GLOBAL HEALTH 2035

A World Converging within a Generation

PRACTICE BRIEF

Implementing Pro-Poor Universal Health Coverage

Lessons from country experience

The June 6–10, 2015 workshop at the Rockefeller Foundation Bellagio Center in Italy on implementing pro-poor universal health coverage was supported by The Rockefeller Foundation and the United States Agency for International Development.

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Background

Universal health coverage (UHC)—ensuring that everyone has access to quality, affordable health services when needed—can be a vehicle for improved equity, health, financial well-being, and economic development. In its 2013 report, *Global Health 2035*, the Commission on Investing in Health made the case that pro-poor pathways towards UHC, which target the poor from the outset, are the most efficient way to achieve both improved health outcomes and increased financial protection (FP).[1] Countries worldwide are now embarking on health system changes to move closer to achieving UHC, often with a clear pro-poor intent. While they can draw on guidance related to the technical aspects of UHC (the "what" of UHC), such as on designing service packages, there is less information on the "how" of UHC—how to maximize the chances of successful implementation.

Motivated by a shared interest in helping to close this information gap, a diverse international group of 21 practitioners and academics, including ministry of health officials and representatives of global health agencies and foundations,[2] convened at The Rockefeller Foundation's Bellagio Center for a three day workshop from July 7–9, 2015. The participants shared their experiences in, and discussed the limited evidence on, how to implement UHC, focusing on a set of seven key questions from across five domains of UHC (Figure 1). This Practice Brief, which is aimed at health reformers, policymakers, program managers, and advocates of UHC, summarizes key lessons from the Bellagio workshop on implementing pro-poor UHC.

Key implementation lessons

1. Generating and sustaining political will for UHC

- **UHC advocates have successfully used policy windows to push UHC to the top of the agenda.** Examples of such windows include crises (e.g. the economic crisis in Argentina in 2001–2002 was an important factor in building political will for UHC); the widespread realization of the harms of existing health policy (e.g. the harms of user fees); or a country's poor performance in an international ranking of health outcomes. Pushes during election years can be particularly effective.
- **Framing the case for UHC using ethical and legal arguments can help to persuade stakeholders.** Many countries already have a constitutional right to health, which provides a valuable foundation on which to make the case for UHC. If they do not, UHC advocates could draw upon international agreements or treaties, such as the Universal Declaration of Human Rights, that recognize a right to health. Framing pro-poor UHC in terms of social solidarity can have resonance with some stakeholders.
- **Securing the support of the finance ministry is important in getting UHC on the political agenda and moving subsequently towards UHC.** Making the economic case for increased health investment may not always be persuasive. Other arguments that may be convincing center on the stabilizing effects of UHC—how it can help to prevent a cost explosion and promote value for money, social stability, and fiscal sustainability. Realistic cost estimates that show the cost of scaling up *all key programs together*, including the health systems strengthening costs, can help to persuade the finance ministry of the feasibility of moving towards UHC.

Figure 1. Seven key questions on implementing pro-poor UHC

Political and public engagement	Generating and using evidence	Expanding UHC	Promoting quality and efficiency	Fostering international collective action
Q1. How can political will for UHC be generated and sustained? **Q2**. How can civil society be engaged in supporting UHC and pushing for more rapid progress?	**Q3**. How can information be generated/used to support implementation of UHC? **Q4**. How can coverage with financial protection (FP) & needed health services be measured, monitored, and maintained especially among the poor?	**Q5**. How best can countries manage the evolution and growth of service coverage and forms of FP?	**Q6**. How can countries use incentives to improve the quality & efficiency of health services, whether provided directly or purchased externally?	**Q7**. How can international collective action best support country efforts towards UHC?

- **If the process is captured by one political party, the chances of successful reform may be lower.** In Ghana, for example, multiple political parties acknowledged the harms of user fees and were supportive of a national health insurance scheme to address the problem.
- **There will be multiple sources of opposition to UHC, but these can be anticipated and countered.** Managing opposition from many different sources (Table 1) is based on marshalling evidence-based arguments and approaches as well as understanding the political process. Public sector controls can be used to reassure opponents that health services can be efficiently delivered in the public sector. Election watchdogs can be helpful in preventing UHC schemes from being used for political purposes.

