Towards Universal Social Protection: Lessons from the Universal Health Coverage Initiative

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Towards Universal Social Protection

Lessons from the Universal Health Coverage Initiative

By Ji-Yeun Rim and Caroline Tassot
Universal social protection (USP) is becoming high priority in many developing countries’ agendas. However, information on what has worked well – and not so well – is limited. This study reviews a wide range of recent country experiences with universal health coverage (UHC) financing and implementation in order to draw lessons and help governments elaborate policies for USP and the extension of social protection. It looks at different pathways and delivery and financing challenges to universalism in health coverage and takes a close look at equity issues. It concludes with some key takeaways from UHC implementation and its implications for USP. One important message of this study is that while the UHC experience cannot be mechanically transposed to the USP agenda, a number of lessons can be drawn. Moreover, the benefits in terms of coverage and equity of better integrating USP and UHC appear tremendous.
Foreword

The quest for universal social protection is becoming a high priority in national and global agendas. As policy makers and development partners consider the possibility of supporting universal social protection, the need to draw lessons from ongoing initiatives that champion universality in social protection becomes apparent. This is why examining the experiences accumulated with the implementation of the universal health coverage (UHC) agenda is of considerable interest.

This study is an important contribution to the Development Centre’s work on inclusive societies and its objective to help partner countries identify emerging issues, design innovative solutions to social challenges and build more cohesive societies. During the Fifth High-level Meeting of the OECD Development Centre Governing Board, the Centre’s member countries adopted a Policy Statement with key principles on advancing Universal Social Protection and calling upon all countries to live up to their commitments to develop nationally owned social protection systems, including social protection floors, coherently with Agenda 2030 and the relevant SDGs.

The study challenges us to think deeply about the interlinkages between access to healthcare and social protection coverage. It is intended to sharpen our understanding of the challenges and opportunities to deliver on and finance universality; how equity is being conceptualised, managed and measured as countries move along the UHC road; how trade-offs within dimensions of equity and between equity and other social goals are being managed; what influences these choices; and, ultimately, what lessons can be drawn from recent UHC achievements for the conceptualisation and implementation of universal social protection (USP) and the possible integration of UHC and USP.

This work provides a thorough quantitative and qualitative review of UHC implementation, including country experiences from Burkina Faso, Ghana, India, Indonesia and Kyrgyzstan.

This work adds to the policy debate on the links between universal social protection and UHC in two important ways: first, it demonstrates that progress on USP and UHC can take different paths but that these are often mutually supportive at country level. A long-term and system approach would be needed to better exploit the synergies between the two initiatives. Second, it shows that besides similar inclusive development goals, UHC and USP also share a number of common challenges, such as the problem of the “missing middle”, with basic service provision available for the poor and more comprehensive support available only for the wealthiest, leaving the near-poor very vulnerable.

We hope it will stimulate discussion among development stakeholders on some of the common barriers and possible solutions to USP.

Mario Pezzini
Director of the OECD Development Centre
and Special Advisor to the OECD Secretary-General on Development
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The team was led by Alexandre Kolev, Head of the Social Cohesion Unit, and Ji-Yeun Rim, Co-ordinator of the EU-SPS, under the guidance of Mario Pezzini, Director of the OECD Development Centre and Special Advisor to the OECD Secretary-General on Development, and Federico Bonaglia, Deputy-Director of the OECD Development Centre. The report was drafted by Ji-Yeun Rim and Caroline Tassot, drawing from background papers prepared by Oxford Policy Management, with inputs from Alexander Pick and Riku Elovainio of the OECD Development Centre and Anna Choi, Independent Expert.

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### Abbreviations and acronyms

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<tr>
<td>ASPIRE</td>
<td>Atlas of Social Protection Indicators of Resilience and Equity</td>
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<tr>
<td>BDT</td>
<td>Unified Database (Basis Data Terpadu)</td>
</tr>
<tr>
<td>BPJS</td>
<td>National Social Security Administration (Badan Penjamin Jaminan Sosial)</td>
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<tr>
<td>BPL</td>
<td>below poverty line</td>
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<tr>
<td>CBHI</td>
<td>community-based health insurance</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>EU-SPS</td>
<td>European Union Social Protection Systems Programme</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>HAQ</td>
<td>Healthcare Access and Quality</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>JKN</td>
<td>Public Health Insurance (Jaminan Kesehatan Nasional)</td>
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<tr>
<td>LEAP</td>
<td>Livelihood Empowerment Against Poverty programme</td>
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<tr>
<td>LMICs</td>
<td>low- and middle-income countries</td>
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<tr>
<td>MCH</td>
<td>maternal and child health</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MLSD</td>
<td>Ministry of Labour and Social Development</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NCD</td>
<td>non-communicable disease</td>
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<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>OOP</td>
<td>out-of-pocket (expense)</td>
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<tr>
<td>PBPU</td>
<td>non wage or informal workers</td>
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<tr>
<td>PKH</td>
<td>Family Hope Programme (Program Keluarga Harapan)</td>
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<tr>
<td>PPU</td>
<td>wage or formal workers</td>
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<tr>
<td>PPP</td>
<td>purchasing power parity</td>
</tr>
<tr>
<td>RAMU</td>
<td>National Health Insurance Scheme (Régime d’Assurance Maladie Universelle)</td>
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<tr>
<td>RSBY</td>
<td>National Health Insurance Scheme (Rashtriya Swasthya Bima Yojana)</td>
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<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>THE</td>
<td>total health expenditures</td>
</tr>
<tr>
<td>TNP2K</td>
<td>National Team for the Acceleration of Poverty Reduction (Tim Nasional Percepatan Penanggulangan Kemiskinan)</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>USP</td>
<td>universal social protection</td>
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<tr>
<td>USP2030</td>
<td>Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals</td>
</tr>
<tr>
<td>VAT</td>
<td>Value Added Tax</td>
</tr>
<tr>
<td>WDI</td>
<td>World Development Indicators</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WB</td>
<td>World Bank</td>
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Policy makers across the world are increasingly seeking a way to deliver on and finance universal social protection (USP), as enshrined in the Universal Declaration of Human Rights and spelled out in Goals 1.3 and 3.8 of the 2030 Agenda for Sustainable Development. Efforts to move towards USP are also mirrored in the launch of the Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals (USP2030) in 2016. Looking ahead, in order to help governments invest in the extension of social protection and inform policy guidance on universalisation, information on what has worked well – and not so well – in terms of universal provision and financing is greatly needed. In this context, the necessity to draw lessons from ongoing initiatives that champion universality in social protection becomes apparent.

The main objective of this study is to review a wide range of recent country experiences with universal health coverage (UHC) implementation, to which policy makers may refer in order to draw lessons and elaborate on their own pathways to USP. It asks the following key questions: What lessons can be drawn from UHC for USP? How can we monitor progress towards universal delivery and what do we need in terms of data systems? How can we address gaps in investments and resources to finance UHC and USP? What are the different options and modalities taken by countries to reach the shared objective of universal social protection? Are some models more conducive to equity? What are the linkages between UHC and USP?

This study starts with the recognition that investing in UHC has a strong economic, social and political rationale. From a pure economic rationale, access to health care can help households cope with risks and protect their consumption and assets against adverse shocks, which leads to a more efficient use of resources. UHC can also affect the allocation of resources and time use in the household, which in turn have implications for income growth (OECD, 2019[1]). Besides its instrumental goal, health coverage can also convey political and social values, such as social solidarity, inclusion, reconciliation, participation, confidence in public stewardship and human rights. Entitlement to health coverage and financial protection is an important good even in the absence of need and utilisation.

This study is based on a mix of quantitative and qualitative data analysis, including in-depth case studies conducted in Burkina Faso, Ghana, India, Indonesia and Kyrgyzstan. The findings show that while the UHC experiences cannot be mechanically transposed to the USP agenda, a number of lessons can be drawn.

First, context matters; countries have chosen different healthcare extension paths and there is no single blueprint for delivering on universality. By and large, the review of UHC reform shows that trajectories are driven by political economy considerations, including domestic politics, actors and interests; the role of development partners; and international agendas. Progress in universal provision has also been achieved through quite different modalities of delivery and financing, and policy approaches.
Second the difference between reality and rhetoric can be important when it comes to adequate and equitable financing and delivery issues. Experiences from UHC implementation suggests that no welfare system can continue to expand the coverage and depth of its benefits without the necessary resources. While overall health represents a tiny share of total ODA, the domestic financial commitment to health has been too limited to support equitable UHC in some settings. On the path to UHC, developing countries face the dual challenge of resource mobilisation and resource allocation. Although there is no one path to UHC, there appears to be some convergence on core design issues, including moves towards integrated pooling, single purchaser systems, which mix contributory and non-contributory members. Moreover, there is growing evidence that not all health sector policies that are considered UHC are necessarily equitable or pro-poor, or at least not to the fullest extent. Many UHC policies have focused on financial entitlements of population groups without a matched emphasis on the equitable availability and quality of healthcare supply. This has often undermined the effectiveness of UHC policies. More comprehensive and participatory policies that address supply-side and demand-side constraints and engage communities in design issues tend to have achieved better results.

Third, whatever the model is, UHC has close linkages with social protection and UHC should not be considered a stand-alone or isolated policy scheme. UHC and social protection share the common goals of reducing vulnerability, increasing protection against shocks, and investing in human capability. Moreover, social protection and UHC are mutually supportive in several ways. On the one hand, governments with the motivation and resources to develop one are also likely to invest in the other. Health system reforms have indeed often taken place in the context of broader welfare policy expansion. On the other hand, social protection measures can be crucial in eliminating demand-side barriers to accessing health services, thus supporting UHC. While many countries acknowledge the interlinkages between social protection and UHC, policies are typically articulated independently. Often, the lack of a national poverty identification system, funding constraints, decentralisation of health insurance schemes, or institutional rigidity hamper better synergies between programmes. The lack of integration of institutions and agencies working on health and social protection highlights the need for long-term approaches and system-building processes. Health and social protection stakeholders are most likely to interact at the targeting level, when identifying eligible populations and enrolling them in programmes. Such interaction is particularly crucial for households exiting social assistance programmes, who are very vulnerable when facing the risk of health expenditures and a potential fall back into poverty. The systems-building process usually begins with the formulation of a social protection policy, which lays out a vision for integrating different schemes and achieving better coverage. Integration can also happen across pillars. Health system policies and mechanisms designed to support UHC can be considered to both cut across the three pillars of social protection and to represent a fourth pillar of a social protection system. The benefits of an integrated social protection system are manifold. It facilitates provision of a social protection floor, whereby individuals are appropriately protected throughout the life cycle. The OECD Social Protection System Review: A Toolkit recommends assessing information sharing across the social protection sector through information management systems, as well as linkages between social protection registries and other databases, such as civil registries or census data.

Fourth, health and social protection policy makers often grapple with similar challenges in terms of coverage, targeting, financing and monitoring. Enrolment rates in social insurance programmes remain a challenge both for UHC and USP. Moreover, while the focus on targeted subsidies in health and social assistance offers potential gains in efficiency and
equity, risks are also created. One the one hand, any targeting errors or barriers to registration for households will be multiplied across sectors, with the potential for an exacerbation of inclusion and exclusion errors regarding the targeted beneficiaries. On the other hand, rigid targeting systems can leave the near-poor exposed, thereby highlighting the need for either a fully universal system (wherein all have automatic entitlement to a shared package, financed from pooled resources such as taxes) or a more graduated approach in the implementation of UHC and USP in order to avoid abrupt cut-off points for entitlement. Financing is another area where social protection programmes and UHC face similar challenges. Across the country case studies, there appears to be a convergence on social health insurance, funded in large segments through tax financing, as a common mechanism for progressing towards UHC. However, adequate funding levels and mechanisms remain a challenge, especially when domestic resource mobilisation is limited and when national growth is slowing. An empirical analysis of 10 countries carried out by this study shows that out-of-pocket (OOP) payments as a percentage of total health expenditure declined in each country since 2000, with the exception of Indonesia. However, none of the 10 countries are below the 20% of the total household expenditure threshold which has been recommended by the WHO to keep catastrophic health expenditures within acceptable levels, indicating that further progress is needed on financial protection. Moving towards universal provision comes also with new requirements in terms of accountability mechanisms and monitoring systems, while also putting forward the question of private providers’ real capacity to fill the gap in public provision in countries with limited regulatory capacities.

This study argues that while the UHC experience cannot be mechanically transposed to the USP agenda, a number of lessons can be drawn. The report starts by analysing the pathways to universalism in health coverage (Section 1). It then takes a close look at equity issues, drawing on country-level experiences (Section 2). Section 3 then discusses the linkages between UHC and USP, and concludes with some key takeaways from UHC implementation and its implications for USP.
1. The pathways to universal health coverage

Policy makers across the world are increasingly seeking a way to deliver on universal social protection (USP), as enshrined in the Universal Declaration of Human Rights and spelled out in Goals 1.3 and 3.8 of the 2030 Agenda for Sustainable Development. Efforts to move towards USP are also mirrored in the 2016 launch of the Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals (USP2030). During the Fifth High-level Meeting of the OECD Development Centre Governing Board, the Centre’s member countries adopted a Policy Statement with key principles on advancing Universal Social Protection and calling upon all countries to live up to their commitments to develop nationally owned social protection systems, including social protection floors, coherently with Agenda 2030 and the relevant SGDs. Looking ahead, in order to help governments invest in the extension of social protection and inform policy guidance on universalisation, evidence and information on what has worked well – and not so well – in terms of universal provision is greatly needed. In this context, the necessity to draw lessons from ongoing initiatives that champion universality in social protection becomes apparent. This section examines five countries’ experiences with universal health coverage (UHC) and draws lessons on the challenges related to equity of coverage, impact measurement and financing.

1.1. A short history of UHC

Universal health coverage means 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” (WHO, 2010[2]). UHC “is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion” (WHO, 2017[3]). Reducing poverty and promoting equity and inclusive development have also been fundamental principles driving national and global social protection initiatives. Access to healthcare constitutes a core part of social protection, and indeed social protection measures can impact both healthcare needs and financial capacity to access health services. Consequently, policies seeking to expand healthcare provision and social protection have often occurred hand in hand.

The 1978 Alma-Ata conference on primary health care brought together UHC and social protection for the first time as global policy recommendations to achieve equity and social inclusion. The resulting “Health for All” Declaration affirmed access to healthcare as a human right and as a social goal and economically imperative measure for all societies. Universal access to healthcare was seen as achievable only in conjunction with public social protection measures and social and economic development (WHO, 2008[4]). The Declaration also stressed the need for holistic health systems and comprehensive coverage, which would go beyond coverage to also reach a decent level of benefits, including prevention and health promotion services. This was seen as the only plausible path to guaranteeing good health as opposed to merely providing medical treatment to people when they are sick (Navarro, 1984[5]).
Since Alma-Ata, initiatives to extend healthcare coverage have received varying support within the global health community. Throughout the 1980s, the implementation of Structural Adjustment Programmes (SAPs) – a form of conditional lending introduced by the World Bank, the US Treasury and the International Monetary Fund (IMF) in the developing countries shaken by oil crises and conflicts and with the view to restore macroeconomic stability – largely contributed to erode public healthcare systems due to their conditionalities, including: 1) the reduction of spending on public health; 2) the introduction of user fees or cost sharing; and 3) the focus on a very restricted package of services (Kentikelenis, Stubbs and King, 2015[6]; Robert and Ridde, 2013[7]; Thomson, Kentikelenis and Stubbs, 2017[8]). In order to respond to the challenges of under-funded healthcare systems, the World Health Organization’s (WHO) Africa Regional Assembly of 1987 launched the Bamako Initiative, consequently adopted by several African countries. The Bamako Initiative sought to improve the efficiency and effectiveness of health financing at national level in order to promote equity. Key measures included the reorganisation of health services, cost-sharing schemes and the sale of essential drugs at a low cost (Knippenberg et al., 1997[9]). However, due to the continued collection of user fees and additional revenue extraction through drug sales without adequate exemptions for the poor, the measures had a negative impact on equity with large out of pocket payments among poor households (Ridde, 2003[10]; Uzochukwu and Onwujekwe, 2004[11]).

Thirty years after the Alma-Ata conference the values of people-centred primary healthcare, community participation and equity again came to the fore with a reinvigorated and broad interest in UHC as a driver of social inclusion and poverty reduction (WHO, 2008[4]). In 2005, the World Health Assembly (WHA) explicitly defined UHC for the first time as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access”. This was coupled with the WHA58.33 resolution calling for financial mechanisms such as prepaid and pooling systems to facilitate achievement of UHC. In 2010, the WHO stated that if governments wanted to come close to universal coverage they needed to reduce reliance on direct payments by encouraging the risk-pooling and prepayment approach (WHO, 2010[2]). In 2012, the United Nations General Assembly called on all governments to “urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services” (UN, 2012[12]).

The global momentum for UHC has intensified since the Sustainable Development Goals (SDGs) were adopted in 2015. While the Millennium Development Goals (MDGs) targeted specific conditions (e.g. malaria) and populations (mothers and children), the SDGs redirected attention to a broader transformation of healthcare systems. They emphasised the need to “ensure healthy lives and promote well-being for all at all ages” (SDG3), alongside the need for greater social protection, as well as the reduction of inequality within and among countries (SDGs 1.3 and 10, respectively). The Social Protection Floor Initiative, introduced in 2012 by the International Labour Organization (ILO), reinforced this message.

In parallel with the increased focus on UHC, a growing concern emerged about rising inequalities and how to tackle them at both global and national levels (Collier, 2007[13]; Lawson and Martin, 2017[14]; OECD, 2015[15]; Ravallion, 2014[16]; Stiglitz, 2012[17]). This highlights the renewed global interest in public investment for comprehensive healthcare and social protection systems as primary ways to achieve equity, poverty reduction (Barrientos and Hulme, 2010[18]; Devereux and Sabates-Wheeler, 2004[19]; Stiglitz, 2009[20]) and economic growth (OECD, 2019[1]; Bloom, Canning and Sevilla, 2001[21]). In fact, “leaving no one behind” is the core objective of the Agenda 2030 and the SDGs. UHC
is seen as a key element of Agenda 2030, as it also aims to break illness-poverty cycles and reduce social inequalities.

