medical Insurance were the most satisfied with the scheme.<sup>263</sup> Financial protection increased with *Mutuelles* enrolment in Rwanda, and beneficiaries included poor people.<sup>264</sup> Overall, catastrophic expenditure was almost four times as great as for those who were uninsured.<sup>265</sup> Similarly, a protective effect of having insurance was observed in Mexico's *Seguro Popular*,<sup>266</sup> and this was consistent for poor households within the scheme.<sup>267</sup> Studies in Ghana<sup>268</sup> and Thailand<sup>269</sup> also found insurance coverage to have a protective impact on poor households.

Yet, in many of the countries reviewed, the financial protection effect of insurance is limited. Many have persistently high OOPS, despite insurance coverage, which contributes to inequities. Insurance was found to have a marginal effect on OOPS in Ghana, where enrollees spent 72% of what the uninsured paid out-of-pocket.<sup>270</sup>

In China, high co-payments were reported in multiple studies,<sup>271,272,273</sup> compounded by a low reimbursement rate to patients.<sup>274</sup> This limited the financial protection for poor and rural households, and those with chronic conditions.<sup>275,276</sup> Indeed, one study estimated catastrophic expenditures to be twice as frequent for poor and rural families than for wealthy and urban households.<sup>277</sup> Progress has been made to reimburse patients faster,<sup>278</sup> but co-payments remain high.<sup>279</sup>

Several studies noted high OOPS for inpatient care, even for the insured. Cost was found to be a major barrier to accessing healthcare in China in 2007; 70% were referred to hospital but refused to go, citing financial problems, while over 54% of inpatients who discharged themselves early did so because of escalating costs.<sup>280</sup> In Vietnam, 'modest' benefits failed to relieve poor households of the heavy financial



## IN MANY OF THE COUNTRIES REVIEWED, THE FINANCIAL PROTECTION EFFECT OF INSURANCE IS LIMITED. MANY HAVE PERSISTENTLY HIGH OOPS, DESPITE INSURANCE COVERAGE, WHICH CONTRIBUTES TO INEQUITIES.

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burden from accessing healthcare, despite enrolment in a health insurance scheme for poor people and voluntary health insurance schemes.<sup>281</sup> The scheme for poor people was also found to have a negligible impact on utilisation among the poorest households. This was attributed to high co-insurance rates.<sup>282</sup>

Of the nine key informants who discussed the topic of health financing, there was agreement that OOPS and voluntary health insurance are *not* conducive to achieving UHC. “Introducing healthcare user charges was the most dreadful screw up in terms of excluding poor people and having a detrimental effect on their health,” one key informant stated. “Paying for health services at the point of delivery is a terrible idea, it’s the worst way of paying ... It impoverishes people and [...] deters people from getting the health services they need.” This informant went on to say, “a poor household has to make terrible decisions: do they sell an animal or a house or something to get healthcare, or do they just hope to get better ... But they might end up dying?”

### POOLED RISKS AND RESOURCES AT SCALE FOR CROSS-SUBSIDISATION

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Reforms that increase pooling at the level of the whole population should inherently increase equity, but sometimes pooling reform involves only a subset of the population enrolled in particular schemes. These types of scheme-based pooling reforms may not improve overall levels of equity. However, the basic pooling principle is applicable in all contexts – the larger and more non-discriminatory the pool, the more opportunity there is for cross-subsidisation from the rich and healthy to the poor and sick.<sup>283</sup>

When designing a risk pool, or strategies to adapt existing pools, critical questions in relation to the specific context include: How are existing pools arranged? Who has and who needs to have coverage? What are the services they will be covered with? What will be the limits on OOPS for each intervention and how will any fee scales be made progressive? What can be done to reduce fragmentation and consolidate pools to enable redistribution across income and health risks? Which population groups will be covered first? What will the implications for sustainability of overall public health financing be?

### ENSURING INCLUSION OF ALL VULNERABLE GROUPS

By definition, entitlements that are universal are inclusive and equitable.<sup>284</sup> Whether this translates into effective coverage will depend on the relative impact of other access barriers on those who are disadvantaged and whether the quality of care available to them is sufficient.<sup>285</sup> Where the same services are available to all, the middle-classes – who are better able to assert their needs – can help raise the quality of care.

**BOX 10**  
**UNIVERSAL HEALTH COVERAGE IN THAILAND<sup>296</sup>**

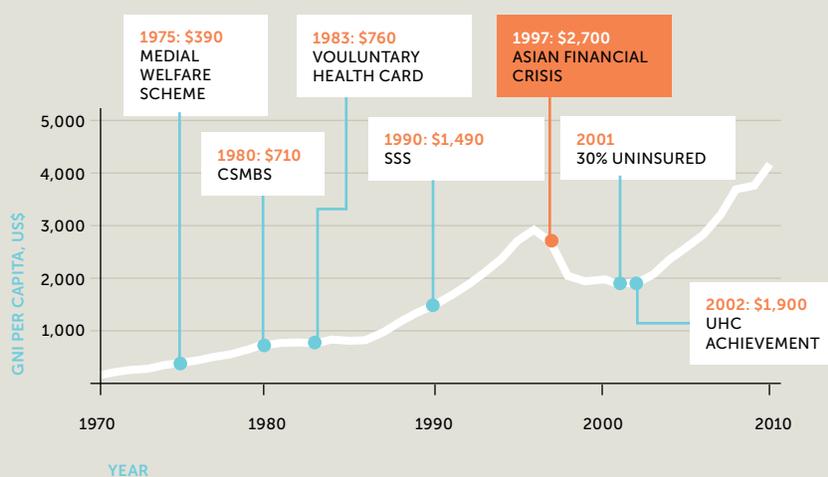
Thailand has proved that a country does not have to be rich to achieve UHC.

Before 2000, health insurance coverage was fragmented, with multiple schemes serving different population groups. The Medical Welfare Scheme covered poor and vulnerable people, including children and the elderly. A public-subsidised voluntary insurance scheme was introduced for the informal sector. Civil servants and private employees were covered under the Civil Servant Medical Benefit Scheme and Social Health Insurance, respectively. At the turn of the century, 30% of the population remained uninsured.

In response to this challenge, the Thai government successfully introduced and implemented a Universal Coverage Scheme (UCS) in 2001, combining the Medical Welfare and voluntary insurance schemes and expanding coverage to the approximately 18 million people who were previously uninsured. This scheme was fully financed by general government revenues. Key enabling factors included political will, the economic and social context and the health system, as well as the effective Civil Registration Scheme through which all newborn babies receive a unique identification.

UCS was rapidly scaled up to cover 75% of total population within a year, with the remaining 25% covered by civil service and private employees' schemes. Just a few years after the 1997 financial crisis, gross national income (GNI) in Thailand was US\$1,900 per capita (Figure 8).

**FIGURE 8**  
**THAILAND'S PATHWAY TO UHC AGAINST GNI PER CAPITA, 1970–2010**



**EQUITABLE PROGRESS TOWARDS UHC**

The UCS has greatly increased equity in coverage of health interventions and financial risk protection. Equity in finance has been promoted through reliance on general taxation – direct, indirect and other government revenues – of which direct taxes tend to be the most progressive source of revenue.

The benefit package is available free at the point of use, removing direct OOPS. As a result, public subsidies are effectively reaching the populations most in need. Among the poorest quintile, the incidence of catastrophic health expenditures (defined as >10% of total household expenditure) fell from 6.8% in 1996 (before UCS) to 2.9% in 2009, and among the richest quintile from 6.1% to 4.7%.<sup>†</sup> Reduction in medical impoverishment has also been impressive (Figure 9).

**FACTORS AFFECTING PROGRESS**

Various factors have contributed to the equitable progress made and the achievement of universal coverage in Thailand:

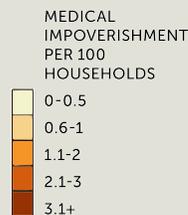
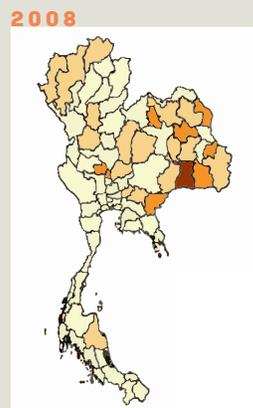
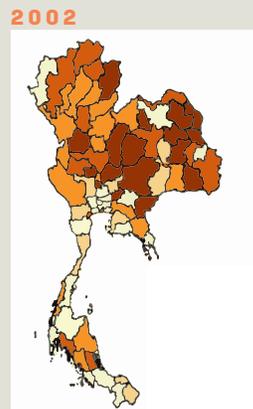
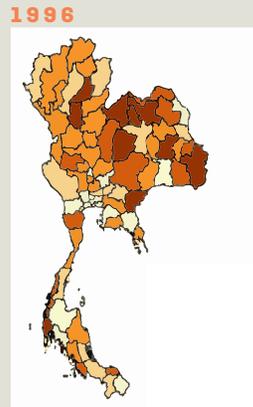
- responding to public pressure for a general tax financed system: collecting premiums from UCS members in the informal sector was neither politically palatable nor technically feasible in 2001
- increased public resource allocation and more evidence-based budgeting through the per capita budget proposal and evidence of service utilisation and unit cost
- sustained political and financial commitments, despite political rivalry in the last decade
- popular ownership of the UCS and mechanisms for accountability
- continued economic growth enabling expansion of the benefit package.

<sup>†</sup> PATIENTS MUST PAY THE FULL COST OF CARE WHEN BYPASSING PRIMARY CARE, OR WHEN ACCESSING PRIVATE FACILITIES.

**FIGURE 9**  
**HOUSEHOLD MEDICAL**  
**IMPOVERISHMENT**  
**MAP, PRIOR TO UCS**  
**(1996), AT THE TIME OF**  
**UCS IMPLEMENTATION**  
**(2002), AND SIX**  
**YEARS AFTER (2008)**

The benefit package includes all outpatient and inpatient services, rehabilitation, health promotion and disease prevention, including medicines. As capacities to raise resources have increased, the benefit package has gradually expanded to be more comprehensive, covering care for high-cost catastrophic illnesses. For example, universal access to antiretroviral therapy for people living with HIV was introduced in 2003 and renal replacement therapy in 2007.

One significant strategy of UCS is to promote primary healthcare through the 'close to client' district health system. Primary care units are available throughout the country and in reach of rural populations. The UCS also facilitates public health interventions at the community level through financial transfers from local government to the Community Health Fund.



Many countries have embarked on more targeted approaches, whereby schemes are designed for specific population groups. Where eligibility criteria are simple and inclusive, these schemes may be effective in reaching poor and rural populations. For instance, in Mexico's *Seguro Popular*, 59% of the increase in access to prenatal care was by women who previously had little or no access to healthcare.<sup>286</sup> Challenges associated with more complex entitlements or targeting approaches are presented below (page 38).

Many countries' paths to UHC have begun with schemes for the formal sector. But as a key informant noted, "the notion that we will start with the formal sector then work to the informal sector is fundamentally inequitable." Where informal employment is widespread and insurance coverage is determined by employment-linked contributions, inequities in coverage will be exacerbated.<sup>287,288</sup> Efforts to extend insurance to migrant workers in Shenzhen province, China, failed to be mandatory, with employers selecting the more affluent or 'qualified' workers for enrolment to the detriment of poorer, higher-risk workers who are left to bear a high financial burden when accessing care.<sup>289</sup>

Having separate pooling schemes for different population groups undermines the objective of risk and resource pooling, limiting the opportunity for cross-subsidisation between population groups. Such segmentation produces unequal packages of benefits and unequal insurance coverage, as was found in Colombia.<sup>290</sup> In Vietnam, the poorest enrollees in the compulsory health insurance scheme were less likely to access inpatient care than their wealthier counterparts. Inpatient utilisation was even lower for enrollees in the health insurance for the poor scheme.<sup>291</sup> Other research on insurance schemes in Vietnam urged the government to enrol relatively healthier people into the voluntary scheme in order to improve the efficiency of the risk pool.<sup>292</sup> If pools can be merged to provide adequate redistribution of resources to cover benefits provided, competition across varied providers may support reforms aimed at improving the efficiency of health systems.

A key informant warned that even if intended to be temporary or transitional, embarking on separate health insurance schemes for different population groups at the outset may be difficult to unravel, leaving the system permanently segmented. Despite efforts to consolidate schemes in Brazil between 1998 and 2008, segmentation contributed to persistent income-related inequity in health service utilisation and health outcomes.<sup>293</sup> Chile faces a similar predicament, due to the absence of solidarity across different population groups which was not addressed by health system reforms.<sup>294</sup> However, as the rich pay a greater share of total taxation and this is the funding source of the public insurance system, there is cross-subsidisation.<sup>295</sup> Without significant public subsidies, a scheme for poor people will be a poor scheme. Thailand responded to this challenge in 2002 by consolidating some of its previously separate risk pools into a tax-based Universal Coverage Scheme, although there are still differences in resourcing between other schemes in the country<sup>xxi</sup> (Box 10).

