

Financing Universal Health Coverage in the Post-2015 Agenda

Issue Brief

Prepared by the Thematic Group on Health for All

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EXECUTIVE SUMMARY

Achieving universal health coverage (UHC) means implementing policies to ensure that all people receive the health services they need without suffering financial hardship. Most importantly, UHC is a critical and often cost-effective element in any strategy to address poverty and social exclusion, key pillars of the post-2015 sustainable development agenda. An effective UHC system requires several key components:

- 1) Adequate human resources (doctors, nurses, community health workers (CHWs), etc.)
- 2) Adequate facilities fully provided with essential drugs, equipment, and other supplies
- 3) Adequate financial resources so all people, regardless of wealth, can obtain needed services without experiencing financial hardship

Across the world, governments increasingly recognize that **public** financing mechanisms hold the key to UHC. Here the two main sources of funds are general government revenues (tax financing) and social health insurance contributions. Both of these mechanisms involve pre-payments into a pooled fund for equitable distribution and, most importantly, compulsory contributions. This ensures that the healthy and wealthy cross-subsidize the costs of health services for the sick and the poor, which is central to achieving UHC.

There are many estimates on how much financing is needed. Chatham House published a report recommending that all countries strive to spend at least US \$86 on health per capita, and achieve a target of spending 5% of GDP on health.¹ ODA and other forms of aid will be critical to achieve UHC in the least developed countries (LDCs) until such time as they are able to raise sufficient funds domestically.

INTRODUCTION

Considerable progress has been made in the achievement of the MDG targets on health. Under-five deaths worldwide fell from over 12 million in 1990 to around 6.6 million in 2012, and maternal deaths worldwide

¹ Chatham House. *Shared Responsibilities for Health A Coherent Global Framework for Health Financing*. 2014. Available at http://www.chathamhouse.org/sites/files/chathamhouse/field/field_document/20140521HealthFinancing.pdf

dropped by 47% over this period. Despite these achievements, several countries will not meet the targets, and many countries making progress have done so only in certain populations, increasing inequalities across socioeconomic gradients, ethnicity, gender, and geographically marginalized subgroups. If we hope to sustain progress during 2015-2030, much greater emphasis will need to be placed on reducing these inequalities. Universal health coverage (UHC), with its added emphasis on universality of coverage, provides a strategy that integrates improvement of average outcomes with closing gaps in achievement.

WHAT IS UHC AND WHY IS IT IMPORTANT?

Achieving universal health coverage (UHC) means implementing policies to ensure that all people receive the health services they need without suffering financial hardship. There are several inputs for an effective UHC system:

- 1) Adequate human resources (doctors, nurses, community health workers (CHWs), etc.)
- 2) Adequate facilities fully provided with essential drugs, equipment, and other supplies
- 3) Adequate financial resources so all people, regardless of wealth, can obtain needed services without experiencing financial hardship

For UHC, these must be organized by a well-governed health system that provides integrated, quality promotive, preventive, curative, palliative, and rehabilitative services. This includes public health services, such as infectious disease monitoring and ensuring food safety. Further, UHC must be supported by policies and services addressing the wider social and environmental determinants of health for individuals and populations. National commitment to universal health coverage must be embedded in a rights-based framework.

When implemented properly, UHC can dramatically improve health outcomes, reduce inequality, and generate economic growth. A study using data from 153 nations found that a 10% increase in government spending on health led to an average reduction of under-5 mortality by 7.9 deaths per 1000 and adult mortality by 1.6 (women) and 1.3 (men) per 1000. The source of the funding (government expenditure vs. out-of-pocket) was significant, with a *rise* of 11.6 female deaths per 1000 on average in response to a 10% higher out-of-pocket share.² The same study also demonstrated that “broader health coverage generally leads to better access to necessary care and improved population health, with the largest gains accruing to poorer people.”³ The Commission on Macroeconomics and Health⁴ quantified the link between improved health and greater economic growth, finding that a 10% improvement in life expectancy at birth increased economic growth by 0.3-0.4%. Finally, there is anecdotal evidence that the implementation of UHC is popular politically and has benefits for politicians supporting it.⁵

² Rodrigo Moreno-Serra and Peter C. Smith. Broader health coverage is good for the nation’s health: evidence from country level panel data. *Journal of the Royal Statistical Society A*. 2015.