The WHO emphasises that achieving UHC is an ongoing process for all countries, and that it involves continuing adaptation to changing health needs, health technologies and capacities (WHO, 2015[21]). UHC is a key development issue: despite increasing global coverage in recent decades, the latest estimates suggest that at least half of the world’s population do not have full coverage of essential services, while around 9% were tipped into, or pushed further into, extreme poverty because of health spending (WHO and The World Bank, 2017[22]). UHC is not intended to be an “add on” to a health system: rather, UHC should help transform and strengthen the health system, helping to make it more effective, efficient, equitable and sustainable.

Nearly all OECD countries have achieved UHC. Their experience provides evidence that UHC improves health outcomes such as life expectancy. For a selection of OECD countries and emerging economies (Brazil, the People’s Republic of China, Colombia, Costa Rica, India, Indonesia and the Russian Federation), a clear positive association exists between life expectancy at birth and UHC indicators on health coverage, i.e. population covered by a core set of services (population coverage); out-of-pocket (OOP) payments (financial coverage); and general practitioner (GP) density (service coverage) – as well as total health expenditures (as an overall health coverage proxy). A clear negative relationship exists between OOP payments and life expectancy, whereas GP density is positively associated with life expectancy. Finally, the relationship between total health expenditure and life expectancy is also positive (Pearson et al., 2016[23]).

OECD countries’ experiences provide the following policy recommendations for a successful UHC strategy: 1) cover the whole population and prioritising financial coverage over breadth of service coverage; 2) secure fiscal space without an over-reliance on payroll taxes, as working-age cohorts will dwindle; 3) invest early on in health promotion and disease prevention; 4) strengthen primary care; and 5) make better use of data through advanced information systems (Pearson et al., 2016[23]).

Given the importance of UHC, the international community agreed as part of the SDGs that by 2030, everyone should have access to essential, quality healthcare, regardless of their ability to pay. Scaling up UHC to achieve that goal will involve significant additional financial, human and other resources. This is particularly true for countries facing rapid population growth and/or the rise of chronic non-communicable diseases (NCDs), which require constant management for long periods and are costly to treat. However, there are complex technical, institutional, public financing and political economy issues that need to be addressed in scaling up UHC. UHC impact on health outcomes also depends on other factors and policies outside the health sector, including environmental policies and regulatory provisions. Given the scale of the challenges, no country can afford to waste financial and human resources – or political capital – while scaling up UHC. Special challenges also arise in fragile and humanitarian settings where 60% of global maternal deaths, 53% of child deaths and 45% of newborn deaths occur (Every Woman Every Child, 2015[24]).

1.2. Reaching UHC

The pursuit of UHC and its multifaceted ambitions comes with intrinsic prioritisation challenges. While the literature on UHC is large, there has been relatively little attention paid to how equity is conceptualised, managed and measured as countries move along the
UHC road; how trade-offs within dimensions of equity and between equity and other social goals are managed; and what drives these choices. A fully achieved UHC can be understood to comprise *de facto* coverage of the entire population, a comprehensive range of high-quality benefits and adequate protection against the financial risks incurred due to ill health. It is worth noting that high-quality health systems that ensure efficient spending and use of health services should also be an important measurement criterion for UHC (Kruk et al., 2018[25]).

UHC is founded on the idea that securing universal access to healthcare based on need reduces poverty and strengthens livelihoods, leading to increasing equity and inclusive growth within societies. Thus, “universalism” within UHC is often juxtaposed with selectivity or “targeting”, although in practice these often coexist in hybrid forms of welfare provision. The dichotomy drawn between the two concepts arises not only from the differences in their practical implications, but also in their ideological foundations. Some have put forward the importance of broad-based coverage, recognising access to healthcare as a basic right that shall be enjoyed by the entire population. Others, in contrast, have stressed the need for selectivity, promoting targeting the “truly deserving” as a financially efficient form of public investment.

Selectivity has been shown to contribute to inequities that exist both on the vertical (between different socio-economic classes) and horizontal (between the poor in different geographical areas) axes (Kidd, 2015[26]; Mkandawire, 2005[27]). However, selectivity can occur in different forms, ranging from strict “negative selectivity”, principally seeking exclusion through means testing, to “positive selectivity”, focusing on marginalised groups of people and/or needs through easily observable socio-demographic, economic and geographic characteristics (such as age, employment status and residence in hard-to-reach areas) (Vilcu et al., 2016[28]). While means testing is seen as a measure based on the ideals of individual responsibility but with unexpected negative effects of equity and social cohesion, positive selectivity has been adopted as a means to prioritise and tackle health inequities. Taking additional measures to guarantee healthcare provision, to refugees for instance (who are otherwise excluded from citizenship-based entitlements), allows coverage of populations with specific needs (MacGregor, 2017[29]).

However, there is now consensus that coverage should be truly universal as opposed to targeted only to the poor. This is not only a “rights” consideration, but an issue of efficiency. In the absence of UHC, people delay receiving services and end up presenting themselves to health services with much more severe and costly conditions to treat. The question then becomes about access to which specific services – which must be of good quality and reflect people’s needs.

It is in this context that (Gwatkin and Ergo, 2011[30]) have put forth the concept of “progressive universalism”: strategic targeting of the most disadvantaged in order to achieve equity. Two pro-poor pathways can be adopted in order to achieve UHC within a generation: the first through publicly financed insurance to cover essential healthcare interventions and to tackle NCDs, which disproportionately affect the poor; the second through a larger benefit package funded by a range of financing mechanisms, while poor people are exempt from payments (Jamison et al., 2013[31]). Thus, positive selectivity through different means of targeting the disadvantaged (e.g. programmes with direct or indirect targeting, schemes tackling diseases disproportionately affecting the poor, user fee or insurance premium exemptions, etc.) can function as a pro-poor measure that supports the path towards UHC in an equitable manner, when introduced as a starting point for further expansion (Carey, Crammond and De Leeuw, 2015[32]).
UHC advocates must gain political and financial support for health sector reforms, potentially in the face of significant resistance. Key equity dimensions of UHC that need to be negotiated include population coverage (who to cover first), benefit/service coverage (what benefits to provide), financial protection (how much of the costs to compensate) and service quality (what are the required standards of service). This highlights the importance of political economic factors behind the achievement of UHC. Indeed, UHC policies have often emerged as a result of social pressure and government commitment (Savedoff et al., 2012[33]; Yi, 2017[34]).

Several low- and middle-income countries (LMICs) have successfully implemented UHC policies. Particularly relevant for developing countries are the experiences of Colombia, Costa Rica, Ethiopia, Korea, Malaysia, Mexico and Latvia. Malaysia reached UHC within two to three decades, Ethiopia’s health policies have drastically increased population coverage and improved health outcomes, and 19 Latin American countries have a constitutional guarantee of access to healthcare (Savedoff et al., 2012[33]). As the 1985 Good Health at Low Cost report highlighted (Halstead et al., 1985[36]), the first LMICs which achieved universal primary healthcare, such as China, Costa Rica and Sri Lanka, committed to equity not only in the area of health but also beyond in the spirit of the Alma-Ata Declaration (Balabanova, McKee and Anne Mills, 2011[35]), demonstrating the importance of universal welfare provision across sectors. It is worth noting, however, that constitutional guarantees do not necessarily mean effective implementation and coverage. Effective coverage – measured by three components: need, use and quality – has been suggested as a relevant and actionable metric for tracking progress towards achieving UHC (Ng et al., 2014[36]).

Despite current global policy aspirations, achieving UHC is particularly challenging, especially in LMICs. While dealing with underdeveloped healthcare systems, many LMICs face limited public revenues and capacity to pay, severe epidemiological issues, high prevalence of infectious diseases and, recently, a rise in NCDs, in addition to rapid population growth, particularly in Sub-Saharan Africa. Consequently, UHC is a key development issue: the latest estimates suggest that at least half of the world’s population do not have full coverage of essential services, while between 3% and 9% were tipped into, or pushed further into, extreme poverty because of health care spending (WHO and The World Bank, 2017[22]).

1.3. Understanding trade-offs in equity

Equity can be defined in different ways but is understood in this report to include notions of fairness (an allocation and use of resources that reflects social values and priorities); access to healthcare according to need, not means; contribution according to ability to pay; and a focus on reducing inequalities between socio-economic groups and tackling exclusion of marginalised groups (Figure 1.1). As equity has a number of dimensions, there can be trade-offs within equity goals as well as between equity and other domains, such as efficiency or sustainability, as well as quality of services (Table 1.1). Inequity in health coverage leads to “differences in health that are considered unfair and unjust” because they could be avoided through equalising coverage across populations from different socio-economic, cultural, ethnic and gender groups (Whitehead, 1992, p. 434[37]).
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Figure 1.1. Overall dimensions for UHC trade-offs


Table 1.1. Examples of trade-offs in UHC implementation

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Trade-offs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sectoral</td>
<td>Investments in social determinants of health versus healthcare goods, affecting the distribution of UHC across social groups.</td>
</tr>
<tr>
<td></td>
<td>Addressing wider (outside the health sector) barriers to access in specific regions, e.g. through road building.</td>
</tr>
<tr>
<td></td>
<td>Investing in poverty reduction through other channels, which will benefit UHC indirectly, versus direct investments in improving equity in UHC.</td>
</tr>
<tr>
<td>Resource mobilisation</td>
<td>Change in pooling arrangements, benefiting some groups more than others.</td>
</tr>
<tr>
<td></td>
<td>Shift to more progressive financing sources – can be managed in order to expand access but can threaten entitlements and quality for some in the short term (e.g. where user fees are not adequately replaced at facility level).</td>
</tr>
<tr>
<td></td>
<td>Changing rules on contributions (e.g. caps on social health insurance contributions) and subsidies – changing financing incidence across groups.</td>
</tr>
<tr>
<td>Quality of care</td>
<td>Quality versus quantity – e.g. expansion in delivery facilities in India through the Janani Suraksha Yojana (JSY) voucher scheme, a safe institutional delivery plan for poor mothers, without equivalent focus on ensuring that services are respectful and appropriate, and of good quality (or, conversely, providing higher-quality services to a more limited population group).</td>
</tr>
<tr>
<td></td>
<td>Focus on effective care at the cost of responsive care (e.g. prioritising medically appropriate care over client reception and attention, or vice versa).</td>
</tr>
<tr>
<td>Resource allocation</td>
<td>Investments in infrastructure or staffing, which affect real access to quality care, at some levels of the health system or in some regions more than others.</td>
</tr>
<tr>
<td></td>
<td>Investments in supply-side versus demand-side barriers to UHC, with distributional effects.</td>
</tr>
<tr>
<td>Service package</td>
<td>Preference given to a subset of services based on feasibility, funding streams, current infrastructure, current expressed demand or other pragmatic factors (rather than those which are most cost-effective or equitable).</td>
</tr>
<tr>
<td></td>
<td>Non.choices: Open mandates offered, allowing for access on a “first-come, first-served” basis.</td>
</tr>
<tr>
<td></td>
<td>Prioritising services with high social demand, such as curative care, over promotive and preventive services, even where these may be more cost-effective and equitable.</td>
</tr>
<tr>
<td></td>
<td>Introducing new services into the essential package – such as treatment of NCDs – at the risk of reducing attention to, and funding of, established components, such as maternal and child health (MCH).</td>
</tr>
</tbody>
</table>
1. THE PATHWAYS TO UNIVERSAL HEALTH COVERAGE

Public-private partnerships, which expand access to services but may differentially benefit groups with greater physical or financial access.

Investments in specific disease areas versus wider health systems – these can have different short- and long-term implications for access and equity, as reflected in the debate on vertical programmes and health system strengthening.

Population coverage

Easy-to-reach groups covered first for feasibility and political reasons, as well as to create momentum which will hopefully extend to other groups over time.

Prioritisation of specific demographic groups for services, such as mothers and children, regardless of income level and other factors of vulnerability, due to ease of targeting and socially acceptable prioritisation.

Focus on needs of the poorest (e.g. positive discrimination actions or means-tested waivers), leaving the near-poor exposed to risks.

Focus on entitlements of core groups, such as citizens, at the expense of more socially marginalised groups, such as migrants, or focusing on meeting the needs of one vulnerable group (e.g. informal workers) at the cost of another vulnerable group (e.g. people with disabilities). Given the complex intersectionality of disadvantage, choosing prioritisation criteria that are inclusive, affordable and minimise targeting errors is challenging in most contexts.

Costs covered

Prioritising potentially catastrophic payments, such as hospitalisation, over less financially risky (but often frequently used) services, such as outpatient care.

Focusing on some cost elements – such as in-facility costs – over others – such as access costs, indirect costs or the cost of drugs – due to pragmatic factors such as funding availability or administrative channels for funding.

Trade-offs between dimensions of the cube

Extending benefits to new population groups at the expense of "depth" (e.g. financial protection or quality of services); in some cases this can increase catastrophic payments, as those who were not previously service users become users.

Choices between targeting population groups (such as children) for inclusion in coverage versus targeting diseases or health needs (e.g. people with HIV).

Health outcomes

Focusing on maximising population health gains (for example, through purchasing or provider payment systems) over reducing exclusion of specific vulnerable groups or closing relative gaps in population health outcomes.

Establishing UHC and social protection entitlements, which protect the current generation while creating liabilities for future generations can raise important intergenerational equity choices.

Source: Oxford Policy Management background paper for the EU-SPS.

In 2014, the WHO produced a seminal report, *Making fair choices on the path to universal health coverage*, which remains the main guidance for countries seeking UHC and equity (WHO, 2014[38]). It provides a useful normative framework and recognises the interplay of effectiveness and costs with equity. The report proposes three steps:

1. Classify services into high-priority ones, using the criteria of cost-effectiveness, priority to the worst off and financial risk protection.
2. Expand access to high-priority services, including through the reduction of OOP payments and increasing mandatory, progressive pooling.
3. Ensure that disadvantaged populations, such as low-income groups and rural populations, are not left behind.

The report emphasises the need for deliberative processes and accountability in order to ensure fair choices. It also highlights some unacceptable choices, including:

1. expanding coverage (for example, through fee removal) for medium- or low-priority services before achieving near to universal coverage for high-priority ones
2. giving priority to costly services (delivering financial protection) over those which would deliver more substantial health benefits at lower cost
3. expanding coverage for relatively well-off groups or those with higher coverage over coverage for those who are less well-off or have lower coverage
4. prioritising coverage for those who are able to pay, rather than, for example, those working in the informal sector
5. shifting from OOP payments to mandatory ones in a way that makes the financing system less progressive.

This current report examines the extent to which several focus countries integrated equity concerns and implications from a political economy standpoint. The starting point for the analysis is the recognition that UHC implementation paths and choices are informed by different social preferences, including differential weights for distribution of health benefits versus poverty alleviation, for example. Implementation is complicated not only by the political economy context and the decision-making process, which is discussed later in this report, but also by the interaction between domains such as efficiency, equity and sustainability, which means that more general choices can still have equity implications.

In addition to trade-offs (which imply a balancing of different objectives and social goods), governments may also simply make poor choices, in the sense that no social good is advanced (for example, when funds are embezzled or used to purchase tools to oppress the population), and often make constrained choices (for example, where resources are controlled externally, e.g. by donors). Policy choices can also have important unintended consequences for equity, which are not trade-offs in the sense of being explicitly considered and containing conflicting benefits.

1.4. Monitoring progress in UHC

Effective and accurate information about population coverage, access to healthcare and quality of care requires reliable data. However, in many developing countries, even a basic monitoring system may fall short of accounting for the truly vulnerable population, for instance those in remote areas. With the lack of a systematic and accurate national identification system and data on healthcare and social protection, it is difficult to know precisely who is actually receiving the benefits, track the accessibility or service utilisation in detail, and determine the quality and the outcome of the services. In other words, it is difficult to paint the entire picture of who is being left behind in terms of social protection and UHC. Monitoring of equitable UHC remains hampered by a lack of disaggregated data for many indicators, making it extremely challenging to monitor coverage as well as adequacy of services. The three main challenges to monitoring UHC are therefore sourcing reliable data, measuring effective coverage (i.e. quality of services) and monitoring equity (WHO and The World Bank, 2015[39]).

The country case studies on UHC implementation in this report (Section 2) reveal important gaps in the extent and quality of monitoring equity at the national level. Even in countries where equity appears high on the agenda, it will be undermined if data and analysis are not there to support active monitoring. In Ghana, for example, there is no analysis of utilisation by different groups within the National Health Insurance Scheme’s (NHIS’s) membership. In wider annual sector reviews, out of 45 indicators regularly reviewed in order to assess overall performance, only 7 relate directly to equity. Many of the indicators are either uninformative (for example, the proportion exempted within the NHIS is reported, even though this is not directly linked to need or deprivation) or unpopulated due to lack of data (e.g. the proportion of households within the first quintile that are insured under the NHIS is not available on an annual basis).

The lack of granular information to monitor service quality is equally a problem. In Kyrgyzstan, for example, the high level of maternal mortality, even when births occur in
hospitals, suggests persistent problems in the quality of care. However, without more detailed information on how quality is experienced by different groups, it is hard to assess the root causes. Government support for enhanced and comprehensive data collection and analysis is therefore crucial.

Internationally comparable and recommended measures of equity could, however, alleviate some of these issues. In terms of practical monitoring of UHC, the WHO and the World Bank have developed a UHC monitoring framework that examines:

- coverage of essential services
- inequality within coverage of essential services
- OOP health expenditure in order to ensure financial protection (WHO and The World Bank, 2017[22]).

Coverage is defined using tracer indicators falling into four main areas: 1) reproductive, maternal, newborn and child health; 2) infectious diseases; 3) NCDs; and 4) service capacity and access. In each area there are four indicators and all of them are expressed on a scale from 0 to 100, whereby 100 means full coverage. A UHC service coverage index – a single indicator computed from tracer indicators of coverage of essential services – was developed to monitor SDG indicator 3.8.1. The WHO has started reporting on these indicators and generating an overall UHC service coverage index.

