

Global Action toward Universal Health Coverage



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Overview

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

Global Demand for Quality, Affordable Health Services

In the summer of 2013, scores of Brazilians gathered in the streets to protest the government's perceived inadequacies, including problems with health care. The overcrowded, underfunded public health system was known for chronic shortages of doctors, medicines, and even bed sheets.² Although health care is guaranteed by the government and supported by high tax rates, citizens were paying premiums to

¹ Nellie Bristol is a fellow with the CSIS Global Health Policy Center. The author would like to thank the following for their help with this paper: Murray Aitken, IMS Institute for Healthcare Informatics; Jessica Alpert, CSIS; Jesse Bump, Georgetown University; Karen Cavanaugh, U.S. Agency for International Development; Jorge Coarasa, World Bank; Kees de Joncheere, World Health Organization; Matt Fisher, CSIS; Alisha Kramer, CSIS; Edward Kelley, World Health Organization; Vinca LaFleur, West Wing Writers; J. Stephen Morrison, CSIS; Ariel Pablos-Mendez, U.S. Agency for International Development; Nina Schwalbe, GAVI; Andreas Seiter, World Bank; Amy Shipow, CSIS; Ellen 't Hoen, former policy and advocacy director of Médecins sans Frontières; Anita Wagner, Harvard Medical School; Adam Wagstaff, World Bank; and Shiyun Zhu, CSIS. Special thanks to Pharmaceutical Research and Manufacturers of America, particularly Jennifer Young and Fumie Griego; David Evans, World Health Organization; Amanda Folsom, Results for Development Institute; and Robert Marten, the Rockefeller Foundation. Opinions in the paper are solely the author's.

² AP, "Middle Class Brazil Family Explains Why They Joined Mass Anti-Government Protests," CBS News, June 27, 2013, <http://www.cbsnews.com/news/middle-class-brazil-family-explains-why-they-joined-mass-anti-government-protests/>.

private insurers in order to bypass the public system.³ Middle-class and poorer citizens alike demanded better quality, more affordable care. Fearing further instability, the government responded, agreeing to set aside 25 percent of oil royalties for health care.⁴

The Brazilian public is not alone in desiring improved health services. Around the world, as national incomes increase, so has demand for affordable, quality health care. The growing movement to ensure health services to all at a price that does not create undue financial pressure for individuals seeking care—a goal known as universal health coverage—has touched almost every country and as a result has risen on the agendas of key international organizations including the World Health Organization and the World Bank. The need can be dire. In some places, 11 percent of the population each year suffers severe financial hardship as a result of seeking needed medical care.⁵ Globally, 150 million people annually experience financial catastrophe related to medical expenses.⁶

Of course, universal health coverage is not a new idea. More than two dozen high-income countries, including the United Kingdom and Canada, have facilitated health services for their citizens, some for decades. But now, countries like Thailand and Mexico are leading the way for developing countries; Mexico in 2003 introduced *Seguro Popular*, which provides access to comprehensive health services with financial protection to more than 50 million Mexicans previously lacking coverage.⁷ Lower-income nations also are determined to make progress. Over the last decade, Rwanda's Mutuelles de Santé covered more than 90 percent of the population, lowered direct payments from patients, and increased health services use.⁸

Yet, achieving universal health coverage is a complex, long-term undertaking that challenges even the most affluent societies. Rich countries with advanced health protection systems, such as Germany and Canada, struggled to ensure sustainable health services financing as economies slowed and demand for services continued to rise. Even in places considered well on their way to universal health coverage, such as Brazil, the quality of services too often is poor and the portion of care patients must pay themselves remains untenably high. In many developing countries, the challenge is exacerbated by a host of additional obstacles including inadequate tax-collection systems, corruption, weak management and oversight, insufficient skilled personnel, and difficulties in identifying and reaching the most vulnerable citizens.

Above all else, the push toward universal health coverage is a political process: Governments have to be willing to spend more money on health care. Through taxes

³ Ibid.

⁴ AFP, "Brazil Leader Hails Law Marking Oil Funds for Services," August 19, 2013, <http://www.google.com/hostednews/afp/article/ALeqM5gAnBgvpMdVSvEy8Yz7kT205IahCQ?docId=CNG.8f00d4ecf1b1b17e9311412b9f9a5df2.311&hl=en>.

⁵ World Health Organization (WHO), *World Health Report: Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO, 2010), http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf.

⁶ Ibid.

⁷ Felicia Marie Knaul et al., "The Quest for Universal Health Coverage: Achieving Social Protection for All in Mexico," *Lancet* 380, issue 9849 (August 16, 2013): 1259–79.

⁸ Andrew Makaka et al., "Universal Health Coverage in Rwanda: A Report of Innovations to Increase Enrolment in Community-Based Health Insurance," *Lancet* 380, S7 (October 21, 2012), [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60293-7/fulltext#article_upsell](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60293-7/fulltext#article_upsell).

and premiums, citizens have to commit to health financing pools that they themselves will benefit from, but which also can transfer resources from rich to poor and from the healthy to the sick. Universal health coverage also involves working through vested interests. For example, the private sector plays a huge and varied role in health around the world. Its capacities range from service delivery to medicines and supplies manufacturing to donor funding.⁹ Health coverage expansions globally are expected to provide even further private sector opportunities. The global drug market, for example, is expected to rise to more than \$1.2 trillion by 2017, up from \$965 billion in 2012.¹⁰

Yet, inherent conflicts of interest between the public and private sectors can easily complicate progress toward universal health coverage; health care providers, manufacturers, and suppliers may protest income reductions, fixed prices, regulations, and other measures aimed at keeping health care costs in check, ensuring quality, and modernizing practices. Countries that have been the most successful in moving toward universal health coverage have all to varying degrees engaged in political negotiations with diverse constituents as health coverage was broadened over a number of years.¹¹

Although the U.S. health system and American health politics are unique in many respects, U.S. efforts to expand health coverage illustrate some of the political and practical challenges at hand. Despite having by far the most expensive health system in the world—costs total \$8,508 annually per capita, in contrast to the next most expensive country, Switzerland, which pays \$5,913¹²—15 percent of the U.S. population lacks health insurance.¹³

After decades of failed attempts to overhaul the U.S. health system, with reforms opposed at various times by fiscal conservatives along with coalitions of physicians, insurers, and employers, Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA promised to provide coverage for a significant portion of the uninsured and to institute broad-based reforms to make insurance more affordable and comprehensive.

But opponents have challenged the law repeatedly both through legislation to repeal it and in the courts. They object to the program's cost (estimated at \$710 billion for the

⁹ See Jeffrey L. Sturchio and Akash Goel, *The Private-Sector Role in Public Health: Reflections on the New Global Architecture in Health* (Washington, DC: CSIS, January 2012), http://csis.org/files/publication/120131_Sturchio_PrivateSectorRole_Web.pdf.