³ Rodrigo Moreno-Serra and Peter C. Smith. Does progress towards universal health coverage improve population health? *The Lancet* 380. 2012. pp. 917–23. Available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61039-3/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61039-3/abstract).

⁴ *Macroeconomics and health: investing in health for economic development*. Report of the Commission on Macroeconomics and Health: Geneva: World Health Organization. 2001.

⁵ The Lancet Commission on Investing in Health. *Global Health 2035: Report of the Lancet Commission on Investing in Health*. Dean T. Jamison (chair). *The Lancet*. 2014. Available at <http://www.thelancet.com/commissions/global-health-2035>.

There is strong support by world governments for UHC. In December of 2012 the UN General Assembly passed a resolution on global health, which urged “governments, civil society organizations and international organizations to promote the inclusion of universal health coverage as an important element in the international development agenda, and in the implementation of the internationally agreed development goals.”⁶ The World Health Organization fully supports UHC, passing several resolutions on improving the quality of care, financing UHC, and monitoring progress towards UHC. WHO Director-General Margaret Chan said, “I regard universal health coverage as the single most powerful concept that public health has to offer. It is inclusive. It unifies services and delivers them in a comprehensive and integrated way, based on primary health care.” Several groups have also called on UHC to be a priority of the Sustainable Development Goals (SDGs) for the period 2015-2030, including the Open Working Group for Sustainable Development Goals,⁷ the Sustainable Development Solutions Network, the High Level Panel of Eminent Persons on the Post-2015 Development Agenda,⁸ and the Global Compact.⁹ Further, several existing international agreements commit countries to ensuring that all individuals have access to treatment when ill, and are protected from the risks of ill health and cost of treatment, including both the 1948 Universal Declaration of Human Rights and the 1966 UN International Covenant on Economic, Social, and Cultural Rights.¹⁰ The rights of workers to a safe and healthy environment are covered by several conventions of the International Labour Organization (ILO).¹¹

HOW TO FINANCE UNIVERSAL HEALTH COVERAGE (UHC)

Equity is key to UHC; every person must be covered and services must be allocated according to need, with the most vulnerable people the first to receive services. The goal is for an equal consumption of services in relation to need among all socioeconomic groupings (i.e. no difference between men and women, rich and poor, different racial or ethnic groups, various age cohorts, etc.) A free market for health services is unable to deliver this type of system. Publically financed UHC is the only means to achieve this end.

⁶ UN Resolution A/67/L.36. Available at http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36&referer=http://www.un.org/en/ga/info/draft/index.shtml&Lang=E.

⁷ Open Working Group for Sustainable Development Goals. *Outcome Document*. 2014. Available at <https://sustainabledevelopment.un.org/index.php?page=view&type=400&nr=1579&menu=35>.

⁸ High Level Panel of Eminent Persons on the Post-2015 Development Agenda. *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. 2013. Available at <http://www.un.org/sglmanagement/hlppost2015.shtml>.

⁹ UN Global Compact. *Post-2015 Agenda and Related Sustainable Development Goals Issue Focus: The Role of Business in Improving Health*. 2014. Available at https://www.unglobalcompact.org/docs/issues_doc/development/Post2015/Health_Issue_Brief.pdf.

¹⁰ The Universal Declaration on Human Rights (1948) states that, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care and necessary social services, and the right to security in the event of unemployment, sickness . . .” (<http://www.un.org/en/documents/udhr>) The International Covenant on Economic, Social, and Cultural Rights (1966) states that everyone has the right “To the enjoyment of the highest attainable standard of physical and mental health,” and calls for “The creation of conditions which would assure to all medical service and medical attention in the event of sickness.” (<http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>)

¹¹ For a full list of ILO conventions on occupational safety and health visit <http://ilo.org/global/standards/subjects-covered-by-international-labour-standards/occupational-safety-and-health/lang--en/index.htm>.

Financial contributions should be based on ability to pay, with the rich contributing the most and the poorest least. **Public** financing is essential. Progressive contributions should be pooled into a collective fund governed by the state to ensure equitable distribution, with the state as the main actor in raising sufficient revenue and spending it efficiently and equitably. Unfortunately, most countries currently use other private financing models, with negative effects on the affordability and equitable access to quality care.

