

Paper by the Commonwealth Secretariat*

Universal Health Coverage: Experience and lessons from SADC countries

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Abbreviations and acronyms

CMR	child mortality rate
GDP	gross domestic product
GHED	Global Health Expenditure Database
MDGs	Millennium Development Goals
MNCH	maternal, newborn and child health
NCDs	non-communicable diseases
OOP	out of pocket
PFM	public financial management
PHE	public health expenditure
PPP	purchasing power parity
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SADC	Southern Africa Development Community
SDGs	Sustainable Development Goals
THE	total health expenditure
UHC	universal health coverage
UNGA	United Nations General Assembly
WHO	World Health Organization

A note about data used in this paper:

The health data used in this paper have been drawn from the WHO Global Health Observatory databank unless otherwise noted. The financing data have been drawn from the World Bank databank (available at: <http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators#>) and the WHO Global Health Expenditure Database, available at: <http://www.who.int/health-accounts/ghed/en/>. Some tables show distribution of services by wealth quintile and these data have been drawn from the Health Equity Monitor, available at: <http://apps.who.int/gho/data/node.main.nHE-1540?lang=en>. These data were not available for all SADC countries. Data are generally rounded to the nearest whole number and are shown for the latest year (usually 2015, 2016) or as indicated in the relevant table and summarised in the annexes.

This paper was originally published in three different papers in May 2018 and in May 2019 which were focused on Commonwealth countries. This version combines extracts from the three papers with updated data (where available) and text. It also deepens the analysis on SADC countries and expands some elements.

Summary and main messages

Funding health services to meet the needs of all people can accelerate development and help to enable every individual to reach their potential. Despite costing more to national governments in the short term, there are considerable overall benefits to societies in the long term and universal health coverage (UHC) has been demonstrated to pay back its initial debt to national economic growth in multiples. UHC is the central mechanism for achieving Sustainable Development Goal 3 of healthy lives for all at all ages (SDG 3, Target 8) and is a leading health priority for many SADC countries. Many have already made formal commitments to accelerating and achieving UHC.

This paper aims to support discussion and lesson learning among SADC states. It combines and slightly updates several papers written in the last two to three years to support countries develop their policy analysis around UHC. This composite version of these papers first explores the features of UHC and sets out progress made towards achieving the three dimensions of UHC, including expanding coverage to the whole population, increasing the range of services available and, crucially, extending financial protection. For example, progress has been made in almost all countries in reducing preventable death in women and children and other vulnerable groups and in targeting health funds towards those most in need.

The paper considers what “leaving no one behind” means and how countries can develop UHC policies to reach the unreached. Although health is widely understood to be a human right,¹ guaranteeing access by all people to quality health services is challenging in most contexts. The first UHC *Global Tracking Report* estimated that 400 million people do not have access to basic health services, while every year 100 million slide back into poverty as a result of healthcare expenses.² The 2019 monitoring report showed that this number is increasing still rather than decreasing.³ UHC requires careful, and sometimes highly ambitious systems reforms to improve mechanisms to raise, pool and distribute funds for health services. Conceptualising and agreeing the dimensions of ‘universality’ before embarking on systems design is vital to ensuring that no one is left behind. Universality is not guaranteed. It is difficult to reach the most marginalised and there is a risk that countries will find that the easiest way to report progress on UHC is to ‘focus provision on those portions of the population who are already closest to the target, deepening inequality and poverty’.⁴

Eight critical UHC related challenges are then identified and discussed using evidence from Commonwealth countries. These challenges are derived from the objectives, the functions and the constraints related to advancing UHC picked out in sections 2 and 3 of the paper. They are: i) expanding fiscal space for health; ii) focusing on raising public funds and on compulsory, not voluntary, payment mechanisms; iii) risk pooling and how to reduce

¹ For example, Rudiger A (2016) ‘Human rights and the political economy of Universal Health Care: Designing Equitable Financing’, *Health and Human Rights Journal*, Vol. 18 No. 2, December or Forman L, C Beiersmann et al. (2016) ‘What do Core Obligations under the Right to Health Bring to Universal Health Coverage?’, *Health and Human Rights Journal*, Vol. 18 No. 2, December

² WHO and the World Bank (2015), *Tracking Universal Health Coverage: First Global Monitoring Report*, available at: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1

³ WHO (2019) Primary Health Care on the road to Universal Health Coverage, Geneva, September 2019.

⁴ Puras, D (2016), ‘Universal Health Coverage: A Return to Alma-Ata and Ottawa’, *Health and Human Rights Journal*, Vol. 18, No. 2, December.

catastrophic spending; iv) whether to create a health spending target; v) identifying approaches for getting more health for the money, including through better financial management systems vi) financial drivers of exclusion; vii) strengthening health systems and viii) scaling up primary health care.

The main experiences shared in this paper are:

- All countries can make progress towards UHC, whatever their current situation or financing arrangements;
- No country has achieved UHC without relying primarily on public financing;
- Public financing comes from compulsory, pre-paid sources such as direct and indirect taxes, rather than voluntary, private sources;
- While there is no clear spending target associated with successfully achieving UHC, most countries will have to commit at least 5 per cent of their GDP on public health financing and, in the poorest countries, at least US\$86 per capita;
- As countries increase their commitment to public financing, reliance on out-of-pocket (OOP) payments declines, strengthening equity and improving financial protection, one of the main aims of UHC;
- Expanded access to services by the poorest will require public funds and cross-subsidies from the rich and healthy to support those who are poor or sick. Therefore, UHC systems should aim to build the largest funding pools possible;
- UHC requires difficult choices to be made; countries get better results when they concentrate resources where they are most needed;
- An approach to UHC that prioritises inclusion from the start is a sound basis for UHC decision-making and can ensure that the poorest are not punished for being unable to pay for basic and life-saving healthcare;
- Priority setting is a political process, although the capacity to distribute and spend funds across the whole health system, especially at the periphery, often leads to spending in favour of urban, hospital-based care (in many countries, public expenditure systems don't work efficiently);
- Priority setting for health should instead be undertaken in an open and transparent way and aim to maximise the impact of limited resources on health across a whole population;
- Reducing disease incidence and preventing sickness boosts household well-being and supports economic growth, preventing a slide into poverty by millions of people. It is thus crucial to ensure that UHC efforts include sufficient investments in public health, health promotion and prevention and environmental health, and are not just focused on curative health services;
- Countries should thus improve financial management to spend all available resources as efficiently as possible.
- UHC approaches should ensure that in designing systems that promote entitlement (health cards etc.), they do not inadvertently erect additional barriers for the vulnerable and marginalised thereby increasing rather decreasing the number of people left behind.

Recommendations

Based on the key messages, and on the idea that all countries can make progress irrespective of their economic context, the following recommendations are aimed at making practical advances towards UHC. Among the most important of these are:

- **Recommendation 1: Promote the discussion of UHC at the political level**, particularly in parliament or among political leaders and cross-party fora. Aiming to achieve UHC is a political decision and the first crucial step is to make concrete political (and public) commitments to its advancement.
- **Recommendation 2: Develop an explicit national understanding of and commitment to leaving no one behind**. As countries develop an overarching concept of UHC that is right for their context, they should include a comprehensive understanding of what it means to leave no one behind and set out explicit commitments to ensuring equity and inclusion as they advance UHC.
- **Recommendation 3: Identify what services are already ‘universal’ and start building on these**. Most countries already offer some services to everyone. Typically, these include disease control-related services such as immunisation, the treatment of tuberculosis (TB), and prevention services, health promotion and public health services. In some countries, some demographic groups have specific entitlements (under 5s, over 65s) or certain treatments (such as for some kinds of cancer) may be available to everyone.
- **Recommendation 4: Focus on the ‘universal’ part of UHC**. Countries should ensure that right from the start, all people have genuine and meaningful **access to a core set of high-priority services** irrespective of their geography, demographic profile, socio-economic status or legal status in the country. The most successful countries reach everyone with a limited range of services and then build up the package of care to be covered. Reaching everyone is vital to achieving UHC and requires overcoming barriers to access which may not be related to health facility infrastructure or fees for services. They may be linked to cultural, language, geographic, social or gender-related issues. Invest in **data monitoring and tracking**. To measure progress and address lagging performance, it is vital to understand who has access to what services.
- **Recommendation 5: Invest in measuring and understanding equity needs**. Active operational research is helpful to understanding the dimensions of exclusion that operate in different contexts. Once the unreached or excluded have been identified, and the mechanisms or reasons why they are excluded identified, countries can begin to **develop policies that address exclusion and promote inclusion**.
- **Recommendation 6: Ensure that entitlement arrangements do not deepen inequity and exclusion**. Countries should design administrative arrangements and entitlement systems carefully to ensure they do not exclude those who are already marginalised.
- **Recommendation 7: Develop a national health financing plan** to map out existing and future health resource mobilisation. The plan should focus on domestic resource mobilisation strategies from public funds and other sources in line with the parameters set out in this paper, strategies to decrease or remove out-of-pocket payments, and approaches to ensuring that available funds are pooled to fund the health costs of the entire population and not a select few.

1. Introduction

Since the Sustainable Development Goals were agreed by the United Nations General Assembly (UNGA) in September 2015, interest in, and investment around the advancement of universal health coverage (UHC) and its associated systems have accelerated rapidly. The pressure to expand coverage continues to increase as a result of: growing non-communicable disease prevalence, morbidity and costs; continuing the unfinished business of the Millennium Development Goals (MDGs, i.e. HIV, AIDS, malaria, TB and maternal and child mortality); recognition that access to health is a human right; as well as, in some contexts, stagnating or declining donor assistance to health. Technical progress has advanced the ability to prolong lives and reduce premature mortality and, as populations age, their health needs increase. In many countries, as private health services become more available, especially to the growing urban, employed populations, the share of out-of-pocket payments by individuals can go up if social health insurance arrangements are not put in place.

More and more countries are moving towards publicly financed healthcare systems that cover the whole population for essential health services, reducing preventable illness and death, particularly in women and children. In addition to the emotional distress a death causes, there are cost implications – to families, communities and the national economy. Premature deaths have a disproportionate effect and can inhibit economic growth. For every 10 per cent gained in life expectancy, economies can expect a boost of 0.3 to 0.4 per cent in annual growth.⁵ Eliminating preventable child mortality is vital to increasing national life expectancy. For every dollar spent on key interventions for reproductive, maternal, newborn and child health, about US\$20 in benefits could be generated.⁶

Poor health or the premature death of a breadwinner or primary caregiver can reduce household income and create expenses that can lead to children being removed from school and sent out to work. Land and other assets may be sold, and families can fall back into poverty. UHC aims to ensure that all people in a household have access to basic health services in ways that also provide financial protection. UHC can thus make an effective contribution to strengthening social security, economic well-being and overall satisfaction with public services, releasing household resources to be spent on other priorities and ensuring that catastrophic health costs are avoided.

The political commitment needed to design and implement the large-scale changes that are linked to UHC (such as levying new taxes, developing new payment mechanisms, delivering expanded access) can quickly absorb significant time and resources among policymakers. Although these systems are critical to guaranteeing the resources needed and the rights of citizens to access services, if not handled carefully they can also become a means of exclusion and marginalisation. Even in the most well-organised countries, people slip through the net and may be excluded from services for administrative, financial or other reasons, foreshortening the achievement of the ‘universal’ element of UHC. As the first *Global Report* on UHC identified, more than a hundred million people are thrust back into poverty every

⁵ WHO (2001), *Investing in health: A Summary of the Findings of the Commission on Macroeconomics and Health*, WHO, Geneva.

⁶ Partnership for Maternal, Newborn and Child Health (PMNCH) (2013a), Knowledge Brief 24: ‘The Economic Benefits of Investing in Women’s and Children’s Health’, available at:

http://www.who.int/pmnch/knowledge/publications/summaries/knowledge_summaries_24_economic_case/en/ and PMNCH (2013b), Knowledge Brief 28: ‘The Investment Framework for Women’s and Children’s Health’, available at:
<http://www.who.int/pmnch/knowledge/publications/summaries/ks28.pdf>

year as a result of the financial demands associated with illness and healthcare needs. Thus, while UHC can be a powerful driver of equity, delivering citizen access and improving quality of life, it can also exacerbate inequity and widen divisions within societies, worsening existing cleavages.

In this context, UHC can be an opportunity, if delivered the right way, to meet one of the strongest needs of populations everywhere.⁷ It provides an opportunity for political authorities to shift resources in ways that reduce inequity and genuinely close the inclusion gap. Funding health services to meet the needs of all people can accelerate development and help to enable every individual to reach their potential. Despite costing more to national governments in the short term, there are considerable overall benefits to societies in the long term and UHC has been demonstrated to pay back its initial debt to national economic growth in multiples. For example, the Lancet Commission on Investing in Health (2013) found that the economic benefits of achieving a grand convergence of global health outcomes would, depending on the income level of the country, outweigh the costs by a factor of 9 to 20 over 20 years from 2015 to 2035.⁸ In country after country, where it has been well thought out and delivered, UHC has acted as a means to sustainable nation-building.

In the wake of the High-Level Meeting at UNGA 2019 and the publication of the second global monitoring report on UHC⁹ in support of the delivery of SDG 3.8¹⁰ most countries have started thinking about how to progress their health systems towards UHC. The range and quality of experience, guidance and technical support has broadened considerably. This paper aims to identify some of the lessons and challenges experienced by SADC countries¹¹ so far in order to foster discussion and mutual learning among countries. UHC is a long-term commitment that requires engagement by the whole of government, significant public sector reforms and sometimes complex public financing arrangements. Sharing experience and lessons across countries can help avoid common pitfalls and accelerate progress.

1.1 What is UHC?

UHC is defined by the WHO as a means of organising, delivering and financing health services in such a way that 'all people obtain the health services they need without suffering financial hardship when paying for them'.^{12,13} UHC thus combines two attributes: first, everybody is covered by a package of good-quality essential health services; second, UHC provides financial

⁷ See, for example, World Bank (2005), *Dying for change: Poor people's experience of health and ill-health*, World Bank Washington, DC, available at: <http://documents.worldbank.org/curated/en/2005/12/6114408/dying-change-poor-peoples-experience-health-ill-health>

⁸ Jamieson, DT, LH Summers et al. (2013), 'Global Health 2035: A World Converging within a generation', *The Lancet*, Vol. 382, Issue 9908, 1898–1955.

⁹ WHO (2019) Primary Health Care on the road to Universal Health Coverage, Geneva, September 2019

¹⁰ SDG Target 3.8 is: *Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*

¹¹ SADC member countries are listed here <https://www.sadc.int/member-states/>

¹² World Health Organization (2014), '*What is Universal Health Coverage?*' [online], available at: www.who.int/features/qa/universal_health_coverage/en/ (accessed 26 March 2016).