¹⁰ IMS Institute for Healthcare Informatics, "Global Use of Medicines: Outlook through 2017," November 2013, <http://www.imshealth.com/portal/site/imshealth/menuitem.762a961826aad98f53c753c71ad8c22a/?vgnnextoid=9f819e464e832410VgnVCM10000076192ca2RCRD&vgnnextchannel=a64de5fda6370410VgnVCM10000076192ca2RCRD&vgnnextfmt=default>.

¹¹ William D. Savedoff et al., "Political and Economic Aspects of the Transition to Universal Health Coverage," *Lancet* 380, issue 9845 (September 8, 2012): 924–32.

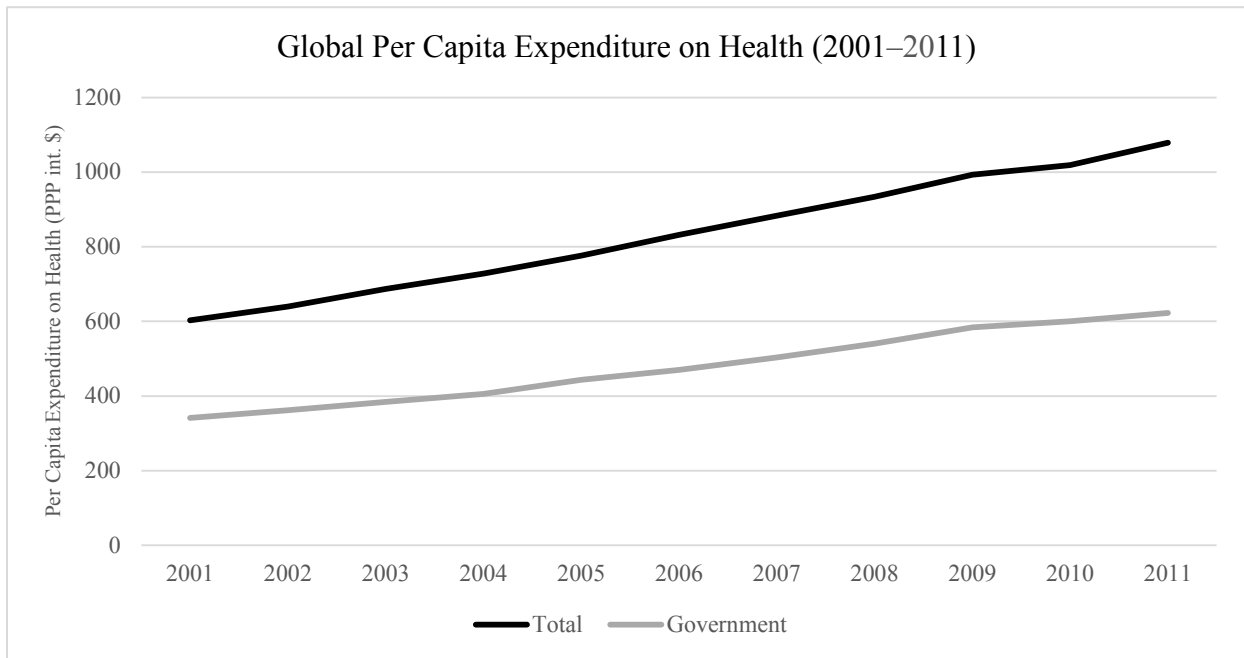
¹² Organization for Economic Cooperation and Development (OECD), "OECD Health Data 2013," <http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm>.

¹³ Robert Pear, "Percentage of Americans Lacking Health Insurance Falls Again," *New York Times*, September 17, 2013, http://www.nytimes.com/2013/09/18/us/percentage-of-americans-lacking-health-coverage-falls-again.html?_r=0.

period 2014–2019¹⁴), what they see as overregulation, and an excessively large role for the federal government. While the ACA thus far has withstood these attacks, it also has been subject to a variety of implementation glitches. The federal computer system designed to connect enrollees with health plans initially was seriously flawed, delaying sign-up for millions of uninsured. In addition, some who already had insurance experienced unexpected coverage changes.

Yet, however daunting its achievement may be, even in the richest countries, the concept of universal health coverage greatly appeals to citizens and lawmakers around the world. Expanding health coverage holds the promise of reducing poverty, increasing equity, and promoting social stability—results that are hard to oppose. In addition, developing countries are faced with a rising wave of noncommunicable diseases, such as cancer and diabetes, for which their health systems need to be better prepared. More sustainable health financing and service delivery mechanisms will help countries meet these challenges.

And so the movement is gaining steam. Across the globe, national, regional, and international initiatives are under way to address barriers and provide models and assistance for governments seeking to expand health coverage; universal health coverage is even being discussed as a possible goal for the United Nation’s post-2015 global development agenda (see appendix 1). As a result, millions more people globally now have better access to health services and countries are prioritizing health spending (see graph below).



Data source: World Health Organization Global Health Observatory Data Repository, “Health systems: Health financing,” 2013, <http://apps.who.int/gho/data/node.main.484?lang=en>. Graph created by Matt Fisher and Nellie Bristol, CSIS.

¹⁴ Jessica Banthin and Sarah Masi, “The Estimated Budgetary Impact of the ACA’s Coverage Provisions Has Changed Little on a Year-by-Year Basis since March 2010,” Congressional Budget Office, May 14, 2013, <http://www.cbo.gov/publication/44176>.

This paper is intended to be a primer on this increasingly salient global issue by discussing the following:

- A brief history of country efforts toward universal health coverage
- The activities of international organizations and other global players
- The key requirements and the tough challenges in creating a universal health coverage system

How Did Universal Health Coverage Emerge as a Global Concern?

Countries Prioritize Health Coverage Expansion: WHO defines universal health coverage as “ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.” Each country travels a unique path toward universal health coverage, guided by its own history, politics, and existing health and financing structures. Movement toward expanded coverage is driven by increasing incomes and sustained social pressure to expand coverage.¹⁵

Germany is credited with starting the first universal health coverage system through its social health insurance plan, instituted in 1883. The United Kingdom began its system in 1948. As GDP rose in many places, the number of countries adopting health coverage expansion programs accelerated and by 2009, 58 largely higher-income countries had adopted foundation legislation for universal health coverage and met health care access criteria for universal health coverage.¹⁶ Developing countries also began pursuing broad-based coverage expansions including Chile in 1952 and Brazil in 1988.¹⁷ More joined the movement in recent years, including countries as diverse as Ghana, China, India, South Africa, and Vietnam.¹⁸

The World Health Organization Takes the Lead: While countries took on the issue at home, government responsibility for health also was a discussion topic internationally. The 1978 International Conference on Primary Health Care, convened in Alma-Ata, Kazakhstan, by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) is considered a historical turning point in the international movement toward universal health coverage. The resulting Declaration of Alma-Ata, focused on government responsibility for “an acceptable level of health for all people of the world” and prioritizing primary care,¹⁹ was signed by 143

¹⁵ Savedoff et al., “Political and Economic Aspects of the Transition to Universal Health Coverage.”

