Universal health coverage (UHC) has gained prominence on the global health agenda. UHC is a social goal that enables everyone to receive the quality health care they need, irrespective of ability to pay, without suffering financial hardship in the process. Achieving UHC will enhance the health of the population—and in turn, strengthen the foundation for a country's sustainable economic growth and development—by covering people marginalized under existing health care systems, improving medical benefits for those who are covered, and protecting against the financial risks associated with illness, injury, or disease.

The World Bank and the World Health Organization (WHO), in collaboration with other international agencies, are supporting developing countries as they move toward UHC (Cotlear et al. 2015; WHO and World Bank 2017). UHC can be advanced by expanding the demand for health care and, crucially, by increasing the quantity and quality of the supply of health services. UHC reaches everyone who needs health care but does not preclude complementary or additional health insurance and services contracted on a voluntary and private basis.

**Measuring Progress toward Universal Health Coverage**

UHC is a challenging goal for most countries, yet substantial progress has been made in recent decades. The progress toward UHC can be measured with respect to service coverage and financial protection. To measure the provision of essential health services, WHO and the World Bank have devised and recently made available a UHC service coverage index. This is a composite index based on selected indicators representing various aspects of comprehensive health coverage, such as health services, receipt of a health care intervention, the availability of human and physical health care resources, and relevant regulations (WHO and World Bank 2017).

Figure 1 concentrates on the dimension of service coverage, plotting the UHC service coverage index against GDP per capita. As expected, the figure shows that the coverage of essential health services is related to national income per capita. It also shows, however, that the relationship is not deterministic; health service coverage can be driven by policy choices and implementation. Kenya and Vietnam, for instance, have higher UHC service coverage indexes than Nigeria and Indonesia, despite having much lower GDP per capita.

Figure 2 concentrates on the dimension of financial protection. Progress in this area can be partly assessed using indicators on catastrophic spending on health (WHO and World Bank 2017). The figure plots the incidence of catastrophic spending on health—defined as household expenditure on health exceeding 10 percent of total household expenditure or income—versus the UHC service coverage index. The figure shows that catastrophic spending on health does not necessarily decrease as health service coverage increases. This suggests that providers deliver and charge for additional—and sometimes unnecessary—services (Wagstaff et al. 2018). The policy implication is clear: it is important not only to cover more people, but also to cover a larger share of total health expenditure.
with efficient financing mechanisms and improve management of providers through effective provider-payment reforms and training.

Three Main Considerations for Universal Health Coverage

Policy makers need to address three considerations in relation to UHC: the population to be covered, the health services to be provided, and the financing mechanism to be used (WHO 2010; Cotlear et al. 2015). Consideration 1. The Population to Be Covered: Targeting the Most Vulnerable Groups

Under current health care systems, some population groups have had difficulty accessing health services or have been excluded. To achieve UHC, policy makers should identify and target these vulnerable groups (Cotlear et al. 2015): primarily people with low income or limited assets, those with low levels of education, the very young or old, pregnant women and new mothers, people living in rural areas, and those lacking consistent employment. These groups often overlap with those lacking consistent employment. These groups often overlap with pregnant women and new mothers, people living in rural areas, and those with low levels of education, the very young or old.

Children are vulnerable in many developing countries, particularly in rural areas. Various studies show that the under-five mortality rate is higher in rural areas than in urban areas because access to health care facilities is difficult, parents’ level of education is lower, and the quality of infrastructure is poorer (see, for example, Fink and Hill 2013). As figure 3 shows, in countries where the coverage of essential health services is lower, more children die before reaching the age of five.

Pregnant women or those who have recently given birth are another vulnerable group, especially if they live in poor communities. Maternal mortality is higher in rural areas and in poorer and less educated communities (WHO 2015a). More than 99 percent of maternal deaths and complications from pregnancy occur in developing countries with weak health care systems. Young mothers are especially vulnerable. Childbirth is the leading cause of death among girls aged 15–19 years. Early marriage is a risk factor (WHO 2015a).