Table 1. Sources of opposition to implementing pro-poor UHC

Source	Rationale for opposition
Finance ministry	Concerns about the budgetary implications of implementing UHC.
Trade unions	Fears of erosion of the existing health insurance benefits for their members if the scheme is expanded to include the poor and the informal sector. Unions representing health providers might be concerned that their incomes will be eroded or their work times increased.
Private health providers	May argue that public provision is inefficient or inadequate.
Political parties	May feel that UHC is being used for political gain by one party over another.
Businesses, and existing beneficiaries	Businesses may be opposed if they are required to contribute (e.g. through a payroll tax or value added tax increase), particularly if they provide health insurance or health services to their employees. Private health insurance companies selling voluntary insurance might fear the loss of business with a more universal system of financial protection.

2. Engaging civil society in supporting UHC

- **The public can best be engaged through accountability and open, two-way communication.** For advocates of UHC, citizens are a powerful resource, provided that they can be engaged, their demand for health care can be leveraged, and there is a strong high level voice in government who can respond to their demands. Important means of engagement are for health reformers to regularly share with the public their reform plans and the intended impacts of these reforms and to open a variety of channels of public communication, such as using community stakeholder forums and working with the media.
- **Some non-governmental organizations (NGOs) may be opposed to UHC reform plans.** Creating a stakeholder map can be valuable in showing which NGOs are supportive, which are neutral, and which are opposed. Some NGOs focus on advocacy for a particular disease—if the proposed health benefit plan (HBP), defined as a "pre-determined, publicly managed list of guaranteed health services,"[3] excludes interventions for that disease, they could be opposed to the plan. Some NGOs are service providers (e.g., providing cancer services); they may be displaced or disadvantaged financially by UHC schemes. In Mexico, the government asked such NGOs to shift over to providing social support services, such as transportation.
- **Marketing and advertising techniques, used by the consumer goods and technology sectors, can be helpful in UHC advocacy.** These sectors have expertise in identifying and reaching their target audience, refining their messaging to each type of audience through consumer input, and using multiple communication channels (e.g., billboards, radio, TV). These techniques have been successfully adopted in social marketing campaigns with public health goals.
- **National advocacy coalitions, composed of individuals inside and outside government who share common goals and values, can help to raise the political profile of UHC.** Such coalitions have a long history of effectiveness in global public health, in a wide range of policy arenas, including HIV/AIDS and tobacco control. An international UHC advocacy coalition was recently launched to "urge governments to accelerate universal health coverage so that everyone, everywhere, can access quality health services without financial hardship."[4] National advocacy coalitions could play a similar role in forging partnerships between government, academia, and civil society to champion pro-poor UHC.

3. Generating and using evidence to support implementation of UHC

- **The evidence on, and processes used to determine, HBPs offered to citizens needs to be published and disseminated.** While governments have generated and used evidence to (i) advance UHC objectives of equity, efficiency, and FP (Table 2), and (ii) promote the sustainability of HBPs, there has been limited documentation of HBP design and update processes. This lack of documentation is a barrier to institutionalizing good

governance of HBP design and updates. It also limits establishing transparent communication with the public and the sharing of experience that supports cross-country learning.

Table 2. The use of evidence in achieving UHC objectives

UHC goal	Types of evidence	Examples
Equity	Data on: disease burden, utilization, monitoring and evaluation (M&E), cost-effectiveness	AUGE Plan (Chile) Seguro Popular (Mexico)
Efficiency	Cost-effectiveness data (and related global guidance) Unit costs of services by facility Disease burden	PhilHealth (Philippines) HBP for non-communicable diseases (Zhuhai Municipality, China)
FP	Household out-of-pocket spending Data on willingness to pay	RSBY (India) Seguro Popular (Mexico) PIAS (Uruguay)

(Nakhimovsky et al., 2015)