¹⁶ David Stuckler et al., “The Political Economy of Universal Health Coverage” (background paper for the Global Symposium on Health Systems Research, November 16–19, 2010, Montreux, Switzerland), 17, <http://www.pacifichealthsummit.org/downloads/UHC/the%20political%20economy%20of%20uhc.PDF>.

¹⁷ Joint Learning Network for Universal Health Coverage, “Countries,” <http://jointlearningnetwork.org/countries>.

¹⁸ UHC Forward, “Health Coverage Programs,” <http://uhcforward.org/reforms>.

¹⁹ International Conference on Primary Health Care, “Declaration of Alma-Ata,” Alma-Ata, USSR, September 6–12, 1978, http://www.who.int/publications/almaata_declaration_en.pdf.

countries.²⁰ While global health attention since then has swung between health systems approaches and disease-specific programs, the focus on equity in health services has remained a constant theme.

In the middle of the last decade, as health system inadequacies slowed efforts to address priority health concerns such as HIV/AIDS and maternal and child health, and as it became increasingly apparent that an excessive share of the cost of services continued to fall on the poor and sick, policymakers began to focus more on health financing. At the 2005 World Health Assembly (WHA), the world's top health officials committed their governments to developing health financing systems to ensure access to services while mitigating financial risk for the individual.²¹ WHO has prioritized universal health coverage ever since through its world health reports, guidance to countries, and conferences to explore political and implementation issues. Following its World Health Report 2010, "Health Systems Financing: the Path to Universal Coverage," more than 70 countries requested WHO's aid in working toward universal health coverage.²²

WHO director-general Margaret Chan has been a forceful proponent in the current push for health coverage expansion. "In my view," Chan said in her May 2012 speech accepting a second five-year appointment, "universal coverage is the single most powerful concept that public health has to offer."²³

In championing universal health coverage, however, WHO itself illustrates some of the clashes likely to intensify as the movement grows. Disease prevention is considered an important pillar in universal health coverage both because it inherently improves individuals' health and because it reduces costs to the health system. In recent years, the food and beverage industries have come under intense criticism from public health officials, advocates, and others for creating processed products high in sugar, fat, and salt, factors seen as contributing to chronic diseases. But while some public health experts are calling for greater alliance between public health and the private sector in pursuit of disease reduction, through, for example, voluntary product reformulation and curbs on advertising to children, Chan has taken a more confrontational approach. Equating them with the much vilified tobacco industry, in June 2013 Chan took to task food, beverage, and alcohol companies for what she said were industry efforts to oppose and skirt public health efforts that affect their products.²⁴

²⁰ Jesse B. Bump, "The Long Road to Universal Health Coverage: A Century of Lessons for Development Strategy," PATH, October 19, 2010, 32, <http://www.rockefellerfoundation.org/uploads/files/23e4426f-cc44-4d98-ae81-ffa71c38e073-jesse.pdf>.

²¹ World Health Assembly (WHA), WHA58.33, "Sustainable Health Financing, Universal Coverage, and Social Health Insurance," May 25, 2005, http://www.who.int/providingforhealth/topics/WHA58_33-en.pdf.

²² Margaret Chan, "Opening Remarks at the WHO/World Bank Ministerial-level Meeting on Universal Health Coverage," Geneva, February 18, 2013, http://www.who.int/dg/speeches/2013/universal_health_coverage/en/.

²³ Margaret Chan "Universal Coverage Is the Ultimate Expression of Fairness," Geneva, May 23, 2012, http://www.who.int/dg/speeches/2012/wha_20120523/en/.

²⁴ Margaret Chan, "WHO Director-General Addresses Health Promotion Conference," Helsinki, June 10, 2013, http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/#.

Despite the tensions, WHO is looking for ways to better engage commercial entities and other “non-state actors,” such as nongovernmental organizations, while warding against perceptions of conflict of interest.²⁵

The World Bank Group—Guidance and Support: The World Bank Group is actively supporting country movement toward universal health coverage as well. In partnership with WHO and others, it provides countries with guidance and tools to help them gauge their level of health coverage and measure any progress. In February 2013, the Bank released a series of studies that analyzed the “nuts and bolts” of coverage programs in 22 countries and the Commonwealth of Massachusetts.²⁶ The Bank also is developing a universal health coverage assessment tool (UNICAT) to help countries assess the resources they have available to implement universal health coverage. Bank health funding to low- and middle-income countries prioritizes health system performance, a key component of universal health coverage.²⁷

In addition, in partnership with WHO, the Bank in December 2013 released a discussion paper for a standardized monitoring framework to judge country progress on universal health coverage. Equity is critical to universal health coverage, the paper notes, yet there is a risk that poorer and more disadvantaged populations could be left behind, which is why, “in addition to measuring average or aggregate levels of service and financial coverage, it is essential to have measures disaggregated by a range of socioeconomic and demographic stratifiers, such as income/wealth, sex, age, place or residence, minorities and migrants, etc.”²⁸

In concert with the measurement framework, the Bank and WHO proposed two ambitious universal health coverage targets: First, by 2020, to reduce by half to 50 million the number of people who are impoverished as a result of out-of-pocket health expenses, then reducing the number to zero by 2030; and, second, by 2030, to double from 40 to 80 percent the proportion of poor in developing countries who have access to basic health services. The two organizations will work with partners in early 2014 to develop ways to track these targets.²⁹

The U.S. Government and Health Systems Strengthening: The Obama administration has been a vocal supporter of expanded health coverage both in the United States and globally. In 2012 the U.S. Agency for International Development (USAID), long involved in health system strengthening activities internationally, established an Office of Health Systems as the focal point for a network of technical experts. The USAID assistant administrator for global health, Ariel Pablos-Méndez, is an avid

²⁵ WHO, “Public Web Consultation on WHO’s Engagement with Non-State Actors,” http://www.who.int/about/who_reform/governance/who_reform_non_state_actors_consultation_2013.pdf.

²⁶ World Bank, “Universal Health Coverage Study Series,” <http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>.

²⁷ J. Stephen Morrison and Nellie Bristol, “The World Bank Group,” in *Global Health Policy in the Second Obama Term*, ed. J. Stephen Morrison (Washington, DC: CSIS, February 2013), 80, http://csis.org/files/publication/130214_Morrison_GHTransitionVolume_Web_FINAL.pdf.