Disaggregation of these indicators allows the identification of specific disadvantaged groups where inequalities in service access might be particularly high. For some countries, this study found very large inequalities in NCDs by sex, with men performing very badly compared to women in terms of incidence of problems and accessing treatment for their condition. Similarly, while it is argued that the number of per-capita inpatient/outpatient visits cannot measure whether services respond to an underlying need, and as such is not a robust indicator, assessing disaggregated change over time of this indicator remains useful and can be correlated with increased service coverage. One major drawback is that indicators of inequality are often difficult to summarise, and the inequality analysis comes after the average indicator of coverage as “further qualifications”, showing the level of inequality across some of the indicators included in the aggregate coverage index.

Good health systems not only improve health, but also ensure that people are protected from the negative financial consequences of receiving medical care. Health systems often perform badly in this respect, with devastating consequences for households, especially poor ones and near-poor ones (Wagstaff, 2008[40]). Financial protection and capacity to contribute are therefore essential issues for sustainable health systems. The health community considers health expenditures to be “catastrophic”, if spending is above a certain fraction of household income (e.g. when it exceeds either 10% or 25% of total household expenditure, or when it exceeds 40% of non-subsistence expenditure or 40% of non-food expenditure) (WHO and The World Bank, 2015[39]). Another important indicator is to classify health spending as “impoverishing” if it is sufficient to make the difference between the household being above the poverty line or below it, i.e. in the absence of the medical outlays the household’s resources would have been sufficient to keep its living standards above the poverty line, while with the outlays its living standards are pushed below the poverty line (Wagstaff, 2008[40]). OOP expenditure, measured at the country level as a percentage of total health expenditure (THE) through national health accounts, is also used as an indicator of risk of incurring catastrophic expenditure.
Identification of beneficiaries and information about eligibility, enrolment, and transfers or services are equally challenging for social protection. Within the field of social protection, agencies and ministries often work in silos, thereby limiting the efficiency of programmes to reach their target population and provide the intended services and transfers. It is of utmost importance to address this issue of integrated databases across both health and social protection sectors in order to maximise the gains from information sharing and minimise the costs of collecting such information. Unified databases or social information systems are key to systematising knowledge across myriad programmes.

Finally, several points need to be considered when attempting to improve data collection methods and measurement in the context of developing countries. First, it is essential to provide quality training for statisticians and those who will conduct the surveying and data collection. Second, having a statistics department that is independent and has the infrastructure to handle large-scale data collection will be important. Having accurate data will make these linkages easier to track and will increase synergies between different policies that are inherently related to one another. Although the information on health, social protection and other public interventions can help inform policy makers to gauge the extent of coverage, access, quality and effectiveness, as these policies are interconnected, it is also highly sensitive. It is thus necessary to design appropriate data protection protocols and confidentiality policies when developing such joint databases.

Furthermore, it is important to develop systems of health accounts. The OECD, together with the WHO and Eurostat, developed a manual on the System of Health Accounts (SHA), which provides a standard framework for producing a set of comprehensive, consistent and internationally comparable accounts in order to meet the needs of public and private sector health analysts and policy makers. Health accounts provide a systematic description of the financial flows related to the consumption of healthcare goods and services. Their intent is to describe a health system from an expenditure perspective. As more countries implement health accounts, there are increased expectations from analysts, policy makers and the general public for more sophisticated information to monitor health system performance (OECD, Eurostat and World Health Organization, 2017[41]).

1.5. Addressing gaps in resource mobilisation and resource allocation

No system can continue to expand the coverage and depth of its benefits without the necessary resources. The financial commitment to health has been too limited to support equitable UHC in some settings. While overall health represents a tiny (6%) share of total ODA, the domestic financial commitment to health has been too limited to support equitable UHC in some settings (OECD, 2018[42]). On the path to UHC, developing countries face the dual challenge of resource mobilisation – with tax revenues representing only 18.2% of GDP in Africa and 22.6% in Latin America (OECD, 2018[43]) – and resource allocation – with health spending as a percentage of GDP in low income countries standing at nearly half of that in high income countries (WHO, 2018[44]).

In Indonesia, healthcare is decentralised and local governments are mostly responsible for providing care, resulting in healthcare infrastructure favouring more developed parts of the country, both in terms of the number of facilities and service quality. The variation between geographical areas tends to correlate with the areas’ socio-economic status, which can exacerbate the inequity of access and service coverage. As shown in the country studies (Section 2), even with different country contexts, there is room and rationale for improving public and private partnerships for better access to and equity of healthcare.
In India, despite a rapidly expanding economy that has grown almost consistently since the 1990s, public health spending has not kept pace and has attracted limited incremental financing over the years. States in India are allocating less than 6%, on average, of their budgets to healthcare, and the increase in healthcare supply has been driven by the private sector. The poor incur catastrophic health expenditures even in comparatively richer states, indicating a greater need for financing of healthcare in the country. For India, low spending in healthcare probably has more to do with its low political priority than with resource constraints.

It is better to cover fewer services that are key, than to seek to cover all services poorly or with high degrees of cost sharing. In OECD countries, delineating the range of benefits covered has been crucial to achieving UHC. Most OECD countries have defined, at a central level, a range of benefits covered by residence-based public health system schemes or compulsory health insurance. This is done explicitly, through itemised lists of goods or services covered (e.g. a list of reimbursed medicines or surgical procedures); implicitly, by reference to a broad category of services (e.g. primary care services); positively, by referring to what is covered; or negatively, assuming that everything which is not explicitly excluded from coverage (whether broad categories or specific items) is covered. Countries most often use a mix of these instruments to define the range of benefits covered (Auraaen et al., 2016[45]).

In many countries, the WHO recommendations on “fair choices” – ensuring that the core package of care is cost-effective – appear to be largely neglected. When resources are limited, preventive and primary care should be prioritised, but some UHC policies (such as the NHIS in Ghana) have inadvertently drawn more resources into hospitals and private providers, while public health programmes continue to be donor dependent. The NHIS in Ghana was supposed to bring additional funding, but the money was fungible and the sector also gradually experienced a withdrawal of donors. In Burkina Faso, the exemption policies have to a large extent remained theoretical, as no resources were allocated to support their implementation. More generally, broad or unspecified packages of services risk other forms of rationing, usually in favour of those with more social and financial capital, in resource-limited environments.

This puts forward the question of the role of private actors in filling the gap in public service delivery. In particular, supply-side improvements could require additional investments from well-regulated private providers in countries where public capacity to deliver is limited but where the state has enough capacity to regulate private services and ensure equity. In order to adequately address the issue of resource allocation, a close and constructive dialogue between the Ministry of Finance and Ministry of Health is needed, so that each understands the other’s policy levers and constraints and to show that any increases in budgets for health can demonstrate value for money (James, 2019[46]).

1.6. Global trends on health expenditure

In general, there is a positive correlation between gross domestic product (GDP) per capita and THE as a share of GDP. The 2016 World Health Statistics report shows that countries in sub-Saharan Africa have the lowest health coverage index while countries in Europe have the highest indices (WHO, 2016[47]). A negative correlation exists between GDP per capita and OOP as a percentage of THE, so that relatively better-off countries have proportionally lower OOP expenses. While the level of economic development is generally associated with higher THE and lower OOP expenses, other factors affect health coverage, such as the size of the population (Figures 1.2 and 1.3).
Figure 1.2. Relationship between OOP and GDP per capita

2010-14 average

Note: The size of the circle is proportional to the population of the country.
Source: Authors’ calculation using World Development Indicators (WDI) database.

Figure 1.3. Relationship between THE and GDP per capita

2010-14 average

Note: The size of the circle is proportional to the population of the country.
Source: Authors’ calculation using World Development Indicators (WDI) database.
The Global Burden of Disease Study 2015 finds that a Healthcare Access and Quality (HAQ) Index, which could be considered as one proxy for a UHC tracer index, tends to increase with the socio-demographic index (based on income, years of education and total fertility rates), but significant heterogeneity among countries exists. The HAQ Index improved significantly between 1990 and 2015, going from an average of 40.7 to 53.7, but if all countries had reached the frontier of what could be expected based on the socio-demographic index, the HAQ would be 73.8 in 2015 (Barber et al., 2017[48]). This evidence matches research by (Moreno-Serra, Millett and Smith, 2011[49]) who find a causal relationship between measures of UHC and health outcomes. In a review of the existing evidence (Gaynor, Moreno-Serra and Propper, 2012[50]) conclude that UHC can be a significant factor behind better health, and that this tends to be true specifically for the poor.

In terms of the UHC service coverage index computed as part of the effort to monitor the SDGs (Sachs et al., 2018[51]) there is evidence of strong correlations with health outcomes, a lower but still strong correlation with GDP per capita and level of health spending per capita, and a negative correlation with the level of OOP health expenditure. Moreover, this study also finds a very strong correlation with the level of education and the level of population coverage of social protection, including both social insurance and social assistance programmes (Table 1.2). The results confirm that UHC matters for better health outcomes, and better health is one important component of economic growth. UHC also matters for lowering OOP expenditure, which has an impact on overall household income and well-being.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Correlation</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita (USD PPP)</td>
<td>0.59</td>
<td>154</td>
</tr>
<tr>
<td>Health expenditure per capita (USD PPP)</td>
<td>0.62</td>
<td>157</td>
</tr>
<tr>
<td>OOP health expenditure (% of THE)</td>
<td>-0.47</td>
<td>157</td>
</tr>
<tr>
<td>Expected number of years of schooling</td>
<td>0.82</td>
<td>157</td>
</tr>
<tr>
<td>Percentage of population receiving social protection</td>
<td>0.64</td>
<td>96</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>0.77</td>
<td>157</td>
</tr>
<tr>
<td>Under-five mortality rate</td>
<td>-0.79</td>
<td>157</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>-0.71</td>
<td>157</td>
</tr>
</tbody>
</table>

Source: Authors’ calculation using World Development Indicators (WDI) and the Atlas of Social Protection Indicators of Resilience and Equity (ASPIRE) databases.

Analysis using data for 35 OECD countries covering the period 1995 to 2015 shows that making economic growth more inclusive can translate into meaningful gains in living standards across key dimensions of well-being and different socio-economic groups. In most OECD countries, gains in life expectancy reflected factors both within and beyond the healthcare system. On average, across the 35 OECD countries, a 10% increase in health spending was associated with a gain of 3.5 months of life expectancy. The same rate of improvement in healthier lifestyles (10%) was associated with a gain of 2.6 months of life expectancy (fewer smokers with 1.6 months and decreased alcohol use with 1.0 month). Wider social determinants also mattered; a 10% increase in income was associated with a gain of 2.2 months of life expectancy, and a 10% increase in education with 3.2 months. In practice, larger changes in the main determinants of health may be reached, leading to larger life expectancy gains. For example, if smoking rates and alcohol consumption could be halved, together these could lead to a gain of 13 months of life expectancy (James, Devaux and Sassi, 2017[52]).
2. Universal health coverage in practice: Country case studies

This section summarises the findings of country studies in Burkina Faso, Ghana, India, Indonesia and Kyrgyzstan, including introductions to health policy and trends in each country as well as findings related to trade-offs in equity and universal health coverage (UHC). The analysis provides a brief history of UHC and social protection in each country, and explores issues of equity trade-offs and the political economy for sequencing of choices as each country moves towards UHC.

2.1. UHC in Burkina Faso

Burkina Faso is a low-income country with a population of 18 million. The economy is heavily reliant on the primary sector (agriculture and livestock), which employs about 90% of the active population. Although GDP growth slowed to 4% in 2014 and 2015, it is expected that economic growth will rise in 2018-19 with high levels of public investment. The country ranked 175th out of 177 countries on the Human Development Index in 2002 and ranked 185th out of 188 in 2015. The poverty rate fell slightly between 2009 and 2016, from 46% to 40.1%, and remains particularly acute in rural areas. General life conditions improved in Burkina Faso, with particular improvements in primary education and water access. Between 2000 and 2015, life expectancy at birth increased from 50.5 to 59 years and most maternal and child health indicators improved, although women receiving four antenatal care visits reduced from 16% to 14% between 2003 and 2014, and the use of modern contraception was low and saw only marginal improvements (7% to 10% over the same period).

The health sector is heavily dependent on external funding, with donors funding 75% of all expenditures, although the share of government expenditure allocated to health is high (11% as of 2014) (WHO, 2014[38]). Households continue to fund a large share of health expenditures, although these remain stable. Since 2000, the explicit focus on achieving UHC has resulted in a series of targeted free care and subsidised care initiatives, including free preventive maternal care in 2002, Emergency Obstetric and Neonatal Care (Soins Obstétriques et Néonataux d’Urgence; SONU) in 2006, and free care for pregnant women and children under five years of age in 2016.

There has also been a focus on supporting community-based health insurance (mutuelles), although in 2013 this only covered 1.5% of the population. The culmination of the journey was a law enshrining UHC as a government goal in 2015 and the conceptualisation of a Universal Health Insurance Scheme (Régime d’Assurance Maladie Universelle; RAMU) in 2015, although it has not yet been launched. The UHC law aims to ensure universal access to the same basic package of care for all.

All Burkinabés (except the national forces) will be expected to contribute to the RAMU through the payment of a premium, although the poor will be subsidised through government funds. The premium levels and the basic benefit package have not yet been
2. UNIVERSAL HEALTH COVERAGE IN PRACTICE: COUNTRY CASE STUDIES

2.1.1. Social protection in Burkina Faso

Discussions regarding the need to offer social protection to all Burkinabées started in 2001, with various attempts at defining a national-level social protection policy, driven by different ministries, eventually failing, in part due to a reported lack of support from key development partners, such as the World Bank. However, attempts to develop a national co-ordinated approach continued and, in 2009, Burkina Faso adhered to the social protection floor concept and started a process of rationalising and consolidating interventions to promote access to basic social services for all, including the poorest and most vulnerable people.

The National Social Protection Policy was thus launched in 2012, targeting a ten-year period (2013-22). It states that social protection can be defined as a set of public interventions that help households and individuals to better manage risks and reduce their vulnerability and poverty by providing them with better access to social services and employment.

According to the ILO, while it encompasses social security, social assistance, social services and health, social protection in Burkina Faso is characterised by its low coverage and heterogeneity (Louis dit Guérin and Pino, 2014[53]). In particular, social insurance remains limited to civil servants and formal workers, reducing its coverage to 5% of the working population (SOLIDAR, 2016[54]). The social assistance programmes around cash transfers and food vouchers are also extremely limited in their coverage. As a result, in 2015, only 7.5% of the population was covered by at least one social protection benefit, corresponding to the SDG indicator 1.3.1, with only 2.7% of elderly individuals receiving a pension and 3.6% of the vulnerable population (e.g. children, informal workers, the elderly without contributory pensions) receiving a non-contributory cash benefit (ILO, 2017[55]). Overall, public social protection expenditure, including health, represented 2.7% of GDP in 2014-15 (ILO, 2017[55]).

2.1.2. Equity trade-offs

All policy makers in Burkina Faso concur that it is not financially feasible to provide universal quality care for all possible interventions, particularly in a context of financial difficulties. The first choice focused on population groups to be covered: the emphasis has been on women, children and Millennium Development Goal (MDG 6) related disease sufferers. According to key informant interviews, each of these groups was supported financially by donor funding, and hence there was not, as such, an explicit, nationally led reflection on which groups should be covered. The literature also states that health officials conceptualised the provision of services for the poor as an issue that hampered health system development and should not be prioritised (Fonteneau et al., 2004[56]). Even the latest drive to extend population coverage to the poor is less a nationally owned and debated decision than it is the following of an international trend, heavily influenced by the World Bank and other donors.

While to date the package of services has been linked to the targeted population groups (i.e. antiretroviral therapy, antenatal and postnatal care, etc.), there is now a nationally led reflection on what services should be included in the RAMU. A costing and modelling exercise is ongoing in order to assess what the country can afford, based on available resources and the target population in mind. Interviews have confirmed that there is an
explicit discussion of trade-offs within the working group tasked with defining the package. Discussions are also ongoing within the UHC technical working group on the level of premiums that should be set for the RAMU, with a focus on the impact that this would have on people’s ability to access quality healthcare. There will be a provision for the premium to be subsidised for indigents. A lack of technical capability at country level, as well as a need to follow donor priorities, has hampered explicit consideration of these trade-offs previously.

2.1.3. Policy instruments for UHC

There have been limited synergies between social protection and UHC to date in Burkina Faso, and some key gaps remain. The unified registry, when operational, will support only the most vulnerable (the poorest 10% of people in the country), leaving all those unable to pay for services behind. The inclusion of the mutuelles, very limited in their coverage, in the RAMU or in the social protection reflection, has also not been addressed. The fragmentation between ministries also needs to be addressed if the linkages between UHC and social protection are to be realised. The current reliance on external parties does not support long-term sustainability.

Until 2008, there were no explicit policy linkages between social protection and UHC. However, while not explicit, there was an understanding that various health-related initiatives, i.e. the various exemptions of specific groups from paying user fees, were part of a set of social protection policies. The fragmentation between ministries and the government’s inability to pass a unified national social protection policy meant that the linkages remained theoretical.

Since 2008, however, the creation of the Conseil National pour la Protection Sociale, specifically tasked with developing and implementing the new social protection policy, has led to greater policy dialogue across ministries. In the social protection policy, an explicit mention is now made of the health fee exemption and subsidisation schemes in place in the country as social protection mechanisms.

There are many ongoing social protection programmes in Burkina Faso, mainly led by non-governmental organisations (Catholic Relief Services, for example), and United Nations (UN) programmes (including the World Food Programme and UNICEF), with some programmes supported by national ministries. The fragmentation makes it difficult for the government to oversee initiatives and make active linkages between health and other social protection initiatives.

The most concrete planned link between UHC and social protection comes in the form of a planned unified registry. This initiative is being driven by the World Bank. The aim of this registry would be to develop a common definition of indigents and a targeting methodology across social sectors, including health.