Even where separate voluntary schemes are effective in improving utilisation and financial risk protection for their beneficiaries, the efficiency of multiple separate initiatives in their ability to produce a net increase in funding is questionable.<sup>297</sup>

### CHALLENGES OF ENROLLING POOR PEOPLE IN VOLUNTARY CONTRIBUTORY SCHEMES

In voluntary contributory schemes, enrolling the intended beneficiaries can be challenging.<sup>298</sup> The cost of premiums is a common cause of low enrolment of poor people, who are more sensitive to prices. As with user fees a flat-rate premium is regressive and disproportionately disadvantages poor people, perpetuating inequities in access and financing.<sup>299</sup> As a result of unaffordable premiums, many voluntary schemes fail to enrol poor people, for instance in Colombia<sup>301</sup> and in the former community-based health insurance scheme in rural China, where the net benefit of insurance favoured wealthier farmers.<sup>301</sup>

In contrast, when premiums are set relative to income levels, enrolment may be more progressive, as was seen

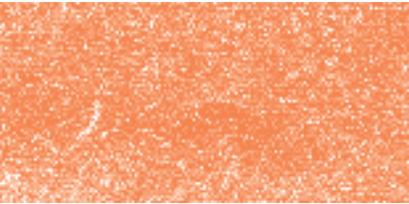
in Mexico's *Seguro Popular*.<sup>302</sup> In another example, reforms started in China in 2009 to achieve UHC included increased financial protection, particularly for rural residents. The rural New Cooperative Medical Scheme (NCMS) has become primarily government funded insurance, heavily subsidising individual contributions. The lower insurance premiums, combined with waivers for poor and vulnerable people through the Medical Financial Assistance (MFA) programme, has led to high actual enrolment rates for the NCMS, which was always nominally compulsory. Simultaneous abolition of co-payments for many services in some counties has reduced OOPS for NCMS enrollees.<sup>303</sup>

The abolition of premiums for pregnant women in Ghana had an impressive impact on equity in utilisation of maternity services and financial protection.<sup>304</sup> However, the exemption criteria for 'indigents' in Ghana have been deemed too strict, leaving many poor people unable to afford enrolment.<sup>305</sup> While exemptions by economic status are more progressive than flat-rate premiums, they are also costly and notoriously difficult to implement.<sup>306,307</sup> The challenge in determining household income level undermines the payment of contributions according to income and the targeting of exemptions in both Ghana and Tanzania.<sup>308,309</sup>

There are mixed experiences regarding the distribution of OOPS following the introduction of a voluntary insurance scheme. In some cases OOPS declined, while in others there was no change or even an increase among members.<sup>310</sup> Even where it may seem progressive, poor and vulnerable people who remain uninsured may be foregoing needed services due to the financial implications of seeking care. This was observed in Rwanda<sup>311</sup> and Vietnam.<sup>312</sup>

Voluntary schemes are extremely limited in their ability to ensure wide enrolment, cross-subsidise and provide sufficient financial risk protection. Rwanda has overcome some of these challenges by mandatory enrolment, cross-subsidisation at large scale, and substantial public subsidies from general revenues (with government spending on health increasing

XXI WHILE STILL BEING UNABLE TO UNIFY THE TWO FORMAL SECTOR SCHEMES (FOR CIVIL SERVANTS AND PRIVATE SECTOR WORKERS).



## VOLUNTARY SCHEMES ARE EXTREMELY LIMITED IN THEIR ABILITY TO ENSURE WIDE ENROLMENT, CROSS-SUBSIDISE AND PROVIDE SUFFICIENT FINANCIAL RISK PROTECTION.

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five-fold from 2002–11<sup>313</sup>).<sup>xxii</sup> By 2006, *Mutuelles* contributions only accounted for about 5% of total health spending, and this proportion is likely to be even lower now.<sup>314</sup> In 2010, enrolment was over 90%, and differentiated premiums by economic status have recently been introduced.<sup>315</sup>

### LEAKAGE OF SUBSIDIES, MISSING THOSE MOST IN NEED

Using targeted exemptions or waivers can also be problematic. Identification of those who are poor and vulnerable is no easy task. The fluidity of the poverty line means a household's status may change often, and in LMICs, information and capacities for evidence-based targeting may be inadequate. This can also be costly. Moreover, in many low-income countries, particularly where poverty is widespread, the quota for beneficiaries may fall far short of the number of eligible persons.

The evidence base of effective targeting is mixed,<sup>316</sup> and dependent on the methodology adopted. A programme to provide poor women with vouchers for maternal care in Bangladesh was effective, with utilisation increasing particularly for the poorest households.<sup>317</sup> Similarly, the Healthcare Fund for the Poor in Vietnam had disproportionately poor beneficiaries, with limited leakage to wealthier households. This programme utilised the more rigorous targeting methods of the Hunger Eradication and Poverty Reduction programme that combine individual and geographic characteristics.<sup>318</sup>

Other efforts have been less successful at reaching intended beneficiaries. Another study in Vietnam reported that community targeting to enrol people living with disabilities left the majority uninsured. In this case, the author recommended more standardised methods, to be administered by a third party.<sup>319</sup> Concern about political patronage undermining the allocation of exemptions was raised in a paper on Colombia.<sup>320</sup>

Quoting a key informant: “Moving away from entitlements based on strictly contributory approaches by using funding from general revenues to fully or substantially subsidise the coverage of those who are unlikely to be able to pay directly for their coverage, and thereby getting people of different social and income groups into the same pool, has been an important drive in a lot of countries.” This was confirmed in a recent literature review, emphasising the persistent challenges of enrolment of the informal sector in contributory schemes.<sup>321</sup>

### STRATEGIC PURCHASING FOR EQUITABLE PATHWAYS

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The purchasing function forces policy makers to consider what benefits will be provided, who will provide them, and how providers will be paid. This is a critical lever for equity as the services should respond to the needs of all and, from an equity perspective, ensure that the needs of the poorest are met.<sup>322</sup> As a key informant argued, “it is not only about targeting the poorest or other groups, it is about ensuring that a systematic approach delivers to these groups.”

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XXII WHILE ENROLMENT IN CBHI IS NOT MANDATORY, HAVING HEALTH INSURANCE IS.

## BENEFITS THAT RESPOND TO THE NEEDS OF POOR PEOPLE

The contents of the benefit package should be determined by a combination of factors, informed by: the epidemiological profile (ie, the different diseases and health needs) across different sections of society; the cost-effectiveness of interventions; inclusive participatory processes; the relative contribution of barriers to access; unmet needs; and the sources and scale of potential financial hardship, with a particular emphasis on those of poor and marginalised populations.<sup>323</sup> In most LMICs, a pro-poor distribution of publicly-funded services is necessary to achieve access according to need across the population.<sup>324</sup> Designing the benefit package also requires the availability and quality of information, technical capacity to analyse the data and decide what is offered and to whom, and the institutional arrangements to support this.<sup>xxiii,325,326</sup>

An equitable pathway requires “applying different intensities in introduction of interventions to those whose needs are greatest, to counter the inverse care law,” noted a key informant. Another added: “Specifying the benefit package is important, as it can be used as the basis of entitlements, rather than some vague guarantee of ‘healthcare for all’, which risks being captured by the wealthy.” As a government’s resources increase or efficiencies improve, this package should expand,<sup>327</sup> the level of public subsidy should rise, and the quality of care should be upgraded.

Various studies stress the inadequacy of benefit packages to respond to the needs of poor people. Without sufficient priority to the needs of the poorest and most vulnerable, benefits may be skewed to the advantage of those who are better-off. In Ghana, OOPS remained high for costs such as drugs, tests, and antenatal and inpatient care.<sup>328</sup> In Rwanda, two studies noted the limitation of the benefits of *Mutuelles*,<sup>329</sup> as families enrolled in the scheme still fall into poverty, particularly due to inpatient care.<sup>330</sup>

When outpatient care was included in the New Rural Cooperative Medical Scheme in China, people of

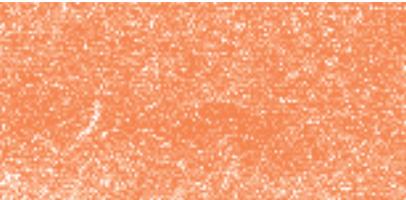
lower income levels benefited most from increases in utilisation of outpatient services at village and township levels. This strategy may also reduce the need for inpatient care among poor people, lessening the implications for OOPS.<sup>331</sup> Another study from China reflected that including outpatient services from the outset might help more vulnerable enrollees feel the benefits of insurance and thereby reduce the number of drop outs.<sup>332</sup> Other studies have noted the importance of including ambulatory care and medicines<sup>333</sup> in the benefit package, as this is where the burden of OOPS most disproportionately affects poor people.

## EQUITABLE PRIMARY HEALTHCARE BENEFITS FOR ALL

Various countries’ experiences point to important characteristics of an equitable benefit package. Targeting the benefits to the needs of poor people can be an effective strategy to channel public subsidies to those who are most vulnerable. Several countries have had positive experiences of making specific services free at the point of use for all people. This avoids the challenge of targeting by poverty criteria. For example, universal free maternal care in Ghana prompted equitable uptake in facility-based deliveries.<sup>334</sup> In Brazil, the introduction of a universal package of health services, free at the point of use, is associated with increased equity in coverage of services between 1998 and 2008.<sup>335</sup> The expansion of this package to include universal free antiretroviral treatment (ART) led to increased and more equitable coverage of ART.<sup>336</sup> More equitable outpatient utilisation through Vietnam’s insurance programme for poor people may be related to increased transparency due to the uniformity of the benefit package.<sup>337</sup>

As a key informant proposed, providing access for all to strong primary healthcare<sup>338</sup> that is free at the point of use for all people should be a priority for equitable progress towards UHC, particularly in LMICs: “This is where you can make a difference very quickly.” The primary healthcare strategy in Bogotá, Colombia,<sup>339</sup> and the Family Health Strategy in Brazil have taken this approach and seen improvements in equity of service coverage.<sup>340</sup>

XXIII THE SCOPE OF THIS PAPER DOES NOT ALLOW FOR A BROADER DISCUSSION ON THE CHALLENGES OF ADDRESSING NEED, EQUITY, AND COST-EFFECTIVE ANALYSIS



## WHEN OUTPATIENT CARE WAS INCLUDED IN THE NEW RURAL COOPERATIVE MEDICAL SCHEME IN CHINA, PEOPLE OF LOWER INCOME LEVELS BENEFITED MOST FROM INCREASES IN UTILISATION OF OUTPATIENT SERVICES AT VILLAGE AND TOWNSHIP LEVELS.

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### INCLUDING INPATIENT CARE IN THE BENEFIT PACKAGE

Inpatient care can be prohibitively expensive for poor people. In many countries, there remains a pro-rich bias to inpatient utilisation – such as in China’s rural areas.<sup>341</sup> The insurance provisions for people living with disabilities in Vietnam are inadequate to protect against the heightened financial burden they face when accessing public inpatient care – estimated at double the population average. This may be due to the additional indirect costs incurred, such as medications and transportation of accompanying carers.<sup>342</sup>

### ENABLING ACCESS FOR THE POOR TO APPROPRIATE PROVIDERS

Another important consideration is whether the assigned providers of the benefit package are within reach of poor and vulnerable people. Another study in Rwanda documented that *Mutuelles* enrolment for poor people resulted in increased use of modern health providers.<sup>343</sup> In Vietnam, voluntary insurance does not cover care provided by commune health centres – the main source of care for those enrolled in the insurance programme for the poor.<sup>344</sup> Accessing care from assigned public hospitals was costly and difficult for rural residents.<sup>345,346</sup> While the private sector remains the predominant provider of care for poor and marginalised communities, such as minority ethnic communities in Vietnam, consideration should be given to integrating them into the insurance system,<sup>347</sup> provided that the quality of care is improved and the government has effective capacity to regulate.

### ALIGNING PROVIDER INCENTIVES

Efforts to link financing functions are important to achieve the equity objective of UHC, for instance, through complementing user fee removal with performance-based purchasing to align incentives.

