GLOBAL HEALTH 2035

A World Converging within a Generation

Implementing Pro-Poor Universal Health Coverage:

Evidence, Challenges, Questions

A Background Paper for the Commission on Investing in Health

Bellagio Meeting on Progressive UHC

July 6-10, 2015

This Bellagio meeting is kindly hosted and supported by the Rockefeller Foundation, with additional support from the United States Agency for International Development (USAID).

EXECUTIVE SUMMARY

Universal Health Coverage (UHC) can be a vehicle for improved equity, health, the financial well-being of households and ultimately, development. Yet, for these outcomes to be achieved, a number of questions about how to implement policies aimed at moving closer to UHC – such as which health services to provide, how to pay for them, how to most effectively and efficiently ensure their delivery, and how to ensure financial risk protection and equitable access for the poor – must be answered.

The *Lancet* Commission on Investing in Health (CIH), in its 2013 report *Global Health 2035: A World Converging within a Generation (GH2035),* made the case that countries should pursue progressive (pro-poor) pathways towards UHC that target the poor from the outset. The report's authors argued that progressive universalism is an efficient way to achieve both improved health outcomes and increased financial protection.

Countries around the world are embarking upon health system changes that move them closer to achieving UHC. Much has been written about ***what*** steps countries have taken and are currently taking to: 1) Set and expand guaranteed services, 2) Develop health financing systems to fund guaranteed services and ensure financial protection, 3) Ensure high-quality service availability and delivery, 4) Improve governance and management of the health sector, and 5) Strengthen other aspects of health systems to move closer to UHC.

Less well documented, however, is experience with ***how*** countries have tackled and are tackling some of the difficult – often sensitive – questions around implementing UHC while ensuring coverage of the poor at no or low cost. For example, how are countries able to build and sustain political commitment for UHC over time, and manage opposition to pro-poor service delivery? How are they able to secure and maintain the necessary health systems finance over the long term and move away from direct out-of-pocket payments at the same time? How do countries ensure adequate institutional capacity, and expand services where this capacity is weak? How can they best engage civil society and the general public to ensure health systems are responsive to population needs?

In this paper, we provide a brief introduction to UHC. We then provide an overview of the major issues, questions, and challenges related to ***how*** countries can successfully implement pro-poor strategies for UHC. It is these questions that will form the focus of discussion at the Commission on Investing in Health meeting on pro-poor pathways to UHC in Bellagio during July 6-10, 2015. The discussions at this meeting will provide critical context from country experience, to begin answering some of these essential questions. These discussions will form

the backbone of a pro-poor UHC implementation guidance document, to be used by ministries of health and finance and other stakeholders as they move to reach their UHC goals. Our discussions will also touch on major gaps in the UHC evidence, and opportunities for collaboration across countries; thus it is our hope that this work and the guidance document will provide messages relevant to researchers and the international community about their role in supporting countries on the path to UHC.

Abbreviations

CEA: cost-effectiveness analysis
ECEA: extended cost-effectiveness analysis
FRP: financial risk protection
GDP: gross domestic product
HBPs: health benefits packages
HICs: high-income countries
HSS: health systems strengthening
JLN: Joint Learning Network
LICs: low-income countries
LMICs: lower-middle-income countries
MICs: middle-income countries
NCDs: non-communicable diseases
P4P: pay-for-performance
UHC: universal health coverage
UMICs: upper-middle-income countries
USAID: United States Agency for International Development
WHO: World Health Organization

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Introduction

Poised to be a central component of the post-MDG global health framework, Universal Health Coverage (UHC)[1] can be a vehicle for improved equity, health, the financial well-being of households and ultimately, development. Margaret Chan, WHO's Director General, has called UHC the "single most powerful concept that public health has to offer." Questions central to UHC – such as which health services to guarantee, how to pay for them, and how to most effectively deliver them – have faced governments since the earliest days of national health reforms. More recently, attention has also focused on how UHC can ensure financial risk protection (FRP) in health as well.[2] Each year 150 million people suffer health-related financial catastrophe,[3] and 100 million people are pushed into poverty as a result of out-of-pocket health expenditures (Xu *et al*. 2007). The poor are the most at risk for catastrophic health expenditures and disproportionally suffer from inadequate access to high quality health services (Kruk *et al*. 2009).

Gwatkin and Ergo (2011) coined the term "progressive universalism" to describe the pursuit of steps towards UHC that seek to protect the poor from the outset. As they describe it, progressive universalism has at its center "a determination to ensure that people who are poor gain at least as much as those who are better off at every step of the way toward universal coverage, rather than having to wait and catch up as that goal is eventually approached." Examples of steps to protect the poor from the outset include ensuring coverage packages target diseases that disproportionately affect the poor, prohibiting the exclusion of the poor (and those in poor health) from insurance plans, and exempting the poor from paying user fees or insurance premiums.

The *Lancet* Commission on Investing in Health (CIH)[4] in its seminal 2013 report, *Global Health 2035: A World Converging within a Generation (GH2035),*[5] endorsed the call for progressive universalism, making the case that progressive ("pro-poor") pathways[6] towards UHC, which

[1] In this paper we do not examine the meaning of UHC, nor the justifying steps towards its achievement (the so-called "why" of UHC); instead we assume that the reader is already supportive of the concept and familiar with key UHC literature, such as WHO (2014), WHO (2010), World Bank (2014), World Bank and WHO (2014), and Nicholson *et al*. (2015).

[2] Health economists have long been concerned about financial risk protection in health, while public health professionals have long been concerned with access to needed services. UHC has brought these two concerns together and heightened their interdependence.

[3] Where "financial catastrophe" is defined as devoting over 40% of non-food spending to out-of-pocket health expenses (Xu *et al.* 2007).

[4] Chaired by Lawrence H. Summers and co-chaired by Dean T. Jamison. See here for the full list of 25 CIH Commissioners.

[5] See www.globalhealth2035.org for links to the report, accompanying appendices, editorials, and background working papers.

[6] We have opted not to use the term "pathway" in this paper, as it implies that there are normative uni-directional ways towards UHC. Yet each country starts from its own circumstances (historical circumstances within and outside of the health sector, political commitment, fiscal depth, analytical capacity, system discipline to respond to decisions that are made at the top). Thus we have instead chosen to use terminology that

target the poor from the outset, are the most efficient way to achieve both improved health outcomes and increased financial risk protection. GH2035 proposed two possible progressive pathways towards UHC within a generation. In both proposed pathways (see Box 1), coverage is universal: *everyone* (not only the poor) is assured that they will have access, if needed, to the same set of guaranteed services.

Box 1: Two possible progressive pathways that countries can take towards UHC

In the first pathway, public funds from general taxation, payroll taxes, or both cover an initially narrow set of essential health interventions, such as those necessary to achieve "a grand convergence" in maternal, child, and infectious conditions, and a basic package of interventions to tackle NCDs (e.g. the WHO's essential package of best-buy interventions for NCDs). This pathway directly benefits the poor, as they are disproportionately affected by these health conditions. The second pathway specifies a larger benefit package from day one, funded through a wider range of financing mechanisms, such as mandatory premiums and copayments, but poor people are exempted from premiums and copayments. The poor are covered through public funds (e.g. they do not pay any contributions to the "insurance").

Countries around the world are now embarking upon health system changes that move them closer to achieving UHC. There is increasing agreement that a universal – rather than targeted – approach to UHC is the best way forward in most settings (Nicholson *et al*. 2014). There is also a growing empirical literature on UHC. Much has been written about what we, in this paper, call "the what" of UHC, meaning ***what*** steps countries have taken and are currently taking, and what steps technical experts have recommended, with regards to five core UHC action areas: (1) Setting and expanding guaranteed services, (2) Developing health financing systems to fund guaranteed services and ensure financial protection, (3) Ensuring high-quality service availability and delivery, (4) Improving governance and management of the health sector, and (5) Strengthening other aspects of health systems to move closer to UHC (Box 2).

Box 2: Five areas that countries must consider to achieve effective UHC

1. Setting and expanding guaranteed services
2. Developing health financing systems to fund services and ensure financial protection
3. Ensuring high-quality service availability and delivery
4. Improving governance and management
5. Other health systems strengthening measures to enable UHC

Less well understood, however, are the best strategies countries can take to address some of the difficult and sensitive questions around implementing UHC while ensuring coverage of the poor with needed services and with financial protection.[7] There is also a gap in knowledge about ***how*** low and

recognizes the unique nature of each country-specific setting (for example: "steps towards UHC" or "interventions that strengthen UHC that proactively benefit/protect the poor").

[7] Nicholson *et al*. 2015 recently called for "more attention and research…(to) be devoted to the practical issues of UHC implementation".

middle income countries have worked to tackle some of these questions and challenges. This lack of information about the ***how*** of UHC implementation is in part due to the non-linear process through which countries implement health system reforms, often with stops and starts that are influenced by politics, administrative and technical challenges, and resource constraints (Stefan Nachuk, personal communication), as well as the ever evolving fiscal and political environments in which UHC decisions are made.

In the following section of this paper we lay out a set of critical "***how***" questions around UHC implementation challenges. These implementation questions and challenges will be discussed in Bellagio, where we will draw on country-specific examples, to 1) inform the evidence-base and suggest best practices for achieving pro-poor UHC, 2) identify opportunities for the international community to support country implementation plans, and 3) outline a future agenda (including research) that will guide pro-poor UHC implementation. The discussions and experiences shared during this meeting will form the basis of a UHC implementation guidance document,[8] designed to help ministries of finance and health and other stakeholders think through how to best ensure a pro-poor focus and address common challenges as they implement steps towards UHC, as well as provide insights for the international and research communities on steps they can take to most effectively support LMICs as they work towards achieving UHC.

[8] A rough outline for this implementation guidance document can be found in Annex VI.

The HOW of UHC implementation: central issues and unanswered questions

In the following pages (up to and including page 13), we highlight key issues, and underlying "***how***" questions, critical to the implementation of pro-poor UHC. These questions emerged from our review of the literature and our conversations with country implementers and academic experts. Many of these questions cut across several of the key areas (listed in Box 2 above) that countries must address as they move towards UHC, and remain as central challenges countries are confronting in the achievement of their UHC goals. As such, these questions will form the focus for our discussions in Bellagio, with each session devoted to addressing a set of these questions.

Session III[9]: Generating and Sustaining Political Will and Financial Commitment for Progressive UHC

UHC is a policy issue, requiring policy-makers to develop and implement new policies and regulations that facilitate the movement towards UHC and to raise significant funds that will enable it to happen. Implementation of these policies often requires establishing new health systems actors (e.g. insurers), and/or introducing significant changes to the relationships between actors. As such, UHC can be a very political process, and achieving UHC goals will require political commitment from the highest levels. These challenges lead to a series of underlying questions:

1. How can leaders in the Ministry of Health and UHC reformers/advocates best generate and sustain greater government political will for, and financial commitment to, equitable and progressive UHC, ensuring that the poor are included from the outset?
2. How can countries successfully address political challenges, and effectively manage opposition to different aspects of UHC implementation[10]?