²⁸ WHO and World Bank, “Progress towards Universal Health Coverage at Country and Global Levels: A Framework,” December 2013, http://www.who.int/healthinfo/country_monitoring_evaluation/UHC_WBG_DiscussionPaper_Dec2013.pdf.

²⁹ Jim Yong Kim, “Speech by World Bank Group President Jim Yong Kim at the Government of Japan–World Bank Conference on Universal Health Coverage,” December 6, 2013, <http://www.worldbank.org/en/news/speech/2013/12/06/speech-world-bank-group-president-jim-yong-kim-government-japan-conference-universal-health-coverage>.

proponent of universal health coverage as a way to provide sustainable, rational financing for health services. “As developing economies grow, they will inevitably spend more on health,” Pablos-Méndez wrote in a USAID blog.³⁰ “Without thoughtful organization of the system, however, there tends to be an explosion of unregulated private services paid for out-of-pocket, which leads to inefficiencies and health bills that cause families to sink back into poverty.”

Other key proponents include UNICEF, the International Labour Organization, and the Inter-American Development Bank, as well as Germany and Japan. Developing countries also are helping each other. The Joint Learning Network for Universal Health Coverage is an innovative platform for countries to share their practical implementation experiences. The JLN is governed by the participating countries, funded by the Rockefeller Foundation and the Bill & Melinda Gates Foundation. It is supported by a network of technical partners including the Washington, DC-based Results for Development Institute (see appendix 2). JLN is one of a number of universal health coverage projects funded by the Rockefeller Foundation, which has been a major driver in the movement. It also funded a pivotal September 2012 universal health coverage series in the British medical journal *The Lancet* and has provided grants to the World Health Organization, including for the 2010 World Health Report on health systems financing.

Universal Health Coverage: What Does It Take?

The government typically is the major player in coverage expansion as a payer, a provider of health services, and/or a regulator of health care delivery and private insurance. In planning their programs, countries typically weigh three dimensions of coverage expansion: who, which services, and what proportion of costs will be covered.³¹ Since reducing the health-related financial burden on individuals and families is a top goal of universal health coverage, a critical component of any system is the development of health care financing pools (see glossary, appendix 3). Money collected through government revenues or premiums is used to pay for at least a basic set of health benefits to the broadest population possible. Governments also must devise methods for ensuring vulnerable populations are receiving adequate services and make sure health resources are being used efficiently.

Securing Sustainable Financing

Health care is expensive. According to WHO, out-of-pocket costs push 100 million people into poverty each year. Developing adequate and sustainable financing mechanisms for health services has the potential, if managed competently, not only to lessen severe financial hardship for individuals but also to provide more reliable funding for health systems expansion.

³⁰ Ariel Pablos-Méndez, “Building the Foundations for Sustainable Health Services,” USAID Impact Blog, September 26, 2012, <http://blog.usaid.gov/2012/09/a-kid-in-a-candy-store-building-the-foundations-for-sustainable-healthcare/>.

³¹ WHO, “World Health Report,” 13.

WHO recommends that to expand coverage for their populations, low- and middle-income countries³² may first need to increase the amount of their budgets they devote to health. In order to ensure access to critical interventions, for example, low-income countries would need to spend an average of \$60 per person, a significant jump from the current average of \$32 per person.³³

For many countries, increasing the efficiency of revenue collection will be essential to support larger health financing pools. “Even in some high-income countries, tax avoidance and inefficient tax and insurance premium collection can be serious problems,” WHO notes.³⁴ In addition to payroll taxes, many countries have turned to other revenue-raising methods, including value-added and sales taxes, and levies on items like alcohol and tobacco. Ghana, for example, raised consumption taxes by 2 to 5 percent and the funding now supplies 61 percent of the budget for its National Health Insurance Scheme.³⁵

Many countries that have successfully expanded health coverage have done so through either tax-based systems or compulsory social health insurance systems. In tax-based systems, general tax revenue is the main source of funding, and governments provide or purchase health services. In social insurance-based systems, workers, the self-employed, commercial entities, and the government all contribute. In addition to the traditional models, some countries now pursuing universal health coverage are doing so through unique “hybrid systems” that nonetheless share common features including use of tax revenues to subsidize certain populations and steps toward creation of broader risk pools.³⁶ Individuals in most systems often still are required to contribute directly to the costs of care, and services are purchased from both public and private health care providers.³⁷

The goal of expanded coverage systems is to pool resources to share financial risk among participants. Removing the need for direct out-of-pocket payments at the time of care is the most effective way to ensure that individuals seek the care they need and do not face undue financial pressure in the process. WHO considers health care payments to be “catastrophic” if they consume more than 40 percent of an individual’s yearly income after deducting for food expenses. It adds: “It is only when the reliance on direct payments falls to less than 15–20 percent of total health expenditures [nationally] that the incidence of financial catastrophe routinely falls to negligible levels.”³⁸

Many advanced health-financing systems rely on funds collected through employment, but this method often is complicated and unreliable in developing

³² The World Bank categorizes economies based on gross national income (GNI) per capita. Low-income countries are those with GNI per capita of \$1,035 or less. Lower-middle income is \$1,036–\$4,085. Upper-middle income is \$4,086–\$12,615. See World Bank, “How We Classify Countries,” <http://data.worldbank.org/about/country-classifications>.

³³ WHO, “World Health Report,” 10.

³⁴ Ibid.

³⁵ Gina Lagomarsino et al., “Moving Towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia,” *Lancet* 380, issue 9845 (September 8, 2012): 933–43.

³⁶ Ibid.

³⁷ WHO, “Technical Briefs for Policy-Makers: Achieving Universal Health Coverage: Developing the Health Financing System,” 2005, 2, http://www.who.int/health_financing/pb_1.pdf.

³⁸ WHO, “World Health Report,” 42.

countries. Many low- and middle-income countries have large informal sectors—portions of the population that are working outside the official economy. For example, the International Labour Organization (ILO) estimates 83.5 percent of the population in India is employed in unregistered commercial entities.³⁹ Not only are these populations unavailable to contribute to state financing pools, but they are also difficult to monitor to ensure they are receiving needed health benefits.

