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April 2012

Oren Ahoobim, Dan Altman,
Laurie Garrett, Vicky Hausman,
and Yanzhong Huang

The New Global Health Agenda

Universal Health Coverage

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April 2012

Preface

Laurie Garrett

The tremendous escalation between 1990 and 2008 in international support for global health programs spawned a massive increase in medical and public health services throughout poor countries. In middle-income countries, especially Brazil, Russia, India, and China (the BRICs), the commensurate rise in chronic, noncommunicable diseases (NCDs), and continuing concerns over infectious scourges have coincided with this new era for global health. Combined, the largely infectious diseases–focused global health initiatives and rising demand for chronic disease and traumatic injuries management have placed a tremendous burden on health systems all over the world.

The surge in funding and interest, largely propelled by the expanding HIV pandemic, led to rapid proliferation of medical and public health programs, fragmentation and competition among them, and disorder. The explosion in both health initiatives and basic medical services occurred all over the world, but particularly in sub-Saharan Africa, Southeast Asia, and eastern Europe. As donor-financed programs expanded in those regions, most of Latin America and the BRICs made heavy domestic investments in their health systems, growing both the services they provided and public demand for both basic and secondary health care.¹

These extraordinary increases in provision and demand for health care sharpened focus on three bottom-line needs all of these countries—and many wealthy nations—share:

- health financing schemes that cover the costs of care without putting health consumers, governments, or providers at risk of bankruptcy or severe economic hardship
- systems of health-care delivery that can absorb the many now-fragmented services and provide accessible treatment and prevention universally to those in need

- a health-care workforce worldwide that should be at a minimum five million persons larger than it is currently, that displays a deeper range of skills, and that features greater attention to health management and community-based caregivers²

All three issues rose in urgency with the financial collapse of 2008, subsequent recession, and resulting declines in donor support for global health programs.³ Donor states have sought ways to spend less money while managing to save the same number of, or more, lives.⁴ Health services have been consolidated, especially by the U.S. government under its Global Health Initiative. The World Health Organization (WHO) and its multilateral partner agencies have sought to bring new emphasis to strengthening health systems. Great rhetorical emphasis has been given to moving the global health mission toward sustainability. Across the board, donors and multilateral players are now searching for ways to build systems of public health and medical care in poor and middle-income countries that can eventually survive without external support.⁵ That goal can only be attained if all three of the above-stated needs are met.

Critical to appreciating the promise, and limitations, of universal health coverage (UHC) is recognition of what is not included in the concept: access to quality health care and health personnel. UHC schemes, whether provided entirely by government or in combination with private sector insurance, aim to ensure that all citizens have access to payment plans that cover some, or all, of their health-care costs. It is possible for UHC to exist in a society, yet leave the citizens without quality health care due to lack of a health systems infrastructure, or to the absence of adequate numbers of skilled personnel.⁶ A society may, for example, feature payment schemes that allow pregnant women fully covered obstetric and gynecological services, including postnatal and infant care. Yet those women and their babies may remain at unacceptably high risk of dying during pregnancy or delivery because medical services are not regionally distributed, staffing is not provided on a 24/7 basis, and facilities are poorly supplied and unhygienic. In such cases, availability of UHC may prevent untoward medical costs but will not save lives.

Conversely, in both rich and poor countries, various forms of medical and public health services exist in the public and private sectors, but accessing care is prohibitively costly to patients and families.⁷ Pregnant

women, for example, may reside in proximity to a medical facility but never use its services for obstetric, gynecological, or pediatric care due to family poverty, lack of medical insurance, or corruption within the medical system that imposes additional costs.⁸ The mother or baby may die for lack of health care, purely for want of sufficient financial resources to allow access to available services.