2.1.4. Conclusion

Burkina Faso has until now taken a targeted approach to equity, focused on the need to ensure that the most vulnerable would be able to access services. The vulnerable were defined on the one hand as children under five years of age and pregnant women, and on the other as those suffering from specific diseases (HIV, malaria and tuberculosis in particular), but did not include the poorest segments of the population or those living with a disability, those living farthest away from a health centre or those living with any other form of vulnerability. Exemptions for payments by the indigent – for example, in the
delivery subsidy policy which ran from 2006 to 2016 – were not funded and were therefore not implemented. More broadly, there is a lack of monitoring of the equity impact of health policies on the population.

However, Burkina Faso is now moving, at least in its long-term vision, from a targeted to a universalist approach to equity. Equity has been incorporated into the RAMU law in relation to mandatory membership as well as the provision of exemptions for indigents and other vulnerable categories of people. The package of care is to be the same across all groups and regions, and is to be based on pooled funding. These are only plans at this stage and the details are still to be determined, including how indigents will be defined.

In terms of equity of service delivery, Ouagadougou has the densest health network and the largest proportion of health personnel (39.4% of medical doctors and 20.8% of midwives) (Beogo et al., 2014[57]). The city houses 9.9% of the public health facilities and 60.3% of the private health facilities in Burkina Faso. On average, people in Ouagadougou reside within a mean radius of 1.7 km from a health facility, whereas the nationwide mean radius is 6.4 km (Beogo et al., 2014[57]).

2.2. UHC in Ghana

Despite fast growth and reaching middle-income status in 2010, 8.5% of Ghana’s population of 29 million remain in extreme poverty and many more are vulnerable to shocks. Moreover, the Government of Ghana has faced significant fiscal constraints since the mid-2010s. In particular, health provision has been unequal across regions, with the northern regions faring worst. Health expenditure is low and out-of-pocket (OOP) payments (as a percentage of total health expenditure) rose from 27% in 2010 to 30% in 2015. Coverage of essential health interventions has been increasing, but there are concerns about the quality of care, which affects all, but affects the poorest in particular. Rural and northern areas have fewer staff and other health inputs. Under-five mortality is twice as high for the poorest children than for their richest counterparts.

In the 1990s, Ghana relied relatively heavily on user fees, with 15% of public funding derived from “cash and carry” revenues. At the same time, a large number of fee exemptions were introduced, although these were never adequately funded or implemented. In the late 1990s, a series of sector reforms began, including a sector-wide approach that aimed to introduce a separation of functions among regulators, insurers and providers, as well as a policy to strengthen community healthcare, known as Community-Based Health Planning and Services (CHPS).

However, perhaps the most significant step towards UHC was the creation of the National Health Insurance Scheme (NHIS) in 2003. This scheme, partly contributory but mostly financed through an additional levy of 2.5% on Value Added Tax (VAT) payments, provided access to a benefits package in public and private facilities and included a growing range of exemptions for the poor, for children, for pregnant women and for the elderly. This pooled funding, shared benefits package, and growing range of population groups exempted from contributing were all features that promoted equity within the NHIS.

There are, however, equity issues linked to this funding structure: while all Ghanaians contribute through VAT, only those paying the registration fee and an annual premium can access services. Those premiums vary with income, and can be set by districts for informal workers who may not have a stable income (Alfers, 2012[58]). Initially, identification of the poor was restrictive and the coverage low, although this later improved through linkages with social protection programmes, such as the Livelihood Empowerment Against Poverty
(LEAP) programme. Major barriers for the poor continued, however, in terms of low awareness, stigma, limited access, and the practical and financial barriers to registering and renewing NHIS cards. In addition, late reimbursements to providers meant that informal payments by NHIS members persisted.

### 2.2.1. Social protection in Ghana

Ghana finalised its social protection policy in 2015, which “seeks to provide relief from destitution for those sections of the population who for reasons beyond their control are not able to provide for themselves” (MoGCSP, 2015[59]). It focuses on reducing exposure and increasing the population’s resilience to risks, shocks and exclusion. It aims to provide social protection floors across the life cycle, particularly for the extreme poor and the most vulnerable populations, with a strong focus on social assistance. The five flagship programmes at present are the LEAP programme, Labour-Intensive Public Works (LIPW), a school feeding programme, NHIS fee exemption, and Basic Education Capitation grants.

The LEAP programme provides income transfers and social services for different categories of households in extreme poverty, households with orphans or vulnerable children (OVCs), people over 65 years of age and people with disabilities. The programme aims to alleviate poverty and targets the very poor, which at the start of the programme stood at approximately 15% of the population. The household members would also benefit from complementary benefits, such as the school feeding and capitation programmes. The programme combines both unconditional (for households with people with disabilities and/or elderly people) and conditional (for households with OVCs) mechanisms. The conditions include: 1) sending children to school; 2) not allowing child trafficking or labour; 3) enrolment of family members in the NHIS; and 4) birth registration of all children, along with attending postnatal care and completing immunisation (Abebrese, 2011[60]). These conditionalities are, however, described as “soft” and there is no mechanism for their enforcement.

While the LEAP programme has documented successes through impact evaluations (in 2013 and 2017), its contribution in relation to beneficiary needs is small, as is its simulated impact on extreme poverty – a reduction of 8%, using 2014 data, according to the World Bank (Cotlear et al., 2015[61])). This is in part due to its limited funding, which is consistent with Ghana’s overall modest spending of 1.6% of GDP on social protection (excluding health), including 0.5% on social assistance (compared to a Sub-Saharan African average of 4.5% of GDP). Within the social assistance budget, only 13% is allocated to the LEAP programme, which is seen as one of the social assistance programmes that is better targeted to the poor. A World Bank simulation suggests that 0.5% of GDP allocated to a well-targeted social assistance programme could eliminate extreme poverty (assuming perfect efficiency of transfers) (Cotlear et al., 2015[61]). Improved coverage by the LEAP programme, as well as a larger budget, would be required for it to meet its goals. According to a 2017 evaluation, the size and regularity of payments to households increased over the programme’s lifetime, but the median share of household consumption was 13% at end line, compared to international benchmarks of 20% (Angeles et al., n.d.[62]). The LEAP programme also remains dependent on donor funding to cover about half of its costs.

Ghana’s social protection coverage, while expanding, is still limited among the poor – only 25% of the extreme poor are covered by the LEAP programme, only 10% of rural households are included in the LIPW, and only 31% of households in the poorest quintile have valid NHIS cards (Cotlear et al., 2015[61]). Contributory pension coverage is also low, with only 8% of the elderly receiving a pension. Overall, the government spent 5.4% of
GDP on total public social protection expenditures in 2010 (the latest year for which data were available), and 18.3% of the population was covered by at least one social protection programme, ranging from 41.7% for mothers with newborns to 16.4% of elderly populations and 5.6% of children (ILO, 2017[55]).

While there is a clear link between social protection and UHC through the LEAP programme, which identifies the poor who qualify for free NHIS membership, in reality, implementation remains problematic, as demonstrated by the low coverage of LEAP programme beneficiaries with active NHIS cards (Cotlear et al., 2015[61]). Failure to renew and use NHIS cards indicates a range of problems, including the cumbersome nature of the procedures and, perhaps, some of the unseen costs of NHIS use – including costs to access facilities – and the poor quality of care received once there.

More broadly, it is clear that both the NHIS and the LEAP programme focus on extreme poverty, leaving the large group of near-poor unprotected. Some may be captured within the other generous exemption categories – for example, children, pregnant women, and the elderly – but there remains a large population which cannot afford to join the NHIS or is deterred by other barriers of cost and quality mentioned above. This is reflected in the overall coverage rates, which are stuck at 39%, and OOP payments, which remain significant at 27% of overall health expenditure.

2.2.2. Equity trade-offs

During the process of establishing the NHIS, trade-offs between sustainability and coverage were recognised but not adequately addressed. The aim was universal coverage with a broad package, along with what were seen as additional resources. The political imperative meant that a narrower package with greater exemptions was not a realistic option, nor was there much discussion about the possible wider health system effects on the uninsured.

As implementation began and some of the issues outlined above became apparent, the debate focused on how to improve efficiency, for example through changes in the payment and claims processing systems or through reorganising the funds in 2012. A more efficient approach to identifying the poor was introduced by linking with the LEAP cash transfer programme. However, equity trade-off issues remained largely underestimated and under-analysed. For example, the NHIS Membership Department does not assess utilisation by membership category, which would be one basic element in understanding whether vulnerable groups are gaining effective coverage.

NHIS membership is hovering at around 39% of the population, although the coverage by region varies. Seventy-two per cent are exempt from paying premiums; these include children under 18 years of age, pregnant women, persons over 70 years of age, Social Security and National Insurance Trust (SSNIT) pensioners, and indigents. Indigents, LEAP programme beneficiaries and pregnant women are also exempt from registration fees. According to the NHIS Membership Department Indigents have grown as a proportion of overall active members, from 1.7% in 2005 to slightly less than 14% in 2016. However, renewal rates are low – reported to be 50% among LEAP programme beneficiaries (Cotlear et al., 2015[61]). Barriers to enrolment and active membership include inability to pay, poor access to facilities, cumbersome registration and renewal procedures, and perceptions of poor quality of care (including long lines, poor provider attitudes and informal payments).

Despite the extension of exemptions and the links with the LEAP programme, NHIS membership remained pro-rich, with 49% of individuals in the poorest quintile not registered, compared with 39% in the richest quintile. Indigents were also found in all...
income groups, indicating poor operationalisation of this category. Looking at the benefits incidence of different social assistance programmes across quintiles, only the NHIS exemption for children under 18 years of age was found to be pro-poor, with indigents and maternal exemption beneficiaries marginally less likely to be found in the poorest quintile than would be expected on average (Cotlear et al., 2015[61]).

Analysis of NHIS membership by income quintile using 2008 Ghana Living Standard Survey (GLSS) data reveals a sharp gradient, with only 12% of Quintile 1 (poorest) households having full NHIS insurance (and 62% with none), compared with 36% of Quintile 5 (richest) households with full insurance (and 41% with none). The figures show that in 2008, three years into the full implementation of the NHIS, the majority of households still had not even a single member with NHIS membership.

Despite the generous exemptions offered on premiums, coverage of exempted groups remains surprisingly low. For example, an International Labour Organization (ILO) report from 2015 reported that membership for children stood at 34% (on par with national coverage at that time). However, the elderly (57%) and women (59%) were more likely to be members than the active population and men, which does match with exempted groups (ILO, 2015[63]). Regional membership also varied considerably according to NHIS Membership Department data for 2016, from 18% of the population in the Western Region to 108% in Volta. Overall, utilisation is at 2.8 visits per year, according to the NHIS Membership Department – much higher than for the uninsured population. It is also important to examine rural/urban differences in membership. According to 2011 figures, 40% of NHIS-accredited facilities were private, 54% were government owned and 6% were private not-for-profit. It is likely that the private facilities are predominantly urban and increase NHIS spending on urban members.

Early studies found the LEAP programme’s targeting to be fairly accurate,1 but there are, of course, errors, which are of magnified importance as the Ministry of Gender, Child and Social Protection (MoGCSP) is becoming the gateway to all targeted programmes. The Ghana National Household Registry is now being developed to support targeted programmes across all sectors. Some key informants reported that the LEAP programme is seen as a political programme at the community level, with many not covered and those who are LEAP beneficiaries more likely to be included in other programmes.

According to the impact evaluation conducted in 2012, 90% of LEAP programme beneficiaries were enrolled with the NHIS (seven percentage points higher than the control group). It found educational, health, food security and productivity benefits for participants, including a reduction in morbidity in children aged 6-17. There are, however, some challenges, including delayed payments to beneficiaries, an outdated proxy test, and insufficient social accountability and communication with communities (Cotlear et al., 2015[61]). While 95% of LEAP programme beneficiaries were reported to be enrolled in the NHIS in 2015, many had not renewed their NHIS cards and so could not benefit from membership. The end line evaluation of the LEAP programme reported that 52% of participating households were covered by the NHIS in 2016 (Angeles et al., n.d.[62]) – an improvement on the starting point but still far from UHC. Reported health conditions did not change much for adults with valid NHIS cards; however, their care seeking improved

1 Studies of different targeting approaches found that means testing is optimal in low-poverty areas and geographic targeting is optimal in high-poverty areas, suggesting that the proxy means testing is optimal in neither (Jehu-Appiah et al., 2011[131]).
considerably. The evaluation found that increased coverage did not translate into improved health outcomes or reduced health expenditure for children.

In addition, the coverage of the LEAP programme remains low, estimated at 25% of the extreme poor. Even with the assistance of this programme, NHIS membership coverage remains below the national average in the lowest quintile (31%).

2.2.3. Policy instruments for UHC

At policy level, Ghana’s key social protection strategies – the National Social Protection Strategy (NSPS) and the Ghana Poverty Reduction Strategies (GPRS) I and II – have all laid out approaches combining social assistance and healthcare schemes as being fundamental for poverty reduction. This highlights the understanding among policy makers that health and social protection policies are mutually reinforcing on the path towards development.

At programme level, synergies have been made between the LEAP programme and the NHIS. Since 2008, the LEAP programme has been given the responsibility for identifying the poor on behalf of the NHIS via two linkages. First, LEAP programme beneficiaries are excluded from paying NHIS contributions, although they are still required to pay the annual registration fee. Second, the conditional part of LEAP programme transfers provided to households with OVCs requires registration of family members with the NHIS, as well as uptake of specified health services. These linkages were previously recognised but not well implemented. For example, the poor have long been theoretically exempt from paying user fees, but the funding and identification systems were never effectively put in place. The recent changes which have made linkages more realistic include the facts that the NHIS offers independent funding of exemptions and that the LEAP programme offers a third-party identification system.

From an operational point of view, things are more complex and targeting remains an issue. Eligibility for the LEAP programme is carried out first by identifying poor communities, then identifying the households within those communities that are eligible. A proxy means test is then administered. Community validation is the final stage in the selection process (Cotlear et al., 2015[61]). Although assessments should be periodic, according to key informants, identification has only been carried out once to date. When they are found to be eligible for the LEAP programme, households are automatically entitled to claim NHIS membership, although this requires them to register. Membership must be renewed every year, and the membership card must be replaced every five years.

2.2.4. Conclusion

The NHIS aimed to “ensure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare”, with the policy objective that “within the following five years, every resident of Ghana would belong to a health insurance scheme that adequately covered him or her against the need to pay out of pocket at the point of service delivery” (Agyepong and Adjei, 2008[64]). The approach was therefore universalist. Equity was incorporated in relation to mandatory membership – although this was not feasible in practice – as well as the provision of exemptions for indigents and other vulnerable populations. The package of care was to be the same across all groups and regions. Most significantly, it was based on a pooled public financing mechanism, without which the policy would most likely have gone the way of previous exemption policies: poorly funded and therefore poorly implemented.
Premiums for the informal sector were to be set at the district level and were intended to be income related. However, due to the difficulties of assessing income – in part due to the large informal population – a flat rate premium was set in each district and the variation was not large, thus reducing what could have been a pro-poor charging mechanism. Premiums have risen over the years, but their growth has been limited by the low ability and willingness to pay. According to the NHIS Membership Department, premiums range from GHC 22 (Ghanaian cedi) per person per year in Accra to GHC 17 in the northern regions, reflecting poverty levels, but not by much.

Children were initially to be covered if at least one of their parents was enrolled. However, the NHIS has continued to operate on an individual membership basis. The concern about children being excluded led to a change of policy in 2008, whereby all children under 18 years of age were exempted from premiums, along with pregnant women and the elderly. Those wishing to take advantage of one of the exemption categories were expected to provide proof of their condition or health status. For instance, women must provide a laboratory-certified pregnancy test, and the elderly must provide proof of age (Dixon, Tenkorang and Luginaah, 2011[65]).

Less attention was paid in the original design to the factors that affect equity of uptake – for example, ensuring that registration was a simple, accessible process (people had to reach district towns and fill in cumbersome paperwork, sometimes necessitating repeat visits, additional costs). Moreover, barriers to access – such as living farther away from towns and facilities – work against uptake and use by more remote communities. Meanwhile, registration and premiums remain unaffordable for the poor who fall just above the level of “poor”, which was originally very strictly defined as those with no means of support.

Without addressing these barriers, the NHIS risked increasing use by the non-poor, which in turn meant drawing more public subsidies towards them (Witter and Garshong, 2009[66]). Delays in reimbursement also meant that informal payments (or formal payments, i.e. having to seek care as a paying person even if insured) have remained a necessity for members in many cases.

2.3. UHC in India

India is the largest democracy in the world, with an estimated population of more than 1.3 billion. The GDP annual growth rate for fiscal year 2017-18 was 7.2%. Public finances have remained stable, although there has been an increase in sub-national debt levels. India’s economy has grown steadily since economic liberalisation in 1990, with per capita income doubling in the past decade. The proportion of the population in poverty fell from 45.3% in 1993 to 21.3% in 2011. Income inequality measure by the Gini coefficient has, however, increased from 0.32 to 0.35.

India has made substantial progress in key population health indicators such as life expectancy and child mortality rates over recent decades. Despite these improvements, significant inequalities remain within the country, which correlate to the investments made in social sectors (Makela et al., 2013[67]). NCDs are now the leading cause of death and disability, contributing to more than 60% of deaths. Malnutrition is still the main risk factor causing death and disability, followed by air pollution and dietary risks. Although outcomes have improved since 2005, the degree of inequality between the top and bottom quintiles for indicators such as stunting remains the same.

India’s health service infrastructure and staffing levels are low, and public health expenditure as a proportion of total government expenditure was less than 5% in 2013.
Health is a state matter in India, as per the Constitution, and as such expenditures and allocations vary substantially according to state-level health status. A 2012 report found that only 9% of government health expenditure benefited the poorest quintile, while 40% of government spending benefited the richest quintile (Chakraborty, Singh and Jacob, 2012). Two key health reforms that have shaped India’s journey towards UHC include the National Rural Health Mission (NRHM), launched in April 2005 through the Ministry of Health and Family Welfare (MOHFW), and the National Health Insurance Scheme (Rashtriya Swasthya Bima Yojana; RSBY), launched in 2008 by the Ministry of Labour and Employment for people living below the poverty line (BPL) and those working in the informal sectors. The RSBY is funded by the central and state governments at a ratio of 75 to 25, respectively. It only covers hospitalisation expenses equivalent to USD 460 for a family of five and does not cover costs of outpatient services, which remain a major source of OOP expenditure for the poor.