Session IV: Engaging Civil Society and the General Public to Support Progressive UHC

Designing UHC schemes that are responsive to the needs of the population requires the introduction of mechanisms through which the public can engage in decision-making and hold policy-makers and implementers accountable. Given the diversity of stakeholders and interests in UHC implementation, governments also require strategies to mediate these interests and negotiate conflicts, while maintaining a pro-poor focus to implementation. These challenges raise a number of questions for governments to consider in UHC implementation:

1. How can countries raise population awareness and understanding about the importance of investing in health in general, and UHC in particular?

[9] We begin here with Session III, as Session I on the agenda is an introductory session (welcome, and background to progressive UHC as outlined in GH2035) and Session II is a brainstorming session around development of a UHC implementation guidance document.

[10] We use the term "UHC implementation" as shorthand for "UHC policy or strategy implementation".

1. How can Ministries of Health best engage with civil society, and capture public attention at opportune times?
2. How can countries best engage the public in decision-making to ensure system responsiveness to the needs of the population?
3. How can countries implement accountability mechanisms that ensure responsiveness and engage the public in monitoring and improving UHC systems?
4. How is the general public being engaged (or not) in making decisions about guaranteed services and other decisions?

Session V: Generating and Using Information to Support Progressive UHC Implementation

Adequate information on health systems needs and use is required to inform priority setting and effective policy-making. Information about health systems performance is also essential for identifying when goals are not being met, and for developing appropriate responses. A number of questions remain about the type of information required to guide progressive UHC implementation, the strategies for efficiently and effectively doing so, and for ensuring the capacity to use this data in decision-making:

1. How do countries currently use evidence (and what sorts of evidence) in policymaking and UHC implementation? How can evidence best be used to shape priority setting?
2. What types of information and information management systems do countries need to develop to generate necessary local evidence?
3. How can evidence be better used in UHC reform processes?
4. How can countries, researchers, and international partners work together to ensure better translation of evidence into the policy realm?

Session VI: Measuring and Maintaining Financial Protection

Financial risk protection is an essential goal of UHC – even where high quality health services are available, people will not be able to access these without financing mechanisms that ensure their affordability. In establishing UHC financing that ensures the poor can benefit without financial hardship, countries must firstly raise funds for health, consider progressive approaches to raising funds (e.g. non-regressive tax schemes), as well as ensure that the poor are eligible to access benefits from pooled funds and that these funds purchase services of high priority to the poor. As countries expand coverage, new challenges of cost containment emerge.

1. What political and technical strategies enable governments to raise more funding for health?
2. How can countries best reduce out of pocket payments, increase prepayment, and develop effective pooling and mobilize political and public support?
3. How can countries measure their progress on expanding access and increasing financial risk protection?

4. How can countries increase efficiency and contain costs without eroding coverage or undermining financial protection?

Session VII: Collaborating for UHC – Cross country learning and international collective action

External partners, particularly international donors, are often engaged in countries' UHC implementation and reform processes. Partnerships with such organizations can provide access to essential support and resources, while also raising challenges for countries such as how to ensure alignment across partners and with local priorities. As countries tackle the many complex and political questions of UHC implementation, there are also opportunities for learning across countries based on their experiences navigating such challenges. Several questions emerge about how countries can best take advantage of these many collaborations to implement pro-poor UHC strategies:

1. How can countries embarking on progressive UHC reforms best help each other and how can they learn from the experience of countries that are more advanced on the UHC pathway?
2. Should a lateral ongoing process/network/community of UHC thinkers at country-level be created to share information regularly (e.g. in collaboration with the Joint Learning Network?[11] New networks or platforms?)
3. Should a global coalition for UHC be created? What would this coalition look like/do?
4. How might international collective action[12] best promote and support progressive UHC implementation?
5. How can countries ensure that external funding supports local priorities in relation to UHC?
6. Are current donor modalities capable of dealing with the real "how" questions in LMICs? How might modalities be shifted to respond more effectively and further?
7. How can donors best support definition of priority research questions, and who might conduct the actual research?

Session VIII: Managing UHC Growth – Systems, Services, and Financing

Countries face many challenges in initially determining and later expanding both the population to be covered by UHC schemes and the services that will be provided through these. Countries have taken different pathways – for example targeting the poor for early participation, or working to add the poor into existing schemes for formal sector workers – each raising its own

[11] The JLN for UHC is "a unique practitioner-to-practitioner learning network that is connecting low- and middle-income countries with one another so that they can learn from one another's successes and challenges with implementing UHC, jointly solve problems, and collectively produce and use new knowledge, tools, and innovative approaches to accelerate country progress and avoid 'recreating the wheel'." See http://www.ihi.org/resources/Pages/Publications/JointLearningNetworkUpdate.aspx

[12] Donors can and do play a significant role in the development of health systems, including UHC programs. *Global Health 2035* summarized three major ways that international community can support pro-poor UHC. See Annex VII for a brief summary.

challenges about ensuring coverage, maintaining quality, and reducing fragmentation. Effectively managing the growth of UHC schemes is a central challenge, with each country facing unique challenges depending on the historical process through which UHC has evolved in their context.

1. How can countries best manage the evolution and growth of the UHC system? What services should be guaranteed at the outset, and to whom? Once the resource envelope grows, which additional services should be included?
2. How can countries best ensure that UHC programs rapidly and accurately reach and meet the needs of marginalized populations, including those who are missing out on needed health services or incurring financial hardship due to out of pocket payments?
3. What types of financing mechanisms can effectively ensure financial protection with the informal sector?
4. How can countries expand sources of revenue and generate greater fiscal space for UHC in resource constrained settings?
5. How can countries effectively manage risk pool(s)?
6. How can governments effectively bring together fragmented systems?
7. What role is there for "technology assessment agencies" in managing UHC growth?
8. How do countries determine the level at which services should be provided (e.g. community, primary care center, tertiary hospital)?
9. How do countries determine, and achieve, the appropriate level of integration across platforms (e.g. should HIV testing and treatment be integrated with other services?)

Session IX: Managing UHC Growth – Institutional Capacity

UHC implementation requires leadership and management capacity to establish and pursue strategic policy directions, as well as technical and administrative capacity to implement UHC policies, including sufficient human resources for effective service delivery. Capacity limitations can affect healthy systems performance and efficiency, and undermine public confidence in – and therefore use of – health services. Countries also face challenges in rapidly expanding capacity with growing UHC schemes, and balancing such expansion with needs to maintain quality. A number of questions remain for consideration:

1. How can countries strengthen the development of adequate capacity (intellectual, policy development, management, implementation, monitoring and evaluation) within UHC institutions?
2. How can countries best strike a balance between reform introduction and available capacity?
3. How to ensure strengthened policy and planning capacity including legislation and regulation?

Session X: Investments and Incentives to Ensure Quality and Increase Efficiency

Quality is a critical component of the health service arm of UHC. Expanding health services as part of the strategy towards UHC is of limited value if services are not of high quality. Moreover, services cannot be expanded and quality improved without the availability of appropriate inputs including human resources, infrastructure, and medicines and other medical products, as well as the effectiveness of regulations to incentivize and enforce proper service delivery. In many countries, these challenges are complicated by large and fragmented provider markets, including growing private sectors.

1. How can countries achieve an appropriate human resource balance throughout a country?
2. How can countries incentivize providers so that they have the capacity and are motivated to provide high quality services?
3. How can implementers ensure the availability of high-quality health systems inputs?
4. How can countries and implementers regulate service quality?
5. How can countries best engage with, incentivize and monitor, the private sector?

A note about Annexes 1-V

Please note that Annexes I-V below are roughly organized according to the six WHO health system building blocks[13], while the Bellagio meeting agenda covers issues that cross the different themes. As a result, readers should not expect a one-to-one correspondence between these five annexes and the outline of each of the sessions in the meeting agenda.

Annex I: What are countries doing to set and expand guaranteed services?

Countries face a broad array of challenges in health service provision: they must decide which populations to cover (all vs. targeted groups), determine which health services are guaranteed, cost these guaranteed services, implement mechanisms to ensure that service provision is as efficient as possible, and address issues of fragmentation (different populations receiving different services) that are commonly a part of the pathway to UCH.

Decisions about which services to guarantee depend considerably on each country's specific circumstances. These decisions are often based on a combination of factors, including (i) the country's historical realities, (ii) its current, evolving and projected epidemiological profile, (iii) the desires of the population, (iv) the available and likely future resource envelope, and (v) the political environment.

In this section we discuss:

- Determining populations to cover
- Defining services to guarantee
- CEA and ECEA
- Ensuring value for money
- The reality of fragmentation

Here, we lay out the evidence on what countries are doing in terms of setting and expanding service coverage, defining and costing services, ensuring coverage goals are met, ensuring value-for-money, and avoiding fragmentation. We have opted to use the term "guaranteed services," rather than the traditional term "benefits packages," as the latter is often interpreted too narrowly, focusing on insurance and treatment, and excluding population-wide services, such as vital health promotion and prevention activities. In contrast, "guaranteed services" refers to the set of services (health promotion, prevention, and/or treatment) that a government has committed to providing for its population.

[13] The six building blocks are: service delivery (Annexes III and, to some degree I, in this document), health workforce (Annex V), information (Annex V), Medical products, vaccines & technologies (Annex V), financing (Annex II), and leadership/governance (Annex IV). For more on the six building blocks, see WHO 2007: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

Determining which populations to cover (initial and expansion)

Resources for health are finite, and difficult decisions must be made about how to best use resources in the purchasing and delivery of care. Whether provision is primarily public or private, or some combination thereof, countries must seek to ensure resources are used effectively and efficiently, taking into account equity considerations.

Countries have taken different approaches to setting initial sets of guaranteed services and expanding population and service coverage. One of the more common forms of targeting is determining coverage by employment status. This is particularly true in countries where social health insurance began by covering formal sector employees. Other countries have targeted more limited population groups, such as by geographic location (in the case of Zambia, people living in rural areas) (Lagarde et al 2012), or by health priority (e.g. pregnant women and/or children under 5 years of age) (Yates 2010). The theory behind these approaches to targeting is that they may, in the short run, ensure more rapid health and financial protection for those who need it most (Nicholson *et al*. 2015). However, a consensus is emerging that targeting the poor may *not* be the optimal route in many settings: in the longer run targeting often leads to fragmentation, which is inefficient, increases inequity, and can create barriers to further expanding covering (Nicholson *et al*. 2015). Additionally, there is apprehension that targeted schemes may provide poorer quality services, and incomplete coverage, giving rise to a phenomenon whereby "services for the poor become poor services" (Reddy 2013).