In addition to government funding of health services, many countries have private insurance options, including community-based health insurance and micro insurance, which allow enrollees to voluntarily contribute to a prepayment pool for health care. Especially in the early stages of a country's evolution toward universal health coverage, government programs often are not well developed and other insurance options step in. This is occurring particularly in countries with a growing middle class that is starting to demand more prepayment options.⁴⁰

Even for populations for which the government pays for the bulk of services, private insurance often fills in the gaps. In the United States, for example, Medicare provides a range of coverage for those over 65, but many enrollees also pay for private “Medigap” insurance, which covers what the program doesn't. A similar situation exists in Canada, where public funding accounts for 71 percent of total health expenditures, but private health plans cover about two-thirds of the population to provide benefits such as vision and dental care, and prescription drugs.⁴¹

Yet, the role of private insurance is one of the more controversial aspects of health coverage expansion. As World Bank senior economist Jorge Coarasa explains, “Supporters of expanded health insurance coverage claim that it provides access to care and avoids the long waiting lists, low-quality care, and rudeness often suffered by households using public services provided by ministries of health,” while “opponents vilify health insurance as an evil to be avoided at all costs. To them, health insurance diverts scarce resources from the poor and leads to overconsumption of care, escalating costs (especially administrative costs), fraud and abuse...and, ultimately, an inequitable health care system.”⁴²

The humanitarian organization Oxfam, for example, recommends tax financing and premium collection only from formal sector workers, supplemented with international aid; as Oxfam sees it, “The countries that have made most progress to date have embraced the principles of equity and universality, rejecting approaches that collect insurance premiums from those who are too poor to pay.”⁴³

³⁹ ILO Department of Statistics, “Statistical Update on Employment in the Informal Economy,” June 2012, http://laborsta.ilo.org/applv8/data/INFORMAL_ECONOMY/2012-06-Statistical%20update%20-%20v2.pdf.

⁴⁰ Author communication with Jorge Coarasa, senior economist, World Bank, November 11, 2013.

⁴¹ Sara Allin, “The Canadian Health Care System, 2012,” in *International Profiles of Health Care Systems, 2012*, ed. Sarah Thomson et al. (New York: Commonwealth Fund, November 2012), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Nov/1645_Squires_intl_profiles_hlt_care_systems_2012.pdf.

⁴² Jorge Coarasa, “Scaling Up Affordable Health Insurance: Same Dish, Many Different Recipes,” World Bank Blogs, September 25, 2013, <http://blogs.worldbank.org/voices/scaling-affordable-health-insurance-same-dish-many-different-recipes>.

⁴³ Ceri Averill, “Universal Health Coverage: Why Health Insurance Schemes Are Leaving the Poor Behind,” Oxfam, October 9, 2013, 4, http://www.oxfam.org/sites/www.oxfam.org/files/bp176-universal-health-coverage-091013-en_.pdf.

Selecting the Right Package of Benefits

In developing benefits packages, WHO urges inclusion of health services for HIV, tuberculosis, malaria, noncommunicable diseases, mental health, sexual reproductive health, and child health, but acknowledges that “the dilemma for most countries, in particular low-income countries, is that they are not able to provide everyone with the all the health services they need at an affordable price.”⁴⁴

Countries should strive to provide an increasing number of services over time, while reducing out-of-pocket costs to patients, the organization explains.

One example of a country easing into increased services coverage is Thailand. A middle-income country, Thailand initiated essential health services coverage in the early 2000s, increasing the number of people receiving coverage by 47 million.⁴⁵ Initially, it offered free prescription drugs, outpatient care, and hospitalization, as well as more expensive services including radiotherapy, surgery, and critical care.⁴⁶ Coverage has increased over time; new benefits have included antiretroviral drugs for HIV in 2004 and renal replacement therapy for end-stage renal disease in 2008.⁴⁷ Yet, this good-news story is cautionary too: Meeting the demand for renal replacement therapy could consume more than 12 percent of Thailand’s Universal Coverage Scheme budget and threaten it with financial crisis.⁴⁸

The benefits included in health coverage schemes should be comprehensive, prioritize prevention and primary care, and address the diseases most prevalent in the area being considered. Ideally, as WHO posits, “Decisions about the services that can be guaranteed to the population initially, and which ones should be added over time, are based on people’s need, public opinion and costs.”⁴⁹

But all too frequently, as Amanda Glassman and Kalipso Chalkidou write for the Center for Global Development, the process for deciding what will be covered is much more politicized: “Health donors, policymakers, and practitioners continuously make life-and-death decisions about which type of patients receive what interventions, when, and at what cost. These decisions—as consequential as they are—often result from ad hoc, nontransparent processes driven more by inertia and interest groups than by science, ethics, and the public interest.”⁵⁰ As an example, they say only 44 percent of one- to two-year-olds in India are fully vaccinated, but open-heart surgery is subsidized in national public hospitals.

⁴⁴ WHO, “Questions and Answers on Universal Health Coverage,” <http://www.who.int/contracting/documents/QandAUHC.pdf>.

⁴⁵ Apiradee Treerutkuarkul, “Thailand: Health Care for All, At a Price,” *Bulletin of the World Health Organization* 88, no. 2 (February 2010), <http://www.who.int/bulletin/volumes/88/2/10-010210/en/>.

⁴⁶ Ibid.

⁴⁷ Sripen Tantivess et al., “Universal Coverage of Renal Dialysis in Thailand: Promise, Progress, and Prospects,” *BMJ* 346 (January 2013): 1462, <http://www.bmj.com/content/346/bmj.f462>.

⁴⁸ Treerutkuarkul, “Thailand.”

⁴⁹ WHO, “Questions and Answers on Universal Health Coverage.”

⁵⁰ Amanda Glassman and Kalipso Chalkidou, *Priority-Setting in Health: Building Institutions for Smarter Public Spending* (Washington, DC: Center for Global Development, June 2012), http://www.cgdev.org/sites/default/files/1426240_file_priority_setting_global_health_FINAL_0.pdf.

Health policy experts are urging adoption of more rational approaches to benefits decision making involving cost benefit analysis, budget impact analysis, and a more deliberative process for ensuring covered services provide the best health outcomes for money spent.⁵¹

Reaching Vulnerable Populations

Another key component to moving toward universal health coverage is ensuring benefits reach the people who need them the most: the poor, vulnerable, and marginalized who typically have the worst access to health services, who often pay directly out-of-pocket at the time of care, and who are the most likely to either skip needed care or be impoverished if they seek it.

Japan and many high-income countries in Europe started their coverage expansions with formal sector workers “who are easy to identify and whose regular wage income is relatively easy to tax,”⁵² but as WHO warns, this method can lead to further fragmentation—with those already covered demanding more benefits or lower payments, while those who lacked coverage in the first place continue to go without. In addition to ensuring quality services are conveniently available, reaching those who need coverage the most may require that care be offered for free to people who are not in a position to contribute. But even then, countries have difficulty figuring out who the most vulnerable are, especially in the informal sector, and how to reach them with coverage. Options include equity funds, subsidies for health insurance premiums, health care vouchers, and cash transfers. Mexico, for example, pioneered *Oportunidades*, which provides conditional cash transfers to poor people seeking care from public facilities. The program provided health and other benefits to 25 million low-income Mexicans, nearly all of them women and nearly 70 percent living in rural areas.⁵³

Using Resources Efficiently

One of the greatest challenges in establishing and sustaining universal health coverage is efficiently using scarce health resources. History shows that demand for health services nearly always outstrips a society’s ability or desire to pay for them. Even in the richest countries, costs for health services rises greater than general inflation. In most OECD countries, health spending has risen faster than economic growth since the 1970s.⁵⁴

“While some countries lose more than others, most, if not all, fail to fully exploit the resources available, whether through poor executed procurement, irrational medicine use, misallocated and mismanaged human and technical resources or fragmented financing and administration,” WHO says.⁵⁵ It projects that 20 to 40 percent of

⁵¹ Ibid.