Governance issues with private providers, a lower than expected enrolment rate and sub-optimal benefit package have rendered RSBY, at best, a partly successful vehicle to finance the cost of healthcare for the poor. A number of states with better-than-average health outcomes and state performance (e.g. Andhra Pradesh and Karnataka) also have state-level insurance schemes that provide coverage for the poor of various health services.

The NRHM is funded by the central and state governments (currently at a ratio of 60 to 40, but for poorer states in the northeast, this ratio is 90 to 10). It finances the building of public health infrastructure in both rural and urban areas in those states, with a special focus on the 18 most poorly performing states. However, patients often prefer private facilities if provided with a choice, as public health facilities continue to suffer from a shortage of medical professionals. The NRHM includes voucher schemes (JSY; Janani Suraksha Yojana, JSY) for poor women to promote institutional deliveries.

### 2.3.1. Social protection in India

Social protection in India has evolved into a complex system characterised by low coverage, inadequate benefits, fragmentation and a lack of co-ordination across agencies (Asher, Zén and Dita, 2018). The federal structure in India implies that the design and implementation of social protection programmes is shared between different levels of government, with the union typically designing programmes while the states implement them, and the states may complement those with state-specific programmes. The discrepancies between programmes across states also reflect major discrepancies between states in terms of their population’s level of vulnerability with regard to income, health or education, thereby explaining some of the variation in the state-level priority areas in social protection.

The Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), launched in 2005, aims to enhance livelihood security by providing between 100 and 150 days of work in a year at minimum wage to at least one member of each targeted rural household. It is the largest public works programme in the world, covering almost 60 million individuals in 2015 (Ong and De, 2016).

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2 India is a federal union comprising 29 states and 7 union territories, for a total of 36 entities. The Constitution of India specifies the distribution of legislative, administrative and executive powers between the Union/Federal/Central government and the States of India.
The Integrated Child Development Services (ICDS) Scheme, launched in 1975, offers a package of six services for children in the age group of 0-6 years, as well as for pregnant and lactating mothers. These include: supplementary nutrition; preschool non-formal education; nutrition and health education; immunisation; health check-ups; and referral services.

The Indira Gandhi Matritva Sahyog Yojana (IGMSY) Programme is a conditional maternity benefit programme, launched in 2010 in 52 pilot districts, aiming to improve the health and nutritional status of women and their children. Under this programme, pregnant and breastfeeding women aged 19 years and older are eligible to receive maternity cash benefits (USD 67.2) for their first two pregnancies regardless of their employment status. This transfer is conditional upon medical check-ups, exclusive breastfeeding, vaccinations and attendance at health counselling sessions (ILO, 2017[55]).

The Indira Gandhi National Old Age Pension Scheme (IGNOAPS) aims to protect the elderly by providing a minimum annual pension payment of INR 3 600 (Indian rupees) to individuals aged 60 years and older living under the poverty line, and of INR 6 000 to those aged 80 years and older.

Individuals working in the formal sector can enrol in the Employees’ Provident Fund, the Employees’ Pension Scheme and the National Pension System. However, the coverage through these schemes is very low, with 10 million individuals enrolled.

Overall, only 19% of the population in India is covered by at least one social protection benefit, ranging from 41% of mothers with newborns to 54% of persons with severe disabilities. More so, the adequacy of benefits is an issue, with non-contributory pension benefits representing less than half of the national poverty line in India (ILO, 2017[55]). India spent 2.7% of its GDP on public social expenditures, including health, in 2014.

### 2.3.2. Equity trade-offs

With relatively few public resources devoted to health financing, extending care beyond the BPL segment of the population is a challenge for India, as is reaching the full eligible BPL population, which has to be traded off against the generosity of the package. According to a recent study (Karan, Yip and Mahal, 2017[71]) enrolment varied across the states and districts, with the share of eligible households enrolled in the programme (enrolment ratio) at 57% nationally.

Enrolment ratios varied from lows of 3% in Kannauj and 6% in the Kanpur Dehat district in Uttar Pradesh to nearly 90% in many districts of Chhattisgarh and Kerala. The state of Andhra Pradesh has not participated in the scheme, as it has a generous state-government-funded health insurance scheme that provides more than six times the sum assured by the RSBY. Some states, like Jammu and Kashmir or Madhya Pradesh, are officially known to participate in the RSBY, but none of the districts in these states had enrolled until September 2016. The active presence of state-government-funded health insurance schemes in the states of Karnataka (Vajpayee Arogyashree and Yeshasvini) and Tamil Nadu (Chief Minister’s Comprehensive Health Insurance Scheme), which have better benefit packages than the RSBY (the highest being more than six times that of the RSBY), means that only a few districts within these states have participated in the RSBY.

Evidence for financial protection by the RSBY is limited, with households facing additional payments due to the RSBY’s low ceilings, excluded services, late reimbursement of providers and informal charging by providers to patients (Devadasan et al., 2013[72]). The RSBY covered only 28-38% of the total eligible population as per the poverty estimation.
model in 2011, and only 7% of the total population and 27% of the total insured population of India in 2010 (Vilcu et al., 2016[28]).

Since the BPL list itself has always been a contentious issue, a number of ultra-poor, who may not have been registered under such lists, are unlikely to receive benefits. In addition, the coverage of only the poor population as defined by the BPL list does not include the people whose family incomes are marginally higher than that of the “poor” in the list, but who are also in dire need of healthcare yet cannot afford it themselves (except in public facilities where care is free). By selecting only the poor, the scheme has let go of the opportunity to pool in the non-poor, who could add to the financing through payment of premiums and also reduce the chances of adverse selection.

The RSBY has reportedly provided low-quality services to the poor, as the packaged rates at which the providers had to offer the services were abysmally low (Dayashankar and Mukul, 2016[73]). It pays insurance companies a fixed annual premium per family for providing a package of services for a defined disease category. In order to realise the required profit at such low rates, unethical activities have happened, especially in the absence of monitoring. At present, there is no link between quality and payment. Lack of standardisation of medical care provides ample discretion to providers in terms of package choice, course of treatment and quality of service. Providers select low-cost cases; choose a higher-paying package; select the cheapest treatment plan; use low-quality instruments, consumables and drugs; and discharge patients prematurely, leading to a low-quality, low-cost service (La Forgia and Nagpal, 2012[74]).

While utilisation of care has increased, much of this has been within the private sector, which may not be the most efficient route of extending access. Since the RSBY allows patients to access empanelled private hospitals, utilisation of private sector facilities by BPL patients has increased from 47% to 75% between 2004 and 2013 (Shoree, Ruchismita and Desai, 2014[75]). However, while the benefit package appears substantial compared to the annual fee that the members need to pay, this is not enough for a family of five, and a single episode of hospitalisation with medical tests and drug costs can take away a major part, if not all, of the annual expenditure allowance. Moreover, outpatient expenses and the cost of drugs when not hospitalised are major sources of OOP expenses for patients. The trade-off here has been allowing poor patients to pay OOP for drugs and outpatient services, in return for providing some financial protection against hospitalisation expenses.

2.3.3. Policy instruments for UHC

All social protection schemes, individually and collectively, contribute to social protection and perhaps also to UHC by addressing the determinants of health. However, the “scheme-based” nature of the interventions and vertical structures deter easy interlinking for a more strategic approach towards providing social protection to the poor.

Srivastava (2013[76]) argues that a rights- or entitlements-based approach to providing a social protection floor in India has six dimensions:

1. *Children’s education, nutritional status and health*: The Right to Education Act (2009) and the National Food Security Act, 2013 (also called the Right to Food Act) provided entitlements for free schooling to children and a mid-day meal, as well as food in ICDS.

2. *Employment and livelihood security*: The MNREGS 2005 is a unique scheme that provides livelihoods to rural populations for unskilled manual work, initially at INR 60 per day and later at INR 100 per day, for 100 days per year.
3. **Social pensions**: The National Social Assistance Programme (NSAP), which came into effect on 15 August 1995, represents a significant step towards the fulfilment of the Directive Principles in Article 41 of the Constitution (MoRD, 2016[77]). The programme, having a total beneficiary of more than 33 million people, introduced a National Policy for Social Assistance for the poor and aims to ensure a minimum national standard for social assistance in addition to the benefits that states are currently providing or might provide in future. At present, the NSAP comprises the IGNOAPS, the Indira Gandhi National Widow Pension Scheme (IGNWPS), the Indira Gandhi National Disability Pension Scheme (IGNDPS), the National Family Benefit Scheme (NFBS) and Annapurna Scheme (food security for senior citizens).

4. **Social health protection**: A debate on the right to health is ongoing in India, and the National Health Bill was proposed by the MOHFW in 2009. The High Level Expert Group instituted by the Planning Commission had also recommended a national health package for UHC in 2011.

5. **Food security**: The National Food Security Act, 2013 has provided entitlement to food at subsidised prices to 75% of the rural and 50% of the urban population who are poor. The Public Distribution System (PDS) is also covered under this Act.

6. **Housing**: The National Housing and Habitat Policy 2007 has a goal of affordable housing for all and has advised states to address the issue of providing housing, especially to the poor population. Subsidised housing schemes for economically weaker areas and low-income groups also exist.

A number of rights-based policies have come through the demands of an active civil society in India. Key informants have confirmed that the right to food came through public interest litigations fought by the civil society, which shaped the policy for the nutrition programme, PDS and other related aspects concerning food. Currently, right to health is being discussed actively at various forums, which might bring further reforms to the healthcare sector in India.

In terms of programmes, although a number of social protection schemes exist in India today, these were started essentially as “vertical” schemes and there was no strategic intent to integrate these for simpler administration and monitoring of results. However, Direct Benefit Transfer (DBT) has become a key goal for the Government of India to transfer cash or in-kind resources for a number of different schemes to beneficiaries. With an objective of improving efficiency and reducing the influence of political persons and middlemen on access to benefits, DBT is currently being implemented for 326 cash and 69 in-kind transfer schemes (Government of India, 2018[78]). The MNREGS beneficiaries have already been eligible since 2013 by enrolling in the RSBY instead of the BPL list, which is a good example of programmatic convergence for registry when target beneficiaries are the same.

However, the states are the major implementers of policies in the country, and due to wide disparities among them, a lot depends on the states’ abilities and willingness to link all these schemes together.

In India, the main operational linkage between social protection and UHC lies in the fact that all the social protection schemes (including the RSBY) are directed to the same portion of the poor population. Conditional cash transfers – either for incentivising pregnant women to choose institutional deliveries or, in selected districts, for improving the nutritional status of poorer households – all target the same households. The institutional structures of the
implementing authorities of these schemes are largely independent and have stood in the way of convergence of the various social protection schemes.

The IGMSY conditional cash transfer represents an operational linkage, with the cash transfer targeting mothers who fulfil the requirements in terms of medical check-ups.

With the issuing of Aadhaar (identification cards containing biometric data for the residents of India), the opportunity to integrate various social protection schemes is available today and is being utilised by the central government for transferring direct cash and in-kind benefits. India’s aspirations to move towards UHC through the RSBY and NRHM can similarly be delivered through such integration, provided that the capacity to spend and implement healthcare delivery services increases in the states. The RSBY covered only 28-38% of the total eligible population in 2010 (Vilcu et al., 2016[28]), and its enrolment rate in September 2016 was only 57%. An estimated 86% of the rural population and 82% of the urban population in India are still not covered by any kind of health insurance (Berman, Bhawalkar and Jha, 2017[79]). In order to provide optimal financial protection to a larger eligible population of India, health insurance schemes would need a much higher financial allocation and coverage of people who do not qualify as poor but who are still in need of financial protection for health and other social protection benefits. However, the states are the major implementers of policies in the country, and due to wide disparities among them, their ability and willingness to link all these schemes together is very mixed.

(Berman, Bhawalkar and Jha, 2017[79]) indicate the importance of political economy in the convergence of various programmes at sub-district levels. For instance, the functional efficiency of Village Health Nutrition and Sanitation Committees depends largely on the relationships of the members, and determines whose initiatives get funded or who gets paid first. This is also an important aspect that determines the states’ ability to spend the central grants for specific social protection purposes.

2.3.4. Conclusion

Informal sector workers constitute about 93% of the total workforce in India (Prognosis, 2012[80]). Without any social security, healthcare-related expenditures push families below the poverty line and are one of the most important reasons for rural indebtedness. Fifty percent of the population seeks inpatient care in the private sector (at both for-profit and not-for-profit facilities) and around 60-70% seek ambulatory care (or outpatient care) from private health facilities. In addition, data from the National Sample Survey Office (NSSO) show that patients had to make payments to public health facilities too, which are supposedly free. In India, more than two-thirds of health expenditure is OOP.

One of the key features of the NRHM was a strong commitment to increase public health expenditure from 0.9% of the GDP to at least 3% of the GDP. The other key feature was that it made a clear commitment to the public provision of healthcare services, although it did not rule out public-private partnerships as supplementary and supportive roles. The commitment by the centrally funded NRHM scheme to close the gaps between posts that were sanctioned by state governments and posts that were required to meet NRHM norms represented the first major effort on the part of the central government to create an affordable, accessible and quality healthcare service in the public sector, with a focus on the poorer states. However, due to the variations in the tax base among the states, standards of public services were uneven despite the states’ efforts to raise revenues. Variations in public services can also arise when there are significant differences in the unit cost of providing them. Special transfers made for an intended purpose from the central government to the states are not enough to ensure equity, especially in the poorer states.
In order to further the central government’s objective to provide social security and health assurance to all, the Unorganised Workers’ Social Security Act 2008 was enacted. The Act made it incumbent on the Government of India to provide for the welfare of workers in the unorganised sectors. As per the recommendations of the Act, the central government should “provide social security schemes to mitigate risks due to disability, health shocks, maternity and old age” which all unorganised workers get exposed to and are likely to suffer from. The RSBY provided health insurance to BPL families with the objectives of reducing OOP expenditure on health and increasing access to healthcare, and was later extended to cover defined categories of informal sector workers. However, those just above the poverty line but still in need of protection against hospital costs were neglected.

All the Five Year Development Plans for India have stressed equity in some way, putting the needs of the poor and the disadvantaged at the centre of reforms affecting the health services. The data released periodically by the NSSO, as well as by the District Level Household Surveys (DLHS), also track the state of improvement in the health of the poor, women and children, Scheduled Castes, and Scheduled Tribes. A major element of the recent health reforms was their focus on providing health services to the poor, thereby designing a system for the poor, with an assumption that the rich can take care of themselves through the for-profit private sector. The coexistence of two systems, one for the poor and the other for the rich, is challenging for the concept of UHC.

2.4. UHC in Indonesia

With an estimated population of 261 million people in 2016, Indonesia is the fourth most populous country in the world, comprising 3.4% of the world’s population. Since the late 1990s Indonesia’s GDP has grown rapidly, increasing from USD 215 billion (United States dollars) in 1997 to USD 1 trillion in 2017, and the proportion of the population in poverty has dramatically declined, from 18.2% to 10.6% in the same period.

Indonesia has made substantial progress in key population health indicators, such as life expectancy and child mortality rate. Despite these improvements, large inequalities persist within the country. The average life expectancy varied from 62.8 years in West Sulawesi province to 74.3 years in the Special Region of Yogyakarta in 2012. Moreover, Indonesia is experiencing a rapid epidemiological transition: while in 2000, communicable diseases represented the majority of the burden of disease, non-communicable diseases (NCDs) accounted for two-thirds of the disease burden in 2016, with cardiovascular diseases now the leading causes of death and disability. Communicable diseases (such as tuberculosis, diarrhoea and respiratory infections) and maternal diseases remain a concern, particularly in more remote and poorer areas of the country.

While the right for all citizens to be physically, mentally and spiritually healthy was already mentioned in the Basic Health Law of 1960, the largest changes in the implementation of a healthcare system have taken place in the past couple of decades, with the ambitious declaration made in 2012 to achieve UHC by 2019. The legislative path to UHC has been marked by domestic political concerns, decentralisation and an increasing importance of health services as an electoral asset (Pisani, Kok and Nugroho, 2017[81]).

The National Social Security System (Sistem Jaminan Sosial Nasional; SJSN) Law No. 40 of 2004 mandates universal coverage of social security for all Indonesians, including healthcare, work accident, old-age savings, pension and death (Asher, Zen and Dita, 2018[69]). The SJSN was formulated in 2004 but first implemented in 2014, after the passing of 2011 Social Security Provider Law No. 24 on National Social Security Administration.
(Badan Penjamin Jaminan Sosial; BPJS), creating BPJS Health and BPJS Labour, which focused on the implementation of the health insurance and social security programmes, respectively.

BPJS Health is a non-profit trust fund replacing the PT JAMSOSTEK (mandatory retirement, work accident and death benefits for formal workers in the private sector), Jamkesmas (predecessor of Penerima Bantuan Iuran, PBI, non-contributory health programme) and PT ASKES (mandatory health insurance for civil servants) schemes, which were controversial and unpopular due to operational dysfunctions, inaccurate targeting and problematic supply of services (Pisani, Kok and Nugroho, 2017[81]). BPJS Health’s main mission is to implement the Public Health Insurance (Jaminan Kesehatan Nasional; JKN), in particular to manage its membership, collect premiums from contract providers and make direct payments to providers. It also co-ordinates with BPJS Labour in cases of road traffic injuries and work accidents.

BPJS Health’s operations started in January 2014 with 111.6 million members; membership quickly exceeded the roadmap goal of 121.6 million to reach 133.4 million at the end of 2014, 171.9 million (almost 70% of the population) at the end of 2016, and 205.1 million (78.3% of the population) in October 2018. In order to reach its UHC goal by the end of 2019, BPJS Health would need to cover 257 million individuals, making BPJS Health the world’s largest universal healthcare plan (OECD, 2019[82]).