In countries that target the poor a "missing middle population" is often excluded from service coverage. This "missing middle" includes people – often informal sector workers – who are not poor enough to be covered by publically subsidized schemes, nor wealthy enough to purchase private coverage on their own. The assumption has long been that this "middle" population will voluntarily join private voluntary or social health insurance schemes. However, there is growing evidence that they do not join such schemes. Belonging to a voluntary scheme requires regular out-of-pocket payments that households are often not willing to forgo (Chuma *et al* 2013). In addition, service quality may be so poor as to deter participation in these schemes, or services may be inaccessible, taxing households with indirect costs of transport and lost work time. Therefore, unless services are heavily subsidized (or insurance is compulsory), this middle group typically purchases services directly based on need.

Other countries have chosen to expand coverage gradually to poorer populations as more resources become available. The major challenge with this approach is that many countries have hit a "coverage wall": coverage rates stubbornly hover at around 60-70% in Indonesia, the Philippines and Vietnam, and are considerably lower in Ghana (35%) and Nigeria (5%) (Nicholson *et al*. 2015). In these settings, populations with insurance coverage (likely more

politically engaged than the uninsured) may influence policymakers, providing them with little incentive to support the expansion of benefits to un-covered populations. In Rwanda (Nyadekwe *et al* 2014) and China (Yip *et al* 2012) the "coverage wall" was successfully overcome through injection of large sums of public funding, yet other countries struggle with overcoming the coverage expansion challenge. Covering all population groups can remain a challenge even in settings where large sums have been committed (see example in Box 3).

To address the challenges associated with targeted (e.g. quality concerns, fragmentation), and gradual expansion (e.g. lack of coverage for informal sector and middle income) approaches, Nicholson et al. (2015) recently suggested that achieving full population coverage from the outset, with a smaller package of services, is preferable to "covering selected population groups with more generous packages of services and leaving some people relatively uncovered".

Guaranteeing service coverage on paper however does not mean everyone is reached, and economic growth is not a sufficient – or even necessary – condition to ensure coverage. Ideally countries should measure *effective coverage levels,*[14] for both health areas and interventions, to identify equity gaps and potential barriers to coverage.

Box 3: Covering Migrant Workers

Expanding health insurance coverage to migrant workers poses a challenge in many settings. Despite large influxes of public funding to subsidize populations and massively expand insurance in recent years, Chinese migrant workers country-wide do not y*et* all reap these benefits. This is because they are most commonly insured through the insurance entity covering their home (usually rural) territory, rather than the urban setting where they reside and work (Yip WCM *et al*. 2012). This situation is beginning to change, as cities have begun to allow migrant workers to join city-based schemes; in some cases cities have established migrant-specific programs (Mou *et al*. 2009, Zhu *et al*. 2008).

Defining which services to guarantee (initially and as part of expansion)

Defining guaranteed service coverage is a policy mechanism to explicitly[15] prioritize[16] expenditure on health (Glassman and Chalkidou 2012). By elaborating the inclusion and/or exclusion of services from the package, countries commit to ensuring that specific services are financed and are accessible to their populations.

[14] Defined as the proportion of the population who needed a service that received it with sufficient quality to be effective (Shengelia *et al*. 2005).

[15] Most countries still use the less equitable process of implicitly rationing health services (Glassman and Chalkidou 2012).

[16] This most commonly is done via tools such as essential medicines lists and/or health benefit plans; at least 64 LMICs have established an explicit negative and/or positive package (Glassman and Chalkidou 2012). Increasingly in middle-income countries, technological assessment agencies are playing a central role in explicitly determining which services to guarantee for all (ibid).

The World Health Organization (2014) defines three elements to consider when deciding which services to cover: cost-effectiveness, priority for the worst-off, and FRP. Nicholson et al. also highlighted the importance of reducing inequality when determining service packages (2015); while the World Bank includes a strong emphasis on public health program investment and primary health care principles (2014). Cost-effectiveness analysis frequently suggests that health promotion and prevention are good buys, but political reality, however, often leads countries to first cover treatment services, given the high visibility of such services (D Evans, personal communication). Support for at least some vital health prevention and promotion activities often follows. Rehabilitation and palliation services are commonly not included.

Economic growth can be an enabling factor for service expansion in that growth can allow health spending to increase. However a recent review by the World Bank (2014) found no evidence that economic growth has been accompanied by a greater government commitment to health. Additionally, increased resources for health do not necessarily translate into increased service utilization by the poor. Often, increased spending on health is accompanied by increased demands by the population, and resource allocation decisions may become more susceptible to wealthy populations and interest groups (Glassman and Chalkidou 2012). While a stronger population voice in priority setting is welcome, it is important that this voice be truly representative of the population.

As a result of these many considerations, countries often make context-specific decisions about which services to guarantee. A recent review of 25 countries undertaken by Nakhimovsky *et al.* 2015 found that countries are taking country-specific evidence[17] into consideration when determining which services to guarantee. However, what is lacking in most settings (with a few notable exceptions primarily from Latin America) is documentation of how countries are applying evidence and the quality of that evidence. In addition, and particularly in low-income countries, there is a need for more evidence applied to local contexts; to be useful this evidence can be generated at the local, regional or global levels.

CEA, ECEA, and ensuring value for money

Economic evaluations provide decision makers with information on the tradeoffs in resource costs and public health benefits involved in choosing one intervention over another. The most

[17] Nakhimovsky *et al.* 2015 consider how evidence can be used to design health benefits packages that improve equity, efficiency, and FRP. Examples of "evidence" include (for equity impact): disease burden data, utilization data, monitoring and evaluation data, cost-effectiveness data; (for efficiency impact): cost-effectiveness data, unit costs of services by facility; and (for FRP impact): household out-of-pocket spending and data on willingness to pay.

popular method has been cost-effectiveness analysis (CEA – see Box 4), which simultaneously evaluates the outcomes and costs of interventions designed to improve health. Cost-effectiveness analysis is one important tool for improving the efficiency of health service delivery. Economic evaluations, along with research on safety, efficacy, and effectiveness are crucial inputs for assessing health technologies and interventions for use in low-resource settings. CEA enables program planners to allocate resources to those interventions with the greatest impact on the burden of disease, ultimately improving human and social development in low-resource settings. Evidence of cost-effectiveness can also support advocacy activities.

Box 4: Cost-effectiveness analysis

CEA compares the costs and outcomes of two or more alternatives or compares a new intervention or treatment with the status quo. CEA relates the incremental costs with the net health gain, which is often expressed as a cost per life year gained or cost per death averted.

However, whether and how CEA is used in decision-making depends on both politics and health system capacity and structure. Often, CEA is only one of many considerations influencing health policies and programs, including awareness of the burden of disease, political will to address the problem, and access to financial resources to support long-term interventions. In some cases, CEA can be at odds with popular demand: for example, some countries prioritize the elderly, while CEA would suggest investment elsewhere (J. Bump, personal communication). LMICs often prioritize the young, with an emphasis on communicable diseases. Many countries, and sometimes donors, are reluctant to give NCDs the emphasis that others would argue they deserve (see Box 5). The same can be said in many settings for geriatric, and also, care.

Box 5: LMICs must tackle the growing NCD challenge

LICs and MICs will need to expand their capacity to address emerging challenges associated with aging populations and the increasing incidence of NCDs, while still struggling to reduce the prevalence of communicable diseases and maternal and neonatal mortality. In sub-Saharan Africa, the youngest continent in the world, people who live to 60 years of age can expect to live an additional 15.7 years for men and 17.2 years for women, an increase of 1.5 years and 1.7 years for men and women respectively from 20 years ago (Mathers *et al*. 2015). Living longer exposes people to risks of NCDs, with multiple morbidities in older age. NCDs are not only a growing problem of the aging; we increasingly see very high rates of obesity and diabetes in young populations around the world. The costs associated with treating these diseases can rapidly overwhelm health systems that are still developing, and urgent attention needs to be paid to developing health promotion and prevention programs targeting NCDs in LICs and MICs before it is too late.

Evidence suggests that countries are increasingly using CEA (Nakhimovsky et al 2015), although there is also evidence from some countries, including Colombia and Uganda, that CEA findings are not always incorporated into decision-making where there is political pressure to the contrary (Giedion *et al.* 2014; Kapiriri 2012).

Traditional CEA also has limitations. By capturing incremental costs and benefits to an existing system, it may not capture potential synergies between interventions and does not always capture cost efficiencies. CEA does not assess whether a scaled up intervention is affordable and may not take into consideration health systems constraints (e.g. lack of health workers) to determine whether implementation is feasible. Thus, CEA should be conducted alongside evaluations of affordability and feasibility.

Traditional CEA also does not measure an intervention's impact on equity and FRP. Extended cost-effectiveness analysis (ECEA) is a new approach that measures both the health and the financial protection benefits of one or more interventions, assessing the distributional costs and benefits of the intervention (Jamison *et al*. 2013). ECEA analyses can be helpful to decision-makers because they reveal the financial versus mortality trade-offs between investing in different interventions. Sometimes the interventions that avert the most deaths may not be the same as those that provide the most financial risk protection. For example, a recent ECEA analysis in Ethiopia found that of the three interventions that avert the most deaths, only one (caesarean section surgery) coincided with the three interventions that avert the most cases of poverty (Verguet *et al.* 2015).

In addition to focusing on specific interventions, new information on the cost-effectiveness of different types of delivery platforms, such as clinic-, hospital-, community- or outreach-based strategies will contribute evidence on which service delivery strategies are likely to have the greatest reach and impact at the lowest cost. There is general consensus that good value for money can be achieved by emphasizing primary care and community services, as well as some district hospital services (Jamison *et al*. 2013; Nicholson *et al*. 2015). Examples of the former include Ethiopia's community-health worker scheme (Crowe 2013), and China's barefoot doctors (Weiyuan 2008), both of which contributed to impressive population health gains at relatively low cost.

The reality of fragmentation: guaranteed services may differ by population.

We use the term "universalism" somewhat loosely, to mean "everyone covered." This does not necessarily mean that all people are in the same pool, paying the same premiums and co-payments, and accessing the same services. Instead, the reality in several countries that have made great progress towards UHC (e.g. Mexico and Thailand) is "fragmentation" in which different populations are covered by different schemes, may contribute different amounts, and may be guaranteed a different set of health services. Such fragmented systems may be more costly, and can be inequitable. Nonetheless, including the poor in with at least one mechanism is a move towards improving equity; even in cases where the poor do not have access to as extensive a service package as wealthier populations, they are able to access services they

previously received only through out-of-pocket payments. Some countries have a longer-term vision to reduce or eliminate fragmentation, and with it, inequality. Thailand, for example, has a goal of merging its three existing health insurance schemes (the social security scheme, the civil servants' medical benefit scheme, and the universal coverage scheme (Evans *et al*. 2010)); however to date, this has been politically challenging. It is also possible for governments to play a risk-equalization role between the different schemes, effectively ensuring greater government subsidies go to the scheme covering the poor.