Many health systems try to close gaps in funding by instituting user fees (charging patients for services).¹² However, there is a great deal of evidence from both poor and rich countries that user fees reduce utilization of health services, especially among the poorest households.¹³ A review of five studies found that the introduction of user fees at health facilities caused a reduction in healthcare utilization of 5–51% immediately after the introduction, and the reduction was slightly higher six months later. In contrast, the same review found that reduction or removal of user fees dramatically increased service utilization, with use of curative services rising by 30–50% immediately, and 18–93% a year later.¹⁴ The evidence also shows that user fees affect the poor more than the rich, with the poorest households reducing utilization the most, not seeking service when there are fees, and increasing utilization the most when fees are reduced or abolished.¹⁵ Some argue that user fees reduce the amount of unnecessary care provided, but the evidence from both developing and developed nations are that fees reduce both necessary and unnecessary utilization.¹⁶ Another option is voluntary or private health insurance. This option also leads to widening gaps in care between the wealthiest and poorest groups, and between the healthiest and chronically ill groups. Health economist Dean Jamison's research indicates that voluntary private insurance will not provide UHC effectively.¹⁷ There is a growing body of evidence that increased public spending on health improves outcomes, but increased private spending does not. One paper found that for every \$100 per capita increase in government spending on health under-5 mortality fell by 13.2 per 1000. The same increase in per capita spending of private funds had no effect on under-5 mortality.¹⁸

The World Health Assembly urges countries to “aim for affordable universal coverage and access for all citizens on the basis of equity,” and encourages pre-payment schemes and risk pooling to reduce

¹² A user fee is a fee that a patient must make in order to obtain treatment or other services from a health facility. Examples include consultation fees, medicine charges, hospital tax, etc.

¹³ For one such study see Paul Gertler and Jacques van der Gaag. *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries*. Baltimore, MD: The Johns Hopkins University Press. 1990.

¹⁴ WP Waiswa. *The impact of user fees on access to health services in low- and middle-income countries: RHL commentary*. The WHO Reproductive Health Library. Geneva: World Health Organization. Last revised 1 May 2012. Available at http://apps.who.int/rhl/effective_practice_and_organizing_care/cd009094_waiswaw_com/en.

¹⁵ Ari Johnson et al. Hidden costs: The direct and indirect impact of user fees on access to malaria treatment and primary care in Mali. *Social Science and Medicine* 75, pp 1786-1792. 2012.

Robert Yates. Universal health care and the removal of user fees. *The Lancet* 373, pp 2078-81. 2009.

M Lagarde and N Palmer. *The impact of user fees on access to health services in low- and middle-income countries (Review)*. The Cochrane Collaboration 4. 2011. Available at <http://apps.who.int/rhl/reviews/CD009094.pdf>.

¹⁶ M D Wong et al. Effects of cost sharing on care seeking and health status: results from the Medical Outcomes Study. *American Journal of Public Health* 91:11, pp 1889-94. 2011.

RAND Newhouse report <http://www.rand.org/content/dam/rand/pubs/reports/2006/R3469.pdf>.

¹⁷ Richard Lane and Dean Jamison. Putting economics at the heart of global health. *The Lancet* 382, pp 1871. 2013.

¹⁸ Rodrigo Moreno-Serra and Peter Smith. The Effects of Health Coverage on Population Outcomes A Country-Level Panel Data Analysis. Results for Development Institute Working Paper 2011. Available at <http://r4d.org/sites/resultsfordevelopment.org/files/Transitions%20in%20Health%20Financing%20-%20Effects%20of%20Health%20Coverage%20on%20Population%20Outcomes.pdf>

catastrophic payments.¹⁹ The solution to many of these challenges is greater public financing for healthcare. The two main sources of public funds are general government revenues (tax financing) and social health insurance contributions. Both of these mechanisms involve pre-payments into a pooled fund and, most importantly, compulsory contributions. This enables small contributions over time rather than large upfront costs for catastrophic care. The healthy and wealthy cross-subsidize the sick and the poor, which is vital for the equity principles underlying UHC. It is interesting to note that many countries are developing their own public financing systems using funds from both these sources – sometimes combining them into one large national fund (for example in Indonesia). However, collecting insurance contributions from unwaged people and the informal sector is a major challenge for governments so general taxation revenues are required to subsidize these population groups.