There are two main BPJS Health participant categories: non-contributory members, who are covered by Social Health Insurance for the Poor and Near Poor (Penerima Bayaran Iuran; PBI), and contributory members (non-PBI). PBI members represent the poor and near-poor listed in the Unified Database (Basis Data Terpadu; BDT) and receive a 100% subsidy from the Government of Indonesia, which pays their premiums directly. Statistics Indonesia decides the number of PBI beneficiaries based on the BDT of social assistance recipients (Mahendradhata et al., 2017[83]). In 2014, there were 86.4 million PBI beneficiaries with a social insurance premium of IDR 19 225 (Indonesian rupiahs) per person per month (USD 1.39). PBI members are grouped under the Indonesian Health Card (Kartu Indonesia Sehat; KIS), increasing total beneficiaries to 88.2 million in 2015 and 117 million in 2018. The social insurance premium was set at IDR 23 000 per person per month (USD 1.75) in 2017 (World Bank Group, 2016[84]).

Non-PBI members consist of wage or formal workers (PPU), non-wage earners (PBPU) and non-workers (BP). PPU includes civil servants, military officers, police officers, government officials, government officials with no civil servant status, private workers and workers not included in previous categories but who receive wages, including foreigners who have been working in Indonesia for at least six months. A great majority of these workers had health insurance coverage prior to BPJS Health implementation, for instance through PT ASKES and PT JAMSOSTEK. Private sector PPU members contribute 4.5% of their monthly wages to JKN, with their employers contributing 0.5%; public sector PPU members contribute 2% and their employers contribute 3% (Mahendradhata et al., 2017[83]).

PBPU includes those working without a contract (or independent workers), foreigners who have been working in Indonesia for at least six months, those with irregular incomes, the self-employed and other individuals. They were previously not covered by health insurance but can, under JKN, voluntarily register themselves and their family members. PBPU members can choose among three benefit packages, ranging from IDR 30 000 (Indonesian rupiah) per member per month for benefits in the third class ward to IDR 51 000 for benefit services in the second class and IDR 80 000 for benefits in the first class (Mahendradhata et al., 2017[83]).
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BP includes investors, employers, pension beneficiaries (retired civil servants, retired military personnel, retired government officials, and widowers or orphans of pension beneficiaries), veterans, national independence heroes, widowers, orphans of veterans and national independence heroes, and non-employees. They are not included in the previous categories but able to pay the insurance premiums. Both PBPU and BP are contributory members of JKN and, as such, should pay monthly premiums (OECD, 2019[82]).

2.4.1. Social protection in Indonesia

Indonesia’s social protection programmes have traditionally been relief-oriented interventions rather than integrated systems of preventive programmes that keep families from falling back into poverty (Jellema and Noura, 2012[85]). The Asian financial crisis in 1997, which led to widespread unemployment and a substantial increase in poverty, acted as a catalyst for the government to adopt a stronger set of policies addressing poverty alleviation and to develop centralised, government-oriented programmes for social protection (Perdana, 2014[86]). In the early 2000s, the government’s continued dedication to social protection initiatives was reflected in the introduction of key legislation for social rights and empowerment programmes to alleviate negative externalities associated with the reduction in energy, in particular fuel subsidies (World Bank, 2012[87]; OECD, 2019[82]).

Since 1997, Indonesia has developed an array of social protection programmes to promote opportunities for the disadvantaged and poor. For instance, Indonesia implemented 37 social protection programmes in 2015 (Adioetomo, Aninditya and Radjiman, 2016[88]), up from 30 social protection programmes in 2012 (Adioetomo, Pardede and Quarina, 2012[89]). The Government of Indonesia’s commitment to protecting families from economic, social and environmental vulnerabilities through social protection initiatives is well established in the budget, budget priorities and planning frameworks of 2016 and 2017. Yet, total public social expenditures only represented 1.1% of GDP in 2015 (ILO, 2017[55]).

Indonesia has more than 40 social protection programmes today, including social assistance, insurance and labour market programmes. Since 2015, Indonesia has invested heavily in social insurance, while the expenditure on social assistance as a share of total social protection spending has reduced. In comparison with social assistance and social insurance, labour market programmes to promote economic participation and productive employment amongst vulnerable groups are underdeveloped (OECD, 2019[82]).

The government has undertaken multiple initiatives in order to improve targeting and ensure the continuous delivery of benefits to eligible beneficiaries through programme consolidation and more unified approaches. The development and upgrade of the BDT and better identification of poor and vulnerable households have been integral to this strategy. Various ID cards have been introduced, including the Family Welfare Card (Kartu Keluarga Sejahtera, KKS), the Indonesian Health Card (KIS), the Smart Indonesia Card (Kartu Indonesia Pintar; KIP) for education for students and the Social Protection Card (Kartu Perlindungan Sosial; KPS). Delivery systems are also being enhanced through the use of digital financial services, including mobile money.

Indonesia’s social protection system provides extensive support for poor households through social assistance programmes, such as Rastra, Family Hope Programme (Program Keluarga Harapan; PKH) and Assistance for Poor Students (Program Indonesia Pintar, PIP) programmes. These programmes target the poorest households, and provide subsidised rice, conditional cash transfer, and scholarships for students, respectively. Rastra (formerly Raskin) is a social assistance programme that provides subsidised rice for the poor. It was initiated in 1998 to reduce the impact of rising food prices following the Asian financial crisis.
crisis by reducing the burden on household food expenditure and stabilising the price of rice. Rice accounts for almost one-quarter of poor households’ total average monthly expenditure (Alderman, Gentilini and Yemtsov, 2017[90]; OECD, 2019[82]).

In 2007, the Government of Indonesia launched the PKH, the first conditional cash transfer programme in Indonesia, administered by the Ministry of Social Affairs (MoSA). It seeks to improve the quality of human capital by providing cash transfers that are conditional on households accessing specified health and education services. The PKH helps reduce the burden of household/family expenditure for very poor households (the immediate consumption effect), while investing in future generations through improved health and education (the human capital development effect) (OECD, 2019[82]). As it encourages beneficiaries to access and use basic health, nutrition and education services, it is expected to promote future generations’ opportunities and productivity (World Bank, 2017[91]). In particular, PKH conditionalities consist of health check-ups for pregnant women, newborns and toddlers, and school attendance for children aged 6-18 (OECD, 2019[82]).

PIP supports school-age children aged 6-21 through cash transfers to reduce education expenses and thereby prevent dropout. In particular, it targets poor and vulnerable households in the bottom quartile. Each eligible student receives a KIP. Students can register by bringing their KKS to the nearest education facility or showing their Certificate of Poverty (Surat Keterangan Tidak Mampu; SKTM) (Ministry of Education and Culture, 2016[92]). Beneficiaries are encouraged to use these transfers for school supplies, transport and fees. As of 2017, more than 18 million students had benefited (OECD, 2019[82]).

2.4.2. Equity trade-offs

Considerable efforts have gone into extending population coverage, but the working population in the middle of the income distribution curve are still largely neglected. Although civil servants, those in the formal private sector and the poor are largely covered under the new JKN, a majority of informal sector workers remained uncovered as of 2017. These comprise more than 50% of Indonesia’s population and more than 62% of the workforce. The financial penalties for interrupted membership and the complexity of the rules act as disincentives for those with variable incomes to stay in the scheme.

Sustaining and expanding JKN has led to some restriction in the services available – particularly to those whose premiums are financed by the government. While restrictions, in principle, focus on discretionary services that should not affect medical care, there may be knock-on effects when delays affect clinical outcomes. Genuine limitations in supply may be exacerbated by provider behaviour intended to maximise revenues or profits. The JKN covers comprehensive benefits, from infectious diseases such as influenza to expensive medical interventions such as open-heart surgery, dialysis and cancer therapies, and includes all beneficiaries regardless of their disease status.

The poor and near-poor (40% of the population), whose premiums are entirely paid by the government, are entitled to third-class room and board at either state or private hospitals, and drugs listed in the National Formulary List (essential drugs list, comprising mainly generic drugs). If third class beds are not available, free ward upgrades are not covered by the JKN programme and the patient is required to wait or pay OOP. Ward upgrades are provided to those whose premium is paid by their employer, who are entitled to first- and second-class room and board and to expensive patented drugs. The lack of third-class beds suggests a serious supply constraint on the provision of effective coverage. If those with government insurance are unable to afford an upgrade, this may lead to a delay in treatment, which can have an impact on the severity of the illness and effectiveness of services. The
consequence of these supply limitations is that patients who are either wealthy enough to pay OOP or are covered by employer premiums have faster access to services than those who are supported by the government.

Despite the increase in the number of beneficiaries, outpatient and inpatient utilisation rates have only grown by three and two percentage points, respectively (World Bank, 2017[93]). Barriers to accessing hospitals, such as the need to travel long distances, largely explain the low growth in utilisation (OECD, 2019[82]). Considering this, the Government of Indonesia cannot effectively increase utilisation rates by providing benefits alone; it must simultaneously ease supply-side barriers (Mahendradhata et al., 2017[94]).

A factor preventing the expansion in the number of beds available is the reimbursement rates for JKN government-subsidised patients, which are viewed by many providers as inadequate. The Ministry of Health has set low reimbursement levels for hospitals in an attempt to ensure that services are affordable for the scheme. It pays a fixed amount to inpatient and outpatient hospitals under a standardised coding mechanism called the Indonesia Case-Based Groups (INA-CBGs). These reimbursements fail to incentivise private providers (clinics and hospitals) to register with JKN and supply health services in poor and remote areas. In time they may also drop out from the JKN network, reducing access to JKN benefits. In the public sector and in private facilities that have registered, this may result in gaming behaviour, since facilities can obtain higher rates of reimbursement from patients paying OOP. This potentially exacerbates the delay in treating JKN patients, as those paying for themselves are prioritised.3 Other forms of provider behaviour suggested by interlocutors to increase revenue include diagnosis-related group/cost-related group up-coding, and discharging then readmitting complex patients in order to double-bill the BPJS (Hasbullah et al., 2014[95]). These incentives to cheat the system could be mitigated by equalising the premiums received for JKN patients and changing the way in which providers are reimbursed and regulated.

A final trade-off has been between financial investment and expansion of membership and equity. The Ministry of Finance premiums for PBI have lagged behind the costs of care for this group. Since the BPJS is a quasi-government agency, the Ministry of Finance must ensure that it remains financially viable, necessitating end-of-year emergency financial injections. This pressure has led to the BPJS making financial sustainability one of its main goals for 2017, followed by customer satisfaction and expansion of membership. One suggested solution in order to increase BPJS’s revenue is to remove the salary ceiling for citizens (currently at IDR 5 million, meaning that low-wage earners pay proportionally more contributions than high-wage earners) in order to cross-subsidise lower income groups and pay higher capitation to hospitals.

2.4.3. Policy instruments for UHC

Social protection in Indonesia takes two forms: social insurance (including health insurance through payroll contributions) and social assistance (including conditional cash transfer (CCT), Rastra (Rice for the Poor), disability support, education scholarships and health insurance through government subsidies). The social protection and healthcare initiatives

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3 This behaviour is similar to that seen in the early years of the Viet Nam insurance system, when patients would hide the fact that they had insurance and instead pay OOP in order to ensure speedy access to treatment.
are considered to “speak to each other” and have been developed iteratively, rather than being conceptually integrated from the outset.

The PKH is the Government of Indonesia’s key social assistance programme and was designed to break the transmission of poverty to the next generation by applying conditionalities for families in order to increase their use of public services and improve the health and education outcomes of their children. The PKH showed some improved health (improved prenatal visits and immunisation rates) and education (gross enrolment) outcomes as well as higher expenditures on health and food, but the impact was limited given supply-side constraints. The continuation of the PKH programme and its integration with JKN may allow the mutual reinforcement of the programmes’ outcomes.

In 2005, the Government of Indonesia began developing the Unified Database for Social Protection Programmes (UDB, also known as Basis Data Terpadu untuk Program Penanggulangan Kemiskinan, BDT), an electronic database containing social, economic and demographic information, which allows for scaling-up of social assistance programmes. The National Team for the Acceleration of Poverty Reduction (Tim Nasional Percepatan Penanggulangan Kemiskinan; TNP2K) and the MoSA are responsible for the UDB, which lists 40% of the population to be poor or vulnerable. The UDB is the foundation for various social protection programmes as well as for the JKN. The PKH is the only programme to fully adopt the UDB in order to generate quotas and determine eligibility, and to implement an update procedure. TNP2K, the Ministry of National Development Planning (BAPPENAS) and the MoSA are currently piloting on-demand applications to update the BDT in order to reduce exclusion errors (World Bank, 2017[91]).

2.4.4. Conclusion

Equity is a key principle in the development of social insurance in Indonesia, which aims to improve equitable access to care and provision of basic services, regardless of income and geography. BPJS Health and BPJS Labour benefits include hospital inpatient and emergency treatment, disability payments, compensation where there are no adequate health facilities available, work accident insurance, old-age pensions and life insurance. The SJSN enables continuous (portable) security should a participant move residence within the Republic of Indonesia.

However, there remains inequity in the design and implementation of the programme. By design, the insurance scheme distinguishes health services for PBI beneficiaries. PBI services are only offered in Class 3 hospitals, while informal economy workers paying their own premiums may receive services in Class 2 hospitals and those not receiving PBI benefits may receive services in Class 1 and Class 2 hospitals, indicating challenges to equity in terms of offering the same minimum level of service for all. Class 3 hospitals are considered by some users and non-users to be less professional and more restricted (e.g. with regard to beds) than other classes of hospitals, and to stigmatise users as poor, leading to lower user satisfaction. In addition, access to quality services remains a challenge across many islands, and discussions on providing quality health services and sustaining those services (beyond medical outpost rotations) are required.

2.5. UHC in Kyrgyzstan

Kyrgyzstan is a landlocked country in Central Asia with a population of 6 million people and three main ethnic groups: Kyrgyz, Uzbek and Russian. The country gained independence in 1991 and, as in many other ex-Soviet republics, the economy contracted
dramatically in the following years: it was only in 2005 that its GDP reached its pre-
independence level. In 2014, Kyrgyzstan was classified by the World Bank as a lower-
middle-income country. In the past 20 years, economic growth has been significant,
although there have been short periods of contraction and slowdowns, especially after
the political turmoil in 2005 and 2010, when protests resulted in a change in government. One
of the drivers of economic growth has been the flow of remittances, which represented less
than 5% before 2004 but which are now more than 30% of GDP (one of the highest in the
world) (World Bank, 2017[96]).

With respect to health outcomes, there has been a very significant reduction in infant and
child mortality rates; improvements in the management of diarrhoea, breastfeeding and
child care; and a general increase in access to medical care. Life expectancy is now higher
than it was in 2000, although not by a substantial margin. However, there has been no
improvement in maternal mortality rates as of 2015, compared to 2000. The main causes of
mortality in Kyrgyzstan are cardiovascular diseases (associated primarily with dietary
risks), which account for more than 50% of deaths. Pneumonia and lower respiratory
infections are also a significant causes of death. Health outcomes are relatively equal across
different population sub-groups.

After independence, with the contraction of the economy and the lack of the large subsidies
that the country had previously received from Moscow, public health expenditure reduced
dramatically and the available budget was largely insufficient to support the relatively large
hospital infrastructure. Sixty-nine per cent of outpatients and 86% of inpatients made
payments in relation to their treatment in 1994 (Falkingham, Akkaziieva and Baschieri,
2010[97]). The response was a significant health financing reform and a restructuring of the
health system, with a rationalisation of hospital infrastructure.

In 1996, Kyrgyzstan established a system of mandatory health insurance, creating specific
taxes for healthcare and a fund which became the single purchaser of health services, using
both the budget transfers and the earmarked taxes from social insurance contributions. The
new system was instrumental in pooling resources and equalising transfers based on
capitation rules for primary health facilities and case-based payments for hospitals. The
health delivery system was restructured, reducing hospital capacity, increasing the role of
primary healthcare and introducing general practitioners or family doctors. As part of the
redesign of the health delivery system, much more emphasis was given to primary
healthcare and the attempt to provide the entire population with basic services, with clear
positive equity impacts.

A transparent system of entitlements was created through the State Guaranteed Benefit
Package (SGBP), which provides primary healthcare free at the point of service to
everyone, regardless of their insurance status, as well as a package of services (inpatient
and specialised outpatient treatments) that can be accessed with formal co-payments for all
those who are insured. The benefit package is supplemented by the Additional Drug
Package (ADP), which guarantees discounts on the purchase of medicines containing
certain active ingredients. Such discounts can be obtained by the insured through doctors’
prescriptions. Moreover, some categories of vulnerable people, who either have specific
medical conditions (16 categories) or are considered socially vulnerable (30 groups), are
exempt from co-payments.

Reforms were carried out under three main health programmes: Manas (1996-2006), Manas
Taalimi (2006-11) and Den Sooluk (2012-16). Manas Taalimi (which literally means
“lessons from Manas”) aimed to continue expanding the reforms initiated under Manas, but
saw some political instability, as well as an attempt to misuse the mandatory health
insurance fund. The system was not compromised, thanks to its legislative basis: three laws regulating the provision of health services to the population, the functioning of the health delivery system and the key financing arrangements. More recently, Den Sooluk has put an emphasis on the fight against cardiovascular diseases, maternal and child health, tuberculosis and HIV/AIDS infection.

### 2.5.1. Social protection in Kyrgyzstan

Social protection in Kyrgyzstan today is widely perceived as a basic right of all citizens. This is a vestige of the cradle-to-grave provision of social protection that existed across the Soviet Union. Yet, Kyrgyzstan’s transition to a market-based economy and the economic upheavals since the 1990s have undermined the feasibility of the old Soviet model, resulting in the need for major reforms of the social protection system that continue to this day (OECD, 2018[98]).