People at the low end of the socioeconomic scale are particularly vulnerable to death from non-communicable diseases (NCDs) such as cancer and diabetes. NCD mortality and its risk factors vary depending on a country’s economic development and health policies, but tend to be higher for people living in poor communities and for those with low education and income (Di Cesare et al. 2013). Behavioral risk factors such as smoking, physical inactivity, and unhealthy diets are responsible for most deaths from non-communicable diseases. These behaviors are usually established early in life and have long-term effects.

People who are unemployed or work informally are another vulnerable group. In a country where health care financing is mainly based on contributions from workers in the formal sector, the unemployed and informal sector workers are likely to have lower access to quality health care than workers in the formal sector (Hsiao and Shaw 2007; Wagstaff 2010).

Consideration 2. The Health Services to Be Provided: Choosing Priorities

UHC covers all promotive, preventive, curative, rehabilitative, and palliative health services. However, developing countries must prioritize and select which health services to provide first, given their limited financial and human resources. The main criteria for selecting health services generally include the basic needs of the population and cost-effectiveness. Primary (or basic) health services include reproductive, maternal, and child health care; prevention and treatment of infectious diseases; and information and policy measures to prevent non-communicable diseases (Cotlear et al. 2015). UHC can include more advanced medical treatments as resources increase. Monitoring and evaluating health care services are important to sustain high quality and cost-effectiveness. Reporting and studying these results can help countries learn from one another (WHO 2017a–2017d).

High-quality primary health care is not only universally needed but has also proven to be cost effective (WHO 2014). Yet, the provision of primary health care varies considerably across countries. Consider the case of contraceptives, an essential health service for family planning. As figure 4 shows, in low-income countries, less than 40 percent of women aged 15–49 in marriage or unions use modern contraceptive methods, while the figure ranges from 30 percent to 80 percent in most middle-income countries, and exceeds 60 percent for nearly all OECD countries.

Or consider basic vaccination for infants. Figure 5 examines how many 1-year-olds are receiving a vaccine to prevent illness, disability, or death from diphtheria, tetanus toxoid, and pertussis (DTP3). Although DTP3 coverage for 1-year-olds has increased to a global average of 86 percent over recent decades (WHO 2018a), as of 2016, it was below 80 percent in many countries in Sub-Saharan Africa, as well as some in other regions. These and other gaps need to be addressed.

As NCDs become more prevalent, the need for prevention and treatment is increasing (Di Cesare et al. 2013). Prevention programs such as public campaigns against alcohol and tobacco abuse and early screening and diagnosis of NCDs would protect health and save money. A major risk factor of NCDs is obesity, which has been increasing in all regions. More than half the adults in high-income countries are overweight or obese (WHO 2014).
OECD countries, and developing countries in Europe and Central Asia, Latin America and Caribbean, and the Middle East and North Africa were overweight in 2016 (authors’ calculations based on WHO 2018b). Early prevention of obesity is especially important because overweight and obese children tend to stay obese into adulthood and are more likely to develop conditions such as diabetes and cardiovascular disease. To prevent obesity, information and education about healthy diet choices, urban planning and design to encourage a physically active lifestyle, and fiscal policies using taxes and subsidies as incentives for choosing healthy diets are required (WHO 2016).

As developing countries have become increasingly urbanized, more people have been exposed to road traffic injuries. Road accidents have become the main cause of death among people aged 15–29 years, and 90 percent of worldwide fatalities on the roads occur in developing countries (WHO 2015b). Road traffic injuries place a heavy financial burden on households not only because of medical costs but also because accidents often happen to people of working age. Road safety education along with strong enforcement of road safety laws will save people from injuries and avoidable financial burden.

Consideration 3. The Financing Mechanism to Be Used: Sharing Costs Fairly and Efficiently

In many developing countries, individuals must pay a considerable proportion of their total health expenditure out of pocket (Cotlear et al. 2015). Figure 6 shows that out-of-pocket expenditure is less than 30 percent of total health expenditure for OECD countries, but ranges from less than 30 percent to more than 70 percent for developing countries. Moreover, a low level of out-of-pocket payment does not necessarily mean that people are protected from financial risk: often in developing countries and sometimes even in wealthier countries, people forego health care because medical costs and indirect costs, such as transportation expenses and foregone wages, are too high relative to their income (WHO and World Bank 2017). When out-of-pocket payment is the main method to finance health services, poor people spend a larger share of their income than better-off people do. For the poor, high-cost health services, such as surgery and hospitalization, can lead to catastrophic health expenditure and destitution (Shrime et al. 2015).