A final case, often seen in sub-Saharan Africa, is one in which health-care facilities are in place and coverage is provided through a variety of financing schemes, but clinics are staffed by grossly under-trained personnel and lack even rudimentary medical supplies.⁹ In this scenario, the mother and baby may die, despite having affordable access to care, because the health providers were incompetent or inadequately supplied.¹⁰

No substantial, sustainable improvements in the health of billions of human beings can be realized anywhere in the world unless all three issues—coverage, care, and quality personnel/supplies—are dealt with.¹¹ Though the issues obviously overlap, they are ideally tackled separately; model strategies for poverty avoidance due to out-of-pocket payments for health care are not the same as best policies for training and retaining health-care workers, or for improving the quality of health delivery.

As Yanzhong Huang describes in the introduction of this report, the momentum in favor of UHC is building, especially in emerging-market economies. Though the immediate beneficiaries of such programs are likely to reside in strong-market economies, such as those of Brazil, Chile, and China, the impetus for this twenty-first-century shift in global health priorities was the disease initiatives that targeted extremely poor countries.¹² Implicit in programs providing HIV treatment in sub-Saharan Africa, malaria care in Southeast Asia, and tuberculosis cures in Latin America is free care to those in need, or financing schemes that minimize the economic burden on patients and their families. As these programs shift from external donor schemes to incorporation within national health care, states have maintained their unique coverage principles. In some cases this has highlighted injustice in medical systems, as individuals with HIV, TB, or malaria are fully covered for access to lifesaving medicines, while within the same systems and clinics patients suffering from cancer, heart disease, traumatic injuries, and even other infectious diseases are denied full care without large out-of-pocket payments.¹³

The United Nations' Millennium Development Goals feature several health targets, attainment of which requires innovative health financing.¹⁴ The goal of vastly reducing maternal mortality rates, for example, largely depends on availability of affordable emergency obstetric services. Many poor countries have experimented with voucher systems, providing coupons to pregnant women redeemable for prenatal, delivery, and antenatal services.¹⁵ In the long run, however, such narrowly targeted coverage programs are not sustainable as they place full cost burden on the state or external donors. As Oren Ahoobim, Daniel Altman, and Vicky Hausman explain in this report, a key to sustainability is insurance pooling, which spreads costs over a broad swath of society, mixing the needs and expenses of the very sick with those of the youthful and well.

Increasingly, the global community is embracing noncommunicable disease concerns, especially those that present chronic or lifelong care needs: cancer, diabetes, cardiovascular diseases, hormonal disorders, and autoimmune diseases. The NCD challenge presents a direct threat to health financing schemes in all countries, rich and poor alike. Costs of appropriate management of chronic NCDs are exponentially greater than those presented by infectious diseases, maternal health, and primary care issues. In countries with West European-style single-payer systems of financing, the burden of cost and threat of bankruptcy falls on the state. Most nations lack single-payer health systems, or have such financing schemes in place in theory but lack sufficient resources to make them practical realities. The vast majority of the world's NCD patient population is seen by private health providers, paid for directly out of pocket by the patient or in combination with patient/insurer/government financing.¹⁶ As most nations age demographically, the cost burden of NCD management soars—for states and for individuals, their insurance providers, and in some societies, their employers.

The inability to pay for medicines and treatment constitutes a grave threat to patients and families worldwide.¹⁷ In many societies, the out-of-pocket costs of care constitute existential threats to businesses, farms, and the financial integrity of the family unit. It is not uncommon for these costs to be exacerbated by institutionalized corruption. For example, in China physicians and hospitals will demand payments in cash from patients' families, expelling the sick from care regardless of their health status when families are no longer able to conjure cash.¹⁸ In many circumstances, the quality of services is so intimately tied to cash

provision that poverty can be the cause of death.

All too many nations are now trapped in a cycle in which they cannot either provide essential public goods or push economic development forward. They are locked in poverty and external dependency. Other countries have managed to grow their GDPs and build a business environment, but they lag in provision of public goods and may face civil outrage.