The current system of social protection is embedded in the 2010 Constitution, which was enacted following the change of government in that year. Article 9 stipulates state obligations to:

- Establish decent conditions of life and free personal development as well as assistance to employment.
- Ensure support to socially vulnerable categories of citizens, guaranteed minimal level of labour remuneration, and protection of labour and health.
- Develop a system of social services and medical services, and establish state pensions and benefits as well as other social security safeguards.

The Government of Kyrgyzstan (GoK) has published its first two social protection strategies, covering 2012-14 and 2015-17, respectively. These strategies were based on the identification of vulnerable groups. The first strategy identified four such groups: families and children in a difficult life situation, people with disabilities, elderly citizens, and homeless people. The second strategy specified three vulnerable groups; these were the same as in the previous strategy, with the exception of homeless people. Between these two strategies, the GoK launched the National Sustainable Development Strategy for the Kyrgyz Republic for the period of 2013-2017, a development plan whose recommendations for social protection closely follow the first social protection strategy.

The GoK spends more on social protection than any on other area of expenditure and there exists a broad range of programmes across the main pillars of social protection (social assistance, social insurance and labour market policies). However, these pillars are not equally well developed and have thus evolved at different times in response to different demands.

Social insurance dominates the social protection system through the Social Fund, which provides old-age, disability, and survivor pension payments to the insured and top-ups to defined groups on a non-contributory basis, including military personnel, individuals working in remote areas, and people with disabilities. Because of the high coverage levels, pensions are the principal means of poverty alleviation not only among the elderly but also among younger generations (OECD, 2018[98]).

Social assistance is implemented on a much smaller scale than social insurance. As of 2018, the two largest programmes were the poverty-targeted Monthly Benefit for Poor Families with children (MBPF, previously called the UMB) and the Monthly Social Benefit (MSB), a categorical benefit for people with disabilities and other vulnerable groups. Combined
expenditure on these programmes was 1.2% of GDP in 2015, versus 7.4% of GDP spent on pensions in the same year (OECD, 2018[98]).

As of 2017, the MBPF provides a monthly cash transfer to households with children under 16 years of age (or under 18 years of age if they are still in education) whose per capita income does not exceed the value of the guaranteed minimum income (GMI). The MBPF is intended to mitigate the effects of extreme poverty among households with children. This programme is of utmost importance given that 48.5% of the poor population is under 18 years of age. However, its low coverage rates and low benefit levels constrain its effectiveness.

The provision of social protection in Kyrgyzstan is unsustainable in its current form, both financially and politically. Coverage is far higher for the elderly population than for any other group (only 6.4% of children are covered by at least one programme) (ILO, 2017[55]), and spending on pensions dwarfs expenditure on all other social protection programmes combined (OECD, 2018[98]).

The Social Protection System Development Programme 2015-17 shows a commitment to continuously improving the system of social protection. About 8% of GDP is spent on social protection (Ouchi et al., 2017[99]) and about 2.5% of GDP is spent specifically on social assistance.

2.5.2. Equity trade-offs

In the late 1990s and the beginning of 2000, Kyrgyzstan made a clear choice to provide basic health services to everyone and has geared the delivery system towards that effect, putting an emphasis on primary healthcare. Therefore, there was a deliberate and conscious choice to move towards a universal coverage of essential services. Between approximately 75% and 80% of the population of Kyrgyzstan is insured; other people are covered through indirect mechanisms because they are poor. Some of the uninsured are people who are relatively better off with alternative insurance plans, or people who are simply not attracted by the SGBP.

The socially vulnerable categories have been determined based on medical factors and inherited definitions used by the Ministry of Labour and Social Development (MLSD). Socially vulnerable groups are defined based on the Soviet system through a combination of merit and vulnerability. A study by the World Health Organization (WHO) (Shafique and Jakab, 2013[100]) shows that the overall identification of these exemption categories is very mildly pro-poor and suggests different possible technical solutions to improve the impact of exemption policies on the poor. However, any changes would need to consider both the political economy and administrative costs in implementing a different system. The Ministry of Health (MOH) is responsible for determining the benefit package, which is often revised without much transparency regarding cost-effectiveness and equity impact, or regarding the influence of different pressure groups.

Concerning the determination based on medical factors, there are two different arguments for the exemption policies. On the one hand, purely from a health policy perspective, the reasoning is that they reduce the risk of communicable diseases (for example, tuberculosis), and also considers that people with certain conditions are likely to have higher needs. Indeed, in other countries, it was found that persons with disabilities and chronic illnesses tend to have a significantly higher utilisation of health services, which, if not properly protected, tend to cause impoverishment or catastrophic health expenditures.
2.5.3. Policy instruments for UHC

The policy interlinkage between social protection and UHC occurs in the identification of socially vulnerable groups who should somehow receive “preferential treatment” in the access and use of health services. Essentially, the preferential treatment consists of three key elements:

- exemption from paying for health insurance
- exemption from co-payment or a discount on co-payments when using certain health services
- support to certain groups, such as persons with disabilities and people with chronic illnesses, who receive financial transfers through social assistance or social insurance in order to compensate for income loss, and so are protected against specific health shocks.

Policy-level interlinkages are materialised at the programme level through the mechanisms in place to identify people eligible to receive healthcare free of charge, as well as through certain social assistance programmes through “social passports”. These passports are based on households filling out a special questionnaire about household composition, incomes, household assets and housing conditions, and are managed by the MLSD.

In practice, the social passport approach suffers from various shortcomings, as the most vulnerable populations often do not apply for a social passport, and the identification of vulnerable groups does not always correctly identify the poor. The MLSD is also considering a radical reform whereby the duty to determine who falls below the poverty line will be given to each local authority. This raises a number of questions about the feasibility of the approach not only given the capacity at local level, but also the comparability of potentially different approaches across localities.

Finally, at an administrative level, a practical interaction that often occurs at the community level is that of front-line workers, either from the health or social protection sector, who come into direct contact with households and play an important referral role. Indeed, at community level, social workers who visit households are the gateway for referrals and also for information on access to healthcare (for example, in the identification of a disability). This administrative linkage should potentially be further increased through the appropriate development of common management information systems and the direct sharing of databases.

While there is some co-ordination between the UHC and social protection policies, in practice the MLSD and the MOH often appear to be working in silos. For example, in the most recent and very significant change in child cash benefits, which was to be implemented starting from 2018, the MLSD appeared not to have included any linkages with the MOH.

However, while these linkages exist, they are not always well implemented and assessed. The MOH is said to only receive the list of socially vulnerable groups/households and its eventual changes over time from the MOLSD, but there is no attempt to engage either on the costs of eventual changes to the categories who receive co-payment exemptions or on the utilisation/equity impact of such changes. On the other hand, the MOLSD’s view is that these decisions were taken primarily by the Parliament and that it had little to do with them.
2.5.4. Conclusion

Equity in Kyrgyzstan is based on a sense of solidarity and the need to ensure healthcare access for all. Therefore, there was considerable support for the concept of social health insurance, and an explicit commitment for the reform to equalise resources across oblasts (regions) and to cover remote and rural areas. Similarly, the legacy of the past highlighted the need to provide specific protection to groups who are considered socially vulnerable, including, for example, people with disabilities, as well as those seen as having social merit, such as war veterans. Especially in the first years of transition, there was a perception that everyone was poor and needed to have the right to healthcare.

The recognition of the status of being below the poverty line is granted through the so-called social passport, which assesses the living standards of the household through a questionnaire. The MLSD manages the system of social passports. However, there are a number of significant problems in relation to information about the system and the application procedures. Most poor people are not registered as such, and, in practice, service is often provided at the discretion of the health facilities.

Even though the concept of solidarity was at the heart of the choice to provide mandatory health insurance, this has come under threat recently, with some politicians arguing for individual health accounts. This is likely to become a bigger challenge if the country continues to grow and the quality of services does not increase to keep up with the demands of a relatively more affluent population.
3. Lessons from universal health coverage for universal social protection

Social protection and universal health coverage (UHC) are inherently interconnected in various ways, and can be strategically developed in order to create a mutually strengthening effect. As iterated in both the International Labour Organization’s (ILO’s) Social Protection Floors Recommendation (R202) and the Sustainable Development Goals (SDGs), social protection and UHC go hand in hand. Accordingly, social protection interventions and programmes should provide: 1) access to essential healthcare, including maternity care that meets the criteria of availability, accessibility, acceptability and quality; and 2) basic income security for children, people of working age who are unable to earn sufficient income, and elderly people. The social protection floors and the SDGs emphasise the importance of providing essential healthcare to everyone, with the objective of leaving no one behind, and with an equity perspective so that both poor people and vulnerable groups (children, the elderly, people with disabilities, and women before and after birth) are protected.

3.1. Universal social protection

Social protection is subject to numerous definitions, which vary between countries and between international organisations. As the ILO acknowledges, “differing cultures, values, traditions and institutional and political structures affect definitions of social protection as well as the choice of how protection should be provided” (Garcia and Gruat, 2003[101]). The Organisation for Economic Co-operation and Development (OECD) definition of social expenditure includes public and private benefits with a social purpose grouped along the following policy areas: old age, survivors, incapacity-related benefits, health, family, active labour market programmes, unemployment, housing and other social policy areas. This study takes a flexible approach and embraces country-specific definitions of social protection to guide the work, and alternatively relies on the ILO’s definition, which defines social protection as the guarantees that “should ensure at a minimum that, over the life cycle, all in need have access to essential health care and basic income security”.

Since 2015, the international community has increasingly recognised the crucial importance of social protection, in particular as part of the 2030 Agenda for Sustainable Development. The SDGs refer to social protection in four instances, the most prominent being in SDG 1.3, calling upon countries to implement nationally appropriate social protection systems for all, including floors, for reducing and preventing poverty. Social protection is also included in SDG 5.4 targeting gender equality, SDG 8.5 on decent work and economic growth, and SDG 10.4 on greater equality.

The concept of universal social protection (USP) thus began to be promoted and the Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals (USP2030) was launched at the United Nations (UN) General Assembly in 2016. Countries were invited to join USP2030 through a Call to Action in Geneva in 2019. The rationale is that USP is key to sustained inclusive economic and social development for individuals, communities and nations. It can reduce poverty and inequality, promote social cohesion,
and facilitate human development and access to decent working and living conditions. Social protection can also increase productivity and employability by enhancing human capital and allowing investment in productive assets; raising household incomes, consumption and savings; boosting aggregate demand; and enhancing people’s resilience in the face of shocks and structural transformations (OECD, 2019[11]). Fundamentally, USP is a human right that everyone, as a member of society, should enjoy, including children, mothers, people with disabilities, workers, older people, migrants, indigenous peoples and minorities.

The core principles of USP include protection throughout the life cycle; universal coverage; national ownership; sustainable and equitable financing; and participation and social dialogue. USP is achieved through a nationally defined system of policies and programmes that provide equitable access to all people and protect them throughout their lives against poverty and risks to their livelihoods and well-being. This protection can be provided through a range of mechanisms, including cash or in-kind benefits, contributory or non-contributory schemes, and programmes to enhance human capital, productive assets, and access to jobs.

3.2. Synergies between USP and UHC

The contribution that social protection can make to support underlying health needs, as well as the demand for and supply of healthcare, needs to be first recognised. For example, labour market regulations such as rest periods and OSH measures in general can avert industrial accidents and other health risks experienced by employees without adequate workers’ rights, and so reduce health needs. At the same time, strong regulations can address demand-side barriers, such as the right to time off work to seek healthcare without penalty (De Paz et al., 2017[102]). Existing social protection institutions can be conducive to a strong institutional and governance system in which UHC measures are easier to introduce.

Given the close linkages with social protection, UHC should not be considered a stand-alone or isolated policy scheme. When people have specific health needs, for example following an accident or the birth of a child, this usually not only involves health treatment at an affordable rate, but also often implies income loss due to an inability to work for a certain period and in some cases even involves other family members having to look after the person affected by the health problem. In these circumstances, the social insurance and social assistance transfers can indirectly support health access and people’s well-being. Therefore, it is understandable that different social protection policies, such as pensions, work accident insurance, maternity leave arrangements, disability pensions and social transfers, often reinforce and support healthcare access and utilisation.

When a country seeks to expand its health coverage, existing social protection measures can support the achievement of UHC. By providing financial and in-kind support prior to and during illness, as well as increasing the social and cultural capital of the disadvantaged, social protection measures can be crucial in eliminating demand-side barriers to accessing health services. In some countries, certain vulnerable groups with high healthcare needs (such as people with disabilities) receive both specific assistance to access healthcare (free health insurance, exemption of fees), as well as cash transfers to support their living standards and as a compensation for income loss. This is, for instance, the case with many Conditional Cash Transfer (CCT) programmes, such as Prospera in Mexico. In Brazil, CCTs from the Bolsa Família programme reinforced the impact of the Family Health...
Program (*Programa Saúde da Família*) by improving access to healthcare and decreasing barriers such as transportation costs (Guanais, 2013[103]).

UHC and social protection share the common goals of reducing vulnerability, increasing protection against shocks, and investing in human capability, but policies are typically articulated independently. Existing social protection institutions can also be conducive to a strong institutional and governance system in which UHC measures are easier to introduce. Social protection is correlated with UHC at the national level, either because they are mutually supportive or because governments which have the motivation and resources to develop one are also likely to invest in the other. Both have been heavily promoted by the international community in recent decades. Some good examples of linking programmes were found, and countries are commonly moving towards pooled systems for identifying vulnerable populations. These offer opportunities, but they can also present risks of exclusion if systems have high error rates.

The broader interpretation of social protection flows from the understanding that poverty is a multidimensional challenge that requires not only financial protection but also measures to address issues of human capital and the structural factors in society causing poverty (Hulme, Barrientos and Moore, 2006[104]). This interpretation follows a four-dimensional definition of social protection put forth by Devereux and Sabates-Wheeler (2004[19]) comprising: a) prevention (anticipating negative shocks); b) protection (of people facing poverty by resource provision, through cash transfers for instance); c) promotion (policies promoting human capability by encouraging school attendance, employment retention, medical check-ups); and d) transformation (measures tackling racism, gender issues, social exclusion) (Figure 3.1). As such, social protection policies can support the achievement of UHC through four channels.
First, social protection can prevent negative shocks in the area of health through wider social insurance. For instance, pension schemes allow individuals to retire upon reaching a certain age, thereby protecting them from employment-related health risks. Social pensions—that is, pensions categorically targeting individuals above a certain age (with or without conditionalities related to income or enrolment in pension schemes) to receive a monthly cash transfer—are an example of how social protection may prevent negative health shocks for vulnerable elderly people. These types of pensions have been increasingly implemented in developing countries, now covering more than 100 countries worldwide, including South Africa (Old Age Grant), Thailand (Old Age Allowance) and Mexico (Old Age Pension; Pensión para Adultos Mayores) (Pension Watch, 2018[105]).

Second, income and in-kind transfers alleviate financial and material hardship experienced during illness and can complement the existing healthcare cost subsidies. This is critical, as the direct and indirect costs of accessing healthcare (and the implications of coping strategies to enable payments) can also affect other areas of welfare. One of the core objectives of UHC is to ensure that the use of healthcare services does not have harmful consequences for other social needs (Saksena, Hsu and Evans, 2014[106]). Some examples include the Brazilian Beneficio de Prestação Continuada (for elderly people and people with disabilities) and the South African Child Support Grant, which provides non-conditional income to children, both of which have improved nutrition and facilitated access to other social services, all the while yielding positive health outcomes. The Old Age Grant (OAG) in South Africa, provided to low-income residents 60 years of age and older, has benefited the health and school attendance of children living in OAG recipient households (WHO, 2012[107]). Furthermore, economic support for non-medical costs has
been shown to be a primary enabler of increased service utilisation and adherence to long-term treatment for conditions such as tuberculosis (Lönnroth et al., 2014[108]).

Third, social protection policies promote human capability by contributing towards livelihood assets and empowerment through education, training and employment. These interventions can facilitate the access and utilisation of health services through increased financial, human and social capital. There is strong evidence for education (e.g. through conditional cash transfers) in particular, pointing to its beneficial effect on health both directly, through better economic conditions, and indirectly, through social-psychological resources (de Snyder et al., 2011[109]). By contrast, stress, unhealthy lifestyles, and individuals’ sense of inability to control their lives are all related to poor financial and material conditions, equally leading to poorer health (Sjöberg, 2014[110]).

Fourth, social protection policies promoting social inclusion and women’s empowerment have a transformative power, which can contribute towards tackling social determinants of health and reducing barriers to access and utilisation. These may include, in practical terms, empowering trade unions to provide a voice for the vulnerable; launching public awareness campaigns seeking to change broader attitudes within the society; or implementing policies that specifically empower women (Devereux and Sabates-Wheeler, 2004[19]). Training can also make an important transformative contribution, alongside employment, which has a potential role in reducing gender, ethnic, and other forms of social exclusion in addition to increasing financial resources (de Snyder et al., 2011[109]). Thus, the promotion and transformation dimensions of social protection policies are interconnected, both relating to human and social capital.

It is important to note that health system reform has often taken place in the context of broader welfare policy expansion (Cavangero et al., 2015[111]; Stuckler, 2010[112]). In the context of low- and middle-income countries (LMICs), such policy processes are often related to global social policy making, as many countries draw from global frameworks, such as the Millennium Development Goals (MDGs) and SDGs, in order to shape health policy directions. Access to good quality health services also reinforces the impact of certain social protection programmes, as well as more broadly reducing vulnerability through better health. For example, if households’ access to health services is not financially onerous, this supports social assistance beneficiaries in using cash transfers for other objectives, thus reducing poverty levels and maximising the impact of transfers.

While many countries acknowledge the interlinkages between social protection and UHC, the lack of a national poverty identification system, funding constraints, decentralisation of health insurance schemes, or institutional rigidity all hamper better synergies between programmes. Much remains to be done in reducing inequality of access, healthcare infrastructure and service coverage within countries’ different regions, which often correlate with socio-economic status.