Acknowledging the disadvantages of out-of-pocket payment, many countries have adopted prepayment and pooling health insurance systems. A common financing mechanism uses mandatory contributions to a social health insurance scheme from employees and employers. Many OECD countries and some developing countries, including Chile, Ghana, and Peru, have adopted this arrangement as the main funding mechanism (OECD 2016; Bitran 2014). However, the transition to UHC under a contribution-based system has been difficult even for advanced countries. For example, 127 years elapsed in Germany, 72 years in Luxembourg, and 36 years in Japan between the time that the first law on social health insurance was passed to a law to implement UHC was approved (Carrin and James 2005).

One of the main challenges under the employment-based contribution mechanism is to cover the unemployed and informal sector workers (Hsiao and Shaw 2007; Wagstaff 2010). Governments have resorted to complementary health care services to cover them. Studies show that interventions such as subsidies and information campaigns have limited effects in encouraging informal workers to enroll voluntarily (Wagstaff et al. 2016; Capuno et al. 2016). In addition, the complementary programs require administrative efforts to identify and enroll beneficiaries and demand substantial financial resources to maintain inefficient and fragmented health care systems.

Moreover, these complementary services often overlap with those provided by formal social health insurance, thus distorting the incentives for formal employment (Levy 2008). Indeed, studies of developed and developing countries show that social health insurance systems funded by formal workers’ contributions are associated with a decreased share of formal employment (Levy 2008; Wagstaff 2009).

General tax revenues can also be used to fund a prepayment and pooling system. This financing mechanism aims to cover the entire citizenry from the start. It is more likely to improve equity in health care as compared to the contribution-based mechanism that covers formal sector workers first. OECD countries such as Australia, Canada, and the United Kingdom as well as some developing countries such as Sri Lanka and Thailand have chosen this mechanism and are successfully moving toward universal health coverage (OECD 2016; Rannan-Eliya and Sikurajapathy 2009; Hsiao and Shaw 2007).

Sri Lanka succeeded in providing health services free of charge to all citizens by reforming its health care system in the 1930s and 1940s to be financed exclusively through taxes (Rannan-Eliya and Sikurajapathy 2009). Its public health expenditure for the two decades between 1995 and 2014 ranged from 1.2 percent to 2.1 percent of GDP (World Bank 2017). Thailand shifted from a fragmented health care system including a social health insurance scheme for formal workers to an integrated system financed through general tax revenue in the early 2000s, expanding health care coverage to almost the entire population (Hsiao and Shaw 2007). Its public health expenditure increased from 1.9 percent to 3.2 percent of GDP from 2000 to 2014 (World Bank 2017). Notwithstanding structural and institutional differences, Turkey followed a similar path toward UHC (see box 1).

Using general tax revenues for health care coverage requires a sustainable budget allocation and a strategy to use the limited budget efficiently. For example, to prevent health care providers...
Box 1. A Journey to Universal Health Coverage in Turkey: From a Fragmented to a Unified Health Care System

Turkey successfully unified fragmented health care schemes through a comprehensive social security reform from 2003 to 2012, increasing health care coverage from 64 percent to 98 percent of the population. Public health expenditure increased from 3.8 percent to 4.2 percent of GDP over the period, while household out-of-pocket health expenditure has declined by nearly half since 1999 (World Bank 2017, 2018).

In the initial stage of the reform, the Ministry of Health (MoH) commissioned a stakeholder analysis to identify possible opposition groups—mainly trade unions, white collar civil servants, and health workers—and developed strategies to deal with them. The MoH won over trade unions by reassuring them that the reform would not affect their social security benefits, and reduced the opposition of the civil service by revising a policy so that the reform applied only to newly hired civil servants. To engage health workers who initially opposed the change, the MoH adopted new financing schemes, such as a pay-for-performance scheme that led to higher salaries for many doctors and nurses. Although the main medical associations remained opposed, their impact was diminished as health workers organized new unions and the government won over public opinion.