¹³ Adopted as a resolution at the 2005 World Health Assembly. In 2012, the United Nations General Assembly adopted a resolution on global health and foreign policy that called for action towards UHC. The World Bank and WHO have selected UHC as a key objective to address both the right to health and extreme poverty.

protection from healthcare costs, especially at the point of delivery.^{14,15} The main features of a UHC system include:

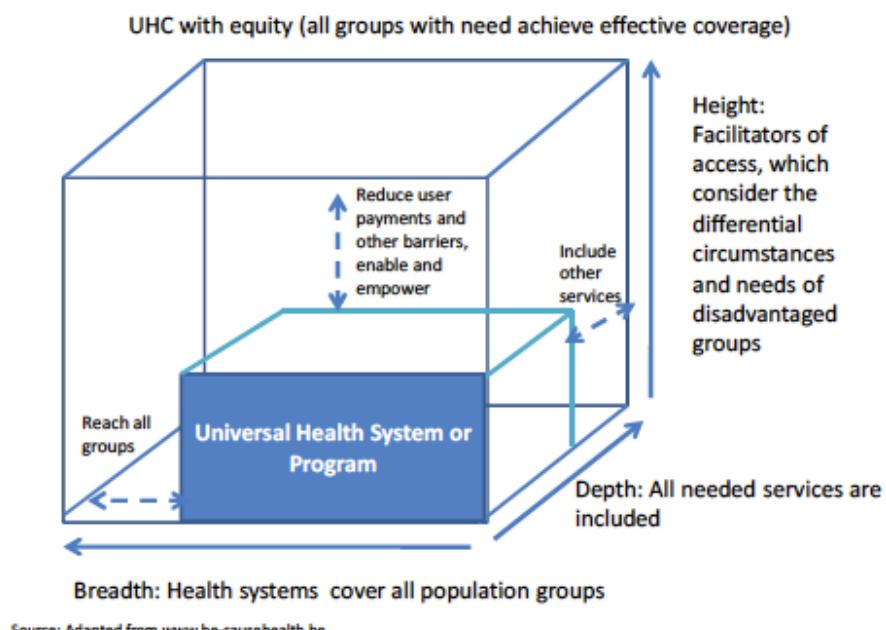
- An efficient, resilient health system
- Affordable care and a system of financing healthcare that doesn't impoverish users
- Access to essential medicines and technologies
- Health workers who are motivated, and sufficient in number and skills
- Efficient, functional administrative and governance arrangements
- Transparency in tracking progress and achieving equity

Achieving UHC requires countries to advance health services in three distinct ways:

1. The proportion of the population covered should extend to encompass all people in a country (universal population coverage).
2. The range of services covered by UHC policies should expand as resources permit, including sufficient investment in essential public health functions. Services must also be accessible and be of adequate quality to be effective.
3. The proportion of the financing required to deliver services should be increasingly drawn from pooled funds raised through compulsory prepayment mechanisms, including general or specific taxation or public social insurance.

Figure 1.1 illustrates how expansion of all three dimensions will advance UHC in all directions.

Figure 1.1 The three dimensions of UHC with equity¹⁶



¹⁴ Yates, R (2015), *Accelerating Progress towards Universal Health Coverage in the Commonwealth*, The Commonwealth, London.

¹⁵ Financial protection ensures that households are not pushed into poverty as a result of incurring the costs associated with accessing needed health services nor that they are forced to spend more than 10 per cent (or 25 per cent) of their non-food income.

¹⁶ An observation about the cube is that it appears to downplay the importance of public health services/ functions and services that support individual and collective health security. While we have not attempted to redesign the cube, we concur that these broader community-focused services and functions should be included.

1.2 The benefits of UHC

UHC has increasingly become the focus of the global health agenda, building on the 2010 WHO *World Health Report*¹⁷ and the boost offered by the SDGs. In 2012, Margaret Chan called UHC, ‘the single most powerful concept that public health has to offer’.^{18,19} Dr Tedros Ghebreyesus, on his election to the role of Director General of WHO in 2017 said, ‘*For me, the key question of universal health coverage is an ethical one...a human right*’, but is ‘...ultimately a political choice. Countries have unique needs and tailored political negotiations will determine domestic resource mobilisation’.²⁰

Adopting and sustaining a UHC system is thus as much a *political* process as a *technical* or *financing* one. Although there are important elements around getting the system right, UHC begins with and is sustained by the commitment of political decision-makers, often in response to citizen demand, to ensure that the whole population can access the quality of health services they need without the risk of financial hardship.²¹ Choosing how to advance universal coverage is different in each country context, but countries that have made progress with UHC have experienced a range of benefits. Evidence and examples are summarised in Table 1.1.

Table 1.1 The multiple benefits of UHC²²

Health benefits	Broad health coverage leads ‘to better access to necessary care and improved population health, with the largest gains accruing to poorer people’. ²³ A study by Imperial College, London, found that a 10 per cent increase in pooled government health spending led to a reduction of almost eight deaths per 1000 children under five. When truly universal, health coverage improves outcomes fastest among the poorest and most marginalised districts, supporting equity and reducing or eliminating disparities within populations. ²⁴ Health coverage should include essential public health services, including prevention and promotion, investments in public goods such as clean air, and in the main determinants of health, including water and sanitation, and the non-communicable disease risk factors such as tobacco, and in nutrition.
Health system benefits	Reaching all citizens with services requires a system that extends to all geographical parts of the country, one that is staffed, equipped, managed and able to meet needs. UHC can act as a driver of and incentive to sustaining investments aimed at strengthening health systems, overcoming bottlenecks and improving the availability and performance of healthcare workers and essential medicines and supplies. In protecting people from shocks, UHC is indispensable for the achievement of individual health security and therefore collective health and human security.
Economic benefits	Healthier populations support economic growth, while unhealthy populations, particularly those afflicted with preventable diseases, can slow down and even stall economic growth. With use of ‘value life years’ to estimate the economic benefits, over the period 2015–35 these benefits would exceed costs by a factor of about 9–20, making the investment highly attractive. ²⁵

¹⁷ Bristol, N (2014), ‘Global Action toward Universal Health Coverage’, Center for Strategic and International Studies, Washington, DC.

¹⁸ Chan, M (2012), ‘Universal Coverage is the Ultimate Expression of Fairness’, Acceptance speech at the 65th World Health Assembly, Geneva, Switzerland, 23 May.

¹⁹ UN Declaration on UHC (2012).

²⁰ Ghebreyesus, TA (2017), ‘All roads lead to universal health coverage’, *The Lancet Global Health*, Vol. 5 Issue 9, e839–e840.

²¹ The term ‘health services’ in this paper will draw on the WHO definition and include promotion, prevention, treatment and rehabilitation, including services aimed at individuals (curative, vaccination) and public health services aimed at populations and including international health regulations.

²² This table was first published in: Beattie et al. 2016.

²³ Moreno-Serra, R, and P Smith (2012), ‘Does progress towards universal health coverage improve population health?’, *The Lancet*, Vol. 380; 917–23.

²⁴ Gruber, J, N Hendren and RM Townsend (2014), ‘The great equalizer: Health Care Access and Infant Mortality in Thailand’, *American Economic Journal: Applied Economics*, Vol. 6 No. 1, 91–107.

²⁵ Jamieson, DT, LH Summers et al. 2013.

	Households protected from financial hardship due to medical expenses are less likely to slip back into poverty. They are less vulnerable, and they earn more. Investments in a package of micronutrients in children increases their incomes as adults by 11 per cent per year. ²⁶ The converse is also true: a leading cause of impoverishment across the world is medical- and health-related costs and it is estimated that every year 100 million households fall into poverty because of medical and health expenses. ²⁷ Some governments have successfully used increases in social services, including health coverage, as a counterweight to less popular reforms such as removing subsidies on fuel or some foodstuffs. ²⁸
Political benefits	As a political process, UHC requires strong redistributive policies and actions by the state, as well as transparent processes for allocation of resources for competing needs across different interest groups. Many politicians have found that extending health coverage to underserved areas is a popular policy and attracts support. It builds universalism and solidarity across social groups in society, acting as a force to unite rather than divide groups. UHC helps countries achieve their international commitments to fulfilling citizen rights to health and other progressive social policies, including advancing gender equality.

Sources: UNICEF data bank; WHO 2015; Yates 2015

1.3 Basic components of UHC system design

UHC systems need to address a number of common design elements set out below. The design of UHC in any context supports the achievement of UHC objectives and helps to overcome constraints.

- **Raising funds:** UHC systems need to be built on stable and predictable funding. How countries raise funds to finance UHC is a crucial part of design. As set out in sections 2, 3 and 4 below, most countries rely on public financing collected through compulsory, pre-paid mechanisms (usually different kinds of taxes). No country has successfully achieved UHC using private financing mechanisms.
- **Pooling resources to reduce fragmentation:** Creating the largest pool of funds raised from different sources is the element of UHC design that enables vital cross subsidisation of the sick and the poor by the wealthy or healthy in society.
- **Spending funds and setting priorities:** A political process, priority setting is focused on what the UHC system will buy with available funds. In this regard, countries use priority setting to ensure funds are spent where they will deliver the best value for money in support of people who need health services most (vertical equity).

1.4 UHC targets in the Sustainable Development Goals

One of the most significant recent developments in support of efforts to advance UHC has been the launch of a global tracking methodology and consolidated report to monitor progress against the two indicators associated with the UHC SDG target.²⁹ These indicators were adopted by the United Nations General Assembly (UNGA) in July 2017 based on recommendations from the UN Inter-Agency and Expert Group (IAEG) on SDG indicators. The two tracking indicators for Target 3.8 respond directly to the three dimensions of UHC expressed in Figure 1.1. They are as follows:

²⁶ Hoddinott et al. 2013, 69–82.

²⁷ Evans et al. 2010

²⁸ Yates 2014, 547–547A.

²⁹ World Health Organization and the World Bank (2017), *Tracking universal health coverage: 2017 global monitoring report*. World Health Organization and International Bank for Reconstruction and Development / The World Bank, 14, available at: <http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf>.

SDG Indicator 3.8.1: Coverage of essential health services This is measured through a composite assessment that includes:

- the average coverage of essential services based on tracer interventions that include infectious diseases, non-communicable diseases, and reproductive, maternal, newborn and child and adolescent health (RMNCAH);
- service capacity; and
- service access among the general and the most disadvantaged population.

SDG Indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income.

In September 2019, the most recent UHC *Global Monitoring Report* was published jointly by the World Bank and WHO. The report sets out the most recent global progress updates on the two UHC indicators. These are newly created indicators to monitor UHC targets and there is not space here to summarise the methodologies associated with tracking each of these targets. However, a brief description is given here, and the current status of SADC countries as reflected in the 2019 analysis is incorporated into Section 2 below.

To monitor the **coverage of essential health services** (Indicator 3.8.1), countries are assigned a composite score determined through a multistage assessment process using existing and historical data for 16 tracer conditions or indicators. The full methodology includes consideration of different types of services (prevention, treatment, palliative, for example, including services that are critical to health but not delivered by the health sector, such as access to clean water), a range of service types (including RMNCAH, non-communicable diseases, infectious diseases), and equity in access across the spectrum of society. The methodological challenges are significant and include measuring quality, equity and the total population in need.³⁰

Financial protection occurs when '*families who get needed care do not suffer undue financial hardship as a result*'.³¹ The indicator measures the proportion of the population suffering catastrophic expenditures, which is considered to be the fraction of the population with out-of-pocket spending on health exceeding 10 per cent, or 25 per cent of household total expenditure or income. Two measures of financial hardship are identified for tracking: **catastrophic** spending measures spending on health that amounts to both 10 per cent or 25 per cent of household income; **impoverishment** measures households that are pushed below the poverty line as a result of health spending at both the 10 per cent and the 25 per cent levels.³² In both cases, results distinguish between the very poor (US\$1.90 per day in PPP [purchasing power parity] in 2011 constant US\$) and the moderately poor (US\$3.10 per day PPP in 2011 constant US\$). The analysis is done using existing data drawn from household expenditure surveys and other poverty data sources.

It should be clearly noted though that the results need careful interpretation because although the low incidence of catastrophic expenditures could be a result of the health financing system's capacity to limit out-of-pocket payments, it could also be due to low levels of service coverage provision. The two indicators therefore work in tandem with each other.

³⁰ See pages 45 of the *Global Tracking Report* for a fuller discussion of the coverage assessment methodology and limitations.

³¹ Op. cit. 24.

³² A fuller explanation of the methodology, together with an assessment of data availability and quality, challenges and global results, can be found in Chapter 3 of the report.

1.5 What does ‘leave no one behind’ mean?

Leaving no one behind means that in both principle and in practice, those who need health services the most are able to access them in an acceptable way without incurring financial hardship. In most understandings of universal, it does *not* mean that everyone has access to every health service. Generally, there is a recognised set of trade-offs that lies behind the definition and delivery of universal health approaches. Critically, ‘universal’ certainly means avoiding an approach to UHC that inadvertently widens inequity or excludes individuals or groups. Whatever definition of universal is agreed, it is important that governments measure and track their progress in delivering universal coverage and that populations are engaged in debating, delivering and monitoring progress.

Section 2: UHC objectives in SADC countries³³

Based on the UHC framework laid out in Section 1, the *objectives* of UHC can be identified clearly (support health, strengthen equity and increase financial protection for individuals and households). Balancing these objectives requires difficult choices to be made. Across SADC, countries are at very different stages of their UHC journeys. This is partly because of different economic development contexts but it is also because of differences in approach, political decision-making, and investment choices which affects the relative importance of each of these objectives in individual countries.

What countries aim to achieve and the extent to which they are able to invest in advancing these choices determines their progress on different UHC dimensions. Each of the UHC dimensions – coverage of the population, the package of quality services offered, and the proportion of costs covered, or financial protection achieved – is briefly assessed below in SADC countries using globally available data.

2.1 Broadening service capacity and scope

Extending the range of services covered by UHC is a persistent challenge in all countries. There are never enough resources to fund **all** the health services that people can consume. Priority setting and decision-making about who should be covered for what services depends on several factors, including the burden of disease, quality of services, resources available and, crucially, political negotiation. Using child mortality rates (CMR) as a proxy for burden of disease, Figure 2.1 shows CMR status in SADC countries, many of which are still working towards extending the most cost-effective health interventions to their whole populations. Nonetheless, the figure illustrates the considerable progress made in reaching children with a wider range of improved, quality services and the dramatic decline in child mortality many countries have achieved. It is worth noting that some countries experienced a dramatic rise in child mortality through the 1990s as a result of several factors including, notably, the AIDS pandemic.

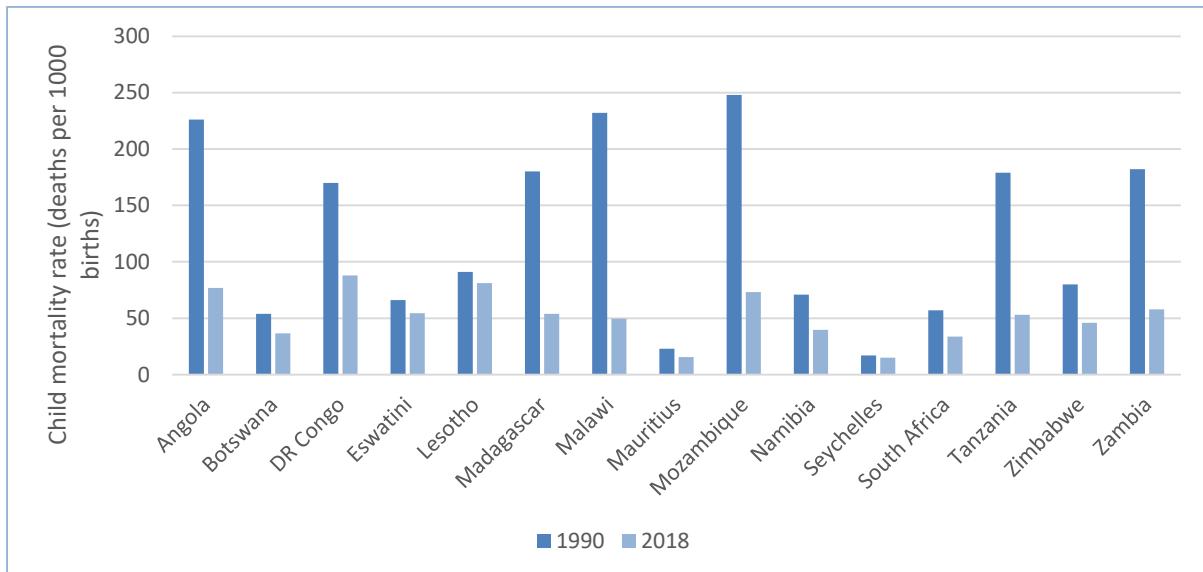
Maternal mortality is often considered a sensitive indicator of the strength, reach and accessibility of health systems. For example, preventing maternal injuries and deaths requires all the health system’s building blocks to be in place and functioning.³⁴ Perhaps one of the

³³ It is likely that some countries have made some progress on closing the equity gap. However, there is no updated data available that enables better comparison

³⁴ The WHO health systems building blocks are available at: http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

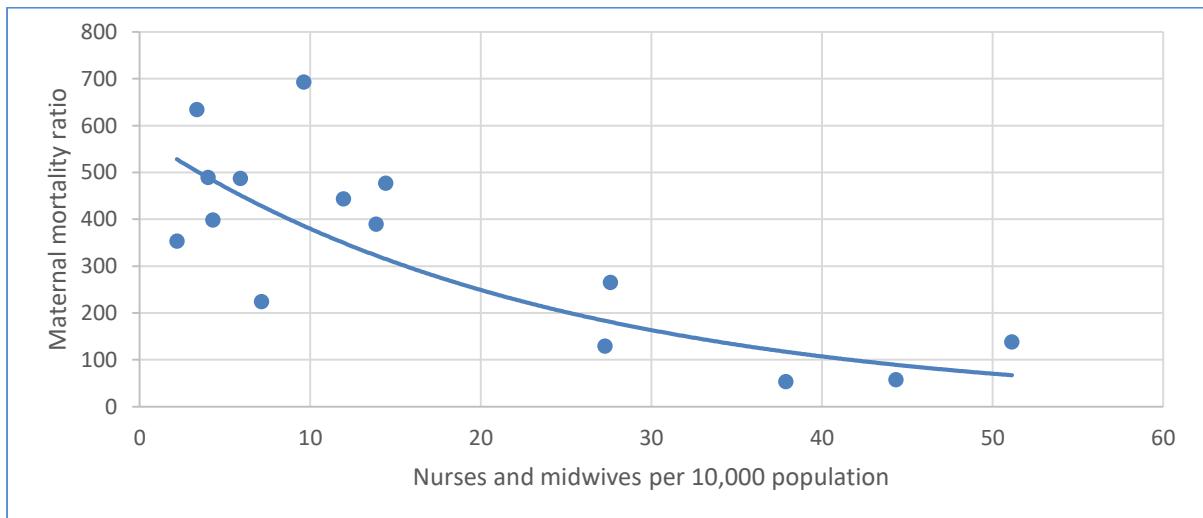
most basic requirements for maternal care is skilled attendance at birth. Using a proxy indicator – nurses and midwives per 10,000 population – Figure 2.2 shows the relationship between skilled attendance at birth and maternal mortality among countries. The data show a clear association between health systems (adequate workforce) and maternal health outcomes. Outliers exist, however, reinforcing the point that countries can make progress on maternal mortality reduction even as they are building workforce density. For example, in some countries, such as Sri Lanka, despite a smaller workforce, maternal mortality is significantly lower than the norm.