Most countries operate a hybrid system of public and private financing. But the emphasis should be placed on reducing out-of-pocket spending and ensuring equality in access to care for all people. Private finance and private insurance schemes should be restricted in their role; schemes such as cash benefits when hospitalized or to cover advanced care are still being evaluated for efficacy and safety. Attention should be paid to ensure that any publically financed care is equal in quality, affordability, and accessibility to private systems. Otherwise, issues of inequality are exacerbated rather than ameliorated.

HOW MUCH PUBLIC FINANCING IS NEEDED?

There have been many attempts to quantify the resources needed to provide high quality care to all people. Of course, a number of demographic, environmental, and cultural factors affect the overall health of a population, whilst the efficiency of healthcare delivery affects the overall cost, making it difficult to estimate costs across populations. It is therefore important that governments work with experts to determine what is most feasible in their country, and constantly evaluate and improve the efficiency of service delivery. That said, there are many good estimates of how much public financing is needed. Recently, Chatham House published a report recommending that all countries strive to spend at least US \$86 on health per capita.²⁰ This estimate is a significant increase from the recommendations put forward in 2001 by the Commission on Macroeconomics and Health that recommended a target of US \$34 per capita.²¹ The expansion of AIDS, smoking, and non-communicable diseases in the past decade are the leading causes of rising healthcare costs.

Another important way to look at health financing is in terms of the percent of a country's GDP spent by governments on health. The Chatham House report recommends that countries strive to spend 5% of GDP on health. This target is also supported by the 2010 World Health Report on financing for UHC that states, "Countries whose entire populations have access to a set of services usually have relatively high levels of [mandatory] pooled funds – on the order of 5–6% of gross domestic product (GDP)." The report also states "It is difficult to get close to universal coverage at less than 4–5% of GDP, although for many low- and

¹⁹ World Health Assembly Resolution WHA64.9. 24 May 2011. Available at http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R9-en.pdf?ua=1

²⁰ Chatham House. *Shared Responsibilities for Health A Coherent Global Framework for Health Financing*. 2014. Available at http://www.chathamhouse.org/sites/files/chathamhouse/field/field_document/20140521HealthFinancing.pdf

²¹ Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development*. World Health Organization. 2001. Available at <http://whqlibdoc.who.int/publications/2001/924154550x.pdf>.

middle-income countries, reaching this goal is aspirational in the short term and something to plan for in the longer run.”²² Taking sub-Saharan Africa as an example, the \$86 per capita spending comes to about \$80 billion USD, or about 5% of the region’s GDP.

As the chart below illustrates, there is a strong correlation between government spending and out-of-pocket spending, with out-of-pocket spending only falling below 20% of total spending when public spending is around 6% of GDP. In addition, using data from the World Health Statistics dataset, we can calculate that the global average of government health care expenditure is 5.1% of GDP. All countries should strive to reach at least this level of financing. It is important that countries strive to meet both the per-capita spending as well as the GDP target; in countries with low tax revenue, even 5% of GDP could be insufficient to provide adequate, affordable services to all people.