- **Even if there is little evidence, countries can move forward on UHC while learning lessons along the way.** While moving forward, reformers should document, monitor, and assess progress, incorporating research into implementation. In the face of resource, capacity, and time constraints, countries may want to pilot test the rollout of guaranteed services—e.g., Ethiopia has rolled out community-based health insurance through a pilot in 13 districts.[5]
- **Eliciting citizen values and preferences is an important step in generating information.** Citizens' priorities may be surprising or may differ from those of the ministry of health, and are important to elicit as a way to boost public confidence in how priorities are set and in fostering accountability. For example, the Yeshasvini health insurance scheme for rural farmers in India began by eliciting the views of farmers themselves, who wanted the scheme to prioritize surgical procedures and outpatient care.[6]
- **There is a clear need for national capacity in data collection and stewardship, and in analysis of data for health systems improvement.** The Ebola crisis in West Africa exposed weaknesses in national health information systems, and has created a window of opportunity to renew efforts in strengthening these systems. This information is required by technocrats and policy-makers to develop plans, assess progress, and modify strategies as necessary, but it also needs to be translated into a language that the public can understand so that public advocacy for rapid progress towards UHC can be effective.
- **Utilization and administrative data, and data from insurance companies (if feasible to access), could all help in designing or refining HBPs.** Data on provider behavior is critical to identify outliers, e.g. providers that provide unnecessary care or populations that obtain insufficient access to services. While the insurance industry may be reluctant to share data because of proprietary concerns, it has a wealth of data and experience that could be immensely valuable to UHC reformers.

4. Measuring, monitoring, and maintaining coverage with FP and needed health services

- **National household surveys that assess out-of-pocket (OOP) expenditure and access to services are important for monitoring FP.** Such surveys should be nationally owned and conducted and should ideally be performed every 2 to 5 years (although some countries, including Thailand, do them annually). In addition to assessing the extent of OOPs, access barriers and non-use of services should also be examined.
- **The "UHC moment" can be used to champion and support National Health Accounts (NHAs).** These accounts, which track public and private expenditure flows in the health sector, can be a valuable tool in reporting changes in OOP expenditure, which strongly correlate with changes in FP. Even so, NHAs—particularly time series NHAs—continue to be under-used in many LICs and MICs. The recent rise in interest in UHC worldwide relating to tracking expenditures on specific diseases, conditions, or population groups could be a window of opportunity to make the case for increased investment in NHAs.
- **Managing costs can ensure that more can be achieved with the available funds (hence UHC goals, including FP, can be reached more quickly).** The three major domains that contribute to excessive costs are (i) *unnecessary services* (e.g. through defensive medicine or using higher cost branded drugs instead of equal quality generic versions); (ii) *inefficiently or ineffectively delivered services* (e.g. service duplication, preventable complications); and (iii) *administrative inefficiency*. Avoiding unproductive cost escalation—using approaches such as strategic purchasing, gatekeeping arrangements, and prescribing of generic medicines—and fostering a strong culture of audit and transparency are important components in achieving and maintaining FP and health service coverage goals.

- **A new tool, extended cost effectiveness analysis (ECEA), can help health planners with priority setting.** An ECEA is "extended" beyond a traditional CEA "in the sense that it not only assesses how much health is gained per million dollars spent but also how much financial protection is purchased."[1] ECEA can be used to compare the health and FP impacts of different health interventions and to examine the distributional consequences of the intervention, i.e. whether or not an intervention is pro-poor. The results should be considered along with other ethical, social, political, and economic considerations, such as benefit to cost ratios and the strength of the health delivery system.[7]