Figure 2.1 Child mortality rates in SADC countries in 1990 and 2018



Sources: WHO and Countdown to 2030

Figure 2.2: The relationship between service delivery and maternal mortality in SADC countries (2014)



Source: WHO Global Health Expenditure Database (GHED) 2014

Health systems are coming under pressure to meet new and growing burdens of disease from many sources. In all countries across the world, the burden on households, health services and national economies caused by non-communicable diseases (NCDs) is likely to grow significantly. Box 2.1 sets out the dimensions and magnitude of NCDs and the importance of

ensuring UHC arrangements cover all people for prevention, diagnosis, treatment and care associated with NCDs.

Box 2.1 Controlling NCDs – a growing imperative

About 70 per cent of all deaths annually are due to non-communicable diseases. For some countries, the rise in NCDs exists alongside persistent communicable diseases. Indeed, the links between RMNCAH and NCDs are significant. For example, of the 40 million annual deaths from NCDs, 18 million occur in women and a large share of these in women still in their most productive years. One in seven pregnancies is affected by gestational diabetes mellitus, while 86 per cent of the annual 266,000 cervical cancer deaths occur in low- and middle-income countries. Cervical cancer, caused by a sexually transmitted virus, is largely preventable with a vaccine now available. Cardiovascular disease is the number one killer of women globally.

Men and women in low- and middle-income countries are much more likely to die from an NCD than in wealthier countries, as they are less likely to be able to access the healthcare they need to preserve and prolong their lives. The barriers to access include, for many, out-of-pocket payments for care, including the cost of regular, usually quite inexpensive generic medicines that can help keep diseases such as high blood pressure, type 2 diabetes and high cholesterol under control, and which enable affected adults to continue working and supporting their families, extending their quality and length of life.

However, the social determinants of NCDs are widely recognised as requiring a whole-of-government approach. Many countries, for example, are putting policies in place to address the major underlying risk factors driving NCDs: diet, exercise, tobacco and alcohol.

As the number of people affected with NCDs continues to rise rapidly, the challenges for governments will be to reduce their citizens' vulnerability to NCDs using a range of instruments – such as indirect taxation on some commodities that increase risk (tobacco, alcohol, sugar). But for those already affected, the challenge will be to reduce the resulting economic, social and health burden. Removing the barriers to accessing vital health services, including affordable quality medicines, lies at the heart of this effort. Not only will this improve the health of the population, but reducing demand on health services through prevention, together with promoting a strong sense of individual responsibility for health, are both crucial strategies to ensuring scarce health resources are used efficiently.

Sources: (1) Comments from delegations to the 2017 Commonwealth Health Ministers Meeting, Geneva, 21 May 2018; (2) Questionnaires completed by Commonwealth Ministries of Health in preparation for this paper (Australia, Botswana, Namibia, Seychelles, Zambia); (3) WHO 2013; (4) WHO Factsheet: 'Non-communicable diseases', updated June 2017; (5) NCD Alliance 2011.

2.2 Extending coverage with equity

The first feature of UHC is that all people are reached with essential health services and that everyone has financial protection from healthcare costs. In most contexts, coverage of the whole population can be challenging and full coverage is hard to achieve.³⁵ For example, geographic distribution, economic migration, rural-to-urban migration, displacement (refugees), criminalisation and/or discrimination of particular populations or behaviours, insecurity, conflict, language and cultural barriers all affect when and how people access services, even when these services are available. However, administrative barriers, including the use of identity cards or other registration requirements, create barriers to coverage and ultimately add costs to the delivery of services, leading to possible exclusion of some people.^{36,37} For many basic health services – especially those that prevent, detect and treat

³⁵ See, for example, Soors, W, J de Man, et al. 2015.

³⁶ Afsana and Wahid (2013).

³⁷ See, for example, Soors, W, J de Man, et al. 2015.

transmissible diseases – it is more effective from a public health perspective to aim for full coverage, regardless of an individual's status in a country.

Box 2.2: The right to the highest attainable standard of health

The right to health is enshrined in the International Covenant on Economic, Social and Cultural Rights. The Covenant was adopted by the United Nations General Assembly in its Resolution 2200A (XXI) of 16 December 1966. It entered into force in 1976 and by 1 December 2007, had been ratified by 157 states.

The right to health is an inclusive right. This incorporates a wide range of factors, including the 'underlying determinants of health' (safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality).

The right to health contains freedoms. These *freedoms* include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilisation, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

The right to health contains entitlements. These *entitlements* include: the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment and control of diseases; access to essential medicines; maternal, child and reproductive health; equal and timely access to basic health services; the provision of health-related education and information; and participation of the population in health-related decision-making at the national and community levels.

Health services, goods and facilities must be provided to all without any discrimination. Non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health.

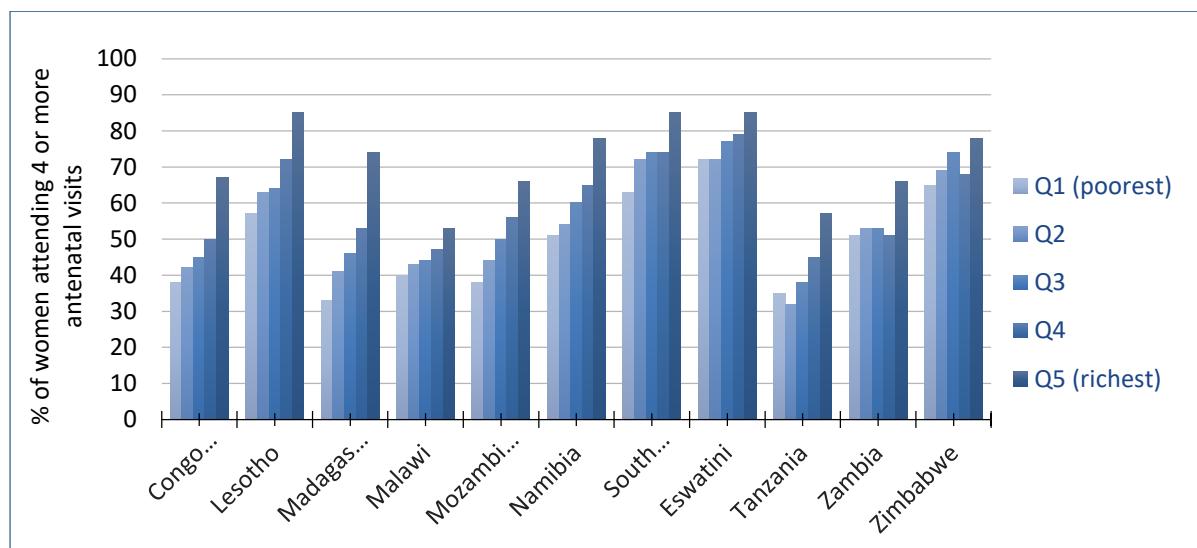
Source: UN High Commission for Refugees and WHO (2008), 'The Right to Health', Fact Sheet 31, available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

Countries are also at different stages in their efforts to reach whole populations with full equity. Service delivery of even the most basic package of care may not reach everyone who needs it. The World Health Organization estimates that in 2015, more than half the world's 7.3 billion population did not receive the most basic services.³⁸

Figure 2.3 shows the distribution of antenatal visits by wealth quintile for the countries where equity data were available. There is a strong association between wealth and access to basic services. The figure shows that progress between countries varies, sometimes significantly. However, in all countries, equity gaps persist, and the wealthier quintiles are more likely to access basic antenatal services. The largest gaps are almost always among populations in the poorest quintiles.

³⁸ World Health Organization and the World Bank 2017, page 14.

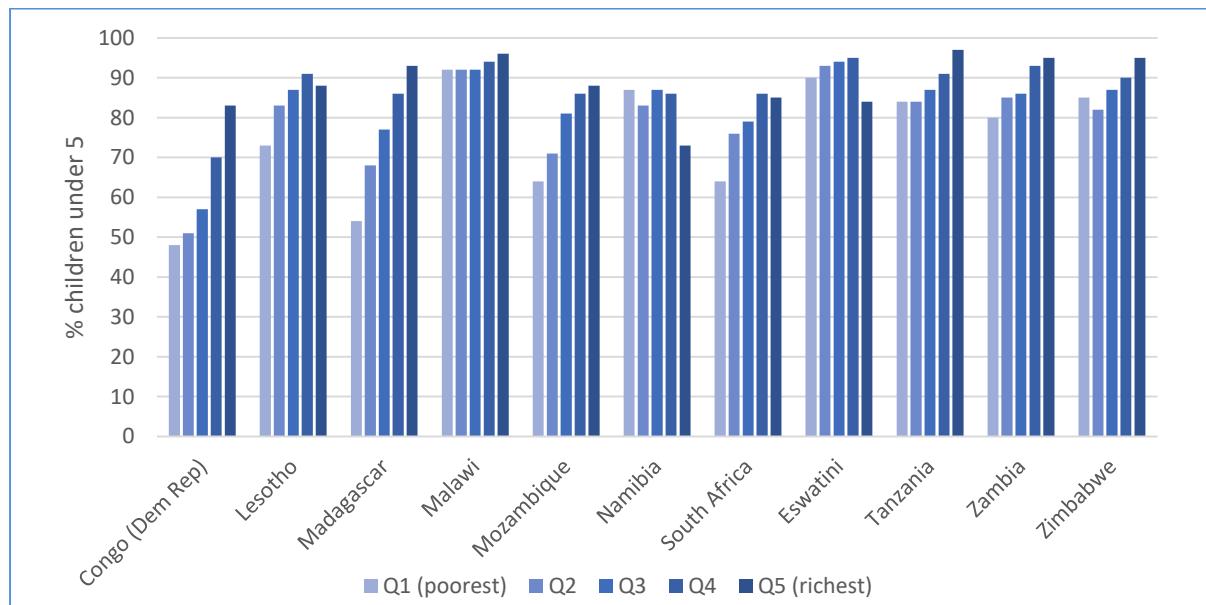
Figure 2.3: Percentage of women attending four or more antenatal visits in selected African countries (2014-2015)



Source: WHO 20146 (latest data shown for SADC countries where available)

For immunisation services, the coverage rate in many countries is generally higher, although still variable within and between populations (Figure 2.4). This may be due to several factors. Vaccinations are often delivered very close to the community, through special campaigns and accompanied by more proactive community engagement. Funding for vaccination services is one of the most reliable through the Global Vaccine Alliance (GAVI) for eligible low-income countries. In most settings, basic immunisation services are delivered free of charge.

Figure 2.4 Immunisation rates (DTP3) among children under five by wealth quintile in selected African countries (2012-2015)

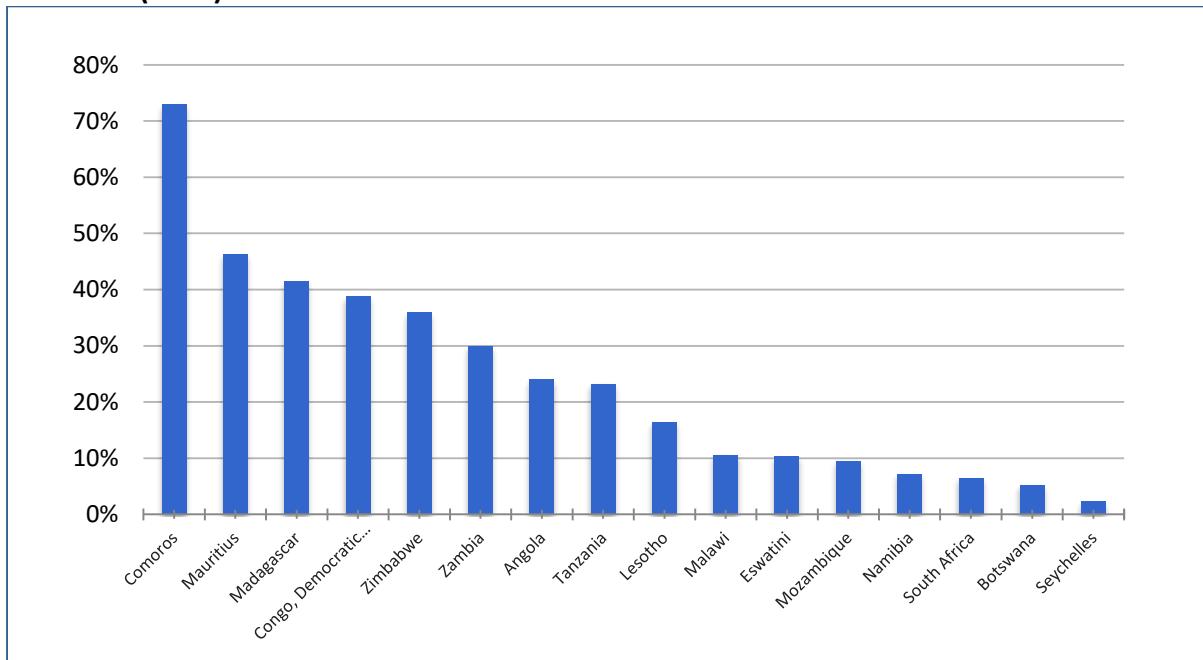


Source: WHO (latest data shown for selected SADC and other SSA countries where available)

2.3 Extending financial risk protection

A critical feature of UHC is that it should provide financial risk protection. The direct costs of healthcare can be catastrophic for households and the poorest are often the hardest hit because they are least able to afford services. To extend financial risk protection, especially to the poorest, countries need to reduce or eliminate direct out-of-pocket (OOP) payments at the time of service delivery. Figure 2.5 illustrates the extent of reliance on OOP payments in some countries.³⁹ In other countries, OOP expenditure appears low overall. This may be because health services are free at the point of care for most people. It may also be because people are not accessing the services they need because they do not have money. Another possibility is that high OOP payments indicate a large, pervasive private health system with a small public sector service. On its own, therefore, OOP expenditure does not necessarily tell the whole story.