Annex II: What are countries doing to develop health financing systems?

In this section we discuss:
- Raising funds
- Pooling risk
- Using funds efficiently
- Considering equity

To facilitate a move to UHC, the health financing system must raise funds, develop forms of pooling to spread financial risks across the population, and develop efficient ways to pay for health services. Any set of essential and "guaranteed" health services will not be available if there is insufficient funding or insufficient inputs to provide them. Even where essential high-quality health services are available, many people will not be able to afford them unless funds for health are pooled to spread the financial risks associated with getting sick and needing to pay for health services. The need to ensure that the financing system is equitable is an additional concern, covering all of the three other requirements. Each of these requirements is discussed briefly below.

Raising funds

All countries struggle to raise sufficient funds for health, with four key factors stretching financial resources: 1) increasing population demands for health services, 1) population aging, 3) the growing burden of chronic diseases, and 4) the continuous development of new, often more expensive, ways of extending life or improving its quality. The greatest pressures on funding are felt in LICs and MICs, which not only have fewer resources but also face the greatest health needs.

It is possible to quantify the absolute shortage of funds in these settings using estimates of the amount required to ensure universal coverage with even a minimum set of health services. Various estimates have been made. While average figures do not reflect the requirements of individual countries, they can provide some idea of the current shortages in low-income settings. For example, analysis for the High Level Task Force on Innovative International Financing for Health Systems suggested that a typical country would require US$60 per capita by 2015 (in 2009 prices) to ensure coverage with a set of services that included essential interventions linked to the MDGs, and a limited set addressing NCDs (WHO 2010).[18] This estimate has recently been updated to $86 per capita in 2012 prices (McIntyre and Meheus 2014).

[18] This was the unweighted average across countries, not the weighted average reported in most of the Task Force documents. This unweighted average gives a better representation of what a "typical" country would need to spend.

Average per capita health spending in LICs in 2013 was only $41.70.[19] This amount includes all sources of expenditures on health, including direct out-of-pocket payments, government spending and the contributions of external development partners. Although LMICs spent an average of $149 per person, 10 of them still spent less than the $86 per capita proposed.[20] The $86 per capita estimate is the lower bound of a more realistic estimate, as it is based on the assumption that nothing would be spent on interventions outside the essential package, and that all funds are spent efficiently. Financing a complete set of services of good quality and with high levels of FRP would cost more like the current levels of expenditure in high income countries, which averaged over $3,000 per capita in 2013.[21]

GH2035 estimated that, to achieve convergence, an additional $23 billion per year would be required from 2016-2025, and an additional $27 billion each year to 2035 (in the 37 low income countries using the 2011 World Bank classification) (Jamison *et al. 2013*). For the 48 countries classified as LMICs, using the 2011 World Bank classification, the estimated costs of achieving convergence would be an additional US$38 billion per year in 2016-2025, and an additional US$53 billion per year in 2026-2035.

There are realistic options for raising additional funds domestically in all settings: (i) out of pocket payments by people who use services; (ii) health insurance premiums paid by people, companies or government; (iii) taxes and other charges collected by government; and (iv) contributions from charitable organizations and/or charitable donations from individuals. We focus on raising domestic funds here – however, contributions from external development partners are an additional option.

- **Out-of-pocket payments** where everyone pays the same amount for a service are inequitable and regressive. They also deter some people from using needed services. There is an ongoing debate about whether out-of-pocket payments should be eliminated entirely for everyone; most high-income countries still require some direct financial contribution for the health services that people receive. There is, however, broad agreement that payments need to be zero or very low for the poor and at a more macro level, WHO has argued that the incidence of financial catastrophe will not fall to negligible levels if total out of pocket payments exceed about 15-20% of national health expenditures.[22] The average in low-income countries remains much higher at 42% in

[19] Unweighted average – simple average across the countries. See http://apps.who.int/nha/database
[20] http://apps.who.int/nha/database
[21] http://apps.who.int/nha/database
[22] This is the level at which the incidence of financial catastrophe linked to out of pocket payments is observed to more or less disappear. It is an aggregate. Countries that raise less than 20% of their total health expenditures from out of pocket payments do not seem to have any financial catastrophe.

2013, and in 12 (of 31 countries) the proportion was above 50%.[23] Certainly out-of-pocket payments should not be used as the main mechanism to raise additional money in most LICs and MICs, where the priority is to reduce reliance on out-of-pocket payments.

- **Insurance Premiums:** Decreased reliance on forms of direct payments, including out-of-pocket payments, requires increasing the amount of revenue from forms of prepayment.[24] Insurance premiums can be paid by households directly or through wage deductions and contributions paid by employers. No national health insurance system now relies solely on wage-related deductions/contributions: even in high-income countries as populations have aged, the proportion of people in wage employment has fallen and wage deductions have had to be increasingly supplemented with general government revenues.
- **Taxes and other charges:** There are many options for raising additional government revenues, at least some of which can be used for health.[25] Briefly, income and company taxes are levied in virtually all countries – although with varying degrees of efficiency – as are indirect taxes such as value added taxes (VAT), or specific taxes on items such as alcohol, tobacco, telephones or their use, and imports and exports of various sorts. Thailand has used some of this general government revenue, supplemented by income from increased tobacco and alcohol taxation, to fully fund its Universal Coverage Scheme as well as to ensure sufficient levels of population-level health promotion and prevention. Ghana increased VAT rates specifically to provide funding for its health insurance, while Mexico has just introduced a tax on sugary soft drinks to not only raise additional money but also to improve health by lowering sugar consumption.[26] Governments can also increase revenues by including more contributors or different types of taxes/charges, and by improving the efficiency of government revenue collection. This has been done successfully in countries as diverse as Indonesia and Uganda, raising substantial new funds (Elovainio & Evans 2013).
- **Increasing share of health spending:** Many counties could also increase the share of government funding currently allocated to health. On average, just over 10% of total government spending in sub-Saharan Africa in 2013 was on health.[27] In South-East Asia, this percentage was even lower at 8.3%.[28] While there is no clear evidence on exactly what proportion of government spending should be directed to health, in 2001 the

[23] http://apps.who.int/nha/database

[24] Excluding charitable donations from the discussion because they are small.

[25] For more detailed description of these options, see WHO 2010, Elovainio & Evans 2013

[26] See the report in *The Guardian* at www.theguardian.com/world/2014/jan/16/mexico-soda-tax-sugar-obesity-health

[27] http://apps.who.int/nha/database

[28] http://apps.who.int/nha/database

heads of state of the African Union in the Abuja Declaration felt that 15% was an appropriate level – since then almost as many of the signatory countries have moved away from that target as have moved closer to it. Ten years after the declaration, in 2011, only 6 signatory countries had met this target.[29]

Pooling to spread financial risk

People who contribute to the pool (or whose contributions are made by a third party such as government or an employer) are able to draw on the pooled funds to obtain guaranteed services (including prevention and promotion, not only treatment). People who do not use pooled funds still contribute, and receive the benefit of peace of mind that the funds are there should they need to use them. Effectively, the healthy subsidize the costs of the sick in the long run. Most pooling schemes develop contribution systems that are progressive so that the rich also subsidize the poor. Government revenues, some of which are used to provide or fund health services, serve the same purpose as prepayment and pooling, as are health insurance funds.

This is the big picture. At the implementation stage, many practical questions emerge:

- Should a separate fund for health (e.g. insurance or for health promotion) be established apart from general government revenues, as in Ghana? If a separate fund is established, should it be a single fund or multiple, perhaps competing, funds along the lines of Holland?
- If so, how should contributions be established – by individuals or by families, linked to income or to wealth, paid by beneficiaries, by employers, by government or a mix of the three? What financing role might donors take on – would they pay into an insurance system rather than financing specific services, as the Global Fund did in Rwanda?
- Should membership be compulsory? How can adverse selection be prevented, where members (e.g., those in poorer health or at higher risk of illness) who will use more services than average are more likely to enroll in health insurance?
- What form of management, control and regulation should be introduced for the fund(s) – within the ministry of health, ministry of labor, semi-government authority, totally independent? What are the rules of the game, should new laws be enacted, do existing laws constrain the ideal operation? How to prevent cream skimming (funds enroll only low-risk individuals): with multiple funds, how to ensure and equal playing field perhaps requiring some form of risk equalization?

[29] Rwanda, Botswana, Niger, Malawi, Zambia and Burkina Faso; see http://www.ppdafrica.org/docs/policy/abuja-e.pdf

Using funds efficiently

The 2010 World Health Report (WHO 2010) estimated that between 20% and 40% of health resources were typically wasted through various forms of inefficiency – some of the most common related to medicines (paying too much, wastage and leakage in supply chains, medicines that do not work[30], under-use of generics), funding high-cost, low-impact health services when low-cost, high impact services are under-funded, and corruption and leakages. The incentives inherent in the health financing system can be important causes of inefficiencies or drivers of efficiency. Chief of these are the incentives linked to the way health services are purchased.

Purchasing in a system where the payer is also the service provider – e.g. where governments not only fund but provide health services – typically takes the form of purchasing the inputs that produce the services: doctors, nurses, and other health workers; medicines; beds and equipment; medicines and other medical products; laboratory reagents etc. Efficiency requires paying the right price for the inputs, ensuring they are used in the right combinations, ensuring the "right" services are provided, safeguarding against corruption and waste, and motivating quality.

Where the payer (e.g. government or insurance program) purchases health services as opposed to inputs, active or "strategic" purchasing encourages efficiency. This requires explicitly considering the costs and benefits of alternative packages of health services, where services should be made available, who delivers them, and the costs and incentives for efficiency and quality that exist in the alternative payment mechanisms potentially available.

Government purchasing is frequently fragmented – central medical stores purchase medicines, medical products and equipment of various types; staff are paid by the human resource department; capital works are financed separately, sometimes outside an MoH. Health facilities or lower levels of government are sometimes able to purchase, using resources they raise themselves or transferred from central government, but can be restricted to purchasing from the central medical stores. Changing from historical line item budgets that do nothing to encourage efficiency to forms of paying for results or outputs can be difficult, but Hungary and Romania are two countries that have recently had considerable success in doing so.[31,32]

[30] The term agreed between WHO Member-States is SSFFC (sub-standard, spurious, falsely-labelled, falsified, counterfeit).

[31] Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health system review. *Health Systems in Transition*, 2008; 10(3): 1-172.