Along with the strategic management of opposing stakeholders, the MoH gradually expanded a health care scheme for the poor and narrowed the gap with the traditional schemes. As a result, the beneficiaries of the traditional health care schemes reduced their opposition to a unified system. By 2012, the health care scheme for the poor was integrated with the traditional ones into a unified health care system with a single package of benefits and a single purchaser.

Source: Authors’ summary based on Bump et al. 2014.

from delivering unnecessary services, some countries have adopted a capitation system, which sets a maximum payment per case (Hsiao and Shaw 2007). Likewise, to control the overutilization of services, some countries use a co-payment system, which requires patients to pay a portion, albeit small, of medical costs (Hsiao and Shaw 2007; World Bank 2013). Also, when introducing a scheme funded through general tax revenues to a system funded by contributions, countries need to establish incentives for people to stay in or shift to the formal sector, such as delinking the payroll tax from health care entitlements (Wagstaff and Manachotphong 2012).

For both financing mechanisms, splitting the purchasing agent from the health care provider makes each party’s responsibility more explicit and leads to higher accountability. The separation of health care funding and delivery responsibilities is increasingly common in UHC programs in many developed and developing countries (Cotlear et al. 2015).

Finally, for countries whose financing mechanisms differ depending on their health care schemes, harmonizing the schemes under the same financing and regulatory system will increase efficiency in administration and budget allocation. However, this has been among the most difficult part of health reforms for many countries because of the conflict of interests among stakeholders (see box 1).

Conclusion

Reviewing the considerable literature on UHC, this brief provides a guide for moving toward UHC based on three main components: people, health services, and finance. A first step is addressing vulnerable populations and providing primary and preventive services. Financing health care services using general taxes in a sustainable and strategic way can achieve more equity and efficiency than a system based on payroll taxes and a patchwork of health care regimes. As with other dimensions of social protection, health care coverage should not be tied to employment status: it should serve people as such and not only as workers. As shown by successful cases, to achieve universal health coverage, a change of perspective is essential from seeing health care benefits as a contingent good to viewing them as an essential public service. Getting diverse stakeholders to cooperate—or at least diffusing strong pockets of opposition—and managing societal and political obstacles strategically are required to make universal health coverage a reality.

References

Bitran, Ricardo. 2014. "Universal Health Coverage and the Challenge of Informal Employment: Lessons from Developing Countries." Working Paper 87077, World Bank, Washington, DC.

Bump, Jesse, Susan Sparks, Mehtap Tatar, Yousuf Celik, Meltem Aran, and Claudia Roxx. 2014. “Turkey on the Way of Universal Health Coverage through the Health Transformation Program.” Discussion Paper 93172, World Bank, Washington, DC.

Capuno, Joseph J., Aleli D. Kraft, Stella Quimbo, Carlos R. Tan Jr., and Adam Wagstaff. 2016. "Effects of Price, Information, and Transactions Cost Interventions to Raise Voluntary Enrollment in a Social Health Insurance Scheme: A Randomized Experiment in the Philippines." Health Economics 25: 650–62.

Carrin, Guy, and Chris James. 2005. “Social Health Insurance: Key Factors Affecting the Transition Towards Universal Coverage.” International Social Security Review 58 (1): 45–64.

Cotlear, Daniel, Somil Nagpal, Owen Smith, Aijaz Tandon, and Rafael Cortez. 2015. Going Universal: How 24 Developing Countries Are Implementing Universal Health Coverage Reforms from the Bottom Up. Washington, DC: World Bank.

Di Cesare, Maniachara, Young Ho Kang, Perviz Ataria, Tony Blakely, Melanie J. Cowan, Farshad Farzadfar, Ramiro Guererro, Nayu Ikeda, Kathleen Kyobutungi, Sohal Oum, John W. Lynch, Michael G.Marmot, and Majid Ezzati. 2013. “Inequalities in Non-Communicable Diseases and Effective Responses.” The Lancet 386(9996): 585–97.