Various studies documented the detrimental impact of perverse incentives on achieving utilisation based on need and financial risk protection for the poor. If the objective is to increase the uptake of priority services, paying providers by fee-for-service for certain services can be effective.<sup>348</sup> However, unmanaged fee-for-service may encourage providers to increase the volume of those services for which they receive higher rates of reimbursement, resulting in unnecessary provision and cost escalation.<sup>349</sup> This was the case for caesarean section deliveries in China, where rates exceed clinical need,<sup>350</sup> bringing into question the value of care provided.<sup>351</sup>

With increased utilisation of health services, prompted by financial coverage (eg, through explicit health insurance or elimination/reduction of user fees), the workload of healthcare providers is likely to rise. To avoid the persistence of regressive informal fees and co-payments, providers must be adequately reimbursed. Failure to do this was identified as a cause for the failure of insurance initiatives in Vietnam.<sup>56</sup> A study of the impact of China’s New Rural Cooperative Medical Scheme also reported high ‘uncompensated burdens’ – the administrative costs incurred by providers which are not reimbursed. These include annual enrolments, processing patient

reimbursement applications, training and renovating the facility according to new mandatory standards. Village clinicians expressed that the scheme had thus been to the detriment of their business, which is likely to have ongoing ramifications in terms of the provision and uptake of village-level health services.<sup>352</sup>

Results-based financing approaches can also be effective at aligning incentives with equity objectives. For instance, in Rwanda, anecdotal evidence suggests that providers reduced their charges and even provided cash transfers to pregnant women in order to receive the reward for increasing the rate of assisted deliveries.<sup>353</sup> Performance-based financing has also been introduced in Burundi. Following the introduction of free maternal and child health services in Burundi, there was a rapid increase in attendance at facilities. As a key informant noted, initially this was problematic, as healthcare providers did not have the capacity to deal with rising demand. However, the government adapted by using performance-based funding to pay facilities for the maternal and child health services they were obligated to provide for free. In effect, this meant replacing the former user fee revenues with prepaid funds (from a combination of government and donor sources). Providers retained autonomy over the use of these revenues and the responsiveness to clients (because the providers were paid for each person treated), which enabled the system to realise the promise of free treatment for mothers and children.<sup>354</sup> The success of results-based financing is heavily dependent on the design of the scheme and care must be taken to avoid unintended consequences, such as over-provision through supplier-induced demand.<sup>355</sup>

## **TAKING A WHOLE-SYSTEMS APPROACH**

While financing is no doubt a necessary lever for equitable progress towards UHC, the evidence confirms that financing alone is not sufficient to achieve UHC or more equitable health outcomes.<sup>356,358,359</sup> The other building blocks of the health system, along with wider factors, also affect equity in pathways towards UHC. These are outlined in the section below.

## **SERVICE DELIVERY FOR QUALITY**

In regard to service delivery, the most prominent issue that emerged from the literature related to quality of care. How to move from coverage to quality is an important question raised by a key informant. Equity in UHC requires equal access to good-quality services according to need. Without improvements in the quality of subsidised care, insurance is not an attractive product to users.<sup>360</sup> Concerns about the impact of poor quality of care in deterring utilisation were raised in many countries, for example in Colombia<sup>361</sup> and Mexico<sup>362</sup>. This may be more of a problem when the costs of seeking care are less of a concern, ie, for those who are less poor. In Vietnam, perceptions of poor quality of care in the public facilities – including long waiting times – was identified as a reason for the insured to opt for fee-paying provision.<sup>363</sup> Similarly, quality concerns contributed to low uptake of maternal services in Bangladesh, despite the alleviation of cost barriers through a voucher scheme. This was also more prevalent among the non-poor than the poor.<sup>364</sup>

How patients are treated when they access care may be a strong factor influencing their perception of quality.<sup>365</sup> For instance, fears of stigma and discrimination were found to deter HIV-positive patients from accessing maternity care in Kenya.<sup>366</sup>

## **GOVERNANCE FOR EQUITY**

Various facets of governance of the health system were identified as important factors affecting equity in pathways towards UHC. Effective government stewardship is vital to regulate the quality of services delivered; implement treatment guidelines; enforce standards for clinical practice; and ensure compliance with policies relating to fees, free services, or waivers and exemptions.<sup>367</sup> These include studies in Colombia,<sup>368</sup> Ghana<sup>369</sup> and Vietnam.<sup>370</sup>

Appropriate planning to strengthen the system as reforms are introduced contributes to the effective implementation of strategies for UHC. In Rwanda, for instance, the government introduced legislation on the entitlement to basic care for the whole population.<sup>371</sup> Preparing for the roll-out of *Seguro Popular* in Mexico involved months of administrative reform,

**BOX 11**  
**PRIORITISING VULNERABLE GROUPS**  
**IN SIERRA LEONE**<sup>378,379,380,381</sup>

When Sierra Leone emerged from over a decade of civil war, health outcomes were atrocious. In 2005, children had the lowest chances of survival worldwide, with an under-five mortality rate of 214 deaths per 1,000 live births. It was also one of the hardest countries to be a mother, with a maternal mortality rate of 1,000 per 100,000 live births.<sup>382</sup>

The health system was broken, infrastructure was weak, and supplies were scarce. There was a desperate shortage of skilled health workers – just two for every 10,000 people in 2008<sup>383</sup> – and they were poorly paid, causing high attrition rates and forcing public health workers to seek parallel employment elsewhere.

Moreover, health workers were dependent on the revenues from user fees. OOPS was the dominant form of financing, constituting 66% of total health expenditure in 2005, while public health expenditure was low, at just US\$22.4 per capita.<sup>384</sup> Poverty was widespread, with 53% of the population living on less than US\$1.25 per day. For the majority of households in Sierra Leone, user fees and other OOPS posed a major barrier to accessing essential health services. For instance, just 43% of mothers had a skilled attendant at birth in 2005. In the poorest households, coverage was as low as 27%.<sup>385</sup> Lack of access to good-quality care perpetuated dismal health outcomes.

**INTRODUCTION OF FREE HEALTHCARE INITIATIVE**

In response to this situation, the President of Sierra Leone took a decisive stance with a pledge to remove user fees for pregnant and lactating women, and for children under five. With the support of development partners, the Free Healthcare Initiative (FHCI) was launched in April 2010.

Following the removal of user fees, utilisation of essential services soared.<sup>1</sup> For instance, the number of children treated for malaria<sup>386</sup> roughly tripled following the introduction of the FHCI.<sup>387</sup>

Planning for the launch and ongoing monitoring to address outstanding challenges in improving the quality of care have been fundamental to the success of the FHCI. Related policies and mechanisms put in place by the government have also been important – eg, the National Health Sector strategic plan and the Human Resources for Health policy.<sup>388</sup> Learning from the experience of other countries, the government acknowledged the importance of preparing the health system to cope with anticipated increase in demand following the removal of fees.

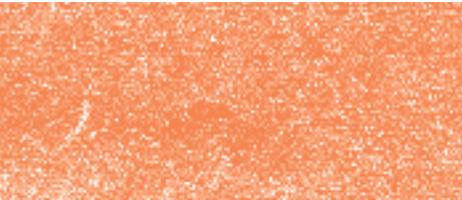
The alignment of development partners behind this initiative was also critical to facilitate such reforms with their provision of technical and financial assistance. For instance, the UK government supported a clean-up of the payroll and an increase of health worker salaries up to five-fold for doctors, improving efficiencies while also helping to attract new recruits and curtail the perverse incentive of charging informal fees. UNICEF is supporting ongoing efforts to address challenges related to the drug supply chain. However, there is still a long road ahead before the system is fully able to deal with demand.<sup>389</sup>

Sustained political will to improve the health status of poor people in Sierra Leone has been catalytic to the success of the FHCI. As the country develops its health financing policy, progressive and innovative mechanisms to raise public revenues must be explored. However, with the country's GNI per capita still at just US\$1,360,<sup>390</sup> donor support will remain critical to sustain the gains made. In addition to raising sufficient domestic and donor funds, ensuring allocated money is translated into health system spending is also crucial.

<sup>1</sup> NEW DATA ON MATERNAL AND CHILD MORTALITY, WHICH SHOULD BE PUBLISHED THIS YEAR (2013 DEMOGRAPHIC HOUSEHOLD SURVEY) IS EXPECTED TO SHOW POSITIVE TRENDS IN HEALTH OUTCOMES, REFLECTING IMPACTS OF THE FHCI. WHILE THE COLLECTION OF ACCURATE DATA IS AN ONGOING CHALLENGE IN SIERRA LEONE, IMPROVEMENTS ARE EXPECTED FROM THIS PENDING SURVEY.

the recruitment and hiring of health workers, and increasing the supply of drugs.<sup>372</sup> Having sufficient and appropriately trained, supported, motivated and equitably distributed health workers in place for smooth implementation is also important, as noted in a study conducted in Vietnam.<sup>373</sup>

Effective collaboration with other actors and sectors can also support equity. For instance, engagement with civil society and other governmental agencies was identified as pivotal in the effectiveness of the equitable expansion of antiretroviral therapy in Brazil.<sup>374</sup> Two key informants also mentioned the role



## INFORMATION IS ESSENTIAL TO MONITOR, EVALUATE AND ADAPT THE DESIGN AND IMPLEMENTATION OF POLICIES TO ENSURE THE PROGRESSIVITY OF EFFORTS TO ACHIEVE UHC.

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of civil society in strengthening accountability in Sierra Leone after the introduction of the Free Healthcare Initiative.<sup>375,376</sup> In Kyrgyzstan, working closely with other government departments, bilateral donors and international partners helped to keep improving access at the forefront of reforms.<sup>377</sup> One key informant commended the capacity of the government in Sierra Leone to harmonise donor support with the Free Healthcare Initiative, which removed user fees for pregnant and lactating women and children under five in 2010. Another key informant stressed that cross-sectoral approaches were critical to address the socio-economic inequalities in maternal and child health. Another key informant called for better mechanisms for accountability to ensure that governments deliver on their promises. In South Africa, the absence of accountability for poor governance, including wastage and misuse of public resources and corruption, were associated with the wide inequities in healthcare.<sup>391</sup>

This is an area where civil society has a particularly important role. A key informant mentioned the need for transparency in budgeting mechanisms so that the population can track resources allocated and spent, noting, “that goes for donor money, as well”. As mentioned above in relation to Vietnam,<sup>xxiv</sup> uniformity in the benefit package across the whole population can promote transparency.

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XXIV AND TRANSPARENCY IN BUDGETING MECHANISMS SO THAT THE POPULATION CAN GET AN IDEA OF WHERE THEIR MONEY IS SPENT. THAT GOES FOR DONOR MONEY, AS WELL.

Decentralisation has been shown to produce mixed results in terms of equity. Fiscal decentralisation was praised for increasing the flow of resources to service delivery in Rwanda,<sup>392</sup> and for empowering provincial and county levels in China, enabling them to allocate resources according to local needs. The same study also warned of the resulting regional inequities.<sup>393</sup> Decentralisation is a broad term and should be approached as appropriate, identifying specific functions that work better locally (such as the management of health facilities), and other things that are better done at higher levels (for instance, pooling resources).<sup>394</sup>

### INFORMATION FOR EVIDENCE-BASED PROGRESS

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Information is essential to monitor, evaluate and adapt the design and implementation of policies to ensure the progressivity of efforts to achieve UHC.<sup>398</sup> A key informant called for monitoring and accountability, both on access and quality, to this effect. Authors attributed the success of efforts to achieve equitable access in Colombia,<sup>399</sup> Kyrgyzstan<sup>400</sup> and Rwanda<sup>401</sup> in part to the existence of strong mechanisms to analyse and adjust the system. Moreover, monitoring and reporting equity in coverage of health interventions and outcomes strengthens the sector’s case for additional investment.<sup>402</sup>

**BOX 12**  
**PRIORITISING FREE UNIVERSAL CARE IN SRI LANKA**<sup>395,396</sup>

Fair and equitable access is a top priority of Sri Lanka's healthcare system. Health system reforms coincided with the introduction of democracy to the country in the 1930s, empowering citizens to demand access to good-quality services and to hold the government accountable for providing this. Accountability has remained a critical factor securing and sustaining the country's commitment to health equity, despite resource constraints.

From the very outset, the Sri Lankan health system was guided by a commitment to free universal care for all citizens. A rural network of well-staffed and equipped health facilities was established to expand access beyond urban areas, addressing geographic barriers. By the 1960s, basic health services were in reach of nearly the whole population. High coverage has been sustained, with 99% of births attended by skilled health personnel in 2007.<sup>397</sup>

Improvements in geographic access and the provision of services free at the point of use have been instrumental in enabling more equitable access. The benefit package includes inpatient, outpatient and community care, and covers a wide range of services from antiretrovirals to coronary bypass surgery.<sup>1</sup>

Despite a gradual increase in per capita expenditure, the contribution from public resources has remained constant, at around 45% of total health expenditure. Although a substantial share of total spending is private, mostly from OOPS, this burden is borne by the wealthy.