[32] Mathauer I. and Wittenbecher F. DRG-based payment systems in low- and middle-income countries: Implementation experiences and challenges. World Health Organization, discussion paper No1/2012. Geneva. 2012

Governments and insurance programs also purchase health services directly from providers. Purchasing agencies are organized along the lines discussed earlier with the management of health insurance funds: as part of government, as semi-government authorities, as private entities. They might be centralized or decentralized. Thailand has a semi-autonomous purchasing body, which has been very successful in changing provider payment mechanisms for both inpatient and outpatient care as part of the universal coverage scheme.

Considering equity

Decisions about all three health financing functions – raising funds, pooling them, and using them to provider or purchase services – have implications for equity which need to be considered explicitly.

Raising funds requires decisions about who pays and how much, which is linked to practical considerations about how much can be raised through different mechanisms and social concepts of fairness and equity. Some taxes are more progressive than others, increasing the likelihood that the rich pay a higher proportion of their incomes than the poor – e.g. income taxes versus consumption taxes. Taxes and health insurance premiums can also be levied with varying degrees of progressivity or regressivity. Sometimes it is complex to evaluate overall equity in health financing contributions – in the Swiss case, for example, insurance premiums are regressive because individuals contribute the same amount (with some adjustment for family size). However, the Swiss who cannot afford to pay the premiums can apply to be subsidized from general government revenues, and the income and wealth taxes that are contributed to government revenues (though not some other forms of taxation) are progressive. Looking at only insurance contributions can be misleading.

With **pooling**, who is eligible to receive benefits from the **pooled funds** is critical. Some insurance programs cover only individuals (i.e. the policyholder), not their families who must be covered in other ways. Other programs cover individuals and their families, although often with a limit on the number of family members who can be covered, and with some additional contributions based on the size and composition of the family.

In terms of purchasing, equity considerations are related to the question of what services are purchased or provided. For example, are the guaranteed services focussed on health risks and problems affecting the poor? Is there sufficient funding set aside for promotion and prevention, and other activities that affect the poor disproportionally?

Although concepts of fairness undoubtedly vary, the principle espoused here is that people should pay according to their abilities and receive benefits depending on their needs. Even this

principle permits considerable variation across countries – e.g. what degree of progressivity in payments is fair?

In conclusion, although this discussion on financing has followed the traditional approach of discussing the three functions of health financing separately, it is how they are put together that is critical. No two countries make the same choices in all of these areas, so no two countries are identical, yet it is the combination of choices made on these components that determines equity and efficiency, and the speed of progress towards UHC.

Health financing decisions are inherently political, so while there is increasing consensus on some of the more macro "what" questions (e.g. out of pocket payments need to be reduced in many countries), there are many practical decisions countries have taken and need to take to implement them; decisions that are moderated by political realities. Mutual sharing of what decisions were possible in different settings – e.g. how many insurance funds were established, how they were governed and regulated, what changes to provider-payment mechanisms were made – and how countries obtained political, professional and public support for these processes, would be enormously useful. Box 6 below outlines some generic steps that need to be taken in developing and implementing these policy options.

Box 6: Possible steps to improve health financing

- Develop the necessary information on which to base decisions. This covers questions such as: how much is currently spent on health, by whom and on what; who obtains the health services they need and who does not; who is currently covered by the different forms of prepayment and pooling (including government service provision), who misses out and why; the extent of financial catastrophe and impoverishment due to out-of-pocket health payments, and the characteristics of the people most effected; the sources of inefficiency and their possible costs (to help identify which are the most important ones to act on first).
- Identify the technical solutions – for raising additional funds (including who pays how much); for prepayment and pooling; for reducing inefficiency and increasing equity.
- Map out possible supporters and opponents of the best options and develop and implement a plan to strengthen support and minimize opposition;
- Engage with ministries of finance, heads of state, politicians, civil society and other interest groups in the language they speak and understand.
- Identify supporters and opponents of change for each option, and elaborate a plan of action for developing the necessary support.
- Identify where legislation or regulation needs to be repealed or strengthened.
- Develop a strategy for monitoring and evaluating the impact of implementation and modifying strategies as necessary.

Annex III: What are countries doing to ensure high-quality service availability and delivery?

Access to quality services is essential to achieve UHC. As *GH2035* notes: "Access to services alone, without protection from financial ruin, provides an empty promise". Similarly, there is little value to insurance or peace of mind in providing FRP alone without access to quality services" (Jamison *et al.* 2013).

In this section we discuss:

- Service availability
- Service use
- Continuity of care
- Barriers to service access
- Roll of non-governmental sector in service provision

This section is about ensuring that the health services that help people to promote and maintain health are available, are of good quality, and are used by the populations that need them. WHO argues that service delivery "is concerned with how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time" (WHO 2007). We extend that definition here to barriers to using these services that are not associated with the questions of financing raised in the last section.

Ensuring service availability and use

Ensuring the availability and use of needed health services involves many interdependent decisions. First **what services** (from promotion to palliation) should be available to meet population needs and system constraints? Secondly, how can countries best reorient their health care delivery model to develop and implement **people-centered services**? Patient-centered care is commonly understood as addressing the needs of the individual seeking care. People-centered care "encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services."[33] Services for one disease or health problem should not be planned in isolation. A focus on the person – not disease complexes – is critical, but frequently difficult to achieve in the face of vertical funding flows or historical organizational structures. In addition, decisions about service availability cannot be taken separately from decisions about ensuring the strength of the health workforce and availability of essential clinical supplies and infrastructure. This is discussed in more detail later in the HSS section.

[33] WHO - see www.who.int/healthsystems/topics/delivery

Ensuring continuity of care

Countries must also strive to ensure **continuity of care:** over the continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services; throughout the life course; and across the various levels of care (e.g. primary care to tertiary hospitals, between public and private providers). Organized provider networks, with appropriate referral systems with clear rules, are important, as are decisions about integration across delivery platforms.

Even though many types of health promotion and prevention are very cost-effective, there is constant pressure to focus service delivery on clinical care. Continued vigilance to ensure sufficient resources (not just finances) for promotion and prevention is needed. When funds are short, these services are relatively easy to cut because the public does not notice their absence immediately (unlike clinical services).

Barriers to service access

Even if services are available where they are needed, people might not use them. Many barriers prevent people from seeking not just treatment but also prevention (e.g. screening for cancers) and curative services. Moving towards UHC requires addressing the main barriers that prevent people, particularly the poor and vulnerable, from using services.

Financial barriers are common, including those linked to out-of-pocket payments, transport, accommodation and food, and lost work time. Barriers can also be linked to gender (e.g., in some countries women cannot travel without a male escort), ethnicity (particular ethnic groups may not be treated with dignity and respect by health workers or may be excluded from becoming health workers), and social or educational status. Box 7 below provides some examples of mechanisms to address demand-side barriers.

Box 7: Addressing demand-side barriers to service access

There are many ways to address demand-side barriers. Cash transfers, both conditional and unconditional, not only reduce poverty but also encourage people to undertake particular health behaviors (e.g. Robertson *et al*. 2013). Conditional cash transfers seem to work best when focusing on preventive behaviors such as having children immunized, but there is little high quality evidence on their relative costs and effectiveness compared with other ways of achieving the same goals (Ranganathan & Lagarde 2012). Vouchers have also been used to overcome financial constraints. These have been used in a variety of programs ranging from the distribution of insecticide-treated mosquito nets in Tanzania to paying for skilled birth attendants to attend the home deliveries of poor women in Bangladesh. Vouchers seem to have had positive impacts but, as with conditional cash transfers, their cost-effectiveness and their long-term benefits on health have not been rigorously assessed (Bellows, Bellows and Warren 2011). In some countries ensuring that female health staff are available, particularly in clinical encounters with females, reduces gender-related barriers. On the other hand, in some countries it has proven to be difficult to post single-female staff to areas where their personal safety is at risk, so improving security for all health workers, particularly females, is an important step.

Role of the non-governmental sector in service provision

Countries must balance the appropriate role for the public and non-governmental sectors (NGOs, faith-based, private non-profit, private for-profit) in service delivery, including in health promotion and non-personal services such as laboratories, medical products, cleaning and catering services. Quality in the non-government sector ranges widely, from “state of the art” facilities to unlicensed medicine vendors. In many settings government regulatory capacity is weak. Governments must expand their capacity to legislate, regulate, and set and enforce quality standards good quality within the non-government sector, which has commonly expanded more rapidly than government’s capacity to oversee and monitor.

There is no particular evidence that the non-government sector is any more or less efficient than the government sector with hospital management, the area where most research has been done (WHO 2010). The relative efficiency varies by country. Countries that have moved most successfully towards UHC have taken a pragmatic approach to expanding service availability by assessing what mix of government and non-government services makes most sense in their settings, and ensuring government has the capacity to set, incentivize and enforce quality standards everywhere. Box 8 below provides some guidance on steps that countries can take to improve service availability and delivery.

Box 8: Possible steps to improve service availability and delivery

- Seek to involve all of the "vertical" health programs in development, review and modification of national health plans, policies and strategies, to avoid programs developing plans in isolation. Only then does it become clear what is feasible and what is not feasible in terms of health service delivery.

- Use planning tools, such as the OneHealth Cost and Impact Tool which estimates costs and impacts of scaling up disease-specific programs and health systems, to identify the constraints to implementing all the program-specific plans and strategies at the same time (see http://www.who.int/choice/onehealthtool/en/)

- Engage external partners in this process, to ensure they buy in to the country's plans rather than try to push for their own agendas.

- Develop dialogue with civil society groups to help understand the population's expectations when planning and implementing health services. This dialogue needs to be at the facility level as well as the broader planning levels. This process should be broad-based representing all of the community's needs.

- Ensure that plans to improve FRP go hand in hand with plans to improve the availability and/or quality of needed health services and that the pace of change in the former does not get ahead of the latter.

- Thoroughly review legislation and regulations and other incentives and disincentives for quality and safety by government and non-government providers if this has not already been done. Ensure the capacity to encourage and enforce safety and quality.

- Do not forget to consider the availability and quality of the inputs to health services – medicines and medical products such as blood, diagnostics, equipment, infrastructure, materials (for health promotion and prevention), and health workers. The sub-systems need to be in place and working well for the end product – the health services – to be in place and working well. Special legislation or regulation might be needed – licensing doctors and other service providers, accrediting hospitals, licensing medicines, medical products and equipment for import and use etc.

- Review the main barriers to people using services, if necessary with the help of local researchers. Develop appropriate responses based on the best available international experiences, adapted to the local setting. If health services are already known to be of such poor quality that people avoid them except when absolutely necessary, improving quality is an important first step.

Annex IV: What steps are countries taking to improve governance and management of the health sector?