Fink, Günter, and Kenneth Hill. 2013. “Urbanization and Child Mortality—Evidence from the Growth in Mexico.” The Lancet 382: 1417–23.

Fink, Günter, and Kenneth Hill. 2013. “Urbanization and Child Mortality—Evidence from the Growth in Mexico.” The Lancet 382: 1417–23.

Hsiao, William. 2007. "The Challenge of Providing Universal Health Coverage from a Cost-Effectiveness Perspective." The Lancet 369: 1305–07.

Levy, Santiago. 2008. Good Intentions, Bad Outcomes: Social Policy, Informality, and Economic Growth in Mexico. Washington, DC: Brookings Institution Press.

DECO (Organisation for Economic Co-operation and Development). 2016. “Universal Health Coverage and Health Outcomes.” Paris.

Rannan-Eliya, Rav, P., and Lankani Srikunagapathy. 2009. Sri Lanka: “Good Practice” in Expanding Health Care Coverage. Research Studies Series 3. Colombo, Sri Lanka: Institute for Health Policy.

Shirlee, Mark G., Anna J. Dare, Blake C. Allaire, Kathleen O’Neill, and John G. Mearsa. 2015. “Catastrophic Expenditure to Pay for Surgery Worldwide: A Modelling Study.” The Lancet Global Health 3 (2): 538–44.

Wagstaff, Adam. 2009. "Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD." Policy Research Working Paper 4821, World Bank, Washington, DC.

Wagstaff, Adam. 2019. "Social Health Insurance Reexamined.” Health Economics 19 (3): 503–17.

Wagstaff, Adam, Gabriela Flores, Justine Hsu, Marc-François Smits, Kateryna Chepynoga, Leander R. Buism, Kim van Wilgenburg, and Patrick Ezouenou. 2018. “Progress on Catastrophic Health Spending in 153 Countries: A Retrospective Observational Study.” The Lancet Global Health 6: e169–77.

Wagstaff, Adam, and Wanwiphap Manachotphong. 2012. “Universal Health Care and Informal Labor Markets: The Case of Thailand.” Policy Research Working Paper 6116, World Bank, Washington, DC.

Wagstaff, Adam, Ha Thi Hong Nguyen, Huyen Dao, and Sarah Iales. 2016. “Encouraging Health Insurance for the Informal Sector: A Cluster Randomized Experiment in Vietnam.” Health Economics 25: 663–74.

WHO (World Health Organization). 2010. The World Health Report: Health Systems Financing: The Path to Universal Coverage. Geneva.

———. 2014. The Case for Investing in Public Health: The Strengthening Public Health Services and Capacity: A Key Pillar of the European Regional Health Policy Framework Health 2020. Geneva.

———. 2015a. 20% Facts on Maternal Health. http://www.who.int/features/factsfiles/maternal_health/en/. Accessed on February 21, 2018.

———. 2015b. Global Status Report on Road Safety 2015. Geneva.

———. 2016. Report of the Commission on Ending Childhood Obesity. Geneva.

———. 2017a. Financial Protection in High-Income Countries: A Comparison of the Czech Republic, Estonia and Latvia. Geneva.

———. 2017b. Financial Protection in the South-East Asia Region: Determinants and Policy Implications. Geneva.

———. 2017c. Health Financing and Financial Protection in the Americas. Geneva.

———. 2017d. Transitioning to Integrated Financing and Service Delivery of Priority Public Health Services. Geneva.

———. 2018a. Immunization Coverage. http://www.who.int/mediacentre/factsheets/fs378/en/. Accessed on February 21, 2018.

———. 2018b. “Prevalence of Overweight (% of adults).” Global Health Observatory Data Repository.

WHO and World Bank. 2017. Tracking Universal Health Coverage: 2017 Global Monitoring Report. Washington: DC. World Bank.

World Bank. 2013. World Development Report 2014: Managing Risk for Development. Washington, DC: World Bank.

———. 2017. “Health Expenditure, Public (% of GDP).” World Development Indicators.