I THE FEW EXCEPTIONS TO FREE ACCESS INCLUDE: FAMILY PLANNING COMMODITIES; SOME PRIVATE-PAYING WARDS IN A SMALL NUMBER OF GOVERNMENT HOSPITALS; AND ONE TERTIARY CARE HOSPITAL THAT WAS CONSTRUCTED WITH DONOR FUNDS AND STIPULATES THE CHARGING OF USER FEES.

Financed by general revenues, the public system taps the incomes of those who can afford to pay through taxation. When accessing care, rich people are encouraged to 'opt out' and use private services,<sup>ii</sup> which relieves pressure on the public system. This pragmatic approach to targeting allows the public system to better respond to the needs of poor people.

Increasing efficiencies in the delivery of services – eg, by keeping lengths of stay in hospitals down and productivity among health workers high<sup>iii</sup> – has also been key to protecting equity in coverage and maintaining quality of care despite tight budget constraints.

Despite impressive progress, a critical limitation of Sri Lanka's health system is the exclusion of non-citizens from eligibility to public services. In addition, while citizens have access to a full range of health services, budget limitations and resulting rationing limits the availability of certain services and drugs to specific hospitals. Patients may be required to travel further for specialist care, creating an access barrier for poor people. While the system has been successful in providing preventive and curative care, it now faces increasing challenges of responding to the needs of an aging population<sup>iv</sup> and a rising burden of non-communicable diseases.

II WHILE THE TECHNICAL QUALITY OF SERVICES IS SIMILAR IN BOTH THE PUBLIC AND PRIVATE SECTOR, PATIENTS MAY OPT FOR PRIVATE CARE DUE TO: BETTER AMENITIES, LESS CROWDED FACILITIES, SHORTER QUEUES, MORE CONVENIENT OPENING TIMES, ETC.

III THOUGH THE REASONS FOR SRI LANKA'S HIGH EFFICIENCY HAS NOT BEEN ANALYSED, IT MAY BE EXPLAINED BY STRONG CENTRALISED CONTROL OF BUDGETS, INPUTS AND OPERATING PROCEDURES; LOW ADMINISTRATIVE OVERHEADS; ETC.

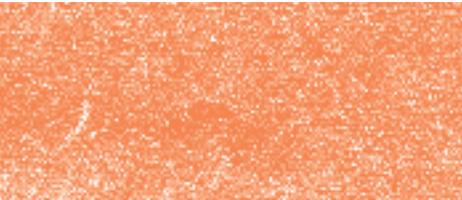
IV LARGELY DUE TO THE SUCCESS OF ITS HEALTH SYSTEM.

## **POLITICAL WILL**

The social and economic gradient of health is a powerful force. Health policy can mitigate some of these impacts if designed and implemented appropriately. But equity must be an explicit and deliberate priority. As a key informant stated, "Unless an effort is made to reach the poor, then the poor always get left out of the interventions." Another key informant added that efforts to reach "all" take time, and so programmes should be explicitly designed in an equity-promoting way.

Political will is instrumental in making equity a priority. Indeed, it is a responsibility of the state as duty bearers to address inequities for realisation of the right to health.<sup>403</sup>

Eighty-eight per cent of key informants identified political problems or inadequate financing as major obstacles to equity in efforts to achieve UHC. Despite strong evidence of the importance of addressing inequities in health, making equity a political agenda is challenging: "It's all too easy for it to fall off the agenda," mentioned one key informant. Another



## AS WITH THE SOCIAL HIERARCHY FOR HEALTH, POLITICAL HIERARCHY TENDS TO FAVOUR THE WEALTHY.

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attributed this problem to the distribution of power, saying “Election and re-election, power is more important than people.” Another key informant added that politicians tend to follow “the course of least resistance”, although the evidence from Sierra Leone and Thailand demonstrate that this is not always the case.

As with the social hierarchy for health, political hierarchy tends to favour the wealthy. With better access to good-quality services, the elite form a powerful political lobby with vested interests to protect the access and benefits they receive. As a key informant explained: “Every country already has some type of financing arrangements, schemes and some existing system. Each faces the difficulty of addressing the vested interests. This has been a big challenge for equity.” Another stressed, “It’s a tricky balance in all countries. What you want is a feeling of solidarity.” The Thai example demonstrates a pragmatic approach to expand equity in coverage (Box 10).

### A SHARED RESPONSIBILITY

The role of development partners was acknowledged in two studies on Rwanda. One study acknowledged the important contribution of donor resources in facilitating increased investment in health that affected more equitable progress.<sup>404</sup> Another noted the unaffordability of premiums and the persistence of user fees for poor people, questioning the extent to which governments and development partners expect poor people to be self-sufficient in funding their own healthcare.<sup>405</sup> Particularly for low-income countries, international support will be critical if even basic benefits are to be available to all people.<sup>406</sup>

# 4. THE INVESTMENT CASE FOR EQUITABLE PATHWAYS TOWARDS UHC

Manouchka, 19, takes her baby nephew, Antoine, three-months-old, for a check-up at Save the Children's health clinic in Camp Pinchinat, Haiti. Antoine's mother died after childbirth and Manouchka has been raising him since he was born.

© SAVE THE CHILDREN / SUSAN WARNER

THIS REPORT has identified some of the emerging lessons from LMICs of health financing policy levers for countries on how to prioritise the needs of poor and vulnerable people when striving to meet the health needs of the whole population. These include:

- Increased and equitable funding for the health system through:
  - ▶ increasing progressive mandatory prepayment mechanisms and revenues from taxation, scaling contributions by ability to pay
  - ▶ eliminating OOPS for vulnerable populations and/or priority services in the absence of effective targeting mechanisms
- Pooled risks and resources at scale:
  - ▶ consolidating pools to increase redistribution across the population
  - ▶ ensuring inclusion for all vulnerable groups
- Strategic purchasing
  - ▶ designing a benefit package that meets the needs of the poorest and most vulnerable
  - ▶ aligning provider incentives through performance-based and other appropriate payment mechanisms.

The evidence also demonstrates that financing is necessary but not sufficient to secure progressive pathways towards UHC. A whole-systems approach must be pursued with coordinated reforms across the building blocks of the health system and beyond the health sector, to address the demand- and supply-side barriers. For instance, quality concerns in service delivery must be addressed. The quantity, quality and use of disaggregated data is critical to inform planning process, monitoring, evaluation and accountability. Effective government stewardship is also important, through building regulatory capacity, strategic planning, and effective collaboration with other actors. Wider enabling factors identified include political will, and appropriate support from development partners.

This list is far from exhaustive. Nevertheless, it is indicative of the opportunities for policy reform to reduce inequities in coverage gaps – an important step to address inequities in health outcomes. Achieving this goal will also require a broader social protection approach and multi-sectoral action to address the social determinants of health.

Identifying an equitable pathway in any country is no easy task. Priority setting and managing trade-offs are complex and challenging, and must start with the existing context – including the policy and political landscape, structure of the health system and public administration, disease burden and distribution of health needs across sub-population groups, fiscal space, and strength of key interest groups. The sequencing of reforms will be defined by assessing opportunities and constraints. An equitable pathway is one that puts the needs of those who are poor and most vulnerable first in all of these reforms.

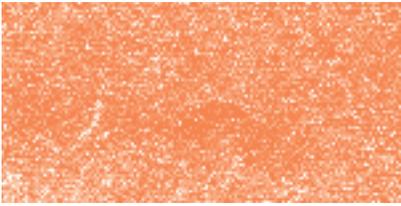
## A CASE OF MORAL OBLIGATION

Investing in equitable pathways towards UHC is the right thing to do from a moral and ethical perspective.<sup>407</sup> Denial of access and impoverishment as a consequence of seeking needed health services is unjust.<sup>408</sup>

## MORE HEALTH FOR THE MONEY

Prioritising the needs of the poor and vulnerable will accelerate progress towards global and national aggregate targets. In many countries, the MDGs will not be met unless inequalities within countries are addressed.<sup>409,410</sup>

The majority of the 6.9 million deaths of children under five years of age in 2011 could have been averted through more effective provision of proven, low-cost interventions.<sup>411,412</sup> In fact, scaling up treatment for childhood diarrhoea and pneumonia to 80% in ten countries could save 1 million lives by 2015.<sup>413</sup> Accounting for the particular vulnerabilities of poor people would increase this estimate.<sup>414</sup>



## IF IN-COUNTRY WEALTH INEQUITIES IN COVERAGE OF A PACKAGE OF ESSENTIAL MATERNAL AND CHILD HEALTH INTERVENTIONS WERE ELIMINATED BY 2015 IN 47 OF THE 75 COUNTDOWN TO 2015 COUNTRIES IT IS ESTIMATED THAT THE DEATHS OF 1.8 MILLION CHILDREN UNDER-FIVE AND 100,000 MOTHERS WOULD BE AVERTED.

Bringing the coverage levels of key services and interventions for the whole population to the same level as already exists for the richest people would accelerate progress to mortality reduction targets. In 37 countries analysed for a study published in the *WHO Bulletin*, eliminating in-country wealth inequalities in coverage, by bringing the poor up to the same level obtained by the rich, would reduce the national average coverage gap by at least one quarter; in three countries this gap could be halved.<sup>415</sup> The aim is to increase use of needed health services for everyone in the population, while pursuing a policy path that simultaneously reduces inequities across various at-risk groups, such as poor people, ethnically or socially marginalised groups, and others being left behind.<sup>416,417</sup>

Research commissioned for this report applied the Lives Saved Tool (LiST) to estimate the impact of more equitable coverage of essential health services on deaths averted. If in-country wealth inequities in coverage of a package of essential maternal and child health interventions were eliminated by 2015 in 47 of the 75 Countdown to 2015<sup>xxv,418</sup> countries it is estimated

that the deaths of 1.8 million children under-five and 100,000 mothers would be averted. This would reduce child mortality by one-fifth and maternal mortality by almost one-third in these countries.<sup>xxvi</sup>

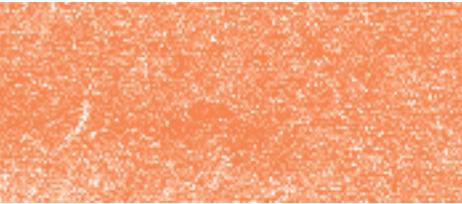
Prioritising equity can improve value for money.<sup>419</sup> A study published by UNICEF in 2010 analysed the potential impact of a pro-equity<sup>xxvii</sup> strategy as compared with the current path<sup>xxviii</sup> on progress rates towards the health MDGs, and the relative cost effectiveness of such approaches. The study found that pro-equity investment strategies accelerate progress towards the health MDGs, and are more cost-effective and sustainable than the current path. In low-income countries with high mortality, this effect was

xxv COUNTDOWN TO 2015 IS A MULTI-DISCIPLINARY, MULTI-INSTITUTIONAL COLLABORATION USING COUNTRY-SPECIFIC DATA TO STIMULATE AND SUPPORT COUNTRY PROGRESS TOWARDS ACHIEVING THE HEALTH-RELATED MDGS. COUNTDOWN TRACKS PROGRESS IN THE 75 COUNTRIES WHERE MORE THAN 95% OF ALL MATERNAL AND CHILD DEATHS OCCUR, INCLUDING THE 49 LOWEST-INCOME COUNTRIES.

xxvi IN THIS ANALYSIS, THE MAJOR ASSUMPTIONS MADE INCLUDE: THAT THE NATIONAL COVERAGE IS SCALED UP TO ITS TARGET COVERAGE OF THE HIGHEST WEALTH QUINTILE LINEARLY IN THEIR PERIOD OF 2013 TO 2015; THAT TARGET COVERAGE OF VACCINES MODELLED IN THE ANALYSIS - HIB, PCV, ROTAVIRUS - WILL REACH THE DTP COVERAGE OF THE RICHEST QUINTILE; THAT INTERVENTIONS COVERAGE DID NOT CHANGE BETWEEN THE ESTIMATES ABSTRACTED FROM THE MOST RECENT DHS / MICS AND OUR BASE YEAR OF ANALYSIS OF 2013.

xxvii A PRO-EQUITY APPROACH WAS DEFINED AS ONE THAT: UPGRADES FACILITIES, PARTICULARLY FOR MATERNAL AND NEWBORN CARE; OVERCOMES BARRIERS PREVENTING THE POOREST FROM ACCESSING CARE, INCLUDING THE ELIMINATION OF USER FEES AND THE EXTENSION OF CASH TRANSFERS TO COVER INDIRECT COSTS; AND SCALING UP TASK-SHIFTING INVOLVING COMMUNITY OUTREACH, GREATER USE OF COMMUNITY HEALTH WORKERS, AND ENHANCED COMMUNITY INVOLVEMENT.

xxviii DEFINED FOR THE PURPOSE OF THE UNICEF STUDY AS THE CONTEMPORARY APPROACHES OVER THE NEXT FIVE YEARS, INVOLVING ADDITIONAL INVESTMENT IN THE TRAINING AND DEPLOYMENT OF HEALTH WORKERS, EXPANDING INFRASTRUCTURE, AND USING MASS COMMUNICATION TO PROMOTE ACCESS AMONG POOR POPULATIONS.