In this section we discuss:

- Defining governance
- Governance challenges
- Strengthening governance
- Measuring governance

Poor governance and high levels of corruption are associated with poorer health outcomes as they often result in inadequate access to affordable and quality health services (UNDP 2011). Concerns about weak health systems, in particular the effectiveness of resource utilization and the quality and responsiveness of delivery systems, including control of corruption, have increased the focus on effective governance as a central feature of UHC. At the core of effective governance is the need to establish a strategic direction that policy-makers can use to set policy priorities and choose appropriate policies and strategies for the finance and delivery of health services.

In this section we provide an overview of 1) the definition of effective health systems governance, including core dimensions and indicators, 2) major governance challenges in achieving UHC, 3) strategies countries are using to strengthen governance, and 4) approaches to measuring and monitoring governance.

Defining governance

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

Discussions of health systems governance focus primarily at the national level, in particular on the role of the public sector in effectively and efficiently using resources to deliver quality health services. Health governance is broadly defined as the set of rules that shape the interactions between policy-makers, healthcare providers, and service users and that determine the types of health policies implemented, the allocation and use of health resources, and the distribution of costs and benefits across populations (Brinkerhoff and Bossert).

Effective governance

This broad definition has been refined to include normative components that outline a definition of “effective” or “good” governance. For example, WHO (2007) defines governance as “ensuring strategic policy frameworks exist that are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.”

These definitions also include a set of outcomes that are expected of health systems: the *effective and efficient* use of resources to ensure that the health needs of a population are met while making the best use of resources; the delivery of high *quality* health services; and *equity* in the allocation of health resources, delivery of health services, and distribution of health benefits across society.

Dimensions of governance

Several key factors are considered essential for facilitating effective governance:

1. *Strategic direction:*[34] The long-term and strategic vision by which policy-makers can define policy priorities and the appropriate role for public, private, and non-governmental actors in health finance and delivery (e.g. open policy-making, clear process for identifying policy options and priorities for health spending).
2. *Leadership*:[35] The level of state leadership, capacity, and legitimacy (e.g. political will to advance health policy. state capacity to enforce rules and incentive structures to influence the behavior of health sector actors).
3. *Accountability:*[36] The mechanisms through which the public can hold key decision-makers (e.g. policy makers, financing institutions, providers) responsible for meeting health systems objectives. These mechanisms should apply across multiple elements of health systems performance (e.g. allocation and utilization of health spending, performance on service delivery targets, responsiveness to population needs).
4. *Transparency:*[37] The clarity of policy decision-making processes and the accessibility of information about implementation, particularly resource allocation and budgeting,.
5. *Fairness:*[38] The presence and extent of rule of law – the fair, equal, and impartial application of policies and procedures. And the control of both financial and non-financial corruption.
6. *Participation:*[39] The presence of a "consensus orientation," in which different interests are mediated with attention to the best interests of the group including the ability of communities and civil society to engage in decision-making, and the responsiveness of the system to community needs, as well as balancing consensus processes with the timeliness of implementation.
7. *Knowledge and information generation:*[40] The availability of the type and quality of

[34] See Siddiqi *et al.* 2009, Balabanova *et al.* 2013, Mikkelsen-Lopez *et al.* 2011, Kaplan *et al.* 2013 and Travis *et al.* 2002.
[35] See Balabanova et al. 2013, Travis et al 2002
[36] Brinkerhoff and Bossert 2008, Siddiqi *et al.* 2009, Mikkelsen-Lopez *et al.* 2011, Kaplan *et al.* 2013, and Brinkerhoff 2004
[37] Siddiqi *et al.* 2009, Mikkelsen-Lopez *et al.* 2011, and Kaplan *et al.* 2013
[38] Siddiqi *et al.* 2009, and Kaplan *et al.* 2013 and Lewis 2006
[39] Siddiqi *et al.* 2009, Mikkelsen-Lopez *et al.* 2011, Kaplan *et al.* 2013 and Travis *et al.* 2002
[40] Travis *et al.* 2002 and Brinkerhoff 2004

health systems information required for priority setting, policy-making, and identifying and responding when goals are not met (e.g. research, public health surveillance, monitoring and evaluation, and policy analysis).

Major health systems governance challenges

Role of the public and private sector in health service provision

The private sector has grown rapidly and now provides a significant portion of care in many LICs and MICs (Forsberg et al. 2011). However, these markets have expanded more quickly than the regulatory and monitoring capacity of the public sector. While the private sector can play a complementary role to the public health system, there are also potential conflicts with the engagement of the private sector in health finance, for example in some countries where the strength of private insurers contradicts the interests of the public sector and challenges the establishment of national health insurance programs. Many countries also face additional questions regarding (a) the appropriate role of the public and private sectors, particularly the role of the public sector as a provider of health services or manager of plural health markets, (b) the appropriate policy and regulatory structures to ensure quality and affordability of health services in mixed health systems (e.g. licensing and accreditation functions), and (c) ensuring government capacity to legislate and enforce policies that align private providers and financing entities with public interests (Siddiqi *et al*. 2009; Vian 2008).

Leadership and technical capacity

Many countries face challenges in promoting health in national development agendas and in establishing and maintaining a strategic direction for health policy development and implementation (WHO 2013). Limited leadership and management capacity, together with insufficient human resources for effective delivery, undermine efficiency and state legitimacy (Brinkerhoff and Bossert 2008).

Participation and transparency

There is often insufficient capacity within the public sector to develop relationships and partnerships to effectively engage and negotiate conflicts between stakeholders, as well as a lack of incentives to develop such capacity (Brinkerhoff and Bossert 2008, Siddiqi *et al*. 2009).

Accountability and transparency

There is a need to increase accountability throughout the health system. This includes (i) the accountability of providers (e.g. through regulations and sanctioning mechanisms) and insurers (e.g. for cost and coverage targets) to the government, and (ii) the accountability of the government and the private sector to the population (WHO 2013, Lewis and Pettersson 2009). At the clinical level, information asymmetry between clients and health providers makes it difficult for citizens to hold providers accountable for the quality of health services – even in

richer countries. On the issue of government accountability to citizens, a major challenge is the lack of awareness about rights and/or low expectations of government that prevent civil society from effectively holding the public or private sector accountable. Further, the lack of clear and accessible information about health sector planning, policy, and financial management processes limits transparency and accountability, enabling corruption (Brinkerhoff and Bossert 2008).

Corruption

The wide range of actors participating in many diverse functions makes health systems particularly vulnerable to corruption. In addition, the asymmetry of information between different actors limits monitoring capacity, and therefore transparency and accountability (Vian 2008).

Regulatory strength and enforcement for financers and providers of health services

States often need to develop greater power and legitimacy, as well as stronger regulatory frameworks, to enforce performance of health sector actors. Such enforcement mechanisms include developing stronger purchasing policies to ensure purchase of generics and lower-price medicines, and setting appropriate incentives to improve provider practice and service mix (WHO 2013).

Knowledge and information

There is need for both more data and stronger use of data in health systems planning and health services delivery (WHO 2013).

Strengthening governance

Strategies used to improve the governance function of health systems include methods of control (e.g. laws and contracts), coordination (e.g. joint strategic planning, cost-sharing or resource pooling), collaboration (e.g. partnerships with civil society, inter-ministerial committees), and communication (e.g. satisfaction surveys, publicly available budgetary information) (Barbazza and Tello 2014). Strong leadership has translated into publicly-announced commitments to moving towards UHC in some cases (see Box 9). Below are some examples of key governance functions and tools that can be applied to facilitate them:

Strategic direction: Tools that can be used to support the development and maintenance of strategic direction in policy development and implementation include both planning tools, such as the creation of a national health plan, as well as implementation tools such as the creation and adoption of operational guidelines and protocols (Barbazza 2014). The collection and use of national health data in health system planning, including procurement and delivery processes, facilitates development of policies that respond to the needs of the country.

Knowledge and information generation: Information on health system needs, use and performance is required to inform effective policy-making. Tools for knowledge generation include periodic audits, public expenditure performance reviews, commissioned reports, health impact assessments, facility assessments and public surveys (Barbazza and Tello 2014).

Box 9: Getting UHC on the Political Agenda (and keeping it there)

Some countries have made very public UHC statements, setting explicit targets and timelines. Indonesia, for example, has committed to achieving UHC by 2019. During the 2014 Indonesian presidential campaign, then-Governor Jokowi made UHC central to his platform, promising an insurance card for each and every uninsured Indonesian, if elected president. Shortly after assuming power, now-President Jokowi acted on his promise and beginning insurance card rollout (funded by savings no longer spent on a fuel subsidy program)[1]. Vietnam has committed to rolling out UHC by 2020, and Bangladesh by 2032.

Accountability: Accountability tools include those designed to increase responsiveness and performance of providers such as performance standards and performance-based payment, licensing and accreditation, and stronger regulations and sanctioning mechanisms. Accountability tools can also strengthen the ability of non-government actors to hold the public sector accountable such as through public spending tracking surveys, routine auditing, and P4P mechanisms (Health Systems 20/20 2102, Chisholm and Evans 2010).

Control of Corruption: Several tools can be used to monitor and control corruption. These include the use of public expenditure tracking surveys, public expenditure reviews and routine auditing, and review of administrative and health financing data including budget records, health facility surveys, and National Health Accounts (Vian 2008; WHO 2008). One example of a tool for controlling corruption is the WHO's Good Governance for Medicine program. This program provides technical assistance to assess corruption in medicine registration, licensing and inspection of pharmaceutical companies, clinical trials, procurement and distribution. It also provides assistance in implementing a 'good governance in medicines' plan within the MOH that responds to areas of potential corruption within the pharmaceutical sector (WHO 2013).

Transparency: Transparency can be promoted by using systems for monitoring policy and implementation, such as through public audits, fact-finding commissions, or watchdog committees, and mechanisms for releasing the resulting information (particularly budgetary information) (Kickbusch and Gleicher 2012, Baez-Camargo 2011).

Participation: Tools that can be adopted to facilitate participation and collaboration across stakeholders include inter-ministerial forums (Kickbusch and Gleicher 2012), open meetings, public workshops, and national forums (Barbazza and Tello 2014). See an example from South Korea below in Box 10.

Box 10: Public Involvement in Health Benefits Packages Decision-Making in South Korea

A few countries actively engage their populations, both through informing/educating them about health care financing and service provision trade-offs, and through proactively soliciting their inputs to decision-making. For example, South Korea for example relies on "Citizen Committees" to collect population preference data about potential new services to include in the health benefit package. Committees have influenced decision-making: recently 9 of 13 additional services included in the HBP were added based on Committee recommendations (Oh *et al*. 2014). Importantly, the South Korean experience has shown that populations do not demand an infinite number of services; instead, once the realities of limited financing and the need for prioritization are understood, populations "may be willing to increase premium contribution to expand some, but not all, benefits when a deliberative decision-making process exists with access to information" (Nakhimovsky *et al*. 2015).