⁵² WHO, “World Health Report,” 49.

⁵³ Inter-American Development Bank, “Mexico to Receive \$600 Million in IDB Financing for Oportunidades Program,” news release, September 5, 2013, <http://www.iadb.org/en/news/news-releases/2013-09-05/opportunidades-program-for-mexico,10557.html>.

⁵⁴ OECD, “Health: Spending Continues to Outpace Economic Growth in Most OECD Countries,” June 30, 2011, <http://www.oecd.org/newsroom/healthspendingcontinuestooutpaceeconomicgrowthinmostoecd-countries.htm>.

⁵⁵ WHO, “World Health Report,” 61.

resources spent on health are wasted.⁵⁶ WHO's top 10 leading causes of health system inefficiency are:

1. Underuse of generics and higher-than-necessary prices for medicines
2. Use of substandard and counterfeit medicines
3. Inappropriate and ineffective use of medicines
4. Overuse or supply of health care services and equipment
5. Inappropriate or costly mix of health workers and unmotivated workers
6. Inappropriate hospital admissions and length of stay
7. Inappropriate hospital size
8. Medicine errors and suboptimal quality of care
9. Waste, corruption, and fraud
10. Inefficient mix/inappropriate level of health care interventions⁵⁷

The cost, safety, and availability of pharmaceuticals are critical elements of sustaining universal health coverage. WHO maintains lists of “essential medicines” based on public health relevance, evidence on safety and efficacy, and relative cost effectiveness.⁵⁸ Nearly all countries have their own version of an essential medicines list they use when developing benefits plans.⁵⁹ While low-income countries can be expected to focus on affordable purchase of essential medicines, most of which are generic, middle-income countries will be in the market for higher-cost, cutting-edge treatments.

Public health experts are encouraging development of mechanisms that help countries transparently judge which medicines are most important and cost effective for their populations. But again, there are likely to be tensions. Health care providers in many places derive at least part of their incomes from selling medicines. In addition, the pharmaceutical manufacturing industry is concerned that national medicines budgets could be cut indiscriminately to achieve cost savings. It urges that medicines not be viewed solely as a cost-driver but as helping avoid other more costly medical interventions.⁶⁰ It also asks that the regulations and procedures for pricing

⁵⁶ Ibid., 15.

⁵⁷ Ibid., 63.

⁵⁸ WHO, “WHO Model Lists of Essential Medicines,” <http://www.who.int/medicines/publications/essentialmedicines/en/index.html>.

⁵⁹ MDG Gap Task Force, *Delivering on the Global Partnership for Achieving the Millennium Development Goals*, MDG Gap Task Force Report 2008 (New York: United Nations, 2008), 36, <http://www.undp.org/content/dam/turkey/docs/Publications/mdgs/MDG+Gap+Task+Force+Report+2008.pdf>.

⁶⁰ Author communication with the Pharmaceutical Research and Manufacturers of America, December 11, 2013.

and reimbursing medicines be transparent and allow for manufacturer input and appeal.⁶¹

Countries must also figure out the most efficient way to design payments so that health care providers deliver high-quality, appropriate, and needed care to patients, but aren't given profit incentives to over-treat. As World Bank economist Adam Wagstaff points out, pulling people into fee-for-service payment systems, in which payments are made for all services provided, actually may be counterproductive to the goal of universal health coverage; the payment method tends to drive up costs and could leave patients paying the same or more out-of-pocket.⁶² In the United States, lawmakers have attempted to transition federal health programs away from fee-for-service care. In the 1980s, Medicare instituted a hospital payment method that provided compensation per patient based on the average costs for treating patients with a similar diagnosis. Other countries, including China, are using the payment system as well. (See appendix 4 for more on China.)

Strengthening Health Systems

A safe, efficient, accessible health care system is the backbone of universal health coverage, but establishing comprehensive systems that provide quality needed care to all populations has been a constant struggle in low- and middle-income countries. In many places, health systems lack adequate infrastructure, supplies, and human resources.

Universal health coverage has the potential to provide additional resources for strengthening health systems. But as Sujatha Rao, former principal secretary for India's Ministry of Health and Family Welfare, explains, the assumption that with provision of coverage, services will be available to meet demand "is not valid in countries like India which not only have broken health systems with huge gaps in supply and infrastructure such as laboratories, labor rooms, equipment and human resources—but is also burdened with communicable diseases that require a substantial component of preventive health."⁶³ Rao argues that for a universal health coverage system to be successful, countries have to set standards of care and ensure they are enforced. (See appendix 5 for more on India.)

That will be a challenge in countries where many health care services are provided by a largely unregulated private sector, with health care providers ranging from highly trained medical specialists to traditional healers, and significant disparities in access.⁶⁴ In sub-Saharan Africa, for example, about half of care is provided by the private sector. For the poorest, about 45 percent of private services are provided by informal providers, while for the wealthiest that figure is only 16 percent. In Southeast Asia, private providers furnish 66 percent of care. Forty-five percent of private care accessed by the poorest is provided by informally trained practitioners,

⁶¹ Ibid.

⁶² Author communication with Adam Wagstaff, research manager, Human Development and Public Services, World Bank, November 22, 2013.

⁶³ Meredith Kimball, "Critical Policy Decisions on the Pathway to Universal Health Coverage: Part 1," UHC Forward, March 24, 2012, <http://uhcforward.org/blog/2012/mar/21/critical-policy-decisions-pathway-universal-health-coverage-part-i?print>.

⁶⁴ David Peters and Gerald Bloom, "Bring Order to Unregulated Health Markets," *Nature* 487 (July 2012): 163–65.

while for the richest, the figure is 8 percent.⁶⁵ Problems arising from an unregulated private sector include misuse of medicines and lack of links to higher levels of care for referral purposes.