## KEEPING TOTAL HEALTH EXPENDITURE CONSTANT, IF THE SHARE THAT IS POOLED FUNDING WERE TO INCREASE BY 10 PERCENTAGE POINTS IT IS ESTIMATED THAT 15 FEWER DEATHS WOULD OCCUR PER 1,000 IN THE UNDER-FIVE MORTALITY RATE OF AN AVERAGE COUNTRY.

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particularly strong. For every additional US\$1 million invested in a pro-equity approach as opposed to the current path, 60% more deaths could be averted.<sup>420</sup>

As the evidence has demonstrated, equitable pathways towards UHC in LMICs involve increasing public pooled funding for health while reducing reliance on OOPS. Research commissioned for this report modelled the impact of more equitable financing for UHC – measured by a higher level and proportion of pooled funds – relative to OOPS (page 26). The results reveal that more progressive health financing can dramatically improve health outcomes. A 10% increase in pooled spending per capita is estimated to reduce the under-five child mortality rate by 9.5 deaths per 1,000 live births in the average country. This causal effect remains strong even after controlling for potentially important observed and unobserved country characteristics, including governance.

Keeping total health expenditure constant, if the share that is pooled funding were to increase by 10 percentage points it is estimated that 15 fewer deaths would occur per 1,000 in the under-five mortality rate of an average country. This could mean approximately 400,000 fewer under-five deaths in India (a 24% decline), almost 100,000 in Nigeria (12% decline), and around 40,000 in each in Bangladesh (33% decline), Democratic Republic of Congo (9% decline) and Ethiopia (19% decline). For Countdown countries that are not on track to meet MDG 4, more equitable health financing through risk pooling could enable 13

additional countries to achieve their target. This is a 76% increase in countries reaching MDG 4 compared to what is currently expected.<sup>xxix</sup>

This effect is amplified in countries where the coverage of health services is more equitably distributed – measured by proxies of equity in coverage of skilled birth attendance by wealth quintile and place of residence. In countries where the health system is more equitable, increasing the share of pooled health spending relative to OOPS could reduce child mortality by a further seven to eight deaths per 1,000 live births. For instance, in Ecuador, Jamaica, Thailand, and Trinidad and Tobago, increasing the current share of pooled health financing by even less than 10 percentage points could bring under-five mortality rates down to very small or virtually zero levels.

The study also tested proxies for equity in other social determinants of health – the female to male primary school enrolment ratio, a lower incidence and depth

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XXIX MDG 4 ACHIEVEMENTS ARE BASED ON THE KEY FOLLOWING ASSUMPTIONS: (1) THE INCREASE IN THE POOLED SHARE OF SPENDING IS ASSUMED TO BE ACHIEVED BY REPLACING PREVIOUS OOPS WITH POOLED SPENDING (IE, KEEPING TOTAL NATIONAL HEALTH SPENDING UNCHANGED); (2) THE COUNT OF COUNTRIES THAT COULD REACH MDG TARGETS BY 2015 IS BASED ON PROJECTED CHANGES IN UNDER-FIVE MORTALITY RATES FROM 2012-2015, CALCULATED USING THE AVERAGE ANNUAL REDUCTION RATE FROM 1990-2011, AND THE DIFFERENCE BETWEEN PROJECTED AND TARGET (BASED ON A TWO-THIRDS REDUCTION) RATES FOR 2015; (3) THE CALCULATIONS OF MDG PROGRESS AND ACHIEVEMENT ARE FOR THE 75 COUNTDOWN COUNTRIES. THE COUNTRIES THAT COULD REACH MDG TARGETS BY 2015 ARE BASED ON PROJECTED CHANGES IN U5MR FROM 2012-2015, CALCULATED USING THE AVERAGE ANNUAL REDUCTION RATE FROM 1990-2011, AND THE DIFFERENCE BETWEEN PROJECTED AND TARGET (BASED ON A 2/3 REDUCTION) RATES FOR 2015.

of poverty, and equity in access to improved water facilities by place of residence – and similarly found that an additional 10 percentage points of pooled funding for health could lead to additional reductions of four, six to seven and eight under five deaths per 1,000 live births (respectively) in the most equitable countries, compared to what the less equitable countries achieve.

More equitable health financing through pooling and prepayment saves lives, and the impact achieved in terms of improved and more equitable health outcomes increases where access to appropriate and high-quality health service coverage is more evenly distributed.

## WIDER SOCIAL AND ECONOMIC BENEFITS

Prioritising equity in pathways towards UHC is also a sensible social and economic investment.<sup>421</sup>

For many primary healthcare indicators, the remaining national burden of disease is increasingly concentrated in excluded and marginalised groups. More likely to be malnourished, to lack access to safe water and good sanitation, and thus exposed to other health risks that are frequently compounded by poverty,<sup>422</sup> these populations are more likely to die preventable deaths.<sup>423</sup> They are also the people who will benefit most from access to good-quality care.<sup>424</sup>

In such cases, prioritising the needs of poor and vulnerable people is not only more equitable, it is also more efficient and cost-effective than mainstream approaches that reach those who are easier to reach first – often called the ‘low-hanging fruit’.<sup>425,426</sup>

More equitable health outcomes allow for greater productivity among poor populations. Healthier children are better able to learn,<sup>427,428,429</sup> and healthier adults better able to work. Financial protection protects households from loss of income and assets or interest on loans and other coping mechanisms when accessing needed healthcare. This strengthens household resilience, supporting poor people to escape the poverty trap.<sup>430,431,432,433,434</sup> En masse, UHC can stimulate economic growth.<sup>435,436,437,438,439,440,441</sup> It can also nurture a more equitable society, promoting social harmony and cohesion.<sup>442,443,444</sup>

The cost of inaction is high.<sup>445,446,447</sup> With time, failure to address inequities will inflate the costs to society, depleting a country’s reservoir of healthy and productive human capital.<sup>xxx,448</sup> This will have repercussions across the development landscape, undermining efforts to achieve universal education targets<sup>449</sup> and ambitions for poverty reduction.<sup>450</sup>

xxx ALTHOUGH IT MAY BE DIFFICULT TO MEASURE THE CORRELATION BETWEEN CHANGES IN HEALTH AND HUMAN CAPITAL, ESPECIALLY WHERE THE INFORMAL SECTOR IS LARGE, SUCH AS IN MANY MIDDLE-INCOME COUNTRIES.

# 5. IMPLICATIONS FOR UHC MEASUREMENT AND THE FUTURE DEVELOPMENT FRAMEWORK





A male health worker explains the possible side affects of vaccination to a young child who brought her infant sibling for inoculation during a monthly UNICEF supported Integrated Management Child Health and Nutrition session in Mangala village, in the Mohammad Raqi district in Kapisa province, Afghanistan.

© UNICEF / SHEHZAD NOORANI

GLOBAL PROGRESS TOWARDS the MDGs has demonstrated that what gets measured is more likely to be accomplished. Therefore, clarity on the metrics for UHC is critical to forge consistent interpretation and to prompt sufficient prioritisation of equity.<sup>451</sup> Equitable progress in health outcomes and UHC must be driven by targets to narrow gaps and indicators that disaggregate coverage and outcomes by multiple dimensions, such as income/wealth, education, sex, age, place of residence (rural/urban), geographic region, migrant status, disability status, religion and ethnic origin (eg, indigenous groups).<sup>452,453,454</sup> The relative importance of these dimensions varies across contexts and populations, depending on the criteria that shape the social hierarchy.

WHO and the World Bank are developing guidance for countries on the measurement of UHC. In this developing framework, proxy indicators will be required for the level and distribution of intervention coverage and financial risk protection.<sup>455,456,457</sup> In selecting these indicators, it is important to balance simplicity and feasibility while recognising that

efforts at measuring inequity must be stepped up. As a key informant questioned, “Are current efforts at measurement enough? No. Can we do better? Yes.”

The future development framework offers a critical opportunity to galvanise investment in the frequency and quality of health data systems, so targets should not be constrained to data currently available. Better evidence on equity could lead to policies and programmes that better respond to the needs of poor people, as well as strengthening capacities for accountability efforts to encourage political will that translates into implementation.

Many of those who are most vulnerable are never registered at birth or death.<sup>458</sup> Universal civil registration systems must be a priority.<sup>459</sup> Where data is available, it is often ‘distribution blind’, failing to capture the socio-economic characteristics of individuals. Existing measures should also be improved where possible, such as the asset indices that are used to estimate wealth quintiles. As one key informant noted: “In countries where 80% of the population are effectively poor, a breakdown by quintiles basically masks this ...because it makes you feel that to prioritise equity you should be focusing on just the bottom one or two quintiles, whereas actually almost the whole population is in need of social protection.”

The relative importance given to targets and indicators set at the global versus the country level is not always clear in current discussions on the post-2015 agenda. National targets can better reflect local priorities and concerns, and may prompt more local ownership of policies to strengthen national planning and monitoring. Consistency in definitions and metrics facilitates independent assessments by civil society and other non-government partners, and may illuminate inequities along attributes a government may not wish to measure, such as gender-based access differences. Global goals and targets thus have merit in aligning priorities, focusing investments and facilitating comparison across countries. They can also establish a minimum standard for all people, everywhere. An appropriate balance should be found between global momentum and monitoring, and national relevance.<sup>460</sup>

To measure progress in achieving health equity, intervention coverage must be measured across all segments of society, with targets set for both gap reductions and increased national averages.<sup>461</sup> If a single measure is politically most feasible, an index may be considered.<sup>462</sup> However, it must be recognised that this would mask important details for explaining rates of progress.<sup>463</sup>

To link global UHC principles to the local level, national objectives and the individual targets for tracer interventions<sup>xxx</sup> should be set with indicators determined by the burden and distribution of disease, identifying proxies across the levels of the health system.<sup>464,465,466</sup> An evidence-based, transparent and inclusive process for establishing appropriate tracers and targets, using UHC as a goal, is critical.

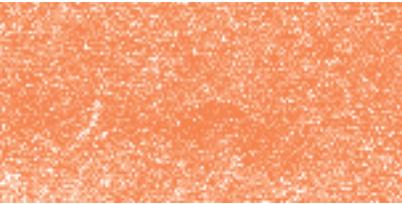
Another challenge is that for many interventions, particularly those relating to non-communicable diseases, mental health and inpatient services, the level of need is not known – unlike for immunisation or skilled birth attendance where the population coverage objective can be reasonably defined as 100% of the target population (ie, all children under five, all delivering mothers). This impedes our ability to assess utilisation based on need.

Tracking the levels and distribution of coverage annually will need better and more frequent data in all countries, including household surveys and complementary research at the local level, which can help to generate information on financial and non-monetary access barriers to inform policy and implementation.<sup>467,468</sup> Reproductive, maternal, newborn and child health interventions are currently most routinely measured, but this will need to be expanded to cover appropriate proxies for non-communicable diseases and other interventions, particularly those requiring clinical diagnosis.<sup>469,470</sup>

The metrics for UHC should also include proxies of the building blocks of the health system, such as a measure of equitable access to a sufficiently skilled health worker, to make explicit the need to invest in better performance of the health system as a means

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XXXI OR INDEED THE TRACER INTERVENTIONS THEMSELVES.



## EXISTING ESTIMATES OF THE FINANCIAL BURDEN TO HOUSEHOLDS OF SEEKING CARE ARE LIKELY TO BE A SUBSTANTIAL UNDERESTIMATE, PARTICULARLY FOR THE POOREST AND MOST VULNERABLE.

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to improved and more equitable health outcomes. This will also help to prevent vertical interpretation of intervention targets. Metrics to track the quality of care must be improved,<sup>xxxii</sup> as this is critical for effective coverage.<sup>471,472</sup>

Existing estimates of the financial burden to households of seeking care are likely to be a substantial underestimate, particularly for the poorest and most vulnerable. Indirect and opportunity costs are not systematically quantified or included in measures, despite the substantial burden they can cause to families – particularly to poor households. Nor are the financial consequences of the coping mechanisms that households employ to deal with high and unpredictable healthcare costs, such as ongoing interest repayments on loans or sale of productive assets like cattle. The consequences of such actions can include reduced consumption of food or education, perpetuating the poverty cycle.<sup>473,474</sup>

Other factors that can facilitate equitable pathways towards UHC can also be important measures to track, such as the passage of legislation on the universal right to health and to address other systematic barriers such as the decriminalisation of men who have sex with men.<sup>475</sup> Using a measure of *vulnerability* can provide a benchmark against which the progressivity of progress towards UHC can be judged.<sup>476</sup> The net-benefit

approach provides information on the marginal cost-effectiveness of scaling up particular interventions to more vulnerable populations, which can inform more equitable strategies.<sup>477</sup> Similarly, needs-adjusted estimates of utilisation and expenditure may help to direct more strategic resource allocation.<sup>478</sup> Improving the sensitivity of metrics for UHC to equity is critical to achieving equitable pathways towards UHC, and must receive commensurate political and financial investment.