Measuring governance

Governments and health system leaders require information about governance in order to to improve governance systems and ensure the desired outcomes of quality, equity, and efficiency. Governance evaluation tools and indicators are commonly divided into four areas:[41]

- **Governance inputs or determinants:** Assess the policies and institutions that make up the health system, to provide an indication of how well the system is set up to facilitate effective governance (Savedoff 2011, Kaufmann and Kraay 2008). Evaluate the presence of specific policy instruments that indicate a strategic vision (e.g. a national health strategy, strategic plans for reproductive health, TB, or childhood immunization) (WHO 2008), the presence of policies designed to increase accountability and transparency (e.g. anti-corruption legislation, licensing systems, payment and accountability structures for health care professionals) (Savedoff 2011, Lewis *et al*. 2009), and the decision-making process in place (e.g. the level and types of partnerships established by Ministries of Health) (Baez-Camargo and Jacobs 2011).
- **Governance processes and performance:** Assess the implementation of the policies and systems in place to understand the gaps between expected and actual practice (Savedoff 2011), and provide insight into how policies may need to be reformed to improve performance (Kauffman and Kraay 2008). Indicators include (a) adherence to policy guidelines (e.g. the implementation of anti-corruption legislation) and (b) the

[41] See Savedoff 2011, Baez-Camargo and Jacobs 2011

effectiveness of incentive and regulatory systems (e.g. measuring the proportion of government funds that reach district-level health systems or the extent of informal payments users pay in order to receive services from the public health system) (WHO 2008).

- **Governance outcomes:** Assess how well health system policies result in the desired health system goals (Baez-Camargo and Jacobs 2011). Measures include, for example, the equitable distribution of health services across populations, the level of efficiency in resource use, and population health outcomes.[42]
- **Contextual factors**: Assess external factors that impact the type of governance structures that need to be in place and the enforcement of these (e.g. labor market indicators, socio-demographic data). For example, information on the share of public and private health providers, and the wage gap between sectors, can inform the type of regulatory functions the public sector will need to take on and the ability of the public sector to implement effective governance in human resources (Savedoff 2011).

[42] For additional indicators to measure and monitor governance see: World Bank, WEF, Transparency International, World Governance Indicators project.

Annex V: What other health systems strengthening (HSS) steps can countries take to move closer to UHC?

In this section we discuss:
- Human resources
- Essential infrastructure, medicines, and health technologies
- Quality improvement

Ensuring the equitable and efficient provision of high quality health services on the path towards achieving UHC will require a number of HSS efforts in addition to those described in the previous sections. In this section we discuss human resources, essential inputs (such as infrastructure, medicines, and health technologies), and quality improvement strategies.[43] Increasing coverage with financial protection and with health services (prevention, promotion, treatment, rehabilitation and palliation) is only possible if the people and other essential inputs are available, of good quality and in the right place. These services will only improve health outcomes if they are accessible and of high quality. As Kruk (2013) has argued: "Poor quality of care…will discourage people from using newly insured services or motivate them to seek private or specialized care, undoing the benefits of financial protection. Improvements in quality must go hand in hand with the expansion of access and financial protection."

Human resources

Efficient health service provision requires the right number, mix, quality (competency and regulation), and distribution of health workers that will meet the health needs of the population (Campbell *et al.*, 2013). Countries face a number of challenges to guaranteeing the adequate **availability, accessibility, acceptability, and quality of health workers**. First, large shortages of qualified workers result from the limited production of health workers, the international migration of trained workers due to growing demand in middle and high income countries, and the number of trained health workers who leave the profession or do not practice due to low pay and poor working conditions (Tangcharoensathien *et al.*, 2015, Kinfu et al. 2009). This is a particular challenge in Sub-Saharan Africa where health worker shortages and the limited availability of training programs are both severe (Hongoro and McPake, 2004). Second, poor quality and availability of health workers in primary health facilities and facilities in underserve areas result from the difficulties of recruiting and retaining qualified health staff (Cometto and Witter; Fulton *et al.*, 2011). Third, poor training and supervision, poor working conditions, and unregulated dual practice also result in low productivity and performance of the existing health workforce (Sousa *et al.*, 2013).

[43] The other WHO health system building blocks (financing, service delivery, and leadership/governance) have already been discussed in previous sections.

Poorly distributed health workforces also result in inequitable health service delivery. Urban areas have a higher health worker density than poorer, rural areas (Kanchanachitra *et al.*, 2011; Crisp and Chen, 2014), and there are often imbalances in the level of health worker training and health needs of the population (Chen, 2010). New human resources challenges are emerging with the growth of NCDs, requiring a greater focus on prevention and the provision of chronic care services at the community level (Beaglehole *et al.*, 2008; Samb *et al.*, 2010).

Practical lessons from experience

Several approaches and lessons emerge from diverse countries about how to train, recruit, and maintain a workforce that will meet the health needs of the population.

Health workforce training: Increasing the production of health workers to meet the growing demand for health services generated by expanded coverage is a priority for reaching UHC (Sousa *et al.*, 2013; Maeda *et al.*, 2014). Efforts to expand the health workforce need to ensure this includes the cadre and skills mix to meet the health needs of the population.

- **Focusing on primary care**: Building a primary care workforce through the use of community health worker programs can expand access in rural and underserved areas. Ethiopia's Health Extension Program has trained over 35,000 health workers to provide basic health services resulting in improvements in many health outcomes in rural and previously underserved areas (Maeda *et al.*, 2014). Thailand expanded the rural health workforce by increasing the recruitment of rural populations into the health professions (Lehmann *et al.*, 2008).
- **Focusing on health worker training**: In-service training is a particular point of contention where disease- or problem-specific programs often plan their health worker training in isolation from each other, resulting in staff spending a disproportionate amount of their time in training rather than performing their duties. The development and review of comprehensive national health plans and strategies, with the involvement of all key stakeholders, is one way of trying to address some of these issues. Pre-service training planning can pose challenges too, as it is often run out of the Ministry of Education, rather than the Ministry of Health.
- **Task sharing**: Task sharing can increase the efficiency of health services provision and ensure the availability of health workers to provide specific health services. Task sharing enables existing cadres of health workers to take on new service areas or creates new cadres of health workers that require less training or tailored training (Fulton *et al.*, 2011), which can expand accessibility to high need services in underserved areas (Crisp and Chen, 2014) while providing comparable quality as staff with higher qualifications (McPake and Mensah, 2008). For example Mozambique and Malawi were able expand access to essential services such as C-sections and HIV/AIDS care by training lay health

workers and non-physician clinicians in the provision of these services (Berman et al 2011, Pereira et al. 2007, Feldacker et al 2014).[44]

However, task sharing can be politically challenging, due to resistance from professional associations seeking to maintain their scope of practice. For example, medical associations in Brazil successfully limited nurses' scope of practice, preventing the implementation of some child health programs, and significantly shaping the overall availability of health workers (McPake and Mensah, 2008).

Recruitment and retention for a balanced skills and geographic mix in the health workforce

Simply increasing the supply of new health staff is insufficient to reach the staffing requirements needed to achieve UHC. Scaling up the workforce requires addressing labor market conditions, the working environment (e.g. availability of drugs and equipment, management and supervision), and health worker career progression opportunities to ensure the right distribution of health workers, as well as their retention (World Bank 2014; Lehmann et al. 2008). Countries have used financial, regulatory, and educational approaches to improving the geographic distribution and retention of health workers (World Health Organization, 2010).

- **Education**: Training health workers in rural health can increase the number of health workers interested in and prepared to serve in rural areas, and increase the rural health workforce (Araujo and Maeda, 2013). Many countries have either located medical schools in rural areas or added rural practice to medical training (World Health Organization, 2010). There is also a need to enact policies that better align health worker training programs with the health needs of the population, as well as policies that support absorbing newly trained health workers into the labor market (Sousa *et al.*, 2013).
- **Regulation**: Compulsory services and other regulatory strategies to improve the geographic balance of the health workforce have improved distribution, but at times are also associated with low retention and low motivation among providers (Araujo and Maeda, 2013). Countries are also taking different approaches to regulating dual-practice in public and private facilities. Indonesia legalized dual practice in an effort to expand health worker availability, while Turkey banned dual practice and increased public sector salaries to increase health worker retention (Maeda *et al.*, 2014).

[44] Mid-level non-physician health workers in Mozambique include *Tecnicos de Medicina Geral* and *Tecnicos de Cirugia*, clinical officers who provide medical and surgical services, respectively.

- **Financial incentives**: Financial incentives are effective for recruiting health workers, but there is little evidence on the impact of financial incentives on long-term provider retention (Buykx *et al.*, 2010). Countries have used incentives such as allowances or bonuses for rural services, as well as other benefits such as training scholarships or housing and transportation benefits (Lehmann *et al.*, 2008). The introduction of hardship allowances for service in rural areas dramatically improved the rural-urban distribution of physicians in Thailand (Tangcharoensathien *et al.*, 2013). Turkey also reduced disparities in the geographic distribution of health workers through the introduction of sliding scale bonus payments linked to the socioeconomic status of the districts in which health workers practice (Maeda *et al.*, 2014).
- **International policy and cooperation**: At a global level, the international community is working to support health worker retention through policies to discourage health worker migration from countries with health workforce shortages. In 2010 the World Health Assembly adopted the Global Code of Practice on the International Recruitment of Health Personnel,[45] which aimed to decrease out-migration from poorer countries by increasing training in richer countries. However, to date, the Code is not working as intended. A 2013 evaluation surveyed key informants from government, civil society and the private sector in Australia, Canada, the UK and the USA, the majority of whom reported low awareness of the code, and little impact of the Code on the policies and regulations in their countries (Edge and Hoffman 2013).

These strategies need to be accompanied by improved human resources management including stronger workforce planning, recruitment and hiring policies, employee relations and career development strategies, and appropriate human resources supervision. Many countries face significant limitations in this management capacity, especially at the sub-national level, which limits the successful implementation of the above strategies (World Health Organization, 2010).

Essential infrastructure, medicines, and health technologies

In addition to human resources, health systems require additional inputs – such as high-quality diagnostics, medicines, health technologies, and health delivery infrastructure – to ensure effective and efficient health care delivery.

Users of health services prioritize these inputs in making determinations about where to seek care, making them essential to increase population confidence in the health system and increase health services utilization. For example in South Africa, users " prioritize medicine

[45] http://www.who.int/hrh/migration/code/practice/en/

availability above many other service attributes, including human resources and the state of healthcare facilities" (Nicholson *et al* 2014, Honda *et al* 2014). Expanding the availability of high-quality affordable medicines can also be a tool to bring people into the public health system: in India, for example, introduction of 324 free generic medicines in Rajasthan resulted in a near 50% increase in public health facility use (Joychen 2013). Prime Minister Modi plans to take this initiative further, announcing in 2014 plans to roll out the scheme throughout the country (Chauhan 2014).