If provision of health as a public good, augmented by provision of private services, is to be realized worldwide in a sustained manner, it needs to be financed through coverage mechanisms that combine principles of risk pooling, antipoverty concepts of elimination of personal bankruptcy due to medical costs, and affordable routine access to care.¹⁹

Coverage without quality care and skilled medical personnel is an empty public good.²⁰ But genuine development cannot be realized in a nation if its productivity is constantly threatened by illness and death, its system has no resilience in the face of natural or epidemic catastrophes, its populace faces bankruptcy as a corollary of illness, and its public goods are externally financed.

World Momentum Builds for Universal Health Coverage

Yanzhong Huang

It might seem hard to believe, but just as the world is recovering from the most serious financial shock since World War II, governments around the world are engaging in serious discussions about how to expand health coverage.

This new wave of universal health coverage has touched nearly one hundred countries, all studying how to institute government-funded programs of health care. This concept is taking off in populous countries and those that have traditionally been UHC “blind spots,” such as Indonesia, China, India, and South Africa. Combined, these four countries account for 40 percent of the world’s population. Unlike the United States, emerging economies are not buying the argument that health care is largely the responsibility of individuals and businesses, with a public provision relegated to the elderly, veterans, and the indigent.

The implementation of UHC could be traced to German chancellor Otto von Bismarck’s introduction of comprehensive medical care that covered large segments of blue-collar workers in the nineteenth century. Germany’s 1883 health insurance bill and other social legislations formed the basis of the modern welfare state. In the post–World War II era, most industrialized democracies and many socialist countries established health programs so that all people had access to affordable health care. According to the International Labor Organization, nearly fifty countries had attained near-universal health coverage by 2008.

Emerging economies are now implementing their own UHC programs/strategies. In India, a national health insurance scheme geared toward increasing access for the poor—Rashtriya Swasthya Bima Yojana, known as RSBY—started in April 2008. So far it has enabled one hundred million people to have cashless, paperless, portable access to inpatient health care provided by more than eight thousand public and private hospitals across the country.¹ The country’s planning commission is considering a report from a high-level expert group, calling

for provision of easily accessible and affordable health care to all Indians by 2022.

Similar dynamics are observed in China, which announced plans to pump \$124 billion into its health sector in January 2009, in a bid to achieve “safe, effective, convenient, and affordable” health care by 2020. By the end of 2011, 95 percent of Chinese citizens have already been covered by some form of health insurance.² While UHC programs and initiatives vary across countries, the government’s political and financial support allows the cost burden of health care to be shared widely and evenly, health-care services to be better utilized, and the health status of individuals to steadily improve.

If these ambitious programs are implemented, most of the world’s population will have access to affordable basic health care in one decade—a true milestone in human history in view of the fact that 1 billion people today lack access and 150 million people face catastrophic costs each year because of direct payments for health care.

In accounting for the rise of UHC, financial capacity is undoubtedly a major factor. The lack of robust economic development in many sub-Saharan African nations may partially explain why only two countries, Rwanda and Ghana, have made significant strides toward UHC in this region. By contrast, robust economic development and fiscal revenue growth in China and India have enabled these governments to invest in their long-neglected health-care sectors.

That, however, does not mean that achievement of UHC is linked to a country’s gross domestic product (GDP) size. As noted by Laurie Garrett and others in a 2009 *Lancet* article, countries with low GDPs such as Costa Rica, Cuba, Gambia, and Gabon attained more impressive prepaid coverage than countries with much higher GDPs.³ Indeed, countries that introduced nationwide health insurance schemes are found not only in upper-middle and high-income economies, such as Brazil, Thailand, and Taiwan, but also in low-income or lower-middle-income economies, including Bangladesh, the Philippines, and Sri Lanka.