Regulation of health services is an area that receives insufficient attention, according to David Peters of Johns Hopkins University and Gerald Bloom of the Institute of Development Studies, but it is an important component of achieving universal health coverage. “Bringing order to unregulated health markets will take broad coalitions that go beyond governments and health professionals,” they argue. “They should include citizen groups, pharmaceutical companies, information technology and telecommunications companies, and associations of informal health care providers. Such coalitions might coordinate disease-surveillance systems, information networks for pricing and sourcing quality drugs and patient referral mechanisms.”⁶⁶

As governments increasingly regulate the private sector, some experts say they need to acknowledge the large role those providers currently play in health care—even informally trained providers. Some countries are working to connect traditional healers and other informal providers with formal health systems and to set standards for practice.⁶⁷ Others are using programs to gradually train informally trained workers to meet a certain level of competency.⁶⁸

Other experts argue that increasing private sector provision of health services is misguided. Columbia University economist Jeffrey Sachs argues that the problems associated with public services—waiting lists, technological lags, and lack of competition—could be mitigated with adequate funding of government health services with the help of international aid. A large private sector, he says, has the potential to inflate health care costs and create pressure to meet the needs of the middle class rather than the poor.⁶⁹

Universal Health Coverage: The Future of Global Health?

Making quality, affordable health services available to an entire population is a difficult undertaking—one that entails a variety of resource and implementation challenges and requires sustained political will. Yet as WHO director-general Margaret Chan underscores, “every country, at any level of development and with any level of resources, can take immediate and sustainable steps in that direction.”⁷⁰

All countries will approach the issue in their own way based on their current coverage arrangements and health systems, resources, history, and political

⁶⁵ Dominic Montagu, “Private Healthcare in Developing Countries,” University of California at San Francisco, <http://ps4h.org/globalhealthdata>.

⁶⁶ Peters and Bloom, “Bring Order to Unregulated Health Markets.”

⁶⁷ Cathy Majtenyi, “Kenya Considers Policy to Regulate Traditional Medicines,” Voice of America, May 29, 2012, <http://www.voanews.com/content/kenya-considers-policy-to-regulate-traditional-medicines/1120662.html>.

⁶⁸ Author communication with Jorge Coarasa, senior economist, World Bank, November 11, 2013.

⁶⁹ Jeffrey Sachs, “Achieving Universal Health Coverage in Low-Income Settings,” *Lancet* 380, issue 9845 (September 8, 2012): 944–47.

⁷⁰ Margaret Chan, “More Countries Move Towards Universal Health Coverage: Opening Statement at the International Forum on Universal Health Coverage,” April 2, 2012, http://www.who.int/dg/speeches/2012/universal_health_coverage_20120402/en/.

environments. Most middle-income countries will be in a position to move more quickly than lower-income countries. Some countries will need international aid to make progress. All countries will need to engage in active, transparent negotiations with all health system constituents, private and public, to ensure services reach the broadest possible population and make the best use of available resources.

Although universal health coverage will remain a work in progress in many places for many years, greater attention to issues such as increasing health spending, improving tax systems, strengthening health systems, and improving equity will pay dividends not only in improved health, but for human development more broadly.

Appendixes

1. Universal Health Coverage and Global Development Goals

With the Millennium Development Goals (MDGs)⁷¹ nearing the 2015 finish line, countries, civil society groups, and international organizations are determining the next global development agenda. WHO and the World Bank argue that including universal health coverage as a goal would encourage continued progress on issues specifically included in the MDGs, such as HIV/AIDS, tuberculosis, and malaria, and maternal and child health, while at the same time ensuring attention for new health priorities such as noncommunicable diseases.

In December 2012, the United Nations General Assembly passed a resolution, supported by the United States,⁷² which encouraged states to recognize the links between universal health coverage and other dimensions of foreign policy, including cohesion and stability, inclusive and equitable growth, and sustainability of national health financing mechanisms. The resolution also recommended that universal health coverage “be given consideration” in discussions of the post-2015 development agenda. Others champion universal health coverage as a goal as well, including the foreign affairs ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand.⁷³

There are nonetheless concerns that the concept of universal health coverage is neither specific nor measurable enough to be effective as a development goal.⁷⁴ In its May 2012 report and recommendations, the influential High Level Panel on the Post-2015 Development Agenda used “Ensure Healthy Lives” as its illustrative health goal, to be measured through specific markers such as ending preventable infant and child deaths; increasing vaccination rates; and decreasing maternal mortality.⁷⁵ Negotiations on the post-2015 development goals continue; the UN General Assembly will make the ultimate decision in September 2015.

⁷¹ The Millennium Development Goals were derived from a declaration adopted in September 2000 by 189 UN member states. They are credited with helping to channel increased aid flows and country attention to development issues prioritized by the goals. There are three specific goals related to health: MDG 4 calls for reductions in child mortality; MDG 5, improvements in maternal health; and MDG 6, combating HIV/AIDS, malaria, and other diseases. For more information, see Nellie Bristol, *Do UN Global Development Goals Matter to the United States?* (Washington, DC: CSIS, May 2013), <http://csis.org/publication/do-un-global-development-goals-matter-united-states>.

⁷² UN General Assembly, “Global Health and Foreign Policy,” Resolution A/67/L.36, December 6, 2012, http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36.

⁷³ Pascal Canfin et al., “Our Common Vision for the Positioning and Role of Health to Advance the UN Development Agenda beyond 2015,” *Lancet* 381, issue 9881 (May 28, 2013): 1885–86.

⁷⁴ Amanda Glassman et al., “A Post 2015 Development Goal for Health—Should It Be Universal Health Coverage?,” BMJ Group Blogs, September 25, 2012, <http://blogs.bmj.com/bmj/2012/09/25/amanda-glassman-et-al-a-post-2015-development-goal-for-health-should-it-be-universal-health-coverage/>.

⁷⁵ High-Level Panel of Eminent Persons, *A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development*, report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (New York: United Nations, May 2013), <http://www.post2015hlp.org/wp-content/uploads/2013/05/UN-Report.pdf>.

2. Joint Learning Network for Universal Health Coverage

On the margins of the 2009 World Health Assembly, a small group of countries grappling with universal health coverage implementation issues informally shared their experiences with each other. Realizing they had similar challenges, they decided to pursue an ongoing dialogue. That was the birth of the Joint Learning Network for Universal Health Coverage (JLN), supported by the Rockefeller Foundation and the Bill & Melinda Gates Foundation.

The JLN provides information exchange and learning opportunities (meetings, webinars, study visits) for health officials from nine countries in Asia and Africa that are committed to the goal of universal health coverage. The network will be expanded to additional countries in 2014.

Country health officials share experiences in program design and implementation, discussing innovative approaches to issues like enrollment of beneficiaries, registration, information technology, quality improvement, and provider payments. “To have people with the same level of economic development learning from each other is very important,” said Tran Van Tien of the Vietnam Ministry of Health.⁷⁶ Implementation issues facing the countries range from who should be included under expanded coverage schemes to ways of identifying the poor. Also challenging for the countries is involving the informal sector in tax paying; alternatives for raising funds for health; and how to structure purchasing arrangements so that health care providers are compensated effectively to provide appropriate and cost-effective care. The network has enlisted technical support from a variety of organizations including the Institute for Healthcare Improvement, the UK’s National Institute for Health and Care Excellence, PATH, PharmAccess, Results for Development Institute, WHO, and the World Bank.