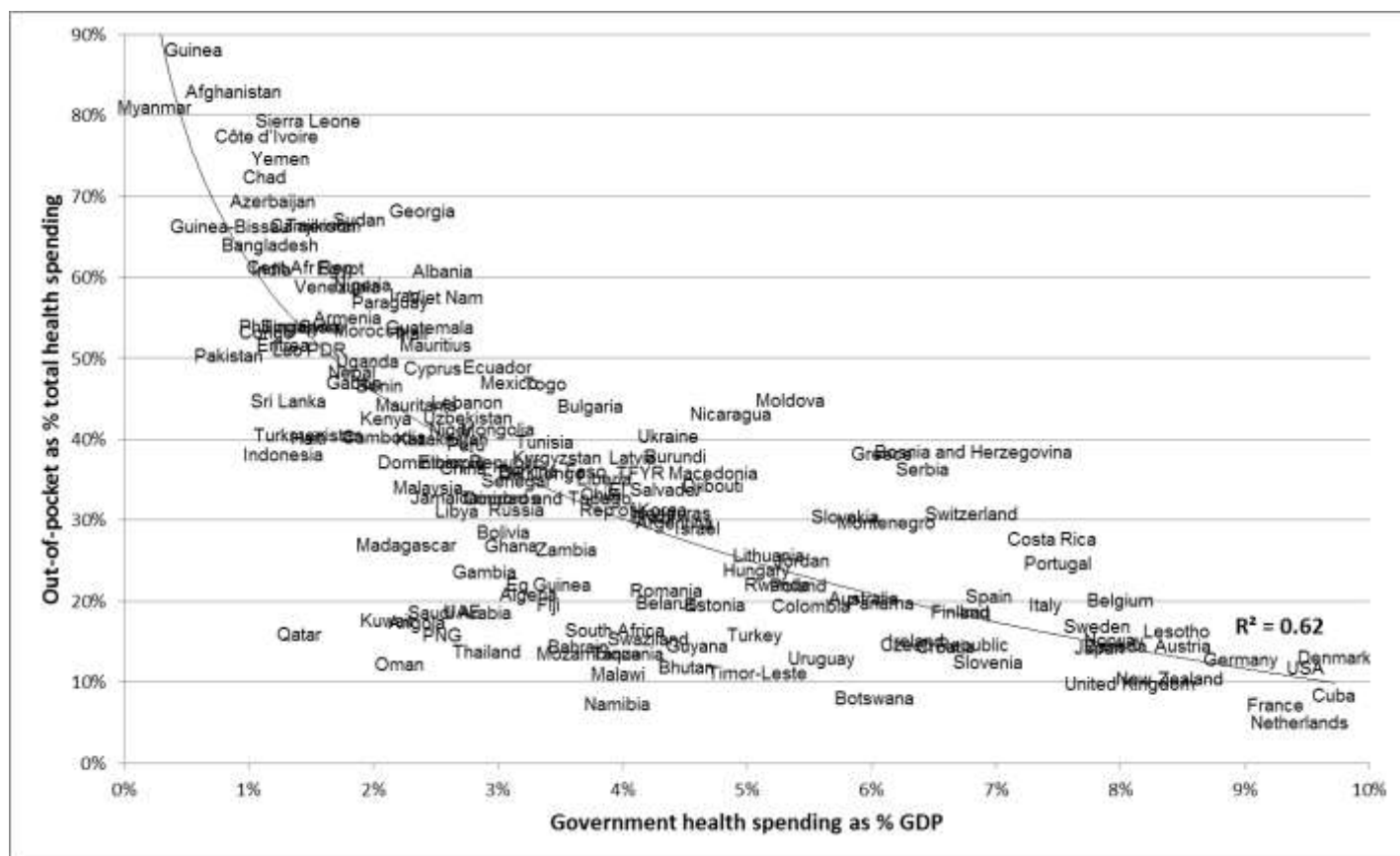


Figure 1: Relationship between government health spending and dependence on out-of-pocket payments (2010)²³

²² WHO. *The World Health Report: Health systems financing the path to universal coverage*. 2010. Available at <http://www.who.int/whr/2010/en>

²³ Updated from D McIntyre & J Kutzin. Revenue collection and pooling arrangements in health system financing. In R Smith & K Hanson (eds.). *Health systems in low- and middle-income countries*. Oxford: Oxford University Press. 2011.

Another metric for financing is the share of the national budget spent on healthcare. This was accepted globally in the Abuja Declaration²⁴ where African countries pledged to spend 15% of their national budgets to the health sector. However, there is broad agreement that spending as a percentage of GDP is a more useful metric, as it encourages countries to consider both revenue generation as well as distribution.

It will be important that countries increase the size of their overall budgets so as to meet both the percentage targets as well as the per capita spending target. Raising taxes or reducing subsidies are policy options to increase government revenue overall. Countries should evaluate their fiscal space to support decision-making, looking at whether their tax to GDP ratio is appropriate or if they can revise tax policy to achieve UHC. Many taxes can have the added benefit of improving public health through changing behaviors; examples include taxes on tobacco and alcohol, which would reduce the overall burden of disease while raising funds to cover healthcare costs. Reducing fossil fuel subsidies, or taxing harmful emissions of nitrogen dioxide, sulfur dioxide, and carbon dioxide would improve air quality and health, and reduce greenhouse gas emissions, slowing climate change. In addition, there are many creative ways to raise new funds. Gabon instituted a tax on money transfers and a tax of 10% on two telecom companies and was able to raise around US \$30 million for healthcare in 2009. Another option is to leverage major sectors of the economy, such as oil and gas, mining, or other activities to generate government revenue. Addressing tax structures can further raise funds. Indonesia saw a dramatic increase in tax revenue by simplifying their tax code to make compliance easier and moving to a digital process to raise efficiency.²⁵ Globally, addressing tax havens, leveling the playing field on corporate tax rates, and increasing the financial transparency of multinational corporations could be transformative.