Many of these economies, including Sri Lanka, Malaysia, and Indonesia, and to a lesser extent Brazil and Thailand, have adopted some important aspects of the British Model, which funds UHC through a government service paid directly through tax revenue.⁴ Others, such as Taiwan, Mexico, and Turkey, choose the national health insurance model under which payment comes from a government-run insurance

program that covers every citizen.⁵ Still others, such as South Korea and Costa Rica, rely on compulsory social health insurance financed jointly by employers and employees through payroll reduction, or the German model. In most countries, though, UHC is pursued through a mixed model of funding. Chile, for example, finances UHC through a public social insurance fund that combines the German contribution model with tax-financed care under the British model for those without income.

Political commitment and health-system capacity are equally critical in this process. According to Kwesi Eghan, a senior program associate for the nonprofit international health organization Management Sciences for Health, many African governments lack the political will to introduce UHC plans or the ability to develop innovative funding mechanisms to pay for them.⁶

Despite decades of robust economic growth, China and India did not seriously consider UHC until it became clear that economic development does not trickle down. In China, the fourth-generation leaders' populist lurch, coupled with the 2002–2003 SARS debacle and the 2008 global financial crisis, underscored the need to expand health care to stimulate domestic consumption and ensure social-political stability. In India, the government pays more attention to UHC than before not only because it is convinced of the necessity of a healthy labor force to compete in the global economy, but also because the delivery of public goods and services has become an election issue since the mid-2000s. As former vice president of the World Bank David de Ferranti recently noted, in implementing UHC it is often 90 percent about the politics and 10 percent about technical design.⁷

Of course, at issue is not just scalability, but sustainability as well. How to sustain existing programs instituted for achieving UHC is a major concern in low-income and lower-middle-income economies. In Rwanda, a nation with a successful UHC program, foreign donors contributed 53 percent of the country's total health expenditure.⁸ In Sri Lanka, another successful example, there is concern about the government's ability to continue to provide health services free at the point of delivery.

Indeed, UHC programs in even high-income economies are struggling to cope with rising health-care costs, flattening economic growth, the globalization of diseases, population aging, the rise of noncommunicable diseases, and increasingly costly medical technology.

The foremost challenge, however, is to ensure that money is spent on beneficiaries of UHC, which would entail improving efficiency and quality on the supply side. As William Hsiao of Harvard University observed, in almost all the countries implementing national health insurance, most of the money spent ultimately went into the pockets of doctors, nurses, and other hospital staff. Again, political commitment is needed to reform the system to avoid UHC becoming another income-transfer program.

Health was historically considered an individual responsibility. Today, most countries have come to realize that they possess a fundamental obligation to protect their people's health. In this sense, no matter how imperfect many existing UHC schemes may be, they constitute a global movement worth sustaining.

The New Global Health Agenda

Oren Ahoobim, Daniel Altman, and Vicky Hausman

THE UNIVERSAL HEALTH COVERAGE MOMENT

For all but the wealthiest households, a lack of insurance can make the most basic medical care unaffordable and the financial consequences of ill health unthinkable. Even the regular purchase of common medicines such as antibiotics, asthma inhalers, and blood pressure reducers can easily tip households into poverty.¹ This is true in wealthy countries and emerging economies alike, yet extending insurance coverage in the latter poses a particularly stern challenge: incomes, though rising, are still low; aid flows are stagnating; and demand is ever-increasing. Universal health coverage can help emerging economies square this circle, lowering barriers to formal care, reducing financial risks, and helping people live happier and more productive lives.

In the past decade, leaders of countries that have implemented UHC have named these same benefits among their major motivations:

A vital component of financial protection consists of broadening the menu of high-quality public services.

—Vicente Fox, president of Mexico²

Prosperity depends mainly and largely on people, so our people must be healthy. . . . We have to invest in the public health systems and make sure that every individual of our country enjoys access and affordability to the public health facilities that exist.

—Paul Kagame, president of Rwanda³

Our country has given itself a precious tool that will contribute greatly to the march toward progress, prosperity, and development. The Universal Health Insurance Scheme (RAMU) is a

powerful mechanism that will allow our economy to count on a robustly healthy workforce for the most effective production of wealth.