Finally, evidence from OECD countries shows that UHC is affordable for most countries, but needs to be achieved with the right policies. Financial sustainability and quality of care must be built into the system from the start. Countries need to have fit-for-purpose service delivery, moving away from cure-centred models and embracing primary care and prevention. It is essential to define well what is and is not covered – essential, cost-effective services – as opposed to having a wide range of services covered with high cost-sharing rates (OECD, 2015[113]).
3.3. Challenges with universalism

3.3.1. The political economy

The political economy of the local context determines UHC paths. The country studies in Section 2 highlight the importance of political economy factors in driving and impeding reforms, including domestic politics, actors and interests; the role of development partners; and international framing. In Ghana, for instance, the National Health Insurance Scheme (NHIS) was created thanks to a window of opportunity opened up by electoral discontent with user fees. However, having made broad promises, especially on the package of care, concrete reforms to address technical weaknesses have not been politically feasible. This highlights the need to use the windows of opportunity for reform carefully, considering the longer term and not just short-term electoral gains.

Furthermore, the administrative rigidity of existing programmes and competition between social protection and health institutions unavoidably affects both the demand-side factors of UHC and social protection. The country studies highlight the information, gender, cultural, religious, geographical and other barriers faced by non-users who are not able to make use of their theoretical UHC and social protection entitlements. The lack of integration can, for instance, lead to lower awareness and create barriers in terms of enrolment and obtaining services or benefits (e.g. due to time or geographic constraints), and may ultimately negatively shape public opinion on the programmes, thereby threatening their sustainability.

3.3.2. Equity trade-offs

Many UHC policies have focused on financial entitlements of population groups, but have not focused as much on the equitable availability and quality of healthcare supply. This is especially evident for key inputs such as staffing, where geographical distribution remains a challenge in all focal countries, undermining the effectiveness of UHC policies. In Ghana, although linkages were made between NHIS exemptions for the poor and Livelihood Empowerment Against Poverty (LEAP) – a conditional cash transfer programme – beneficiaries, in actual fact, practical barriers to registration, continued costs of accessing healthcare, low awareness and low generosity of the transfers reduced the real protection provided by these policies.

In their efforts to implement UHC, countries such as Burkina Faso, which lack national poverty-based household identification and which also have extensive poverty, have relied more on targeting population groups, such as children and pregnant women. Countries with higher poverty levels and/or lower levels of social solidarity, such as India, are more likely to adopt targeted approaches based on income levels.

Reflecting on these trade-offs and the processes through which they were reached makes it clear that countries are not following the normative steps proposed by the World Health Organization (WHO). Trade-offs are rarely made explicit and policies are often reactive to crises or unforeseen problems with previous waves of reforms. Decisions depend on the path already taken, with some decisions being difficult to reverse. In Ghana, for example, there was no examination of which services were high priority (from a cost-effectiveness, equity and financial protection point of view) in the initial design of the NHIS, and revisiting this issue is now almost impossible politically. The service package is too broad for financial sustainability. Benefits incidence analysis highlights that, overall, the exempted categories are not pro-poor.
In larger, more complex countries, such as India and Indonesia, the priority has not been on cost-effective packages but rather on rolling out coverage and some degree of financial protection, with a focus on those who can pay and on the poor. This raises the problem of the “missing middle”. Low funding has also led to quality constraints and some discrimination or inequity within schemes (for example, the three types of hospital beds in Indonesia, or the variation in support across Indian states). Most importantly, supply-side constraints have inflated costs and inserted barriers to access. The decisions about UHC cannot take place without considering how to organise services. Kyrgyzstan stands out in this respect, as its health financing reforms were combined with a reorientation of the health system towards primary care and reforms to other pillars, such as human resources, pharmaceuticals and information systems.

In general, a nuanced and holistic assessment of equity barriers and needs is recommended in each setting. Too often, UHC is understood simplistically as providing insurance coverage, which itself has no value without the complementary elements outlined in this report. Monitoring equity in relation to UHC requires attention to more than the UHC trade-off dimensions proposed by the WHO. The framework presented in this study also highlights the importance of policy choices outside the health sector, including in relation to poverty reduction and social protection, as well as the importance of assessing financial contributions, resource allocation decisions, quality of care, health outcomes, and inter-temporal choices, all of which affect equitable UHC and leave no one behind.

Although there is no one path to UHC, there appears to be some convergence on core design issues, including moves towards integrated pooling, single purchaser systems, which mix contributory and non-contributory members. In this way, universalism and selectivity are combined, although their success in reaching all populations and matching services to needs varies considerably. Similarly, there is no one path to USP, as countries will need to build upon existing institutions, and in particular carefully manage mechanisms between contributory and non-contributory programmes in order to achieve equitable and universal coverage.

3.3.3. Targeting

Despite a majority of sectors and lead institutions working in silos, some policy-level linkages were identified. The most common point of interaction is in the targeting of poor or selected vulnerable groups, where the social protection agencies are seen as having a lead role in all countries. These moves towards integrated targeting across the social sectors offer potential gains in efficiency and equity, not least given the poor record of the health sector in general in identifying individuals for waivers. However, risks are also created, as any targeting errors or barriers to registration for households will be multiplied across sectors, with the potential for an exacerbation of inclusion and exclusion errors regarding the targeted beneficiaries.

The focus on targeted subsidies in health and social assistance can leave the near-poor exposed, thereby highlighting the need for either a fully universal system (wherein all have automatic entitlement to a shared package, financed from pooled resources such as taxes) or a more graduated approach in the implementation of UHC and USP in order to avoid abrupt cut-off points for entitlement.

A common finding from the country case studies is the lack of integration of institutions and agencies working on health and social protection. Health and social protection stakeholders are most likely to interact at the targeting level, when identifying eligible populations and enrolling them in programmes. The lack of integration can impede
operational efficiency gains in terms of sharing data on beneficiaries and benefits, and may hinder the success of social protection graduation strategies. For instance, in limited resource contexts, social assistance may be available only to households below certain income thresholds within a means-targeted approach.

Yet, access to healthcare requires a long-term approach, and is particularly crucial for households exiting social assistance programmes, who are very vulnerable when facing the risk of health expenditures and a potential fall back into poverty. Entitling those who exit social assistance programmes to still benefit from reduced healthcare costs could support their social assistance exit strategy. There is a general need to ensure that social protection and UHC can benefit from synergies, for instance through effective collaboration and information sharing, thereby reducing redundancies and improving policy effectiveness.

Finally, different interpretations of equity can be seen across the country case studies, with some focusing on the ambition to provide a single, shared service across population groups, including more vulnerable populations, and others having a more targeted approach. For the universalist countries, such as Ghana or Indonesia, the challenge has been to address the supply-side barriers and geographic disparities, along with some of the wider barriers for users (including social barriers such as stigma, complex costs of registration, and non-service access costs). Social solidarity is a prerequisite for such universalist approaches, and growth and social differentiation can pose threats to this, as illustrated in the case of Kyrgyzstan.

Large and complex countries, such as India and Indonesia, have to harmonise national schemes while taking into account the very different contexts faced across their regions. In the case of India, matched funding from the capital is one approach, although it is not sufficient to even out the gaps in performance across states. Poorer states need a much higher level of central support in order to provide quality health services to the poor and the disadvantaged. Integration of local UHC policies into national schemes is attractive, but is also high risk if poorly implemented.

3.3.4. Financing

Across the country case studies, there appears to be a convergence on social health insurance, funded in large segments through tax financing, as a common mechanism for progressing towards UHC. However, adequate funding levels and mechanisms remain a challenge, especially when national growth is slowing. In some countries, for example India, key services such as outpatient care are excluded from coverage, with implications for financial protection. Alongside these attempts to extend entitlements, there have been reforms to improve the supply of services, although many countries continue to struggle to reform health systems. The allocation of resources such as staff and drug supplies often varies considerably in price across areas, thereby hampering equity in the supply of healthcare.

Large, decentralised countries face further challenges in trying to develop uniform national schemes across diverse settings. Indonesia’s ambition to introduce a universal benefits package, for example, with one national pharmaceutical formulary, will be interesting to track. Kyrgyzstan, perhaps because of the shock of the post-Soviet transition and recession, stands out for having undertaken more significant supply-side reforms in relation to purchasing, resource allocation and provider payments, as well as for touching on all health system pillars.
An empirical analysis of 10 countries\footnote{Brazil, Burkina Faso, Ethiopia, Ghana, India, Indonesia, Kyrgyzstan, Moldova, Nepal and Sierra Leone.} carried out by this study shows that out-of-pocket (OOP) payments as a percentage of total health expenditure declined in each country since 2000, with the exception of Indonesia. However, none of the 10 countries are below the 20% of the total household expenditure threshold which has been recommended by the WHO to keep catastrophic health expenditures within acceptable levels, indicating that further progress is needed on financial protection. Trends in catastrophic payments over the respective periods analysed for each country (see Annex A) vary across the countries – some improving, others remaining stable, others deteriorating – which reinforces this conclusion. There is also evidence of unmet needs among those who do not incur catastrophic expenditure.

Social protection and health compete with many other priorities of public financing. In many developing countries, tax revenues are not sufficient to meet the desired level of public health and social protection spending. This leads to high levels of OOP spending at private facilities, even among individuals with limited resources. It is also important to note that the tax systems in many developing countries are not very progressive, given their reliance on indirect rather than direct taxation. As a result, generating higher tax revenues might place a particular burden on the poor.

Combining tax financing with contributions offers a mechanism for increasing financing for health and social protection in a more progressive manner, whereby different income groups’ or types of workers’ capacity to pay is reflected in variable contribution rates, with implicit government subsidies for low-income groups that start at 100% for the most in need. Careful analysis is needed regarding whether the taxes on which the government relies to finance spending are pro-poor and should be reallocated by calculating the overall impact of taxes and transfers (OECD, 2018\footnote{[114]}).

Social protection programmes face similar challenges as UHC, particularly in terms of financing and enrolment rates in social insurance programmes. Raising revenues to sustain or expand social protection is problematic in contexts of low tax revenues, high informality and uncertain donor support. One common challenge between UHC and USP on the financing side is that of engaging private employers to commit to enrolling in, and contributing to, social protection for their employees. On the delivery side, there is also the question of the role of private providers, and how far they can help address major equity issues in countries with weak institutions and low capacity to regulate and monitor access.

### 3.4. Towards a systems approach: social protection systems

Amid a global proliferation of social protection schemes over the course of the 21st century, a number of countries are attempting to weave individual schemes into comprehensive and coherent social protection systems, reflected in the wording of the SDG 1.3. The systems-building process usually begins with the formulation of a social protection policy, which lays out a vision for integrating different schemes and achieving better coverage. As of 2015, 77 developing countries had a social protection policy or strategy in place, and 31 countries were planning or formulating one (The World Bank, 2015\footnote{[115]}).

While there is variation across countries, the term “social protection system” usually refers to a framework whereby the three pillars of social protection – social assistance, social
insurance and labour market programmes – are integrated or (at a minimum) co-ordinated. Integration usually involves creating linkages between different programmes under each pillar of the social protection system; for example, combining different food security transfers within the social assistance pillar.

Integration can also happen across pillars. At an administrative level, for instance, different social protection schemes can share data and monitoring systems, which will ideally be linked to other civilian registries. At an operational level, social protection schemes often share enrolment and delivery systems while, at an institutional level, a single institution might be empowered to co-ordinate social protection activities across sectors and ministries. The unified registry system would help identify beneficiaries and avoid exclusion and overlaps of benefits. This would also help develop common definitions of the poor and of the targeting methodology across ministries responsible for social protection and health.

Health system policies and mechanisms designed to support UHC can be considered to both cut across the three pillars of social protection and to represent a fourth pillar of a social protection system. Conceptually, UHC is convergent with the objectives of poverty and vulnerability reduction, since it ensures access to health services and ensures that no one suffers undue financial burden from healthcare payments. Operationally, however, UHC policies and other social protection policies are often implemented under separate governance and administrative processes. Linkages are nonetheless being developed, for example in the use of social assistance targeting mechanisms for social health insurance schemes or, in the case of Indonesia, for example (OECD, 2019[82]), integration of UHC within a national social protection policy.

The benefits of an integrated social protection system are manifold. It facilitates provision of a social protection floor, whereby individuals are appropriately protected throughout the life cycle. This is achieved not only by ensuring that there is a sufficient range of programmes to cover a population’s risk profile, but also by sharing information on different individuals in order to ensure that they are linked to an appropriate programme. A systems approach also minimises costs, both at a government level (by sharing infrastructure and achieving economies of scale) and at an individual level (by reducing the transaction costs associated with applying for different social protection programmes).

Systematisation at an institutional level can be analysed with reference to a country’s social protection policy-making processes and the coherence and co-ordination that exist within and among ministries, between different levels of government and between other actors in the sector. Analysis should examine the existence of co-ordinating bodies and their effectiveness, not only in promoting coherence across the sector but also in aligning social protection with a government’s broader policy framework, such as a development plan and sectoral strategies for education, health, employment, agriculture or economic development. The extent and effectiveness of programme-level co-ordination and coherence across social assistance, social insurance, labour market programmes and health coverage mechanisms should be assessed (OECD, 2018[114]).

The OECD Social Protection System Review Toolkit recommends assessing information sharing across the social protection sector through information management systems, as well as linkages between social protection registries and other databases, such as civil registries or census data. The registration process for various programmes, as well as the mechanisms used to target interventions towards various groups and to evaluate monitoring and evaluation systems, are important aspects to minimise exclusion errors and duplication of benefits. Such analysis will allow the identification of options for scaling up or reforming
particular programmes, establishing new interventions to meet needs not addressed by existing social protection provision, and reprioritising sector resources in order to ensure the system’s sustainability and optimise spending (OECD, 2018[114]).
4. Conclusion

Policy makers across the world are increasingly seeking a way to deliver on universal social protection (USP), as enshrined in the Universal Declaration of Human Rights and spelled out in Goals 1.3 and 3.8 of the 2030 Agenda for Sustainable Development. Efforts to move towards USP are also mirrored in the 2016 launch of the Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals (USP2030). Looking ahead, in order to help governments invest in the extension of social protection and inform policy guidance on universalisation, evidence and information on what has worked well – and not so well – in terms of universal provision is greatly needed. In this context, the necessity to draw lessons from ongoing initiatives that champion universality in social protection becomes apparent.

A key message that emerged from this study is that social protection and universal health coverage (UHC) are inherently interconnected in various ways, and can be strategically developed in order to create a mutually strengthening effect. As iterated in both the International Labour Organization’s (ILO’s) Social Protection Floors Recommendation (R202) and the Sustainable Development Goals (SDGs), social protection and UHC go hand in hand. Social protection interventions and programmes should provide: 1) access to essential healthcare, including maternity care that meets the criteria of availability, accessibility, acceptability and quality; and 2) basic income security for children, people of working age who are unable to earn sufficient income, and elderly people. The social protection floors and the SDGs emphasise the importance of providing essential healthcare to everyone, with the objective of leaving no one behind, and with an equity perspective so that both poor people and vulnerable groups (children, the elderly, people with disabilities, and women before and after birth) are protected.

Based on country studies in Burkina Faso, Ghana, India, Indonesia and Kyrgyzstan, this study has further showed that while the UHC experience cannot be mechanically transposed to the USP agenda, a number of lessons can be drawn. First, context matters; countries have chosen different healthcare extension paths and there is no single blueprint for delivering on universality. By and large, the review of UHC reform shows that trajectories are driven by political economy considerations, including domestic politics, actors and interests; the role of aid partners; and international agendas. Progress in universal provision has also been achieved through quite different modalities of delivery and financing, and policy approaches. Whatever the model is, however, social protection and UHC appear mutually supportive: governments with the motivation and resources to develop one are also likely to invest in the other.

Second, the difference between reality and rhetoric can be important when it comes to adequate and equitable financing and delivery issues. Experiences from UHC implementation suggest that no welfare system can continue to expand the coverage and depth of its benefits without the necessary resources. While overall health represents a tiny share of total ODA, the domestic financial commitment to health has been too limited to support equitable UHC in some settings. On the path to UHC, developing countries face...
the dual challenge of resource mobilisation and resource allocation. Moreover, there is growing evidence that not all health sector policies that are considered UHC are necessarily equitable or pro-poor, or at least not to the fullest extent. Many UHC policies have focused on financial entitlements of population groups without a matched emphasis on the equitable availability and quality of healthcare supply. This has often undermined the effectiveness of UHC policies. More comprehensive and participatory policies that address supply-side and demand-side constraints and engage communities in design issues tend to have achieved better results.

Third, health and social protection policy makers often grapple with similar coverage challenges. Moving towards universal provision comes with new requirements in terms of accountability mechanisms and monitoring systems, while also putting forward the question of private providers’ real capacity to fill the gap in public provision in countries with limited regulatory capacities. The problem of a “missing middle” – with basic support targeting the poor and a more comprehensive package available only for the wealthiest, leaving the near-poor very vulnerable – is also frequently encountered, both with the implementation of UHC and the extension of social protection.
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Annex A

Table A.1. Datasets used for the global data analysis

<table>
<thead>
<tr>
<th>Country</th>
<th>Demographic and Health Survey (DHS)/ Multiple Indicator Cluster Survey (MICS)</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>District Level Household Survey 2002-04 and 2012-13 (data for Andhra Pradesh and Manipur) + 2005-06 and 2015-16 National Family Health Surveys</td>
<td>National Sample Survey data 2004 and 2014, respectively 60th and 71st rounds (data for Andhra Pradesh and Manipur)</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>DHS 2008 and 2013</td>
<td>Sierra Leone Integrated Household Survey (SLIHS, 2003 and 2011)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>2005 and 2016 DHS</td>
<td>2015 Socio-economic Survey</td>
</tr>
<tr>
<td>Brazil</td>
<td>1996 DHS, 2006 Pesquisa Nacional de Demografia e Saúde da Criança e da Mulher (National Demographic and Health Survey of Children and Women) and 2013 National Health Survey</td>
<td>Secondary sources</td>
</tr>
</tbody>
</table>

These were analysed for changing service coverage and financial protection, and disaggregated by quintiles, location and other relevant features, as permitted by the data. Additional background indicators for each country were drawn from the World Development Indicators (WDI), while social protection data were drawn from the Atlas of Social Protection Indicators of Resilience and Equity (ASPIRE) database.