SPENDING PUBLIC FUNDING EFFICIENTLY – GETTING MORE HEALTH FROM THE MONEY

Once adequate funding has been raised, it is important to allocate funds efficiently and equitably to achieve UHC. Throughout the entire health system, there are many opportunities to improve efficiency by investing in cost-effective primary health care services including preventative care, the utilization of ICT-enabled community health workers, use of generic medicines, reduction in unnecessary prescriptions and procedures, the elimination of corruption, and more. Some experts believe that most health systems could improve technical efficiency by as much as 40%,²⁶ making the overall system significantly more cost-effective, whilst other evidence shows that many countries have financed more than 50% of the cost of large scale service expansions from productivity improvements.²⁷ A 2011 study found, for example, that the cost of medicines for treating cardiovascular disease in Sri Lanka was a fraction of the cost per capita than that of Nepal.²⁸ A more efficient procurement system in Sri Lanka is the main driver of this difference, and many countries could make funds go farther with active or strategic purchasing plans.

²⁴ Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. OAU/SPS/Abuja/3. 2001. Available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

²⁵ World Health Organization. *World Health Report 2010 Health Systems Financing: The Path to Universal Coverage*. 2010. Available at <http://www.who.int/whr/2010/en>.

²⁶ World Health Organization. *World Health Report 2010 Health Systems Financing: The Path to Universal Coverage*. 2010. Available at <http://www.who.int/whr/2010/en>.

²⁷ Ravindra P. Rannan-Eliya. Productivity Change in Health Services in Developing Countries: Some Empirical Estimates. In *Health Care Systems In Developing And Transition Countries*. Diana Pinto Masís and Peter C. Smith (eds.). London, UK: Edward Elgar Publishing. 2009.

²⁸ Shanthi Mendis et. al. Total cardiovascular risk approach to improve efficiency of cardiovascular prevention in resource constrain settings. *Journal of Clinical Epidemiology* 64. pp1451-1462. 2011.

Many countries could make funds go farther with active or strategic purchasing plans. In many LMICs, governments pay little attention to mechanisms to improve quality or efficiency. Strategic purchasing involves proactive and explicit decision-making of predefined outputs and outcomes, linking payment to the delivery of these pre-defined products, and selecting the most qualified and efficient providers. The purchaser seeks to improve allocation of resources and service delivery to maximize population health and reduce financial risk.²⁹ Critical factors that influence the effectiveness of purchasing as a policy instrument include: (1) provider payment methods (PPM), and (2) the organizational structure of purchasers.

Each provider payment method has strengths and weaknesses. Fee-for-service (FFS) reimbursement can cause providers to perform unnecessary services to increase incomes. When FFS is combined with expansion of service coverage, it can lead to rapid health expenditure growth and threaten the sustainability of financing, unless it is combined with measures to set an overall, global budget for FFS payments to providers. For example, with China's recent expansion of health insurance coverage the financial burden on households has not fallen, but increased in some cases because health expenditure has grown at an even faster rate.³⁰ However, in Japan and Germany, FFS combined with globally-set budget caps have facilitated expansion of coverage and effective cost control. In countries where services are underprovided, FFS can be used in the initial phase to incentivize providers to offer more services. Some countries (Ghana, Indonesia) have used this mechanism as a way to get buy-in from providers and boost utilization.³¹ However, efforts should be made from the earliest stages to plan for a transition to staying within an overall budget cap, in order to avoid encouraging providers to over-provide in the long term. These include prospective payment methods such as capitation, global budgets, or case-based payment (typically based on Diagnosis-Related Groups) that is combined with volume caps that limit overall expenditure growth beyond a pre-determined limit, as observed in many countries.