—Boni Yayi, president of Benin⁴

Global leaders from the public and private sectors have picked up the UHC banner. The Bill & Melinda Gates Foundation, which is the biggest private donor to global health programs, was a founding supporter of the Joint Learning Network for Universal Health Coverage in 2010. The U.S. government, which is the world's biggest public funder of global health programs, has been working for several years to make health coverage universal in countries ranging from Ethiopia to Peru. Ban Ki-moon, the secretary-general of the United Nations, has pledged his support for UHC as a vehicle for ensuring equity in access to health care.⁵

Even with the necessary political will, capturing the benefits of UHC for households is not always easy. Once implemented, many UHC programs rely on user fees as primary or secondary sources of funding, which lowers the affordability of care. Some countries could also pool risks more effectively with broader coverage of more diverse populations. Still, researchers in academia and in policy circles have measured substantial benefits of UHC for affordability, risk-pooling, and, increasingly, human capacity.

In terms of global political support and the formation of evidence-based policy, this may be an ideal moment for many countries to consider implementing UHC.

HOW DOES UNIVERSAL HEALTH COVERAGE BENEFIT HOUSEHOLDS?

Providing health coverage is for some a moral imperative and for others a sure way to improve social welfare. Its benefits for individuals do not just include longer, healthier lives—in fact, UHC has not always been shown to achieve these goals—but can also encompass financial and social considerations.

Affordability of care. Even when health care is available—hardly a guarantee in poor or remote communities—high prices and scarce

household funds may lead to care being rejected in favor of other spending priorities. Poorer people do not necessarily spend a higher share of their income on health care; rather, they just consume less care, as comparisons between urban and rural populations in several developing countries have made clear.⁶ This decision may not be in society's best interests, however, as untreated illnesses can lead to more severe medical conditions, family disruptions, lost productivity, and contagion. In addition, formal health care can be a vehicle for other initiatives that benefit society, including antismoking campaigns, family planning services, treatment for addiction, and encouragement of health-enhancing behaviors such as exercise.

Risk-pooling. Extending health coverage also benefits individuals by allowing them to pool their risks with the rest of the population, making individuals and even entire communities (when part of a bigger pool) more financially resilient in the aftermath of an adverse event. With insurance, a health catastrophe is much less likely to result in a subsequent financial catastrophe, since most costs are borne by the pool. Without insurance, the results can be devastating: 150 million people suffer the dual catastrophes each year, and health bills impoverish 100 million people each year.⁷ This problem is particularly acute in developing countries, where the share of health costs paid out of pocket by individuals remains much higher than in wealthy countries. The share is strongly correlated with the proportion of the population that experiences financial catastrophe as a result of health expenditures.⁸

Human capacity. Easy access to care and a lower financial burden can combine to raise an individual's capacity for productive, satisfying living. Better access to health care can foster a healthier workforce and reduce absenteeism; on this basis, employers in developing countries have become the major funders of programs like Naya Jeevan and HERproject, which supply catastrophic health insurance and health education, respectively, in the workplace.⁹ As communities thrive and become more prosperous, they can invest more in health care, creating a virtuous circle.

CHOICES IN UHC PROGRAMS

No two countries' systems of UHC are exactly the same. In trying to attain UHC with limited resources, governments need to decide whom to cover, what level of services to offer, and how much of the cost to bear. Government decisions about the extent of coverage may assume that private sector insurance will suffice for one strata of society, while publicly subsidized insurance reaches another strata; combined, the target is "universal coverage." Their choices will affect the degree to which households may realize the benefits of UHC.

Affordability: User fees. A large but decreasing number of countries fund UHC partly through out-of-pocket copayments, deductibles, or other user fees. Such fees are widely acknowledged to have perverse effects in systems trying to attain UHC, however; they tend to reduce access, depress utilization, and increase the financial risks associated with health events.¹⁰ The exceptions are annual premiums that do not affect the cost of care for any specific incident, though these may also need to be adjusted to fit the incomes of the targeted populations.