### A CATALYST FOR PROGRESS

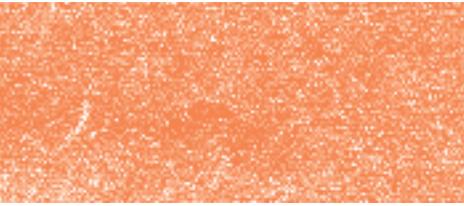
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The MDGs established that great progress in achieving global health targets worldwide is possible. With three out of the eight goals focused on health, the MDGs arguably transformed the field of global health and made the link between health, development and poverty reduction explicit.

Yet the MDGs also had major shortcomings. They ignored health systems, overlooked non-communicable diseases and many social determinants of health, contributed to the fragmentation of health systems and focused on national averages, neglecting inequities.<sup>479</sup> The future development framework must make explicit the need to address inequities between and within countries, and the importance of investments to strengthen integrated systems for more equitable and sustainable gains.<sup>480</sup>

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XXXII INCLUDING PATIENT PERCEPTIONS OF HOW WELL THEY WERE TREATED AND RESPECTED.



**THERE IS ALREADY STRONG SUPPORT FOR UHC GLOBALLY. THE RECENT RIO+20 DECLARATION RECOGNISED THE IMPORTANCE OF UHC FOR "ENHANCING HEALTH, SOCIAL COHESION AND SUSTAINABLE HUMAN AND ECONOMIC DEVELOPMENT."**

Health is a driver and indicator of sustainable development.<sup>481</sup> How health will feature within the post-2015 framework for sustainable development remains undecided.<sup>482</sup> The current discourse reveals a preference for a single health goal, and involves a debate about whether UHC is a goal in itself – as per the draft Sustainable Development Solutions Network (SDSN) report – or a means to achieve an outcomes-focused goal – as per the report of the UN High Level Panel of Eminent Persons (HLP).<sup>xxxiii,483</sup>

There is already strong support for UHC globally. The recent Rio+20 declaration recognised the importance of UHC for “enhancing health, social cohesion and sustainable human and economic development,”<sup>484</sup> and the 2012 UN General Assembly Resolution on UHC received widespread support.

It is clear that UHC must be reflected in the new framework in some way. It offers huge potential as the health system’s contribution to sustain gains in health outcomes made to date and accelerate progress on ending preventable deaths, fostering healthy lives and extending social protection to all people. A system-level and equitable approach towards UHC will redistribute resources for health to respond to population needs and reduce inequities in access to good-quality care. This could have a transformative effect in the battle against poverty, hunger, and disease, and thus enable

more sustainable development. Estimates using the Lives Saved Tool suggest that scaling-up coverage of a package of essential interventions in 47 of the Countdown countries to universal could save more than 4.6 million child deaths, reducing child mortality in these countries by almost 60% (page 71).

The sustainable development framework that follows the MDGs must drive equitable progress through goals and targets that specify reductions in gaps, as well as use of indicators that are appropriately disaggregated. The targets and indicators identified must respond to the needs of the most vulnerable. As one key informant appealed: “As a minimum, whatever the goals are, they must have a distributional component in a way that the current ones [ie, the MDGs] don’t.”

Prioritising equity in UHC is necessary, but not sufficient to deliver more equitable health outcomes. Responding to the social determinants of health, this distributional aspect must be applied across future goals, such that more equitable health outcomes may be realised. This has been referenced in inputs to the discussion on the sustainable development agenda – such as the reports of the HLP report and the SDSN – but it must be maintained and applied through the negotiations of the Open Working Group and full negotiation among Member States. Quoting one key informant: “I would see equity as a principle, a basis, a prerequisite, a foundation against which we must actually take our actions, we must scrutinise our goals.” Another stated: “I am suggesting an ombudsman for equity at the UN level charged with ensuring integration, tracking and responsiveness to equity issues.”

XXXIII IN THE DRAFT SDSN REPORT, THE HEALTH GOAL IS PRESENTED AS: “EVERY COUNTRY SHOULD BE WELL-POSITIONED BY 2030 TO ENSURE UNIVERSAL HEALTH COVERAGE FOR ALL CITIZENS AT EVERY STAGE OF LIFE, WITH PARTICULAR EMPHASIS ON THE PROVISION OF COMPREHENSIVE AND AFFORDABLE PRIMARY HEALTH SERVICES.” WHILE THE REPORT OF THE HIGH LEVEL PANEL OF EMINENT PERSONS ACKNOWLEDGED THE IMPORTANCE OF UHC IN ITS NARRATIVE, IT FAILED TO TRANSLATE THIS INTO TARGETS THAT WOULD INFORM INVESTMENTS.



**A four-year-old is being treated by a doctor on the outskirts of Mingora in SWAT Valley, Pakistan. The girl is suffering with fever and cough. Her mother says she has been playing in contaminated water near her house. The clinic is supported by Save the Children.**

© SAVE THE CHILDREN / JASON TANNER

Moving forward will require the right tools for measurement of equity to be built into health reporting, through routine systems and supplementary methods. The sustainable development agenda offers an opportunity to make a change in the quality and quantity of data available, and this must be seized by sufficient investment – domestically and with the support of development partners.

Accountability mechanisms at local, national, regional and global levels must be established or strengthened, including building the capacity of civil society to meaningfully engage in policy development, implementation and review processes, and to hold stakeholders accountable. The collective duty to realise the right to health as a matter of global social justice must be acknowledged with shared responsibilities to address inequities in coverage and health outcomes.<sup>485</sup> Donors must honour commitments and practise the

principles of effective aid, shifting from a vertical disease-specific preference and heavy earmarking, to investments to strengthen health systems and build domestic capacities.<sup>486,487,488</sup>

Moreover in a world of growing global interdependence, certain factors that undermine equitable progress towards UHC will have to be addressed beyond domestic borders – such as terms of trade that have implications for the price and availability of pharmaceuticals, and the international recruitment of health workers.<sup>489</sup> The future development framework should reflect these requirements, with action across the wider determinants of health,<sup>490</sup> and ensure a system by which all those responsible may be held accountable.

# 6. CONCLUSION AND RECOMMENDATIONS

Too few people have access to the high-quality health services they have a right to and need. And too many households face financial hardship and impoverishment from accessing essential healthcare. There are huge inequities in access to and use of good-quality healthcare and this reflects inequities in health outcomes and unnecessary deaths.

The means and resources exist to bring an end to preventable mortality and foster healthy lives, eliminating inequities in access to good-quality healthcare. And governments and development partners have an obligation to do this.

Equitable progress towards UHC must be the health system's response to this challenge, with the potential to help mitigate inequities in access to health services and financial risk protection, closing gaps in health outcomes. It is also an agenda that can inspire popular and political support.<sup>491</sup>

As more and more countries commit to UHC and embark on this journey, it is crucial that equity is the priority in any route taken. Including civil society,

communities and a wide range of social leaders will be critical if both the ends and means of achieving UHC are to be equitable and just.<sup>492,493</sup> Not only is this the right thing to do from a moral perspective, it is a requirement under human rights obligations. It is also often a wise economic investment. If wealth inequities for essential health interventions were eliminated in 47 of the countries with the highest levels of maternal and child mortality, the deaths of 1.8 million children under-five and 100,000 mothers could be averted. This would reduce child mortality in these countries by one-fifth and maternal mortality by almost one-third.

Moreover, more equitable financing – through pooled prepaid funds rather than OOPS – increases value for money. If pooled funding increased by 10 percentage points as a share of existing resources for health, on average a country would reduce child mortality by 15 under-five deaths per 1,000 live births. This effect is amplified in countries where the health system is more equitable. For Countdown countries that are not on track to meet MDG 4, more equitable health financing through risk pooling could enable 13 countries currently not on track to achieve MDG 4. This is a 76% increase in the number of countries reaching MDG 4 based on current projections.



Julia Vlas assists her one-year-old daughter, Dania, who has a motor delay condition, during a therapy session at the Voinicel Centre in Chisinau, the capital of Moldova. The UNICEF-supported centre is staffed by 10 therapeutic specialists and offers free services to disabled children and their families.

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CONCLUSION AND RECOMMENDATIONS

UNIVERSAL HEALTH COVERAGE:

A COMMITMENT TO CLOSE THE GAP

Investing in equitable progress towards UHC will save lives. It will improve health status, increase productivity, and contribute to economic growth and stronger household resilience.

Country experiences and research reveal important lessons for factors that affect progressive realisation of UHC. This report focuses primarily on the financing functions of the health system – recognising that financing alone is necessary but insufficient for equitable progress towards UHC.

With respect to financing, countries must develop progressive mechanisms to raise revenues for the health sector. They should increase prepaid public pooled funds as a share of funding for health, while reducing dependence on OOPS. This will require increased progressive domestic tax revenues for health and to create fiscal space. Even where mandatory, contributory schemes do not effectively reach the informal sector or those who are poor and most vulnerable. Countries and donors must also honour pledges to invest in health and increase efforts to improve efficiencies within the sector to ensure there are sufficient resources.

The larger the pool of risks and resources, the more equitable the approach will be. Cross-subsidisation and redistribution of resources are imperative for equitable pathways. Starting with a universal entitlement can alleviate the challenges of effective population targeting and prevent segmentation of risk pools.

Strategic purchasing can target public subsidies effectively if the benefit package responds to the needs of those who are poor and vulnerable. The incentives of providers must be aligned to the objectives of the health system, and performance-based financing can be a useful tool for this if designed and implemented appropriately. Efforts should be made to strengthen primary healthcare and referral systems, bringing services within reach of those most in need.

In addition to the financing functions, other factors that affect equity in pathways towards UHC include improving the quality of care, so that it is adequate and appropriate to deliver effective coverage.

Governance is critical to improving quality through regulation. Effective stewardship also involves holistic and integrated planning across the health system for the implementation of a UHC strategy. This requires collaboration across sectors and different actors. Mechanisms for accountability and transparency hold duty bearers their promises.

Political will is instrumental to making equity through UHC a national priority. Another key ingredient to progress is social solidarity. This extends beyond national borders such that development partners share responsibility to facilitate UHC. Adhering to aid effectiveness principles, development partners' support to LMICs in the medium term can be supportive and even catalytic in helping countries implement progressive pathways towards UHC.

The dynamics between these factors determine the extent to which equity is prioritised and realised in effective coverage of health services and financial risk protection. Concurrent efforts must be made to address the wider social determinants. Otherwise, efforts to achieve UHC will continue to fail to reach those most in need.

The catalytic potential of donor support must be tapped, which requires wealthy and poor governments alike to acknowledge their shared responsibility to realise the right to health for all. Bilateral donors must honour commitments to allocate 0.7% of GNI to aid, and all development partners should comply with the principles of aid effectiveness in order to improve how this is spent, shifting from a vertical disease-specific preference to horizontal investments to strengthen health systems.<sup>494</sup> The tools of the International Health Partnership and related initiatives offer a vehicle for aligning investments to gaps in strengthened national plans. Reviving and utilising the Health System Funding Platform presents an opportunity to operationalise these commitments.

As the world debates the content and ambition of the future development framework, UHC must be acknowledged as the health system's contribution to sustainable development, with coordinated action on the social determinants of health across the framework as mutually-reinforcing initiatives. Clear targets for

UHC should guide investments to reduce inequities and strengthen health systems for sustainable gains.

The cost of inaction is high. The current momentum must be seized to maximise the opportunity to promote equity through country commitments to UHC.