Quality improvement

Health service quality is a key objective of a health system and is often considered a third goal of UHC (alongside improved health outcomes and increased financial risk protection) (Kruk, 2013). Nonetheless, the quality of care in many LICs and MICs remains very low (Berendes *et al.*, 2011). It is critical that services are safe and of good quality – and perceived by the population to be so. Reforms meant to improve the health sector can be challenged when service quality does not improve (see examples below in Box 11).

Health service quality is determined by several main factors:

- The availability of appropriate inputs, such as facility infrastructure, medicines, equipment and supplies, and staff
- Provider behavior, including both technical competency and inter-personal skill (Dayal and Hort, 2015).
- The strength of management and supervisory capacity at the facility level, including the presence and enforcement of clinical guidelines, norms, and standards
- The regulatory capacity of the health system more broadly (e.g. to enforce licensing and/or accreditation requirements in public and private sectors)
- The relationship between ministries of health and other regulators (e.g. insurance), and the capacity of governments to promote and ensure quality mechanisms and standards are applied by these regulators

Box 11: Lack of quality improvement hampers reform

In Tanzania, one of the reasons that people have not voluntarily purchased the health insurance that is being promoted in rural areas is the perception that there has been no improvement in the quality of health services on offer. In Ghana, poor treatment by providers gives individuals a dis-incentive to renew insurance coverage. As people in Ghana holding insurance cards do not pay out-of -pocket for services and since health facilities often experience a cash short-fall as insurance payments are late, providers are reported to put clients of the National Health Insurance Scheme at the back of service queues (David Evans, personal communication based on conversations with service providers in Ghana). Building people's expectations through the introduction of health insurance without improving and ensuring quality is a recipe for popular discontent. Improving service availability and quality is a prerequisite for financing reforms to work.

Strategies that countries can use to improve quality of care include approaches at the policy or regulatory level, those that work at the facility or provider level to motivate better practices, and those that address social norms through engaging consumer demand (Mate *et al.*, 2013).

Regulatory and Policy Approaches

- **Setting standards and practice guidelines**: Government agencies and health insurers can introduce a number of regulations to improve quality, such as implementing licensing and accreditation standards and setting practice guidelines (Mate *et al.*, 2013). The success of these regulatory approaches depends in large part on the strength of the regulations and the enforcement capacity of the supervisory agency. In many LICs and MICs, these approaches have had limited impact because of poor legislation or weak enforcement capacity; challenges have also arisen when applying and enforcing standards to growing private sectors (Akhtar, 2011; Sheikh *et al.*, 2012; Kaplan *et al.*, 2013).
- **Financing and market-based incentives**: Countries implementing UHC can drive quality improvements through the introduction of financing mechanisms such as selective contracting and P4P (Dayal and Hort, 2015). The success of these approaches in improving quality depends on how they are structured. For example, contracting is typically designed to increase service provision, not service quality, and therefore there is little evidence documenting quality improvements as a result (Patouillard *et al.*, 2007; Liu *et al.*, 2008). Modifications to the procurement and payment process, such as including P4P, could potentially increase quality outcomes.

  P4P can also be used to incentivize quality improvements among health providers and across health systems. For example, Rwanda implemented P4P to improve the quality of maternal and child health services. The scheme included payment – tied to quality indicators – both for the type of visit (e.g. prenatal care) and the services provided in these visits (e.g. vaccines provided in prenatal visit). The program improved the quality of some MCH services, but not others, and was more successful at improving services that had higher payment incentives (e.g. facility-based delivery) (Basinga *et al.*, 2010). P4P programs can have negative impacts, such as only improving the use and quality of incentivized services at the expense of other services. Therefore the design of any P4P program will shape the ability of this approach to improve quality (Dayal and Hort, 2015). The ability of P4P programs to improve quality also rely on the strength of information and management systems (Eldridge and Palmer, 2009) to monitor gaming of the system and understand unintended consequences. These potential negative impacts have resulted in an "intense international debate" over the use of P4P in LMICs (Honda et al 2012).

Facility/Provider Approaches

Poor provider behavior can result in poor health outcomes and/or unnecessary medical expenses through failures to properly diagnose or treat an illness, or through the provision of unnecessary or ineffective treatments. Health workers' ability to provide high quality treatment is influenced both by their technical skills and level of effort (Leonard and Masatu 2007; Das and Hammer 2014). Improving provider training, knowledge, motivation, and compliance with professional standards and regulations is therefore a central component of improving the quality of UHC schemes (Dayal and Hort, 2015). Many training and education approaches have been taken to improve the quality of health care, such as educational materials and reminders, trainings and workshops, and supervisory approaches such as audit and feedback. However, there is limited evidence on the effectiveness of these approaches in improving the quality of care (Althabe *et al.*, 2008; Bosch-Capblanch *et al.*, 2011).

Customer Approaches

A number of demand-side approaches (e.g. vouchers) have been implemented to (a) increase customer expectations of the health services they are provided, and (b) increase consumers' power to exercise choice in selecting a provider. Vouchers have been shown to improve quality of care (Meyer *et al.*, 2011). Other approaches include public recognition of high quality facilities, such as Mexico's National Health Care Award, and engaging consumers in planning and monitoring health service delivery (Mate *et al.*, 2013)

Annex VI : Progressive UHC implementation guidance document draft outline

First step: assess where a country is right now on the path to UHC, and determine options for moving forward ensuring that the poor are covered from the outset

1. Setting and Expanding Services and Populations to be Covered
    a. Questions/Methods to guide country through a self-assessment of current situation
    b. Given current situation, questions and approaches to work through to identify options to consider going forward
2. Financing Strategies & Mechanisms
    a. Questions/Methods to guide country through a self-assessment of current situation
    b. Given current situation, questions and approaches to work through to identify options to consider going forward
3. Service Availability and Delivery
    a. Questions/methods to guide country through a self-assessment of current situation
    b. Given current situation, questions and approaches to work through to identify options to consider going forward

Second step: combine service financing and provision options

4. Frameworks for thinking through combining options identified under #1-3 above
5. Developing an initial implementation plan

Third step: strengthen the supportive environment

6. Issues to consider to strengthen governance, management and administration
7. Complementary health systems strengthening steps to consider that will enable pro-poor movement towards UHC
8. Mechanisms to secure long-term financial and political support

Fourth step: finalize a country-specific pro-poor health investment plan

9. Finalizing a medium-term (5-year?) plan or steps to modify strategies with a mid-term or intermittent review of existing plans.

Annex VII: International Community Support for Pro-Poor UHC Implementation

It is increasingly clear that some LICs – and even some LMICs - will not be able to find the necessary resources domestically to reach reasonable coverage levels in the next 15 years. However, the role of the international community in enabling pro-poor UHC remains less clear. Donors should arguably provide funds in a way that does not fragment or verticalize growing UHC programs (although Sepulveda and colleagues (2006) have argued that there is an important role for "diagonal" approaches, i.e. HSS that supports measurable health outcomes). Support should reduce – or at least not increase – transaction costs on countries, and align with country priorities. Countries will want to systematically measure progress towards UHC, and donors can contribute to that process, both financially and technically (some ongoing examples are listed in Box 11 below). Finally, donors might support a growing research agenda about how to achieve progressive UHC.

Global Health 2035 summarized three major ways that international community can support pro-poor UHC:

1. Support **policy research**, e.g. on the FRP value of specific interventions and platforms. The report argued that this knowledge "would then need to be combined with evidence of the health benefits of these interventions and platforms to chart possible pathways to UHC that can inform national decision making"
2. Support **implementation research**, "to ensure that today's efforts yield sound empirical guidance for tomorrow's decisions" and,
3. **Help individual countries finance** the institutions for revenue mobilization and pooling, the mechanics of designing and implementing specific pathways for evolution in the benefit package, and the policies for UHC implementation."

Box 12: Examples of Regional and Global Experience-Sharing

Regional efforts, such as the ASEAN Plus Three UHC Network (http://www.aseanplus3uhc.net), contribute to cross-country experience sharing. ASEAN Plus Three "serves as a platform to support and accelerate progress towards well-functioning and sustainable UHC in developing countries and advancing the regional and global UHC agenda".

The international community also supports countries to move closer to UHC through information exchange including south to south and diagonal learning (such as through the normal processes within WHO, the JLN or the USAID-supported Health Financing and Governance Project: https://www.hfgproject.org) through financial support and technical assistance from the World Bank, the Inter-American Development Bank and other regional banks, and through the many other agencies that provide technical and policy support. International and national NGOs are also heavily involved in advocacy, technical support and information exchange. However, despite the many ongoing UHC steps being considered and taken around the world, some countries have suggested that there is an opportunity to share information only when countries are convened by donors (Stefan Nachuk, personal communication).

Annex VIII: Developing a UHC research agenda

To guide the development of a research agenda, Kruk *et al*. (forthcoming) outlined six policy and implementation research[46] agenda items for reaching UHC over the 2015-2035 timeframe:

1. Define a standard benefit package in each country using best epidemiologic data and projections, and cost this package, so that the incremental funding required can be defined. Costing will be essential to mobilize domestic and donor resources for UHC.
2. Evaluate country experience with financing reforms to expand coverage and financial protection to assess impacts and learn implementation lessons.
3. Examine priority policy questions for UHC, such as which types of insurance models and benefit packages are most effective for expanding coverage and improving health outcomes and which are the best ways to scale insurance in heterogeneous settings (e.g., federal systems, decentralized systems).
4. Evaluate health systems reforms to improve efficiency of care delivery to ensure equity and control costs as demand for health rises.
5. Identify mechanisms to assure broad scale interoperability of information systems to allow for the rapid exchange of patient information to improve patient quality of care, and support ongoing PIR related to health systems change.
6. Establish best practices for engaging the non-state sector in expanding service coverage and quality, including the role of social franchising (in which private providers are organized into "networks that deliver specified health services under a common brand, with a promise of quality assurance").[47]

Other items for discussion in Bellagio (beyond those identified by Kruk *et al.*) are to:

7. Identify what levels of a health system require immediate strengthening, and what mix of interventions can be provided at each level. This requires a very different approach to "packages" – as interventions are not evaluated in isolation from the platform used to deliver them and the other interventions going on concurrently.
8. Study the feasibility of and best practices for identifying the poorest, targeting them in different settings, and ensuring that they get the targeted benefits. A new tool, called the Equity Tool, developed by an NGO called Metrics for Management, may prove to be helpful in identifying the poorest households.[48]

[46] Kruk *et al*. define PIR as the scientific enterprise aimed at closing the delivery gap between the health care interventions known to be effective and what is being delivered in practice; the term PIR captures both the emerging field of *implementation research* or *implementation science* and its sister domain, *health policy and systems research*.

[47] http://www.sf4health.org/

[48] See http://m4mgmt.org/projects/equity-tool

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