Figure 2.5 OOP expenditure as a proportion of total health expenditure (THE) in SADC countries (2016)



Source: WHO GHED 2011–16

Section 3: Constraints to UHC progress

Making progress on UHC requires all countries to balance their investments across the three UHC dimensions (extending coverage, broadening range of services and increasing financial protection). This invariable means making difficult choices as countries never have the resources to address all components without constraint. The choices that countries make will reflect multiple considerations even beyond their main objectives in expanding UHC. For example, the kinds of barriers to progress or drivers of exclusion they experience, their different approaches to raising, pooling and spending resources for health, concessions needed to build consensus across political groups to advance UHC policies and others.

³⁹ The figure does not reflect the distribution of the OOP burden and, for example, masks some important omissions or inequities such as the socioeconomic groups most affected.

This section covers some of these barriers and constraints as experienced in SADC countries and sets out where SADC countries have got to in relation to on their UHC journeys so far.

3.1 Those most often unreached

Given the range of SADC countries at all points on the economic development spectrum, this section will identify the groups and populations who tend to be *unreached* in different contexts, the main reasons, and associated evidence drawing on examples/ illustrations from countries affected in a way that enables readers to identify with the meaning and dimensions of the problem.

Table 3.1 Individuals or groups most often excluded from accessing health services

Source of exclusion	Description of how exclusion happens	Group(s) most affected
User fees or co-payments at the point of use and other financing barriers (direct and indirect financing)	<ul style="list-style-type: none"> User fees at the point of care; informal and under-the-table fees required to be paid; Purchase of drugs from private facilities if prescribed medicines are out of stock in public services; Costs of inpatient and life-saving care, including the risk of forced detention; and Indirect costs of accessing care, including transport, childcare and labour foregone. 	<ul style="list-style-type: none"> The poor; Seasonal workers or those whose income is unpredictable; Those who do not control household resources or make decisions about household resources (often women, older people, children); and Geographically remote households who cannot find or afford transport in emergencies
Geography and spatial issues, including distribution and availability of services	Coverage and reach of the health system are insufficient to meet basic needs. This includes a lack of health facilities (and health workers), poorly situated facilities, restricted operating hours and placement of facilities referral arrangements.	<ul style="list-style-type: none"> The most vulnerable people, the disabled, the poorest; Remote communities and those geographically isolated for all or part of the year; and Social groups unable to access services during normal working hours.
Service delivery and provision of care issues including quality of care failures	Services are technically available, but in practice are not present because of a lack of health workers or lack of skills in health workers that are there, insufficient or poor quality drugs and commodities, limited opening hours (for example, closed at night time, so women in labour are not served) and other service delivery limitations.	All people in communities served by under-resourced health services
Experience of care: issues such as a lack of	Confidence in the quality of care is low and deters users from attending; quality of care failures including: rude,	<ul style="list-style-type: none"> Communities that are underserved with sufficient fixed or mobile services;

confidence in health services, staff attitudes to patients, clear communication	complacent or unskilled health workers, insufficient or inadequate commodities, services unavailable when needed, language barriers and cultural norms preventing attendance that are unchallenged by health workers.	<ul style="list-style-type: none"> Mobile groups or minority groups that are socially isolated in a range of ways; and Immigrants, those with language barriers, social and religious groups with deeply rooted norms and customs that proscribe attendance at health services
Administrative entitlement failures: systems mechanics/ administrative controls	Health service requires proof of entitlement (for example, a national health card) or a national or local identity card in order to deliver free or low-cost health services	<ul style="list-style-type: none"> Those not enrolled in the national health system, often including many who are entitled but have not completed the administrative process; and Those who are not entitled under the established rules, such as non-nationals (illegal migrants, visitors, temporary workers, and sometimes refugees or asylum seekers)
Informally established entitlement (informal decisions about entitlement)	Entitlement is sometimes filtered by health workers or informal 'cultural' practices restricting access to certain services, such as by adolescents for reproductive health services (or students in school uniforms). Often a reflection of power dynamics and social norms, for example, where women are required to be accompanied by a male relative.	Those who are most repressed by social norms, including adolescents in relation to reproductive health, women, mobile populations, informal workers, minority ethnic groups and others

In summary, people are excluded and left behind because of a range of structural, spatial, systems, experiential and functional barriers:

- poverty, especially absolute and intergenerational poverty;
- user fees and additional costs, including arbitrary or unpredictable fees;
- social isolation, language barriers, religious, cultural or social norms;
- gender and age-related barriers;
- geographic isolation;
- nationality and/or legal status of individuals;
- administrative barriers and exclusion of those in need due to rules and procedures;
- quality of care failures and a lack of confidence in services;
- insufficient supply of health services to meet basic needs;
- lack of understanding or value placed on health services; and
- lack of engagement in health decision-making or participation in health.

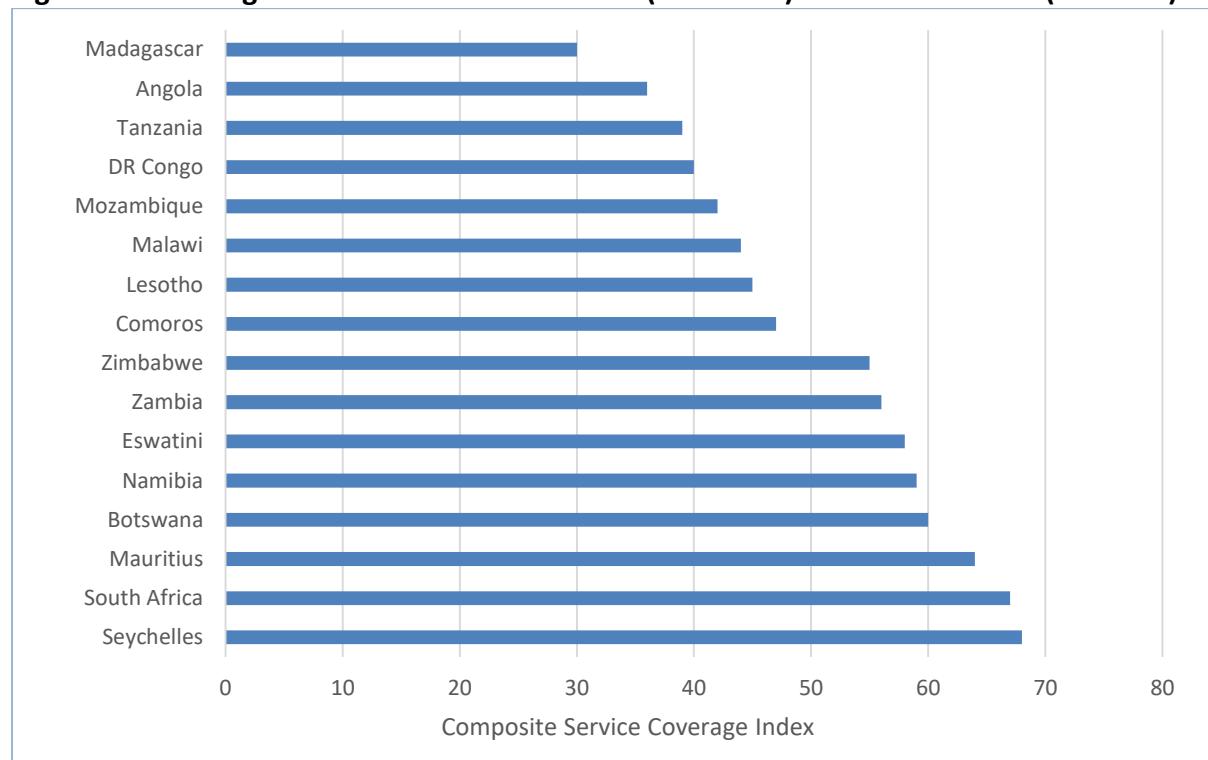
These exclusions amount to a curtailment of the right to health and will result in widening disparities in a UHC context if they are not addressed. Most sources of exclusion can be

overcome with effort, investment, planning and the right kind of support, but as they are often deeply entrenched, it takes time and sustained effort to address them.

3.2 The UHC composite tracking indicator for coverage

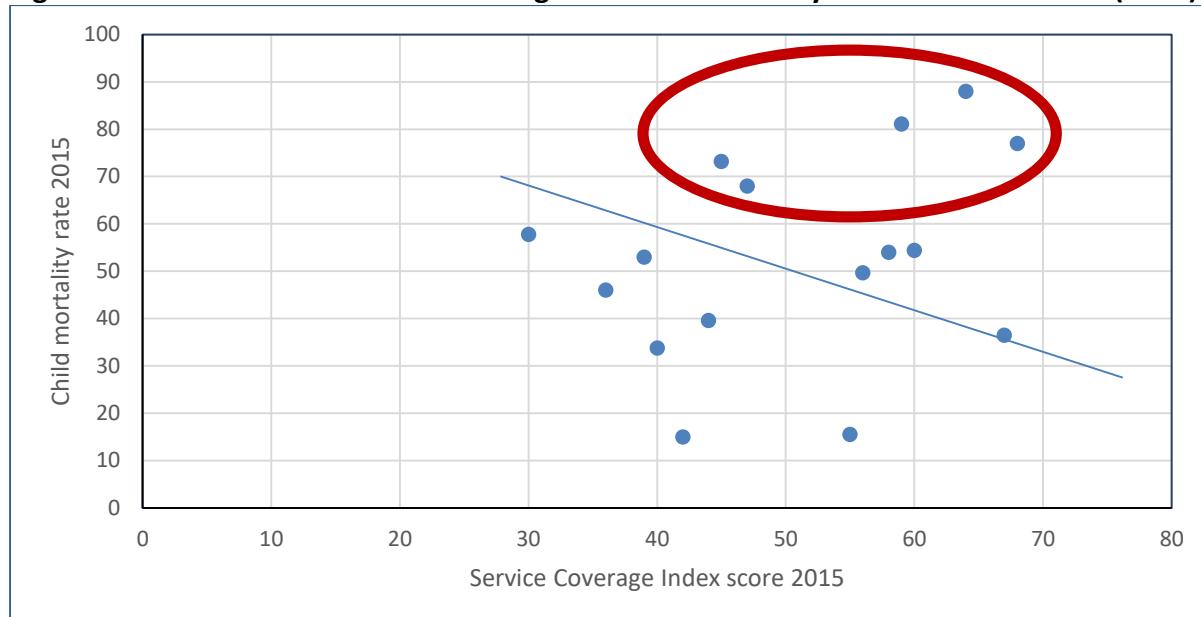
As described above in section 2, the UHC tracking indicator (3.8.1) measures access to a range of essential services including RMNCAH, infectious and non-communicable diseases, as well as service delivery capacity. The 2017 report covers 16 SADC countries and these are plotted in Figure 3.1. Scores do not go beyond ≥ 80 .⁴⁰ Figure 3.1 sets out the composite coverage indicator for all available countries, while Figure 3.2 plots the composite coverage indicator against child mortality to assess whether there is a clear association between the two.

Figure 3.1 Coverage of essential health services (SDG 3.8.1) in SADC countries (2010–15)



⁴⁰ The specificity of the results was considered to be less reliable at the far end of the scale, while anything over 80 was considered to be an acceptable level of coverage for the purposes of measuring UHC.

Figure 3.2 Associations between coverage and child mortality in all SADC countries (2015)



The figure shows a trend in child mortality reduction as countries improve their coverage of health services. However, there are outliers – countries that have relatively better coverage scores but so far continue to have high child mortality suggesting inefficient or inequitable use of resources for health. On the other hand, some SADC countries are positioned well below the line showing better than average child mortality rates given their service coverage.

3.3 Catastrophic spending

One of the two main aims of UHC is to boost financial protection and eliminate catastrophic spending for health. Catastrophic spending has been measured as spending on healthcare that amounts to more than 40 per cent of non-food household consumption or income. The UHC tracking report uses two thresholds (10 per cent or 25 per cent) of total household income or consumption spent on accessing needed health services.⁴¹ Most countries are only just starting to collect data to allow routine tracking of catastrophic and impoverishing expenditure on health and to identify or predict which households are likely to be most affected.

Early studies have found that households in situations requiring catastrophic spending were more often those with elderly or disabled members or children under five, as well as poor and rural households. The authors suggest that these '*types of households may be inherently disadvantaged in many systems as their health needs may be the greatest, but their economic resources the most constrained*'.⁴² Others have found that in health systems where OOP payments comprise less than 15 per cent of total health expenditure, fewer households face catastrophic spending.⁴³

⁴¹ Catastrophic spending on health is defined in the WHO UHC Tracker as 'out-of-pocket spending (without reimbursement by a third party) exceeding a household's ability to pay'. Impoverishing spending on health is defined as '*when a household is forced by an adverse health event to divert spending away from nonmedical budget items such as food, shelter and clothing, to such an extent that its spending on these items is reduced below the level indicated by the poverty line*'. See:

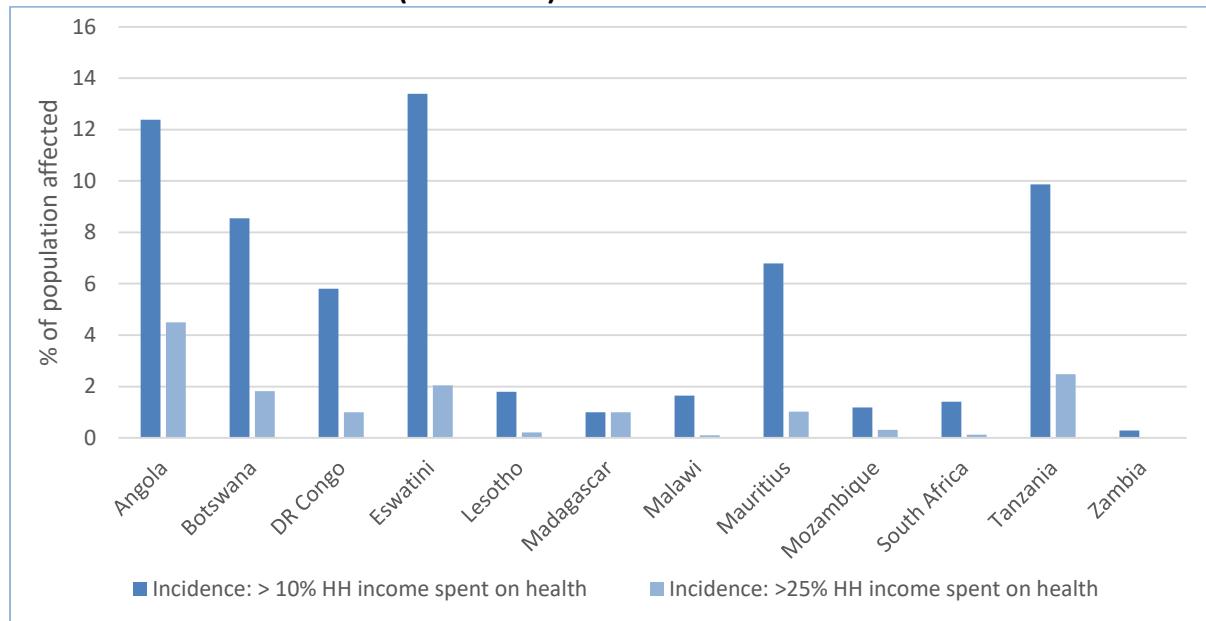
<http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf>

⁴² Saksena et al. 2010.

⁴³ Xu et al. 2005.

Data were available to estimate catastrophic spending in 12 of the 16 SADC countries. These are plotted in Figure 3.3.

Figure 3.3 Incidence of catastrophic payments above 10% and 25% of household (HH) income in 12 SADC countries (2003-2015)



Source: World Bank Data Bank accessed 4 October 2019. Data reflects latest available from countries since 2003.