## RECOMMENDATIONS

### TO GOVERNMENT:

- Demonstrate political will to address inequities and realise the right to health, through committing to UHC and explicitly developing and implementing equitable evidence-based policy
- Increase public resource allocation to health to meet the Abuja target of 15% of total government spending and to exceed the minimum per capita threshold of US\$60 by 2015
- Improve the progressivity of public revenues and the efficiency of the tax system
- Eliminate financial barriers by reducing dependence on OOPS through increased progressive prepayment and removing the financing burden from healthcare, particularly for those who are poorest and most vulnerable
- Develop effective strategies to address indirect OOPS for the poorest and most vulnerable, including broader social protection mechanisms
- Establish universal population entitlements without reliance on contributory mechanisms
- Consolidate risk pools and reduce segmentation
- Ensure the benefit package responds to the needs of those who are poor and vulnerable, including free primary healthcare where necessary
- Align provider incentives with equity objectives including the provision of sufficient and timely reimbursement, fair wages and resources to cover recurrent costs
- Increase transparency and take other measures to improve local and national health accountability
- Institute participatory processes at all stages of policy development, implementation and review, with special efforts to engage poor and marginalised populations

- Reform discriminatory laws, policies and practices which impede equitable progress towards UHC
- Strengthen the evidence basis on the scale, distribution and nature of financial and non-financial barriers, and invest in better and more frequent data collection
- Pursue inclusive and transparent sector reforms to ensure evidence informs policy
- Support the inclusion of strong targets on UHC in the post-2015 sustainable development framework with metrics that reflect the distribution of coverage

### TO DEVELOPMENT PARTNERS (INCLUDING BILATERAL DONORS, MULTILATERAL AGENCIES, CIVIL SOCIETY AND THE PRIVATE SECTOR):

- Increase investment in health and honour pledges to shared responsibility in realising the right to health for all
- Align priorities, technical assistance and funding behind strengthened national plans
- Support the inclusion of strong equity targets on UHC in the sustainable development framework with metrics that guide equitable progress and strengthened health systems
- Invest in strengthening data to monitor and evaluate the distributional effects of efforts to achieve UHC and health outcomes
- Strengthen civil society's capacity to represent vulnerable communities' participation in policy processes and in holding stakeholders accountable
- Address global policies and arrangements, such as trade, that affect countries' ability to pursue equitable pathways towards UHC

# 7. APPENDIX

## REPORT METHODOLOGY

This report presents the findings from various pieces of research that explore the role of equity in pathways to universal health coverage (UHC), factors that affect equitable progress towards UHC, the potential impact of such approaches and implications for the post-2015 sustainable development framework. These include a structured review to explore country experiences, key informant interviews to get the opinions of experts, econometric analyses, a Lives Saved Tool analysis, case studies, and a desk review.

## LIMITATIONS OF THIS REPORT

The limitations of this report include inadequate consideration of the social determinants of health, the other building blocks of the health system, non-financial barriers to access, and their relative contributions to equity and UHC. In addition, the quantity and quality of data available imposed constraints. Disparate definitions of key terms are problematic, leading to discrepancies in how terms are used and interpreted. This report has not attempted to establish definitive terms, but definitions are provided where appropriate.

The section on lessons for equitable pathways was limited to the studies reviewed and the associated countries. The structured review sought to bring rigour to this section, but studies that explore the impact of reforms on the entire population are scarce. Studies did not observe effective coverage, consisting of quality and appropriate care. Focal countries from the review were disproportionately represented in the literature, which may have skewed the evidence presented. The exclusion of non-English language studies is likely to have exacerbated this, for instance for Cuba.

## RESEARCH NEEDS

- More holistic analyses of equity in UHC across the whole population and system
- Updated estimate of rates/numbers incurring catastrophic expenditures and impoverishment and their distribution
- Disaggregation of OOPS
- Applying an equity lens to each building block of the health system and analysing factors that affect equity in progress towards UHC
- Thresholds for equity targets on tracer interventions, health system proxies and financial risk protection

## EVIDENCE OF SUCCESSFUL STRATEGIES TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH STRUCTURED REVIEW

UHC has been recognised as an essential objective of health systems, with many countries taking steps to accelerate progress towards it. Since UHC is defined as universal access to good-quality essential healthcare without financial hardship, addressing inequalities in healthcare is an implicit component. However, there are of course many possible pathways towards UHC, shaped largely by the country's context, history, culture and politics. The consideration given to the poorest, and most vulnerable and marginalised (such as unemployed people, informal sector workers, elderly people, minority ethnic groups, women and children) is undetermined and will vary from country to country.

As many low- and middle-income countries (LMICs) are making significant progress towards UHC,<sup>495xxxiv</sup> this systematic review sought to identify what consideration has been given to equity in the UHC policy process and its implementation, and how effective these measures have been in improving the equity of access to good-quality healthcare and financial risk protection, as well as equity in health outcomes. It also sought to identify valuable lessons for other LMICs to ensure that adequate priority is given to equity within efforts to accelerate progress towards UHC.

xxxiv BASED ON THE LIST OF COUNTRIES IDENTIFIED IN THE *WORLD HEALTH REPORT 2010*, WITH THE ADDITION OF VIETNAM AND CHINA AS SUBSTANTIAL EFFORTS HAVE BEEN MADE IN THE PAST FEW YEARS, AND THE REMOVAL OF LAOS FROM THE LIST AS LITTLE PROGRESS HAS BEEN MADE THERE. THESE DECISIONS WERE APPROVED BY THE LEAD AUTHOR OF THE *WORLD HEALTH REPORT*.

### RESEARCH QUESTION

WHAT ARE THE **RESULTS** OF UHC INTERVENTIONS ON **EQUITY** IN X SELECTED COUNTRIES?

**RESULTS:** On coverage of interventions and financial risk protection, based on the dimension of UHC as identified by WHO in its 2010 World Health Report, Health Systems Financing: the path to universal coverage, as well as on health outcomes

**INTERVENTIONS:** That expand financial risk protection; OR expand financial risk protection AND increase coverage of an intervention

**EQUITY:** Following an economic perspective two dimensions of equity will be considered:

Horizontal equity: reducing social gradient

Vertical equity: analysing the impact on disadvantaged groups

**COUNTRIES:** LMICs that have made substantial progress towards UHC in recent years (Sri Lanka, Mexico, Chile, Colombia, Vietnam, Costa Rica, Brazil, Moldova, Cuba, Rwanda, Ghana, Kyrgyzstan, Thailand, China (including Hong Kong))

Authors undertook a structured literature review.

### SEARCH STRATEGY

Relevant English-language peer-reviewed literature published between 1/01/2000 and 31/12/2012 was identified through database searches using the following search terms:

*Equity or equitable or inequality or inequity or inequitable or healthcare disparities or catastrophic expenditure or impoverishment or financial protection or catastrophic spending or catastrophic health expenditure or CHE or catastrophic payment or catastrophic health spending or catastrophic medical expenditure or healthcare disparities*

AND

*Universal Coverage (MeSH) 'healthcare disparities' [MeSH Terms] or universal health or universal care or universal access or delivery of healthcare or health systems accessibility or New Cooperative Medical Scheme or 'NCMS' or Seguro Popular or 'healthcare financing' or health financing or health sector financing or financial protection or health insurance or universal coverage*

AND

*Sri Lanka or Mexico or Chile or Colombia or Cuba or Rwanda or Brazil or Costa Rica or Ghana or Kyrgyzstan or Moldova or Thailand or China or Vietnam*

AND

*Health*

Initially, the two concepts of 'equity' and 'coverage' were searched separately and then combined.

#### **DATABASES:**

- PubMed (from 2000)/Medline (last two years only)
- Ingenta
- Econlit
- Embase
- Global Health
- The Cochrane Central Register of Controlled Trials and the EPOC group Specialized Register
- WHOLIS
- Web of Knowledge – Social Science Citation Index

Google Scholar will be searched on title and/or abstract, with screening stopping on the 10th page/article which signifies the 10th redundant article in a row.

**Manual searching** of the following key journals in the last one year, reference lists of relevant articles and related systematic reviews, as well as key author searches were also undertaken:

- Health Policy & Planning
- WHO Bulletin
- The Lancet
- Health Economics
- Health Policy
- Social Science & Medicine

Additionally, **grey literature** was gathered from the following websites using 'universal health coverage' as search term:

- Eldis
- World Bank
- Asian Development Bank
- WHO
- Research for Development

The relevant studies were uploaded onto EPPI-Reviewer 4. After removing duplicates, 20–30% of the abstracts were evaluated by two reviewers independently. Upon reaching 100% agreement with another reviewer, the abstracts of all literature were screened by one reviewer for relevance and quality judged as per research question.

## EXCLUSION CRITERIA

All literature describing the efforts to address health inequalities through UHC was included.

### ABSTRACT

Articles were first screened on abstract using the following exclusion criteria: Suggested exclusion criteria:

1. Exclude on date
2. Exclude on language
3. Exclude on topic (Off-topic eg, explore financial markets, macroeconomic analysis... OR primary focus is not health)
4. Exclude on country (does not include any of selected countries–focus country must be specified in title/abstract in order to exclude)
5. Exclude because not a primary study : Exclude if abstract states that the paper is: Editorial, Whole book, Forum, Panel discussion/debate, Collection of papers, Systematic review, Meeting report, Call to action, historical account, Syntheses of literature/evidence, Proposals or protocols, Comment/Opinion/viewpoint/Perspective articles  
OR  
Doesn't analyse data (quality or quantity) or policies or doesn't analyse impact of an intervention  
OR Describes the country profile, specific policy or programme without analysis  
(NB secondary reviews were kept and categorised separately, so that their references of primary sources could be screened.)
6. Exclude because outcome is not analysed with an equity lens (ie, equity of access to services OR financial risk protection OR equity in health outcomes) HORIZONTAL: ie, equity of access to services OR financial risk protection OR equity in health outcomes  
OR VERTICAL: Impact on disadvantaged group (mental health, poor, vulnerable groups such as children or women)
7. Exclude because study doesn't analyse an intervention which expands financial risk protection; or expand financial risk protection

AND increase coverage of an intervention: Either 1) Study doesn't analyse effects of financial protection mechanism as either an independent or dependent variable OR 2) the UHC intervention addressed in the study does not attempt to address financial protection through a financial component as defined by:

- i. A change in financing source/revenue collection mechanism: taxation, donor funds, social health insurance, private health insurance, other private sources like NGOs own resources and out-of-pocket (OOP) expenditure. free access to services. If the study examines access to services without mentioning whether those are free we should include the paper for full text screening.
  - ii. Pooling arrangement (eg, insurance, labour market position...)
  - iii. Purchasing arrangement
8. Exclude on methodological study: Primary focus of study is to assess measurement criteria
  9. If abstract missing, and can't be found, then include to full text stage, unless irrelevant country focus is mentioned in title, systematic review or type of article mentioned (eg, editorial)

### FULL TEXT

1. Exclude on qualitative study: Exclude all papers that do not perform a quantitative analysis of the data
2. Exclude because the intervention group does not have a comparator: Exclude papers that perform an analysis of the intervention group (ie, Cross sectional studies with no comparator) Valid comparator would be:
  - a. Experimental designs
  - b. Quasi-experimental
  - c. Observational with comparator
3. Exclude on outcome: Exclude because the outcome measured is not:
  - a. Access to services
  - b. Financial protection
  - c. Health status
4. Exclude on impact of UHC intervention: Exclude because the objective of the study is NOT measuring the impact of a UHC intervention
5. Exclude on subgroup analysis: Exclude because

the subgroup analysis was not performed according to the PROGRESS-plus categories:

- a. Place of Residence
- b. Race/Ethnicity
- c. Occupation
- d. Gender
- e. Religion
- f. Education
- g. Socioeconomic Status
- h. Social capital
- i. Age
- j. Disability
- k. Sexual orientation

## QUALITY ASSESSMENT

The tool proposed by Effective Public Health Practice Project (EPHPP) was adapted and complemented to answer the quality assessment needs of the papers included. The objective of the quality assessment was to categorise the quality of the evidence found rather than exclude it based on this criteria. However, the studies had to meet at least a minimum number of criteria in order to be included (O3, C2 and G3).

The criteria used to assess the quality were:

### GENERAL

- O1** Does the study have a clear and well-defined research/analytical question?
- O2** Did the author use other methods on top of quantitative methods? (if NO complete section A-G, if YES complete sections A-H)
- O3** Is the intervention clearly identified, described and analysed in the context of UHC?

### QUANTITATIVE ANALYSIS

#### A SELECTION BIAS

- A1** Are the eligible individuals likely to be representative of the target population?
- A2** Are the selected individuals likely to be representative of the eligible individuals?

#### B STUDY DESIGN

- B1** Indicate the study design
- B2** Was the study described as randomised? If NO, go to Component C.
- B3** If Yes, was the method of randomisation described? (See dictionary)
- B4** If Yes, was the method appropriate? (See dictionary)

#### C CONFOUNDERS

- C1** Are the groups similar at baseline
- C2** Are confounders controlled and accounted for and adjusted in analysis using statistical methods?

#### D DATA COLLECTION METHODS

- D1** Were data collection tools shown to be valid?
- D2** Were data collection tools shown to be reliable?
- D3** Where different the sources of information clearly identified and described? (only for secondary data)
- D4** Is the source of information likely to produce good quality data?