5. Managing the evolution and growth of service coverage and forms of FP

- **Health technology assessment (HTA) can help manage evolution and growth.** Using HTA to explicitly set priorities can help to achieve UHC in three ways: (a) the explicit decision-making process can be a valuable mechanism to identify and engage with key stakeholders and to outline rules for reaching a decision; (b) dedicated staff and explicit processes such as those used in HTA agencies can help in translating global agenda setting into national agenda setting, by helping to contextualize decisions at the national level; and (c) HTA can help to show the value of specific health investments, making the case for these investments to the ministry of finance and other stakeholders.
- **Program fragmentation can be a barrier to expansion.** Examples of fragmentation are using separate fund pools to finance HBPs for different population groups and, on the supply side, using separate delivery channels for different diseases and supply chains for different medicines. Fragmentation is a problem that many countries face in their efforts to reach UHC, since they are often starting off with multiple "inherited" schemes (and "vertical programs" with their own delivery points and supply chains). Such fragmentation can create inequity and inefficiency. It can also be a major barrier to further expanding coverage as the groups that have the most generous HBP may be unwilling to risk diluting their "package" by being incorporated into a universal system.[8] The first step in addressing the problem is "diagnosis," i.e. identifying where in the system the fragmentation is occurring and how easy it would be to fix the problem.
- **Steps to increase effective pooling can be taken, even when schemes cannot be fully merged.** Countries should be able to achieve a greater degree of harmonization even if fully merging all schemes is not feasible. Strong leadership is vital, particularly when it comes to aligning different institutions and resources and especially in federal states such as Ethiopia. HBPs and results-based financing can be valuable tools in such alignment. Better pooling and cross-subsidization (from rich to poor and from healthy to sick) can be achieved even without a full merger by varying the size of government contributions to the various schemes. Greater harmonization between ministries, and with international agencies, could also help to reduce fragmentation.
- **Government sponsored health insurance schemes can promote UHC.** Government-mandated health insurance schemes—and national health systems, such as those in the UK, Malaysia and Sri Lanka—can help promote UHC by (i) being a "smart" strategic purchaser of services (or a smart purchaser of inputs); (ii) purchasing more cost-effective services (e.g. in some countries, providers substitute e-mail or phone calls for out-patient consultations on minor health issues); (iii) fostering integrated care; and (iv) using incentives and other tools to promote efficiencies.
- **There may be political opposition to expanding service coverage, which can be anticipated and managed.** Having baseline knowledge on who is being covered by which scheme can help ward off political conflicts during expansion. Protecting expansion decisions from undue influence or competing interests is important—HTA can be helpful in this process. Hiring or appointing ministers with longevity and continuity in mind can also reduce the vulnerability of the process to political influence.
- **Institutional capacity is needed to support UHC expansion.** An important foundation of more rapid movement towards UHC is to embed the key concepts of solidarity, redistribution, progressivity, and responsiveness to citizens in all institutions and processes. Framing UHC from the beginning as key to sustainable development, and as a broad and long-term movement, can also help when it comes to expanding coverage. And, given the political power of health-care providers in many countries, gaining the support of professional societies as early as possible in the pursuit of UHC can help with later expansion.

6. Using incentives to improve the quality and efficiency of health services

- **Fee for service payment gives perverse incentives to providers.** It encourages over-servicing and cost overruns. Where it is unavoidable politically, it needs to be combined with effective controls on both price and volume, which requires effective information systems that allow provider behavior to be monitored. This has been the development in all high-income countries that pay providers using fee for service.

- **Paying providers based on performance achieves modest impacts on quality.** The best available evidence suggests that the largest impact of paying for performance is on coverage indicators, with no impact on outcomes and only modest impacts on clinical quality measures.[9]
- **Public health purchasers need to have the mandate and accountability to purchase high-quality services for the population with FP.** For example, Ghana's National Health Insurance Scheme (NHIS) accounts for 30% of public spending on health and 16% of total health spending;[10] it has the mandate to provide access to the services and medicines in the NHIS HBP and to be pro-poor. Accountability is increased by the annual National Health Insurance Authority's annual report to Parliament on equity.
- **Strengthening of integrated service delivery networks can help to align incentives across levels of care.** Alignment across the continuum of care occurs when services and provider competencies are well defined at the different levels, when there are clear guidelines on when patients should be referred between levels, and when providers at one level have a stake in what happens at different levels.
- **The right balance of autonomy and accountability can help providers to respond to incentives and serve the public interest.** For example, Sri Lanka's strong tradition of "democratic accountability" and of physician support for achieving efficiency and doing "more with less" have been important factors in serving the public interest.[11]
- **Information can be used to understand, motivate, and improve provider performance.** Argentina's Plan Nacer and Programa SUMAR used information on provider performance as a key tool for motivation. These plans, which are performance-based, have included improvements in the collection of data, clarification of the goals of providers, measurement of provider activity and performance, and a more informed dialogue between purchasers and providers.[12]