Some countries are attempting to move away from fee-for-service models to alternative models, such as prospective payments (e.g., use of DRGs) or capitation. However, these often require more capacity to manage, and do not always result in lowered health systems costs. The global experience is that the use of a global budget with measures to control payments to providers to achieve policy goals are more important, whatever the payment mechanism.

A purchasing agency comprised of key stakeholders should determine the universal benefit package, make policy rules and guidelines, determine providers' reimbursement mechanism, and select efficient and high quality providers to contract. Government agencies (health ministries, local health authorities, public autonomous agencies) can take the lead, involving health insurance agencies (including in the private sector), non-governmental organizations (NGOs), the public, and other actors with capacity to select the best

²⁹ Josep Figueras, Ray Robinson, and Elke Jakubowski (eds.). *Purchasing to improve health systems performance*. European Observatory on Health Systems and Policies Series. 2005. Available at http://www.euro.who.int/_data/assets/pdf_file/0004/98428/E86300.pdf.

³⁰ Qun Meng et al. Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study. *The Lancet* 379, pp 805-814. 2012.
W Yip et al. Early appraisal of China's huge and complex health-care reforms. *The Lancet* 379, pp 833-42. 2012.
A Wagstaff and M Lindelow. Can insurance increase financial risk? The curious case of health insurance in China. *Journal of Health Economics* 27:4, pp 990–1005. 2008.

³¹ Akiko Maeda et al. *Universal health coverage for inclusive and sustainable development: a synthesis of 11 country case studies*. World Bank Publications. 2014.

value services. This agency should act on behalf of the population and purchase in bulk for efficiency and cost effectiveness. It would also be essential for this body to set standards on appropriate income levels of physicians and other health workers and to ensure equitable distribution of services.

New technologies leveraging ICT for health can also generate opportunities to raise efficiency. Smartphone-equipped community health workers (CHWs) are easier to manage, can be paid through mbanking apps, and can receive additional smartphone-based trainings. Smartphones also enable workers in the field to receive mobile diagnostic assistance at a lower cost than transporting a patient.^{32, 33} Using ICT across a health system can improve data collection and monitoring trends across populations and improve record keeping on individual patients. Investing in ICT for health has high upfront costs and cost-effectiveness will vary across health systems, but opportunities should be explored.

Efficiency can also be increased through global pooling mechanisms like the GAVI Alliance (Global Alliance for Vaccines and Immunization). GAVI seeks to ensure all children receive WHO-recommended vaccines by fostering collaboration between UN agencies, international development banks, donors, the pharmaceutical industry, and both public and private service providers. They work to reduce redundancies across the system and increase synergies to improve vaccine development, procurement, and deployment. They also support global advocacy and educational campaigns. As a result of their work, the number of children receiving vaccines is at an all-time high and financial resources have been mobilized. In a similar way the Global Fund to Fight AIDS, Tuberculosis, and Malaria has brought together numerous stakeholders across all sectors to hasten progress on MDG 6. The global fund has been critical in both improving the quality of HIV/AIDS care in sub-Saharan Africa and reducing the cost of treatment. These successful partnerships offer solutions to the world's most pressing health challenges, and there are many other health issues that lend themselves to these solutions. However, global support for these organizations, both in terms of expertise and funding, is critical.

If and when strategic purchasing conditions exist, there could be increases in efficiency by purchasing from both public and private service providers. In many LMICs, the private sector already exists and efforts should be made to strategically leverage the private sector to supplement public provision and to foster collaborations. There is some preliminary evidence that this may be the case in China,³⁴ and there may be other settings in which a hybrid model can address the challenges and opportunities of both systems, provided that there are mechanisms for coordination of effort, control of costs, and collaboration of many stakeholders. More research is needed in specific country contexts.

National oversight of UHC also enables countries to focus more on preventative medicine, by valuing the prevention of disease over more costly treatment later. Further, when care is affordable, people are more

³² 1 Million Community Health Workers Campaigning. *About Us*. Accessed January 2015 at <http://1millionhealthworkers.org/about-us>.

³³ Broadband Commission Task Force on Sustainable Development. *Means of Transformation Harnessing Broadband for the Post-2015 Development Agenda*. The Broadband Commission. 2014. Available at <http://www.broadbandcommission.org/focus-area/Pages/post2015.aspx>.