#### E WITHDRAWALS AND DROP-OUTS

- E1** Is information on response rates, non-responses, lost of follow-ups or other adjustments to the samples in the analysis provided?

#### F INTERVENTION INTEGRITY

- F1** Percentage of participants that received the intervention
- F2** Are treatments likely to be consistent in all groups

#### G ANALYSIS

- G1** Unit of allocation compatible con unit of analysis
- G2** Can a temporal relationship be established (intervention precedes effect)
- G3** Is any statistical method used in the analysis? Must be explicit. (confidence intervals, p values, Method as X square, regression...)

### RELEVANCE OF THE QUALITATIVE COMPONENT

#### H OVERVIEW OF THE QUALITATIVE COMPONENT

- H1** Is the relevance of the qualitative component to the overall design of the study justified
- H2** Is the quantitative component of the study generally well described (question, reflexivity, methods and design, analysis and finding)

## EXTRACTION TABLE

Information was extracted into the following table:

### AUTHOR YEAR

Title  
Country  
Region  
Analytical question / Aim

### SOURCES OF DATA

Description of the source  
Eligible population  
Sampling design  
Type of data (panel, cross-sectional...)

### STUDY DESIGN

RCT (cluster/individual)  
PSM  
Cohort study  
Cross sectional  
Repeated cross sectional  
Interrupted time series  
Pre-post differences studies  
Differences in differences  
Case studies  
Controlled before and after  
Other

### TIME PERIODS

Year of intervention started  
Period of data collection

### INTERVENTION GROUP

Number of participants  
Mean age + SD  
% of male  
% of rural  
% of SES

### COMPARATOR GROUP

Number of participants  
Mean age + SD  
% of male  
% of rural  
% of SES

### TYPE OF ANALYSIS + DESCRIPTION OF METHOD

Descriptive  
Multivariate analysis  
PSM  
DD  
RDA  
IV  
Other  
Name of the UHC intervention  
Background / context

### SUMMARY OF GENERAL HEALTH SECTOR REFORM

Target population  
Content of the reform (elements, and how they relate to one another)

How the proposed reform work in theory

### WHO BUILDING BLOCKS TARGETED BY UHC REFORM, AND HOW?

---

Governance (Decentralisation?)

Human resources

Vaccines and pharmaceuticals

Health Information

Financing (who, how: collecting, pooling and purchasing)

Service delivery (who, public/private)

---

### **SUMMARY OF SPECIFIC UHC INTERVENTION ASSESSED**

---

Target population (CUBE)

% of cost covered (CUBE)

Serviced covered (CUBE)

How the proposed intervention works in theory for general population?

How the proposed intervention improves equity?

Intervention received by the COMPARISON GROUP

---

### **WHO BUILDING BLOCKS TARGETED BY UHC INTERVENTION, AND HOW?**

---

Governance (Decentralisation?)

Human resources

Vaccines and pharmaceuticals

Health Information

Financing (who, how: collecting, pooling and purchasing)

Financing delivery (co-payment, reimbursement, HMO...)

Service delivery (who, public/private)

---

### **MAIN OUTCOMES MEASURES**

---

Access/utilisation

Financial protection

Health status

Other outcomes

---

### **RESULTS (STATE IF SIGNIFICANT)**

---

---

Data extraction: general population

Data extraction: equity

---

### **SUMMARY OF FINDINGS**

---

Main conclusions

Conclusion on equity

Unintended consequences

---

### **LESSONS IDENTIFIED BY THE AUTHORS**

---

What worked

What did not work

Why

Policy Implications

## ECONOMETRIC ANALYSIS

This study builds on previous work by Imperial College to develop empirical models of the links between country performance on population health outcomes and broader health system coverage. These models are used with an extended dataset to provide answers to two inter-related questions. First, does progress towards UHC, measured by a higher level and proportion of pooled prepaid funds in health system financing, improve health outcomes after cross-country differences in factors such as national income and the quality of government and institutions are taken into account? Second, do any health impacts from extended pooled prepayment vary according to alternative measures of how equitable countries are, both in terms of health service coverage and broader indicators of socio-economic development?

Country-level panel data were explored using instrumental variable regression methods to explain mortality outcomes as a function of pooled health financing and equity proxies. The chosen econometric techniques applied to panel data (rather than cross-sectional estimation) should offer more robust estimates of effects and better opportunities to investigate causality. However, this means that it restricts the scope of variables that can be used in the modeling.

Publicly available annual data from four main databases were used: World Bank's World Development Indicators, World Health Organization's Global Health Observatory, UNICEF's Childinfo, and the Institute of Health Metrics and Evaluation's Global Health Data Exchange. The period of analysis is 1995 to 2011 (17 years) and the models are estimated on a maximum sample of 160 countries. Compared to previous work by the authors, not only does the current study extend the number of years and countries examined, it also enlarges the scope of the variables included in the analyses.

The following data were examined for this analysis:

- Population health is measured by the under-five mortality rate (deaths per 1,000 live births).
- Health coverage and progress towards UHC are

measured by the level and relative participation of pooled prepaid health spending in total system financing. The indicators included are pooled prepaid health expenditure per capita (ie, health spending from prepaid sources such as general taxes, social insurance contributions, and voluntary insurance payments), OOPS on health per capita, and pooled prepaid health payments as a share of total.

- Various measures of equity are examined. Equity in health service coverage is proxied by the differences (in percentage points) in skilled birth attendance by residence (urban vs. rural individuals) and wealth (individuals in the highest vs. lowest wealth index quintiles). Broader equity indicators include the urban-rural differences (in percentage points) in access to improved water source and improved sanitation facilities, the ratio of female to male primary school enrolment, as well as the ratio of income shares held by the richest and poorest 10% of the population. Two measures of the incidence and depth of poverty are also examined: the poverty gap (mean shortfall from the US\$2 a day poverty line, as percentage of the poverty line) and the poverty headcount (percentage of population living on less than \$2 a day).
- For all the equity and poverty proxies, variables are constructed indicating whether the country belongs or not to the group of 'most equitable' countries, defined as those for which the differences between urban-rural, highest-lowest wealth/income, or gender (and absolute values in the case of poverty measures), are in the bottom half of the distribution, ie, below the corresponding sample median value.
- Additional explanatory variables include: GDP per capita; the primary school enrolment rate; population aged 0–14 as a % of total; population aged 65+ as a % of total; and an index of governance quality calculated across six dimensions (voice and accountability; political stability and absence of violence; government effectiveness; regulatory quality; rule of law; and control of corruption), from the World Bank's Worldwide Governance Indicators.

## KEY INFORMANT INTERVIEWS

### STUDY DESIGN

A series of semi-structured interviews were conducted on the topics of universal health coverage, the current place of equity in dialogues on UHC, and the best paths forward.

### PARTICIPANTS

Key informants were identified and contacted for participation in this study via email. A total of 15 participants were interviewed via Skype, with an additional two respondents replying to questions via electronic survey. All participants work in senior, supervisory positions in academic institutions, non-governmental organisations, governmental health departments or multinational organisations and are employed in issues related to health equity across the globe. Consent for participation was obtained verbally from all participants and confidentiality was agreed.

### DATA COLLECTION

Semi-structured interviews were conducted with key informants to ask questions regarding 1) how UHC is defined and equity is prioritised within efforts to achieve UHC, 2) how equity is currently prioritised in global health agendas, the MDG framework, and country efforts to achieve UHC, and 3) forward-looking, how equity can be promoted as a priority within global health. Interviews were conducted via Skype or by phone as dictated by the key informant, and the informants gave consent for audio recording of conversations.

### DATA ANALYSIS

Transcripts were content analysed to identify and classify categories within the data in relation to the research questions. Stata 12 was used to organise data and facilitate analysis. Quotations from the transcripts were extracted to provide supportive data for each category.

## SYNTHESIS OF FINDINGS

Below is a synthesis of the responses from key informants:

### DEFINING UHC

There was a divergence in definitions of UHC across key informants. Only four informants (24%) used the 2010 World Health Report definition of UHC. Financing was referenced as a component of UHC by 65% of respondents (11 people). Approximately half (47%) noted quality of care, or access to care, in their definition of UHC. Three informants (18%) defined UHC as a package of services; one specified that UHC cannot be described as a discrete package of services. *Key informants acknowledged the discrepancies in how UHC is defined, and 24% noted that clarity and consensus on the definition of UHC would be critical for future progress on the agenda.*

### CONCEPTUALISING EQUITY WITHIN UHC

With variation in the definitions of UHC, it is not surprising that there were different opinions as to how equity relates to UHC. Eight people interviewed (47%) associated improved equity in UHC as prioritising vulnerable populations, while seven (41%) explained this as ensuring equal access to health services. Nine people (53%) specified that equity should be measured across wealth status, with geographic equity (29%) and gender equity (18%) also mentioned by multiple informants. All key informants identified equity as a goal of UHC.

### EQUITY IN PATHWAYS TOWARDS UHC

Fifteen key informants (88%) cited either political problems or financial constraints as major obstacles to achieving equitable progress towards UHC in LMICs, with many respondents discussing these as interrelated factors. One reflected on the long-term impact of trade-offs for equity.

The seven key informants who discussed health financing in relation to UHC unanimously agreed that private insurance schemes are regressive and not conducive to achieving UHC. Four informants (24%) denounced user fees for placing a disproportionate burden on poor people and the informal sector. No key informants made positive reference to user fees. The seven informants agreed that public pooled financing

is essential for UHC. One informant emphasised the importance of progressivity in financing for UHC.

### REFLECTIONS ON MDGS

There was mixed opinion about the commitment to equity in existing global health agendas and the MDGs. Informants acknowledged the role of the MDGs in setting important targets, increasing political will, and making health a global priority. Almost all informants acknowledged that the MDGs did not promote equity in health. Sixty-five per cent of respondents went further to state that the MDGs had been detrimental to equity in health outcomes.

### POST-2015 DEVELOPMENT AGENDA

There was a common concern about the prominence of equity in current debates about the post-2015 framework. Fifty-three informants reflected that discussions regarding equity were largely ideological. Only one informant was more confident that adequate priority was being given to equity in current discussions. Three others said they were optimistic that equity would be an explicit priority as the discussions develop.

The level of ambition for how equity should be reflected in the post-2015 agenda varied across informants. Forty-one per cent called for new metrics to better track equity in progress on health. Instead of additional indicators, 47% suggested disaggregation of existing indicators should be included in the future development framework.

Political will for UHC within this framework was mentioned by three experts (18%). Another three informants noted the need for better evidence on what policies work and why.

## LIVES SAVED TOOL ANALYSIS

The Lives Saved Tool is a modelling tool that estimates the impact of scaling up interventions on child mortality. More information about the tool can be found at <http://www.jhsph.edu/departments/international-health/centers-and-institutes/institute-for-international-programs/list/>

Analyses performed by Victora *et al* and the Countdown's Equity Working Group<sup>495,496</sup> have shown that there are significant equity gaps in maternal and child health intervention coverage within countries. This significant level of inequity is important in determining how to scale up coverage to reach the goal of UHC.

The purpose of this analysis is to model the potential impact of reaching the entire population with a level of coverage of maternal and child health interventions at the same level as are currently being reached by the highest wealth quintile.

### METHODS

Using the most recent estimates of coverage and mortality at the national level, each intervention was scaled up to the level of the highest wealth quintile. A national level scenario which had contraceptive prevalence value set to constant from 2013 was used as the comparison.

### COUNTRIES

Of the 75 Countdown countries, any country without a Demographic and Health Survey/Multiple Indicator Cluster Survey (DHS/MICS) since 2005 was excluded. Only countries with datasets available on the DHS/MICS websites AND which have been recalculated by the Countdown Equity Group were included. This resulted in 57 countries for this analysis.

In *LiST*, inter-agency sources are typically used for coverage estimates instead of DHS or MICS for the following interventions. Information from WHO/UNICEF Joint Monitoring Program (JMP) was used for water and sanitation interventions in *LiST*. WHO/UNICEF coverage estimates for vaccination coverage, and the UNICEF Vitamin A estimates were used. Since only the highest wealth quintiles coverage from reanalysed DHS and MICS are available, the ratio of the wealthiest quintile was applied to the national average to these three types of values to predict what the wealthiest quintile value would be. In cases when starting coverage of interventions are higher than the target coverage, coverage is kept as is and not scaled down.

## ENDNOTES

- 1 SEE: [HTTP://WWW.WHO.INT/FEATURES/QA/UNIVERSAL\\_HEALTH\\_COVERAGE/EN/INDEX.HTML](http://www.who.int/features/qa/universal_health_coverage/en/index.html)
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SMALLER PRIMARY HEALTH CARE UNITS (PHCUS), ALL MANAGED AND  
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