Across the 12 SADC countries for which data exists, almost *16 million people spent more than 10 per cent of their household income to access needed health services and four million people spent more than 25 per cent of their income*. It is worth repeating that the absence of evidence about catastrophic payments for health can have several possible explanations: one is that people don't face the need to make catastrophic payments; a second is that people would make the payments, but do not because the health services they need are just not available; a third is that people do not make payments because they do not have money and thus do not attend the health services.

Based on the evidence available from a range of countries, the most effective strategies to protect against catastrophic spending include the elimination of cash payments at the point of care; comprehensive health promotion and prevention programmes, including immunisation; infectious disease control; family planning and reproductive healthcare; NCD monitoring and prevention (to reduce or eliminate preventable diseases); and policies to protect the poorest from the costs of both acute and chronic diseases (including free medication, access to hospital care and incentives to attend health services).⁴⁴

Section 4: Challenges and Lessons from SADC countries

The path to UHC is a marathon not a sprint

As laid out above, UHC thus requires countries to make progress on delivery, quality, coverage and equity. In advancing UHC efforts, countries face a common set of challenges including securing sustained political commitment, strengthening health systems, consistent

⁴⁴ World Health Organization and the World Bank 2017, page 14.

investment in health systems strengthening, predictable financing and a methodical approach to closing equity gaps. Most of these challenges are not primarily finance related. For example, UHC reforms can go off track if they are not properly supported, publicly resourced or valued by the electorate. They can also go astray when the balance between the three main elements of UHC (Figure 1.1) are not well synched with each other. For example, if the focus shifts too much towards expanding access to a wider range of higher-quality essential health services for a limited segment of the population such as the urban employed, rather than focusing on improving health outcomes for all based on need (equity), progress towards UHC can slow down.

Box 4.1 Political commitment to UHC in SADC countries⁴⁵

At the 2017 meeting of health ministers in Geneva (in which many SADC countries participated), one delegation commented that '*Universal Health Coverage to people across all countries is no longer a choice, it has become an imperative need*'. This reflects the shifting mood around UHC as a citizen's right rather than a privilege for people everywhere, and the deeply political nature of UHC.

In country after country, the political commitment to achieving UHC has become the first fundamental step towards change. For example, in Zambia, the president announced in parliament that a UHC bill would be tabled in 2018. In Seychelles, access to healthcare is a constitutional right and efforts to deliver on that right have been ongoing for decades. Many countries, when asked what the most important step towards UHC was in their experience, cited political commitment from across government and particularly from the Head of State as a crucial foundation to sustained future progress.

Recent statements made about commitments to UHC can be found [here](#).

As observed elsewhere, '*Some of the most common hazards include focusing on setting up the system itself and distributing health cards that create entitlement to services, without also ensuring that the care meant to be delivered is available, accessible and of good quality.⁴⁶ In this case, people may get a health card, but they are not actually better off in terms of their health outcomes*'.⁴⁷ The fundamentals of UHC should thus be in place and will be the main preoccupation for many countries. At root, this rests on a political commitment to ensure all people have access to basic or essential care. Crucially, this involves removing the many barriers to access that exist, including cultural, social, geographic and institutional constraints, in addition to financial barriers.

However, while it is not the only important facet of achieving UHC and, as discussed, is often not the first priority in addressing access, financing for health is nonetheless a vital component of advancing systemic reforms. This section identifies **eight financing challenges** facing SADC countries across the economic development continuum and which will, both separately and together, influence how much progress can be made in advancing UHC. The

⁴⁵ Quotations and examples in Box 3.1 are taken from questionnaires completed by Commonwealth countries about their UHC processes and from the Report of the Ministerial Roundtable 1, Sustainable financing for UHC, Commonwealth Health Ministers Meeting, Geneva, 21 May 2017.

⁴⁶ WHO and the World Bank 2015

⁴⁷ Beattie et al. 2016.

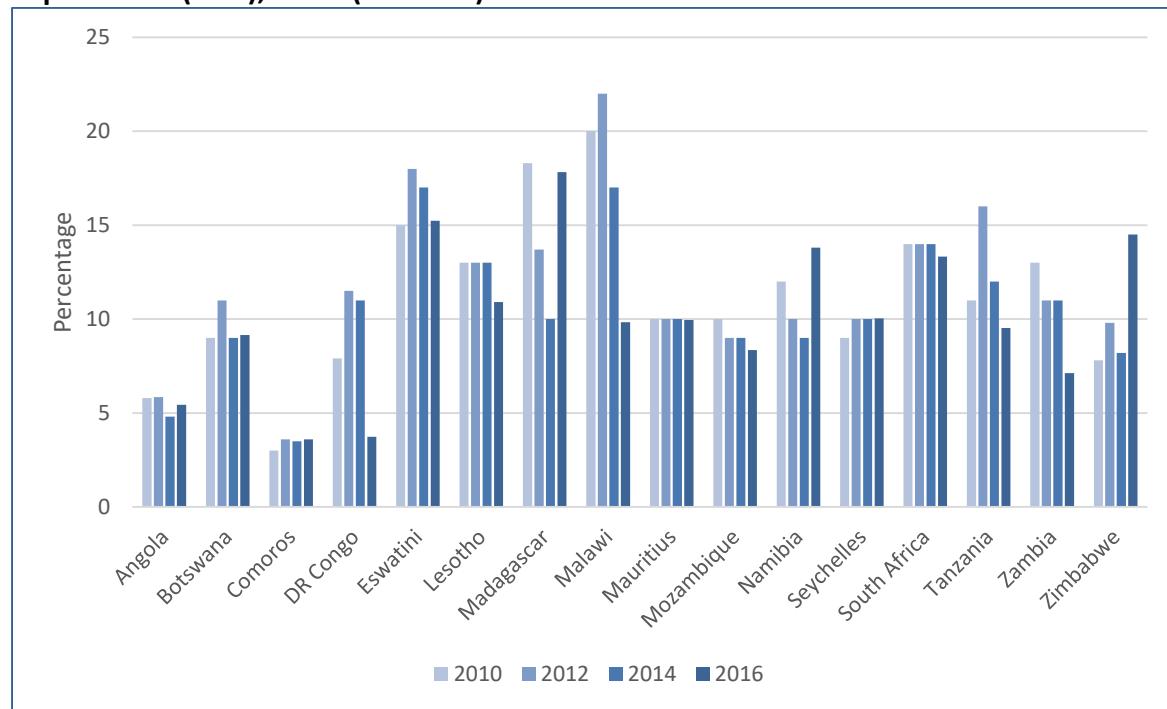
challenges identified here (far from exhaustive) reflect UHC objectives and functions, and the barriers and constraints most commonly experienced in SADC countries.

Challenge 1: Growing fiscal space

Increasing resources available for health services is – for most countries – a critical dimension of progressing towards UHC. Securing increased funding will require sustained political commitment, as well as a growing economy. However, ministers of finance also need to be convinced that increased allocations to health will be used efficiently and effectively to improve health outcomes, support economic growth and extend health networks to hard-to-reach communities. Securing increased financial commitment is thus a political action.

In fact, for many countries, the capacity to consistently maintain an upward trajectory in public health expenditure – even in the context of increasing gross domestic product (GDP) – has been uneven. Figure 4.1 shows the share of government expenditure on health as a percentage of general government expenditure over six years. The data show that government budgetary commitments to health are volatile and few countries consistently increased their health budget over the six-year period between 2010 and 2016. In fact, in many countries, the share of the government budget going to health in 2016 was the same or less than 2010 levels.

Figure 4.1 General government health expenditure (GGHE) as % of general government expenditure (GGE), WHO (2010–16)



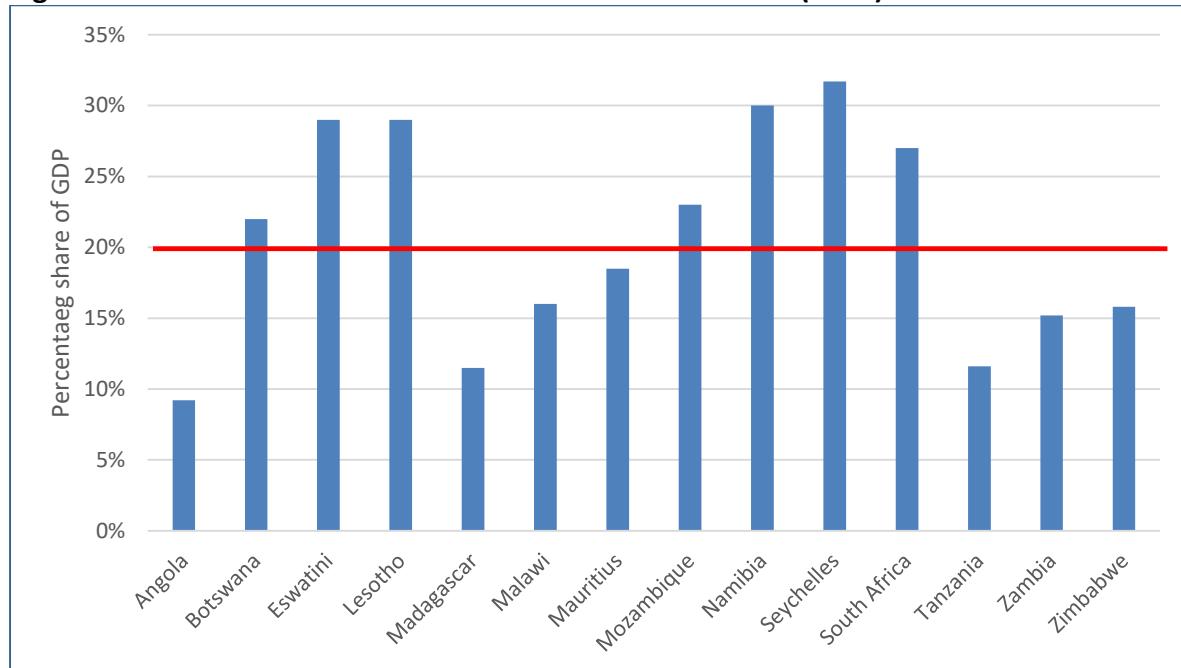
Source: WHO GEHD 2010–16 data

The amount of funding raised from taxation⁴⁸ is linked to the ability to gear up fiscal commitments to UHC. Current recommendations suggest that countries need to raise at least 20 per cent of their total GDP through taxation in order to shift towards UHC. This gives

⁴⁸ Available at: <https://ourworldindata.org/taxation/>

ministries of finance the space to afford the costs of UHC. Figure 4.2 shows the proportion of GDP currently raised through taxation in countries under consideration.

Figure 4.2 Tax revenue as a share of GDP in SADC countries (2014)

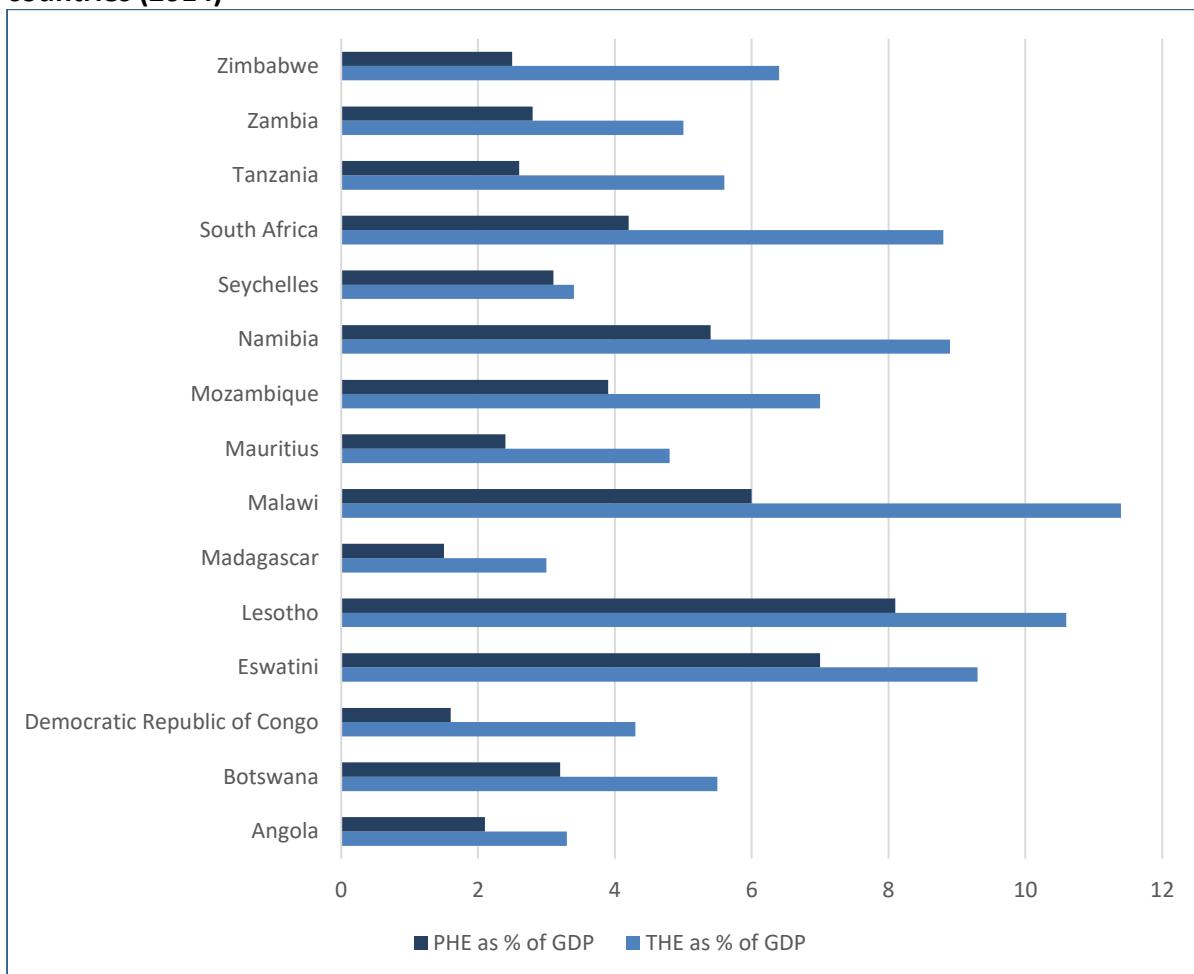


Sources: WHO GHED 2014 and the OECD 2015

Challenge 2: Raising public funds

Resources available for health come either from public mechanisms (tax funding, social insurance and external aid) or through private mechanisms such as private insurance schemes, direct out-of-pocket (OOP) payments or voluntary insurance contributions, often by or through employers. Total health expenditure (THE) calculates spending on health from all sources of financing, including public and private sources. Figure 4.3 shows total and public health spending, expressed as a percentage of GDP.

Figure 4.3 Total health expenditure (THE) and public health expenditure (PHE) in SADC countries (2014)



Source: WHO GHED 2014

The figure shows that many SADC countries still rely substantially on private funding sources to a significant degree. UHC requires predominantly public funding and it is clear that most member states are still working to secure adequate levels of public health expenditure to support UHC.

Sources of public financing

The higher public health expenditure is as a share of total health expenditure, the more control a country will have over how it can allocate resources equitably to respond to its burden of disease. Public sources of financing are compulsory and prepaid. That is, they are (or are very like) taxes and people pay them whether they use the health service or not. The main sources of public finance are shown in Table 4.1, together with common examples.

Other sources of finance are private and voluntary; payments are made because individuals – employees, private households, employers - choose to make them. They may be prepaid through a company health insurance scheme or community-based insurance plan, or they may be made out of pocket (OOP) at the point of service. OOP payments vary from co-payments required by insurance plans, direct payments for diagnostic tests, medicines or consultations, or other direct costs of healthcare paid *at the point of service*. The critical point

is the direct relationship between private (voluntary) payments and an individual's use of health services. Private financing for health usually secures only a limited pool of funds and benefits a defined group of people. There is less scope for cross-subsidy between the healthy and wealthy on the one hand and the sick and the poor on the other.