⁷⁶ Joint Learning Network for Universal Health Coverage, “About,” <http://jointlearningnetwork.org/about>.

3. Glossary

Benefits package: services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services.

Copayment: money that an individual is required to pay for services, usually specified as an absolute amount: a predetermined (flat) fee that an individual pays for health care service, in addition to what the insurance covers.

Cost containment: the method of preventing health care costs from increasing beyond a set level by controlling or reducing inefficiency and waste in the healthcare system.

Cost effectiveness: the efficacy of a program in achieving given intervention outcomes in relation to the program costs.

Cost sharing: this occurs when the users of a health care plan share in the cost of medical care. Deductibles, co-insurance, and co-payments are examples of cost sharing.

Coverage: a person's health care costs are paid by their insurance or by the government.

Fee for service: the health care provider is paid a fee based on what services the provider rendered.

Formal sector: the part of the economy/society that is registered with authorities and that is subject to regulations and standards.

Health system: the people, institutions, and resources arranged together in accordance with established policies to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health. Set of elements and their relations in a complex whole, designed to serve the health needs of the population. Health systems fulfill three main functions: health care delivery, fair treatment to all, and meeting non-health expectations of the population. These functions are performed in the pursuit of three goals: health, responsiveness, and fair financing.

Informal sector: the part of the society/economy that is not registered with authorities and, whether with legal exclusion or without it (de jure or de facto), is not subject to public regulation and does not benefit from public services or goods. For example, support given by a family, friends, and members of a community in times of loss or illness effectively forms an informal risk-protection mechanism. Despite the presumption that such care is voluntarily given, in some cases (for example, providing care to foster children), payment may in fact be given.

Noncommunicable disease: a medical problem that will not improve, lasts a lifetime, or recurs.

Out-of-pocket (OOP) payment: fee paid by the consumer of health services directly to the provider at the time of delivery.

Purchasing pool: health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low- and high-risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Social insurance: compulsory plan under which participants are entitled to certain benefits as a matter of right. The plan is administered by a state or federal government agency aimed at providing a minimum standard of living for lower- and middle-wage groups. Social Security, unemployment compensation, etc., are social insurance programs.

Sources for glossary: Joint Learning Network for Universal Health Coverage, “Health Insurance Terms Glossary,” 2014, <http://www.jointlearningnetwork.org/health-insurance-glossary>; and Kaiser Family Foundation, “Health Reform Glossary,” 2014, <http://kff.org/glossary/health-reform-glossary/>.

4. China

China has made huge strides toward expanding health care for its citizens, starting with its 2009 Three-Year Reform Plan, which authorized an infusion of \$125 billion in targeted improvements in health insurance; essential medicines; public hospital reform; primary care delivery; and public health services with the goal of universal health coverage by 2020. The plan is a “massive undertaking,” according to the World Bank, requiring coordination across 15 national ministries.⁷⁷

China purposely started with a set of “shallow” benefits with plans for expansion.⁷⁸ Several of the programs initially covered only inpatient services, but since the end of 2010, coverage has gradually expanded to outpatient care. Still, as of 2010, beneficiaries bore more than half of inpatient costs and 60 to 70 percent of outpatient expenditures,⁷⁹ and hospital payment reforms have had the effect of encouraging hospitals to discharge early or even refuse admission to sick patients to control costs.⁸⁰

Though China now provides at least some coverage to more than 95 percent of the population, Chinese health reforms are struggling in the areas of resource distribution, regulation and accountability, human resources, and information technology. In addition, the Bank notes, “the current financing and delivery system struggles to transform financial input into effective, efficient, and quality care.”⁸¹ Estimates indicate health care costs could reach \$1 trillion by 2020, or about 7 percent of GDP, threatening deficit spending by health insurance funds by 2017.⁸²

Nonetheless, health experts laud China’s ambitious attempts at health reform although they say adjustments and perhaps a more modest time frame may be required.

⁷⁷ Lilin Liang and John C. Langenbrunner, *The Long March to Universal Coverage: Lessons from China*, UNICO Study Series No. 9 (Washington, DC: World Bank, January 2013), v, http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/01/000356161_20130201172145/Rendered/PDF/749600NWPOCHIN00Box374316B00PUBLIC0.pdf.

⁷⁸ Winnie Chi-Man Yip et al., “Early Appraisal of China’s Huge and Complex Health Care Reforms,” *Lancet* 379, issue 9818 (March 3, 2013): 833–42.

⁷⁹ *Ibid.*

⁸⁰ “Health Care Reform: Feeling Your Pain,” *Economist*, April 27, 2013, <http://www.economist.com/news/china/21576670-despite-extraordinary-progress-reforming-health-care-creating-almost-many-problems-it>.

⁸¹ *Ibid.*

⁸² *Ibid.*

5. India

India traditionally has provided low levels of funding for health; patients themselves pay more than three-quarters of health expenditures. But in the last decade, the country has initiated several efforts to increase coverage, especially to the poor. The National Rural Health Mission, established in 2005, has led to service delivery innovations and increases in government investments in health. Since 2007, new government-sponsored health insurance schemes have reformed systems to govern, distribute, and manage public health resources.⁸³

For example, the Rashtriya Swasthya Bima Yojana (RSBY) program, funded primarily through general government revenues, employs a smartcard technology to enroll poor rural and urban families and facilitate cashless provider reimbursements. RSBY rapidly and successfully expanded inpatient benefits to more than 142 million people, but other challenges remain. For example, the plan is based on inaccurate government means testing, which has allowed nonpoor citizens to receive fully subsidized care, even as people who are covered may not be using services at all.

“In some states, contracted private insurers seem to have high profit margins associated with little service use by enrollees, whereas other insurers struggle to break even,” Gina Lagomarsino et al. wrote in *The Lancet*. “Concern about fraud and quality control are also emerging; the system consists of many fragmented private providers with little quality control.”⁸⁴ The government has designed a quality management system in response that is now being implemented in five states.⁸⁵

⁸³ Somil Nagpal, *Expanding Health Coverage for Vulnerable Groups in India*, UNICO Study Series No. 13 (Washington, DC: World Bank, January 2013), v, http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/01/000333037_20130201141312/Rendered/PDF/750030NWP0Box300exp0anding0coverage.pdf.

⁸⁴ Lagomarsino, “Moving Toward Universal Health Coverage.”

⁸⁵ Ibid.



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