³⁴ Gordon G. Liu et al. The role of for-profit hospitals in medical expenditures: Evidence from aggregate data in China. *China Economic Review* 20, pp 625-633. 2009.

Judy Xu et al. A comparison of outpatient healthcare expenditures between public and private medical institutions in urban China: An instrumental variable approach. *Health Economics*. 2013.

likely to seek medical attention earlier, avoiding more expensive care for more serious conditions. Governance of the health systems at the national level should integrate their priorities with other sectors to better address the social and environmental determinants of health, such as tobacco and alcohol use or air pollution. Health policies can also be better integrated with policies for transportation, household energy, food policy, and other programs that affect human health.

Finally, it will be important that countries keep up-to-date on the most effective treatments for disease, from an outcome and cost perspective. In the UK the National Institute for Health and Care Excellence (NICE) conducts research on health outcomes based on interventions, performs cost-benefit analyses, makes recommendations for covered services, and sets standards for treatment, working in partnership with patients, practitioners, and industry. They pride themselves that science-based guidelines are the result of rigorous, objective studies.³⁵ In Thailand, the Health Intervention and Technology Assessment Program provides a similar function, assessing drugs, equipment, new technology, and clinical practices for effectiveness.³⁶ These impartial agencies are best able to make recommendations on standards of care, to ensure quality and cost effectiveness. The methods of determining what will be covered by UHC and public funds will vary across countries, but each country will need a body to advise health systems about what drugs, procedures, and care options should be covered by UHC.

THE ROLE OF PRIORITIZATION TO ACHIEVING UHC

In practice, no country or society can afford to finance publicly or in any other way every possible service at the highest quality for all citizens and without any restrictions. However, this does not mean that UHC is never attainable. The essence of UHC is that all citizens should have equitable access to a level of care that is considered by that society to be meet a minimum acceptable threshold. For example, in Bangladesh UHC does not provide unfettered access to heart transplants to everyone with cardiac failure, but heart transplants may be part of the socially acceptable minimum threshold in a rich northern European country for patients with medical need. This means that in every country achieving UHC involves prioritizing what is covered in the package of care that everyone should have access to, and during expansion of coverage what elements and populations are covered first.

Generally countries moving towards UHC can prioritize and expand coverage in three different ways:

- (i) They can prioritize coverage to certain groups, *e.g.*, extend insurance schemes to cover the formal sector workers first. A common risk with this approach is that those who are initially covered may oppose expanding coverage to others later, especially if it means cross-subsidizing new beneficiaries.
- (ii) They can cover everyone but limit the range of health interventions initially covered, *e.g.*, cover outpatient services or maternal and child health care first. This can support a progressive attainment of UHC, by allowing the health care system to incrementally add services. However, countries find it useful not to prioritize services purely on the basis of cost-effectiveness, and to also consider financial risk protection aspects. For this reason, countries on this path typically

³⁵ See <http://www.nice.org.uk>.

³⁶ See <http://www.hitap.net>.

fund most inpatient care before they fund most outpatient care. This approach can also benefit from mechanisms to use evidence to decide what services should be prioritized.

- (iii) They can cover most medical treatments so that nobody is denied needed care, but skimp on non-clinical aspects, such as allowing patients to have their own rooms or the convenience of when patients can see a doctor. Several developing countries with UHC have done this, implicitly encouraging richer patients who want superior care to seek private care. This reduces the burden on public financing, *e.g.*, Sri Lanka and Malaysia. However, this approach carries the risk that the poor may be provided worse clinical care, and the ability to prevent this may depend on a country's politics and the strength of its health governance. It may have an inflationary effect on what people expect from health care services since the additional services available for richer patients could become readily visible by the media.

THE ROLE OF DEVELOPMENT ASSISTANCE

In many low-income countries, development assistance will be critical to achieving UHC, especially in the interim period during which they will try to grow their GDP and raise government revenues for long-term self-sufficiency in supporting UHC. Development assistance will be crucial for the poorest countries over the period 2015-2030, as countries try to make progress along all the SDGs, including those on health. What countries need is effective aid to augment their public budgets, with aid prioritized to providing primary health care to the poorest segments of a population. It will be crucial that wealthy countries meet their pledge to provide 0.7% of GNI in ODA and an additional \$100 billion per year in official climate financing by 2020.