Table 4.1 Sources of public finance

Source	Description	Examples
Direct taxes	Taxes paid by households and companies on income, earnings or profits and paid directly to either the government or a public agency.	Income tax, payroll tax (including mandatory social insurance taxes), corporate taxes or capital gains.
Indirect taxes	These are taxes paid on what households or companies spend rather than on what is earned. These taxes are paid to the government indirectly via a third party. These taxes can be ear-marked to support health.	Payments to retailers or suppliers like value-added tax (VAT) or sales tax; excise taxes on the consumption of products such as alcohol and tobacco; import duties.
Non-tax revenue	Revenues from state-owned companies or enterprises; revenue from sovereign wealth funds.	Usually income from mining or other natural resources owned by the state.
Financing from external (foreign) sources	Donor or other income that flows through the treasury is classified on budget as income.	External financial aid and loans.

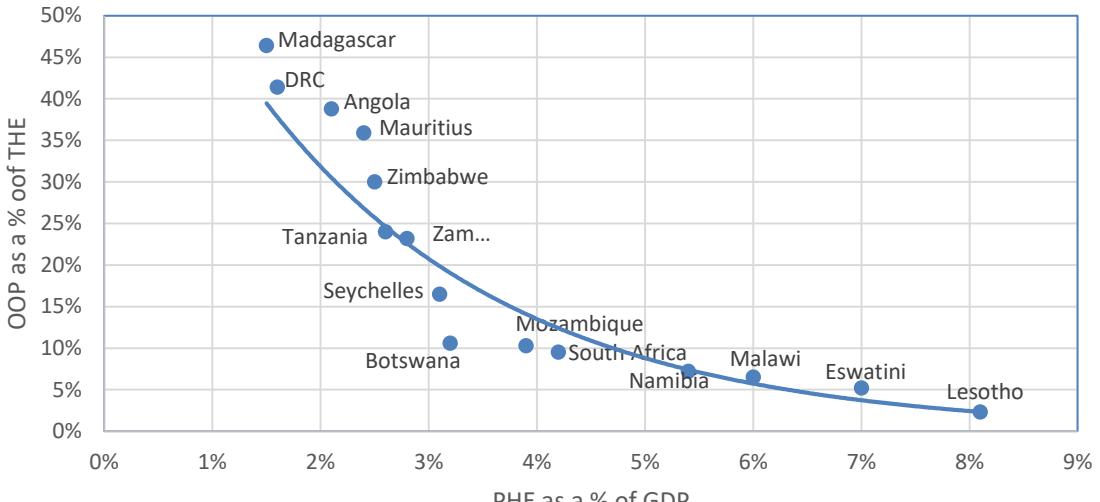
Source: Jowett, M, and J Kutzin (2015), 'Raising revenues for health in support of UHC: Strategic Issues for policy makers', Health Financing Policy Brief No. 1, WHO, Geneva.

Uncapped OOP payments for health are a regressive form of fundraising, exacerbating inequity and preventing the achievement of UHC. In its most recent UHC tracking report, the World Bank and WHO found that "...some 800 million people spend more than 10 per cent of their household budget on healthcare, and almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses".⁴⁹

Uncapped OOP payments work in direct opposition to financial protection, especially for basic health services among the poorest people. As countries increase their public health spending they can shift away from a reliance on OOP payments for health services. Figure 4.4 plots OOP expenditure and PHE as a share of GDP for SADC countries. What is evident in the figure is the clear association between increased public health expenditure with a decline in the proportion of health spending from OOP payments. Although each country has its own context, across the region, (and indeed, this graph looks similar across almost any set of countries), where public investment in health goes up, the need to spend out of pocket goes down.

⁴⁹ World Health Organization and the World Bank 2017.

Figure 4.4 OOP payments decline as public health expenditure increases (2014)



Source: WHO GHED 2014

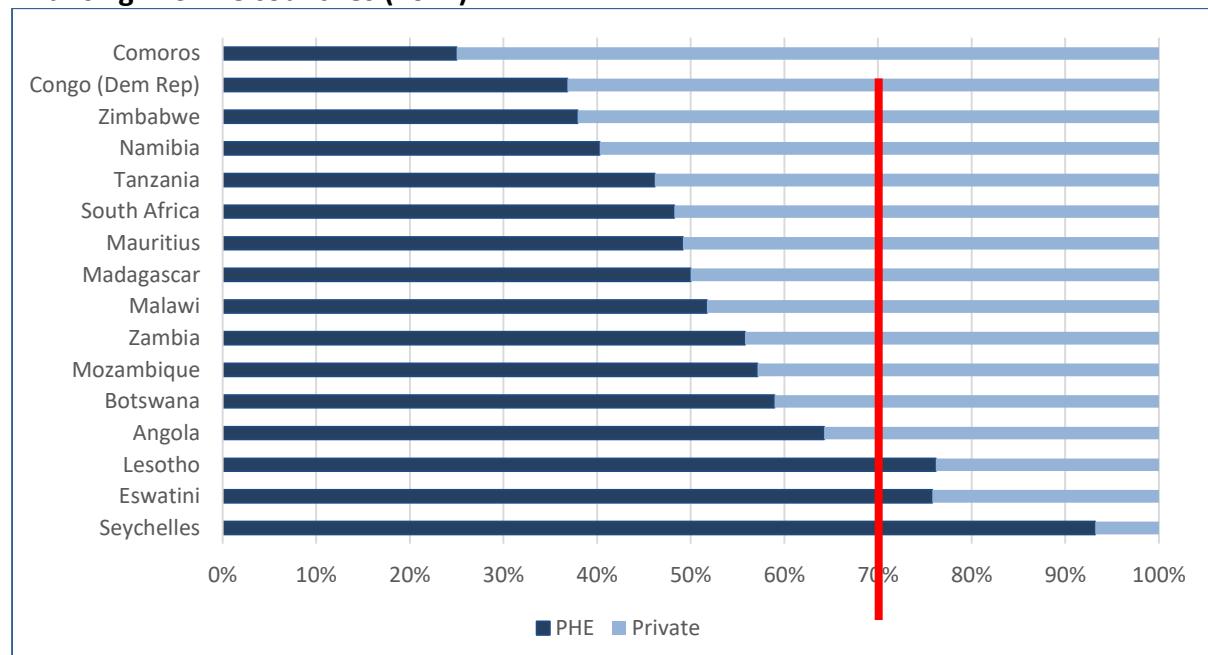
Challenge 3: Compulsory versus voluntary funding

Compulsory financing is thus the critical driver of expanding fiscal space for UHC. Countries relying on publicly funded (compulsory) financing will achieve faster progress towards UHC. Compulsory funding should be pre-paid or paid in forms that are unconnected to service utilisation. This approach allows users to access services without the need for payment at the point of use and is a critical policy to ensure the healthy and wealthy cross-subsidise the sick and the poor, a fundamental principle of UHC.

Some countries have tried to ear-mark taxes as a means to raising additional revenue specifically for health. Indeed, some countries successfully used an HIV and AIDS levy to fund the early response to the epidemic. Ear-marking public funding can make some taxes or levies more acceptable to citizens. However, there are risks and some countries (for example, Ghana) have found that over time, the ear-marked funds have been treated as fungible, not additional, and total public funding to the health sector has not continued to rise.

Figure 4.5 shows the distribution between public (compulsory) and private (voluntary) spending per capita by country. Current WHO guidance suggests that 70 to 80 per cent of THE should derive from public financing in most circumstances. This threshold is marked with a red line in the figure. Most countries rely on private financing for half or more of total health expenditure. Shifting this balance by growing the public expenditure commitment to health will be vital to making progress on UHC.

Figure 4.5 The share of per capita spending on health accounted for by public and private financing in SADC countries (2014)



Source: WHO GHED 2016

Although most health systems have some private financing, the evidence is very clear that progress towards UHC relies on expanding public financing in a steady, consistent and predictable way over a sustained period of time.⁵⁰ In addition, countries where public spending on health is less than 70–80 per cent of total health spending are more likely to have an '*increase in the number of households getting into serious financial difficulties*'.⁵¹ Most SADC countries are spending significantly less than this threshold.

Increase pooling of resources to maximise cross subsidies and reduce fragmentation

In its World Health Report of 2010 (*Health Systems Financing – The Path to Universal Coverage*), WHO said that, '*...the most effective way to deal with the financial risk of paying for health services is to share it, and the more people who share, the better the protection*'.⁵² When it comes to pooling pre-paid health resources, there is 'strength in numbers' and it is better to consolidate small risk pools into larger pools covering ever-increasing proportions of the population. Larger pools tend to be more efficient, because administration costs are spread more widely, and they make more room for cross-subsidisation.

In creating these pools (from different funding sources such as employers, ear-marked taxes, general taxation etc.), it is worth emphasising again that only publicly governed risk pools, where contributions are compulsory and progressive (related to people's ability to pay), can meet the equity requirements for UHC. Private voluntary insurance schemes are unable to achieve this outcome because they can exclude high-need people in society, while wealthier or healthier members may refuse to pay higher contributions or contribute at all if they feel less likely to use health services.

⁵⁰ Jowett and Kutzin 2015.

⁵¹ Ibid.

⁵² WHO 2010

Challenge 4: Should there be a funding target for UHC?

The question then, is, should there be a target for UHC? Figure 4.5 above suggested an association between compulsory pre-payment and diminished reliance on voluntary revenue sources and WHO recommends public finance as the basis of UHC. What, then, should countries be aiming for?

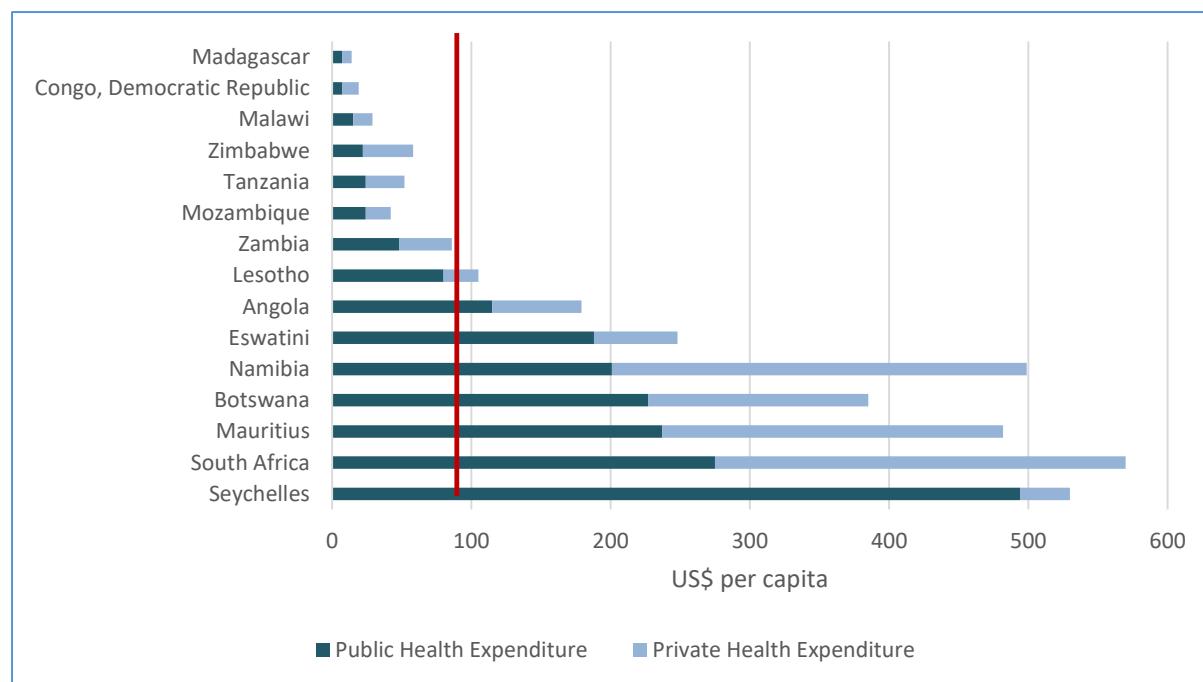
The Lancet Commission on Investing in Health (2013) suggested that countries should aim for **public** health expenditure (PHE) amounting to at least 3 per cent of GDP, but 4 per cent would still be achievable and would deliver faster progress.⁵³ Many countries spend well under the 3 per cent minimum target for public expenditure on health set out in the commission.

In 2014, Chatham House published an estimate of public financing required to achieve UHC, estimating 5 per cent of GDP.⁵⁴ However, the analysis also recognised that even at 5 per cent of GDP, for many countries this would “translate into insufficient resources to fund universal primary healthcare (PHC) services, which we estimate requires a minimum of \$86 per capita (in 2012 terms). Therefore, the target of domestic public funding for health care of at least 5% of GDP should be supplemented with a target of \$86 per capita in low-income countries”.⁵⁵

Figure 4.6 shows per capita health spending by country in current US dollars and distinguishing between public and private spending. Several SADC member states spend more than US\$86 from public funds although only four have reached 5% of GDP (Figure 4.4).

Figure 4.6 Per capita expenditure on health by country distinguishing between public and private financing in current US\$ (2014)

Source: WHO GHED 2014



Source: WHO GHED 2014

⁵³ Lancet Commission on Investing in Health 2013.

⁵⁴ McIntyre and Meheus 2014.

⁵⁵ Ibid.

Although WHO refers to the 5 per cent of GDP as a benchmark (or 6 per cent in some contexts),⁵⁶ it is also clear that progress towards UHC can still be made below this level.⁵⁷ Indeed, looking again at Figures 2.2 and 3.2 above, the evidence is clear that some countries use their resources better or more effectively to achieve equitable health outcomes. As the evidence suggests, they tend to do this by arranging health services to prioritise high-burden health conditions, making services accessible to the poorest, boosting efficiency through reducing the costs of medicines, commodities and diagnostic services, and investing in health worker training, quality and management (among other strategies).⁵⁸

Challenge 5: More health for the money

Getting more health for the money is a critical part of the UHC process. In many countries, regardless of income or health system, the delivery of basic services suffers from inefficiencies and poor targeting. As one analysis recently estimated:

For every US\$100 that goes into state coffers ... on average US\$16 is allocated to health, only US\$10 is in effect spent, and less than US\$4 goes to the right health services. This failure to ensure that public financial resources reach the health services that need them has undoubtedly had a negative impact on health sector results ... compromising efforts to achieve equity in both financial protection and service coverage.⁵⁹

For example, while there is a clear association between child mortality and per capita public expenditure on health, Figure 4.7 also shows that there are outliers – countries that do better (or worse) than expected – and this can be attributed to a range of factors, including better targeting of scarce resources, improved spending and effective financial management in addition to other more health systems-related explanations (prevention programmes, efficiently sourced and distributed medicines, trained staff etc.).

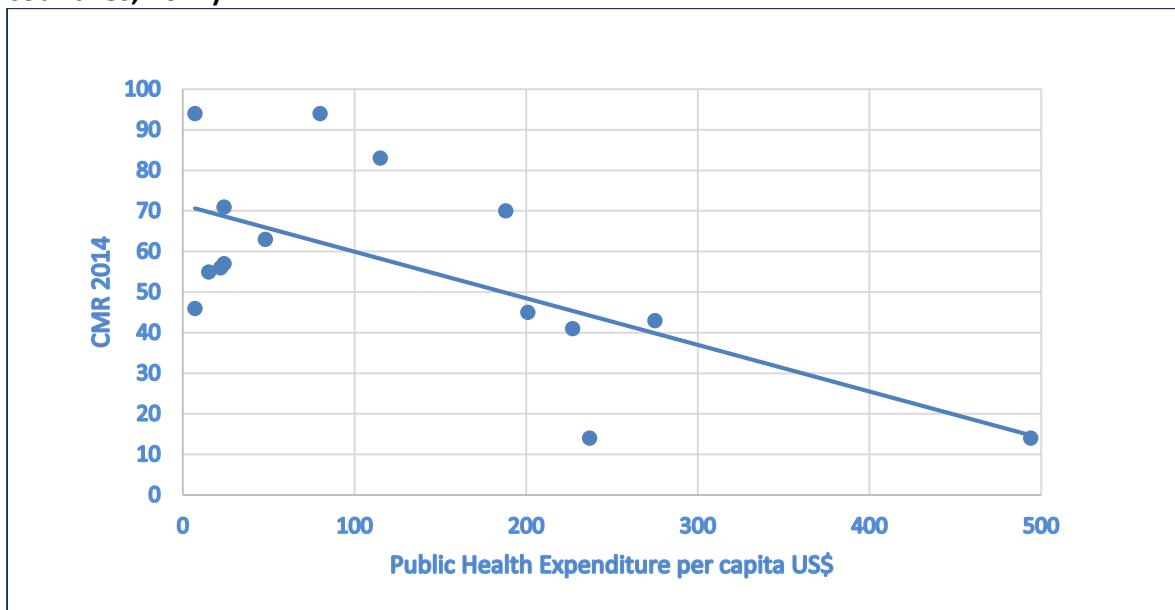
⁵⁶ WHO Regional Committee for the Americas 2014.