7. How international collective action can best support country efforts towards UHC

- **The international community needs to adopt a stronger "country lens" and support domestic agendas.** International collective action can support national UHC processes through provision of technical assistance, capacity building (including building in-country analytic capacity), knowledge generation and sharing, information management, and support for measurement. Such collective action will need to align much more closely with national health plans and strategies. This is even more important now that the Sustainable Development Goals (SDGs) have been adopted by the United Nations. UHC is included as one of the health targets, but the SDGs document argues that *each government would set their own targets* "guided by the global level of ambition."[13] Each country will focus on its own priorities and will need the international community to buy into plans that are feasible and desirable for the country rather than plans wanted by particular parts of the international community.
- **Networks of cross-learning and communities of practice can support UHC.** The Joint Learning Network, the USAID-supported Health Financing and Governance Project, the International Decision Support Initiative,[14] and the P4H Leadership for UHC Programme[15] have shown the value of international network activities in supporting UHC. Regional efforts, such as the ASEAN Plus Three UHC Network,[16] can contribute to cross-country experience sharing. These networks supplement the routine work of agencies such as WHO and the World Bank in supporting countries in their move towards UHC and in sharing information across countries.
- **Development assistance for health (DAH) will need to shift over time towards core "global functions."** One important way in which international collective action can support pro-poor UHC is for DAH to adequately fund the "global functions" of global health, such as providing global public goods (e.g. research and development, knowledge generation and sharing) and fostering leadership and stewardship of the global health system.[17] There is also an important role for continued DAH and technical assistance in initiating efforts to reach UHC particularly in low-income countries with restricted domestic sources of finance.

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References

1. Jamison DT, Summers LH, Alleyne G et al. Global Health 2035: a world converging within a generation. *Lancet* 2013;382:1898–955.
2. Participants at the workshop: Jesse Bump, Cheryl Cashin, Kalipso Chalkidou, David Evans, Eduardo González-Pier, Yan Guo, Jeanna Holtz, Daw Thein Thein Htay, Carol Levin, Robert Marten, Sylvester Mensah, Ariel Pablos-Méndez, Ravindra Rannan-Eliya, Martín Sabignoso, Helen Saxenian, Neelam Sekhri Feachem, Agnes Soucat, Viroj Tangcharoensathien, Hong Wang, Addis Tamire Woldemariam, Gavin Yamey.
3. Nakhimovsky S, Peterson L, Holtz J et al. Using Evidence to Design Health Benefits Plans for Stronger Health Systems: Lessons from 25 Countries. Washington DC: USAID and Health Finance and Governance Project, June 30, 2015. At https://www.hfgproject.org/using-evidence-to-design-health-benefit-plans-for-stronger-health-systems-lessons-from-25-countries.
4. See http://universalhealthcoverageday.org/coalition.
5. Ethiopian Health Insurance Agency. Evaluation of Community-Based Health Insurance Pilot Schemes in Ethiopia: Final Report. Addis Ababa, Ethiopia, May 2015. At https://www.hfg-project.org/evaluation-cbhi-pilots-ethiopia-final-report.
6. Aggarwal A. Impact evaluation of India's 'Yeshasvini' community-based health insurance programme. *Health Econ*. 2010;Sep;19 Suppl:5-35.
7. Verguet, S, Olson Z, Babigumira J et al. Health gains and financial risk protection afforded by public financing of selected interventions in Ethiopia: an extended cost-effectiveness analysis. *Lancet Glob Health* 2015;3(5):e288–96.
8. Nicholson D, Yates R, Warburton W, Fontana G. Delivering Universal Health Coverage: A Guide for Policymakers. Report of the WISH Universal Health Coverage Forum 2015. London: 2015. Available at: http://wish-qatar.org/summit/2015-summit/forumsandpanels/universal-healthcare-coverage/universal-healthcare-coverage.
9. Cashin C, Chi Y-L, Smith P, Borowitz M, Thomson S. Paying for Performance in Health Care: Implications for Health System Performance and Accountability. London: Open University Press, 2014.
10. Schieber G, Cashin C, Saleh K, Lavado R. Health Financing in Ghana. Washington, DC: World Bank, 2012.
11. Rannan-Eliya RP. Levels and Trends of Indicators Related to Universal Financial Risk Protection, Including both Proximate and Distant Determinants. Presentation at First Global Symposium on Health Systems Research, 2010. At http://www.ihp.lk/publications/pres_doc/pres101017.pdf.
12. http://www.worldbank.org/en/topic/health/brief/argentinas-plan-nacer-delivering-results-for-mothers-and-their-children.
13. Transforming Our World: the 2030 Agenda for Sustainable Development. Finalized text for adoption, 1st August 2015. Paragraph 55.
14. http://www.idsihealth.org.
15. http://p4h-network.net/global/cpd.
16. http://www.aseanplus3uhc.net.
17. Schäferhoff M, Fewer S, Kraus, et al. How much donor financing for health is channelled to global versus country-specific aid functions? The Lancet July 13, 2015. http://dx.doi.org/10.1016.

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