⁵⁷ Jowett et al. 2016.

⁵⁸ For example, see WHO and the World Bank 2017, 14; and PMNCH (no date) examining how countries successfully addressed RMNCAH challenges.

⁵⁹ WHO, Health Financing Working Group 2016.

Figure 4.7 Child mortality distributed by per capita public health expenditure in US\$ (SADC countries, 2017)



Source WHO GHED 2014.

Strengthen priority-setting processes to optimise the use of available funds

Decisions about what services will be covered by UHC schemes have technical components (for example, identifying cost-effectiveness, value for money, and health impacts for individuals and populations), and they have very strong links to equity (in access and outcomes). However, many countries have found that the *politics* of priority setting are equally important and potentially controversial. It can be difficult for politicians and policy-makers *not* to respond to interest groups and the (increasing) demands of wealthier (middle-class) populations, especially in urban areas, who tend to want specialist care in new hospitals, whereas the burden of disease in a country may still include a large share of preventable morbidity and mortality underpinned by poverty.

Countries have started strengthening priority setting to address NCDs, for example. These efforts are underpinned by a recognition that prevention is vital if NCDs are to be controlled. Many countries have taken proactive steps to shift resources and efforts to preventive care. For example, in Seychelles, '*the declaration of Universal Health Care was inspired by the principles adopted as the Health for All movement, emphasising primary health care and for the first two decades were characterized by rapid expansion of community health services providing a comprehensive range of health services. At the same time, secondary care, based primarily at and around the Seychelles Hospital, developed at a steady pace*'. In Namibia, an explicit package of care based on around 80 interventions has enabled prioritisation of services, including prevention, detection and management of common NCDs.

Without a transparent process, '*cost-effective health interventions are often the opportunity cost of that response when priorities are not explicitly set*', leading to sub-optimal use of resources for health.⁶⁰ Without independent or at least transparent priority-setting processes, the risk is that priorities are set by individuals responding to their own preferences or pressure from interest groups, lobbies or more powerful groups in society, rather than as a

⁶⁰ Glassman and Chalkidou 2012.

result of evidence about what produces the best health results for the whole population, especially the poorest. South Africa has started to develop a national priority-setting body that aims to recommend investments based on evidence gathered through health technology assessments to support the roll-out of UHC⁶¹.

The inequitable use of resources to fund health services

Where public funds are used disproportionately to fund low-priority services, countries miss the opportunity to broaden benefits and include the poorest. They also tend to miss out on maximising health outcomes given the resources available. *Priority setting* is the process of deciding what health services should be covered under UHC, and who should benefit and when. Priority setting is an inherently political process and is almost always controversial, since it leads to choices about who in society will benefit from public resources (and therefore, also, who will not). However, where countries engage in sound and transparent cost-effectiveness analysis to reallocate available health funding to equity-enhancing health interventions, many more lives can be saved, and the total amount of health purchased with public resources can increase.⁶²

Priority-setting processes need to ensure that the package of benefits addresses the main conditions affecting the poorest people. The main causes of impoverishment should also be covered, such as repeated prescriptions to treat or manage non-communicable diseases (NCDs) over time. This approach is especially important for children's well-being. All too often, an adult family member, perhaps even the main breadwinner, has health needs such as diabetes or heart disease, that require household expenditure to such a degree that children are taken out of school to save money or because their labour is needed to support the family. Thinking about the well-being of children, therefore, means thinking about the well-being of the household as well.

Challenge 6: Tackling financial drivers of exclusion

In its seminal 2010 report on financing for UHC,⁶³ the WHO referenced three inter-related barriers to progress commonly experienced by countries. These were: (i) the availability of resources; (ii) the overreliance on direct payments at the time people use services; and (iii) the inequitable use of resources to fund health services. This section briefly considers experience and progress in SADC countries against these impediments and looks at other barriers that result in some individuals or groups being 'left behind'. The data are drawn from globally available data, but specific examples from individual and smaller subsets of countries are shown to assess particular groups of unreacheds (urban/rural, migrant, unemployed, gender and others).

Raising sufficient funds to reach everyone: incremental growth

Until very recently (and still in many settings), more women and children died from preventable causes than any other groups. Significant progress has been made since 1990 to reduce mortality among the most vulnerable (see Figure 2.1). However, more effort, resources and services are needed if preventable mortality is to be eliminated and although preventive and primary care is highly cost-effective, sufficient funds are needed to expand

⁶¹ PRICELESS SA University of the Witwatersrand, South Africa <https://pricelesssa.ac.za/about/who-we-are>

⁶² Chalkidou, K and A Glassman (2016), 'Priority setting for achieving UHC', *Bulletin of the World Health Organization*, 94, 462-467; doi available at: <http://dx.doi.org/10.2471/BLT.15.155721>.

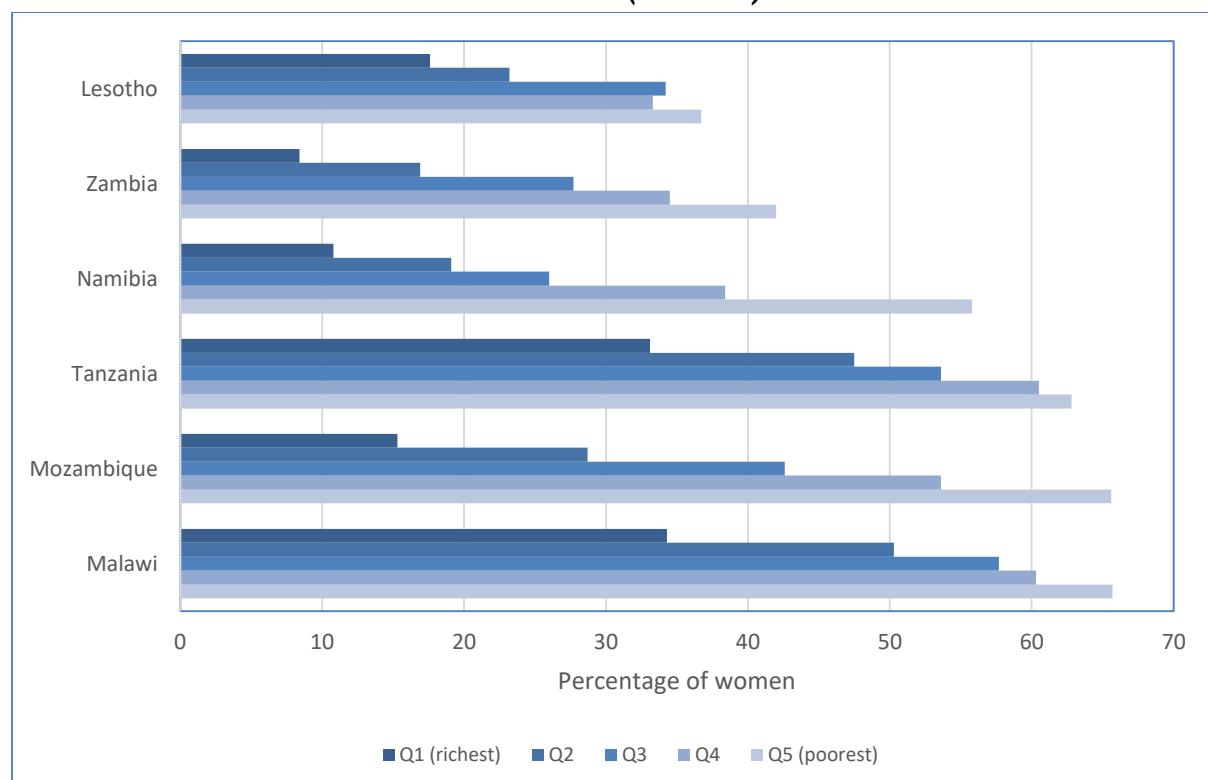
⁶³ WHO (2010), *The World Health Report, Health Systems Financing: the Path to Universal Coverage*, Geneva.

services to geographically remote or, conversely, high density areas, to improve quality and to meet basic needs. UHC systems are largely funded from tax revenues collected through a variety of mechanisms including income tax, value added tax on goods and services, corporation taxes, customs and excise taxes and others. Public funds supplemented by direct employer and/ or employee contributions are then used to fund health services with payments by the government made on behalf of the poorest.

An overreliance on direct payments at the time people use services

The second major barrier to UHC is the overreliance on direct payments at the point of care. The impact of these payments (both official and illicit) is to defer and delay access to services while funds are found, increasing the poverty of the poorest people at a time when they are most vulnerable.⁶⁴ As identified in Figure 1.1, there are three dimensions to UHC (enabling everyone in need to access essential health services without causing financial hardship). Payments made at the point of care target and ‘penalise’ the sick, hitting those worst-off the hardest. They are a major driver of exclusion. For example, among women in a selection of SADC and other countries who were asked what deterred them from accessing health services, the need to find resources was the most significant obstacle, especially for those in the lowest wealth quintile (Figure 4.8).

Figure 4.8 Problems in accessing healthcare: getting money for treatment, % of women in SADC countries where data exists (2013-16)



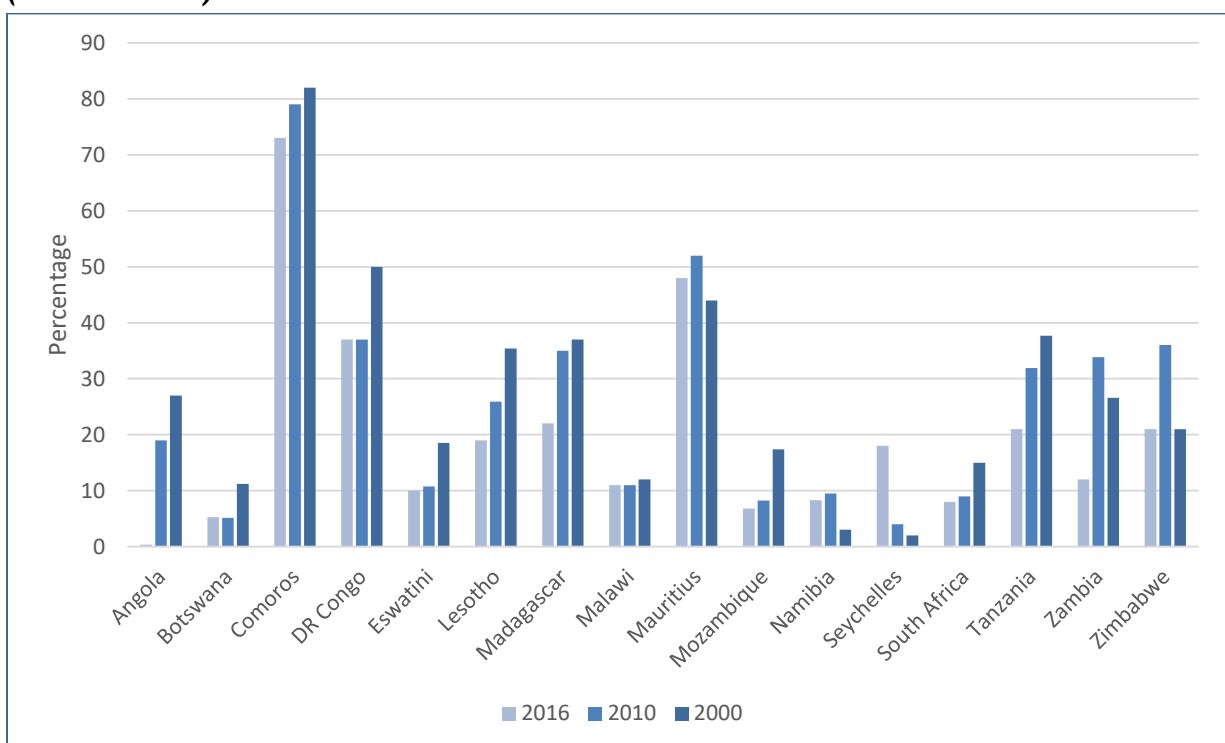
Source: World Bank Data Bank (accessed 8 April 2019)

Out-of-pocket spending is one of the main drivers of exclusion from services. Across SADC countries on the whole, the proportion of out-of-pocket spending on health has been falling since 2000 (Figure 4.9), although it remains very high in a large proportion of countries.

⁶⁴ Qin VM, T Hone, C Millett et al. (2019), ‘The impact of user charges on health outcomes in low- income and middle-income countries: a systematic review’, *BMJ Global Health*, 3, e001087.

The consequences of not having sufficient funds to pay for care can act as a short-term barrier to access and also, in the longer term, reduce trust or confidence in services across the whole community. In both cases, by failing to reach those most in need, the health system is excluding people and effectively leaving them behind. For example, there are currently many examples of hospitals that apparently forcibly detain women (and others) who cannot pay for their care. This is especially the case where there were unforeseen complications and the costs of saving women's lives at birth are being recouped from families.⁶⁵ This practice is the antithesis of universal coverage and is not only a violation of human rights, but also an effective deterrent to others who may have need of life-saving care.⁶⁶

**Figure 4.9 Out-of-pocket spending on health (% of total health spending)
(2000 to 2015)**



Source: World Bank Data Bank

Countries should aim to shift from user fees and other payments made at the time of seeking care to prepayment systems that collect contributions through public revenue collection systems based on principles of equity and progressive taxation approaches. User fee abolition should target high-priority services first to ensure the greatest health impacts are achieved.

⁶⁵ Devakumar, D and R Yates (2016), 'Medical Hostages: Detention of Women and Babies in Hospitals', *Health and Human Rights Journal*, Vol. 18 No. 1, June.

⁶⁶ For example, stories have appeared about forced detention specifically linked to a failure to pay for childbirth care, referencing several countries, some in the SADC countries.

Box 4.1 Leaving no one behind - recent progress from selected SADC and ECSA-HC countries

Lesotho: Taking a primary health care approach, Lesotho has worked with partners to develop an approach to broadening utilization by strengthening health systems and improving health facility performance. The UHC Monitoring and Planning Tool (<https://www.PIH.org/practitioner-resource/universal-health-coverage-monitoring-planning-tool>). The tool helps to address supply-side (provision of care) rather than demand side barriers, aligning staff, drugs, supplies and infrastructure with burden of disease. Utilisation has increased significantly in some districts (for example, in Mohale's Hoek District, facility-based deliveries increased from 7s in 2013 to 1,742 in 2015). ([https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(19\)30035-X/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30035-X/fulltext))

South Africa: In common with other countries undertaking national-scale, politically difficult health reforms, South Africa has established a “war room” in the office of the President to oversee and push forward an ambitious strategy to unify and integrate the health system in what is currently a fragmented and highly exclusive system. The National Health Insurance bill, to be put before parliament, outlines proposals to undertake critical reforms that would see health care delivered free at the point of use in all public and accredited private health facilities, expanding access to the poorest in ways that are currently not available to most. The model will be based on a primary health care approach. (<https://citizen.co.za/news/south-africa/government/2082015/govt-working-to-bring-quality-healthcare-to-all-motsoaledi/>) and <https://www.reuters.com/article/us-safrica-health/south-africa-to-roll-out-sweeping-health-reform-in-stages-idUSKCN1VD0UA>

Challenge 7: Strengthening the health system to tackle exclusion

Addressing the financing barriers identified above (increasing the fair collection of resources, boosting transparency about use of public money, and reducing or eliminating payments at the point of care) are all important dimensions in reaching the unreached. However, crucial as they are, they may not be sufficient to ensure that UHC reaches all. Other barriers also exist. While too numerous to fully review here, this section illustrates the impact of non-financial barriers or systems drivers laid out in Table 3.1 on excluding people from accessing health services and how targeting investments in expanding access and inclusion can reduce barriers to UHC.

Avoiding administrative and “entitlement” gaps

One of the most common ways for UHC systems to fail instead of succeed is through the use of ‘entitlements’ that are administered through complex systems such as identity cards most commonly associated with social health insurance systems. The idea of entitlement can be a powerful tool in the UHC process, guaranteeing access to services for people, sometimes for the first time ever. Many UHC systems use cards or other administrative processes to identify who can have access and, again, this protects and defends the access to much-needed services for those with the right documentation. A national health card or a health insurance identity card or some other identifying system separates those who are entitled from those who are not. However, in many contexts this kind of system creates additional barriers rather than supporting inclusion.

Administratively complex UHC systems that require that every entitled person has ‘paperwork’ to prove their entitlement creates significant barriers, are expensive to administer and can seriously interfere with the UHC principle of cross subsidy and thus universality. Many people are unwilling or unable to participate in the process of health card enrolment. They may have no identity documents. They may face language, cultural, social or other barriers that prevent them from understanding the need for the card or how to obtain one. Furthermore, where the number of health cards (or people with acknowledged entitlement) becomes a factor in determining regional or sub-national budgets for health, entitlements need rules regarding mobility, so that where people are away from their usual home (for example, to work), their entitlements are protected.

Thus, while for some people, having specific entitlements protects access to services or creates access for the first time, for others, the lack of a card (and the administrative process attached to that) can become as much or more of a barrier to health services as any other obstacle. It becomes a mechanism by which large numbers of the population are left behind.

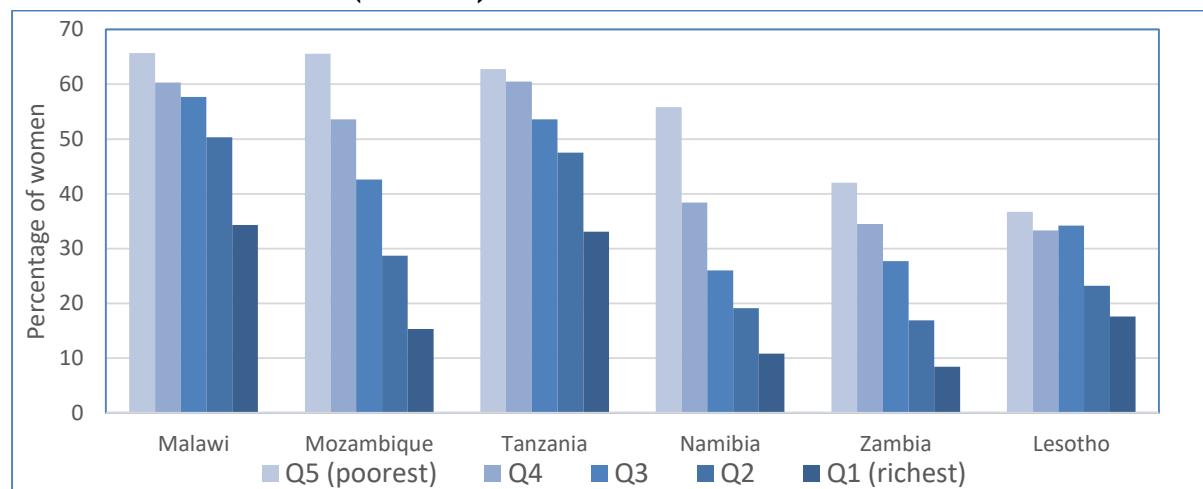
Entitlement mechanisms are also expensive to set up and administer: the staff, equipment and services (issuing cards, replacing lost cards, managing entitlement disputes) become a cost associated with delivering UHC. If this system does not work fairly, or efficiently, the health card can become another layer of exclusion. For example, cards have to be issued across the whole geography of a country, not just once but regularly. In some countries, there are insufficient frontline health workers in some areas to establish an administrative system and this risks prioritising state bureaucracy over healthcare delivery.

Poorly designed and implemented schemes that rely on defined entitlements – rather than access to a broad range of services – can thus create barriers for people and impede universal approaches. Those most often affected are the poorest, the most vulnerable and marginalised, rural dwellers, slum dwellers, undocumented migrants and others. For example, adolescents may not be entitled to a card of their own and may be inadvertently excluded if they require their parents’ permission (and card) to attend for reproductive health services.

Increasing geographic access to services

Geographic barriers are common in most countries and may affect access to services by some of the population. To ensure no one is left behind, UHC systems need to invest in expanding access to basic services for all the population. Figure 4.10 shows how, in a sample of SADC countries, women’s access to health services is affected by distance or geography. The degree to which distance acts as an impediment worsens by wealth quintile. Among all countries for which data are available, the poorest people face greater obstacles in accessing services by virtue of distance.

Figure 4.10 Problems in accessing healthcare: distance from facility, % of women in selected SADC countries (2013-16)

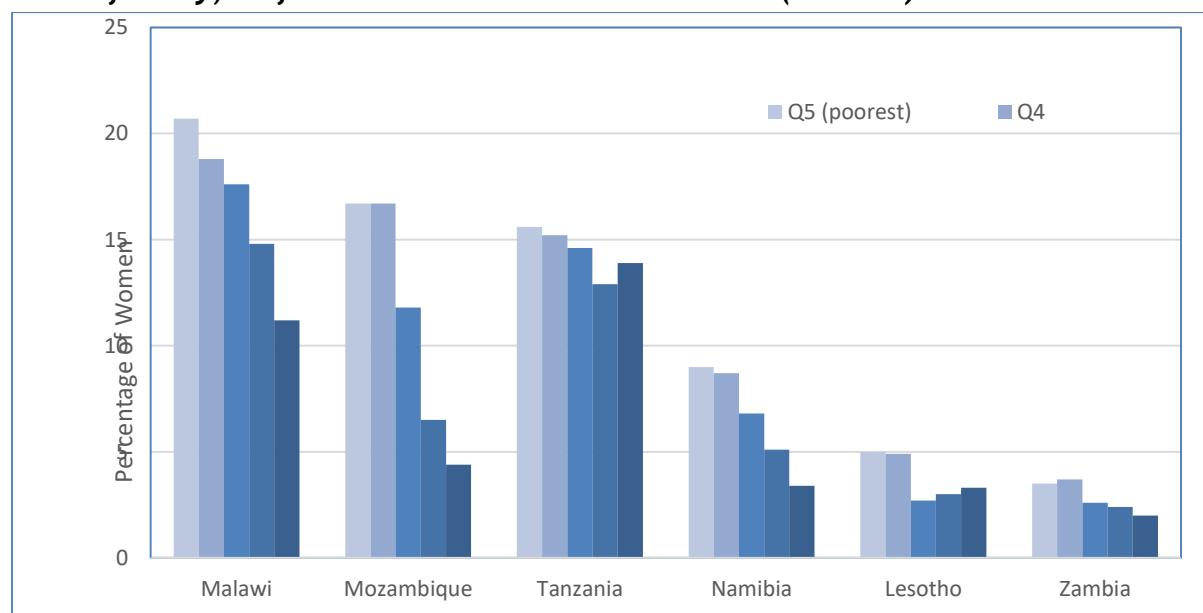


Source: World Bank Data Bank (accessed 8 April 2019)

Expanding social inclusion

Social and cultural barriers, gender discrimination and other barriers affect access to health in a number of ways and can lead to exclusion. Using available data from SADC countries, Figure 4.11 shows the percentage of women (by wealth quintile) who said they had challenges accessing health services because they needed permission (for example, to leave the home). For these women, the decision to seek care lay with someone else in the household (often a husband or mother-in-law). In some settings, there was little distinction among wealth groups although in most, the poorest women (usually the least educated) were more affected by the need to seek permission.

Figure 4.11 Problems in accessing healthcare: Getting permission to attend the health facility, % of women in selected SADC countries (2013-16)



Source: World Bank Data Bank (accessed 8 April 2019)

Challenge 8: Adopting a primary health care approach

The first political agreement to promote the primary health care (PHC) approach was more than 40 years ago, in 1978. The Declaration of Alma-Ata reflected a collective view that the best way to reach people was through the primary health approach, based on five key interrelated principles: accessibility (equal distribution irrespective of race, creed or economic status); health promotion (improving understanding of the determinants of health); appropriate technology (low cost, adaptable, scientifically sound); intersectoral collaboration (with agriculture, education and other sectors); and community participation (engagement of people in their own health).

These basic principles have not changed and despite the failure to fully implement the PHC approach, health leaders have renewed their intention to expand their efforts. The Declaration of Astana,⁶⁷ agreed in 2018, reaffirms a commitment to the fundamental right of every person to enjoy the highest attainable standard of health ‘without distinction of any kind and to the values and principles of justice and solidarity, underlining the important of health for peace, security and socio-economic development’.⁶⁸

‘At its core, the Declaration of Astana urges a redoubling of effort toward developing primary health care as a pillar of effective health systems, labelling it “*the most inclusive, effective, and efficient approach to enhance people’s physical and mental health as well as social well-being.*”³ The declaration envisions a world where we live in health-conducive environments, implying that these are to be achieved through the ‘*bold political choices for health across all sectors*’ that lead towards sustainable primary health care.’⁶⁹

Primary health care has a strong focus on fairness, equity, reaching everyone, being adaptable and responsive even in times of complexity, focusing on prevention, promotion, individual and community empowerment, and managing risk factors. UHC will be advanced more effectively and efficiently with a fully functional and well-delivered PHC approach at its centre.

- Primary health care helps to reduce household expenditure on health by addressing the underlying determinants of health;
- PHC emphasis population services to prevent illness and promote well-being at the community level, which is vital in order to prevent escalation of illness (and the associated increased costs of treating it);
- Community engagement in local health services builds participation, promotes locally appropriate services, increases satisfaction with services, and acts to increase accountability; and

⁶⁷ World Health Organization, United Nations Children’s Fund (2018), Declaration of Astana, Geneva, available at: <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>

⁶⁸ World Health Organization (2018b), *Universal Health Coverage: Primary health care towards universal health coverage*, report by the Director General, WHO Executive Board, 144th Session (ED144/12), Geneva, December.

⁶⁹ See: Galea and Kruk (2019).

- Health systems based on primary care ‘that is first-contact, continuous, comprehensive, co-ordinated and people-centred have better health outcomes’.⁷⁰

While PHC is a well-established idea, it has been challenging to implement in all settings. Yet, the current focus on UHC is an excellent opportunity to reinvigorate PHC efforts. Reaching all people with cost-effective, high-priority services is fundamental to universalism. Addressing the drivers of health and the determinants of vulnerability is essential to affordability of services in the longer term. Community engagement around locally appropriate, good-quality services is the most effective way to reach the most vulnerable or marginalised people.

Section 6: Conclusions, recommendations and next steps

As SADC countries gear up their efforts to expand health services for all in the context of UHC, there are many choices that need to be made, experiences to gain and lessons to learn. Starting out on the right track by using available evidence to guide design and implementation can help reduce politically and financially costly mistakes.

6.1 Conclusions

The key messages emerging from this brief review of some of the main financing questions associated with UHC are:

- All countries can make progress towards UHC, whatever their current situation or financing arrangements;
- No country has achieved UHC without relying primarily on public financing;
- Public financing comes from compulsory, pre-paid sources such as direct and indirect taxes, rather than voluntary, private sources;
- While there is no clear spending target associated with successfully achieving UHC, most countries will have to commit at least 5 per cent of their GDP on public health financing and, in the poorest countries, at least US\$86 per capita;
- As countries increase their commitment to public financing, reliance on out-of-pocket (OOP) payments declines, strengthening equity and improving financial protection, one of the main aims of UHC;
- Expanded access to services by the poorest will require public funds and cross-subsidies from the rich and healthy to support those who are poor or sick. Therefore, UHC systems should aim to build the largest funding pools possible;
- An approach to UHC that prioritises inclusion from the start is a sound basis for UHC decision-making and can ensure that the poorest are not punished for being unable to pay for basic and life-saving healthcare;
- Priority setting is a political process, although the capacity to distribute and spend funds across the whole health system, especially at the periphery, often leads to spending in favour of urban, hospital-based care (in many countries, public expenditure systems don’t work efficiently);
- Furthermore, although priority setting should be guided by need, it is often strongly influenced by other political priorities and by the reality that wealthier populations are

⁷⁰ See: World Health Organization (2018b).

concentrated in urban centres – which often leads to de facto focus on urban, hospital-based care; Priority setting for health should instead be undertaken in an open and transparent way based on health technology assessments, cost-effectiveness analyses and other impartial mechanisms for identifying how to maximise the impact of limited resources on health across a whole population;

- Reducing disease incidence and preventing sickness boosts household well-being and supports economic growth, preventing a slide into poverty by millions of people. It is thus crucial to ensure that UHC efforts include sufficient investments in public health, health promotion and prevention and environmental health, and are not just focused on curative health services;
- Countries should thus improve financial management to spend all available resources as efficiently as possible.
- UHC approaches should ensure that in designing systems that promote entitlement (health cards etc.), they do not inadvertently erect additional barriers for the vulnerable and marginalised thereby increasing rather decreasing the number of people left behind.

6.2 Recommendations

Based on the key messages, and on the idea that all countries can make progress irrespective of their economic context, the following recommendations are aimed at making practical advances towards UHC. Among the most important of these are:

- **Recommendation 1: Promote the discussion of UHC at the political level**, particularly in parliament or among political leaders and cross-party fora. Aiming to achieve UHC is a political decision and the first crucial step is to make concrete political (and public) commitments to its advancement.
- **Recommendation 2: Develop an explicit national understanding of and commitment to leaving no one behind**
As countries develop an overarching concept of UHC that is right for their circumstances, they should include a comprehensive understanding of what it means to leave no one behind and set out explicit commitments to ensuring equity and inclusion as they advance UHC.
- **Recommendation 3: Identify what services are already ‘universal’ and start building on these.** Most countries already offer some services to everyone. Typically, these include disease control-related services such as immunisation, the treatment of tuberculosis (TB), and prevention services, health promotion and public health services. In some countries, some demographic groups have more free access (under 5s, over 65s) or certain treatments (such as for some kinds of cancer) may be available to everyone.
- **Recommendation 4: Focus on the ‘universal’ part of UHC.** Countries should ensure that right from the start, all people have genuine and meaningful **access to a core set of high-priority services** irrespective of their geography, demographic profile, socio-economic status or legal status in the country. The most successful countries reach everyone with a limited range of services and then build up the package of care to be covered. Reaching everyone is vital to achieving UHC and requires overcoming barriers to access which may not be related to health facility infrastructure or fees for services.

They may be linked to cultural, language, geographic, social or gender-related issues. Invest in **data monitoring and tracking**. To measure progress and address lagging performance, it is vital to understand who has access to what services.

- **Recommendation 5: Invest in measuring and understanding equity needs**

Active operational research is helpful to understanding the dimensions of exclusion that operate in different contexts. Once the unreached or excluded have been identified, and the mechanisms or reasons why they are excluded identified, countries can begin to **develop policies that address exclusion and promote inclusion**.

- **Recommendation 6: Ensure that entitlement arrangements do not deepen inequity and exclusion**

Countries should design administrative arrangements and entitlement systems carefully to ensure they do not exclude those who are already marginalised.

- **Recommendation 7: Develop a national health financing plan** to map out existing and future health resource mobilisation. The plan should focus on domestic resource mobilisation strategies from public funds and other sources in line with the parameters set out in this paper, strategies to decrease or remove out-of-pocket payments, and approaches to ensuring that available funds are pooled to fund the health costs of the entire population and not a select few.

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