Affordability: Caps. Affordability can also be improved by the use of annual out-of-pocket caps, which protect households from any additional spending once they have paid a preset amount into the UHC program. Though the out-of-pocket payments may still discourage the use of formal care, the caps offer some protection against financial catastrophe.

Risk-pooling: Structure. UHC programs vary widely in the makeup of their insurance markets. In some countries, like Brazil, all citizens are part of a single federal insurance pool. In others, like Rwanda, the country is covered in a patchwork way by mutual insurance pools organized at the local level. Segregation of pools based on occupation is also a common feature, with government workers and military personnel the most likely to be separated from the rest of the population. Risk-pooling generates more benefits with bigger and more diverse pools; the trick is to cover large populations whose health events are uncorrelated. As a result, decentralization into numerous small pools and segregation of people into different pools—especially when the segregation

corresponds to income levels—can detract from a program’s ability to improve well-being.

Risk-pooling: Enrollment. The size and diversity of insurance pools can also depend on whether coverage is voluntary or mandatory. Though most UHC systems cover all citizens automatically, some are voluntary; coverage is available to all, but enrollment requires action by individuals or entities acting for them. However, relying on individuals to volunteer for insurance can sharply reduce the welfare benefits of the program. Adverse selection, whereby only the people who think they are likely to incur substantial medical costs join the pool, is of particular concern.

MODELS USED TO DATE

Below is a summary of UHC systems whose governments are members of the Joint Learning Network for Universal Health Coverage. Some of the systems are mature, but most are still gaining coverage.

Clearly, the presence of a health system aiming for UHC does not preclude large out-of-pocket spending. Even in countries that have come very close to universal coverage, such as the Philippines, half or more of all spending on health is out of pocket. This may be a direct result of user fees and other charges associated with using the UHC system. In other cases, the persistence of high out-of-pocket costs may be a result of the breadth, quality, or accessibility of services offered by the government’s program. Citizens may choose to purchase services in addition to the government’s offerings. This occurs even in wealthy countries with established national health systems, such as Canada. Though it does not necessarily signify the failure of the government to implement UHC, it can signal inequality in health care and potentially in health outcomes.

FIGURE 1. CHARACTERISTICS OF UNIVERSAL HEALTH COVERAGE PROGRAMS (SELECT COUNTRIES)

<i>Income Group</i>	<i>Country (Year of Imple- mentation)</i>	<i>Diversity of Pool (Types of Individuals Covered in Program)</i>	<i>Size of Pool (Percent of Population, 2010–2011)</i>	<i>Affordability of Care (Out-of-Pocket Share of Total Expenditure on Health, 2009)</i>
Low Income	Kenya (1966/1998)	All citizens	7%	51%
	Kyrgyz Republic (1996)	All citizens	97%	40%
	Mali (2002/2004)	Informal sector	3%	52%
	Rwanda (2002)	Below poverty line Informal sector	74%	25%
Low-middle Income	Ghana (2004)	All citizens	49%	43%
	India (2007/2008)	Below poverty line	9%	50%
	Indonesia (2004)	Below poverty line	32%	35%
	Nigeria (1999)	All citizens	3%	61%
	Philippines (1995)	All citizens	80%	54%
	Vietnam (2003)	All citizens	42%	55%
	Upper-middle Income	Brazil (1998)	All citizens	73%
Chile (1979)		All citizens	64%	34%
Colombia (1993)		All citizens	88%	8%
Mexico (2003)		Below poverty line Informal sector	42%	48%
Thailand (2001)		All citizens	72%	16%

Source: UHC Forward

EVIDENCE FOR THE EFFECTS OF UNIVERSAL COVERAGE

Few UHC programs were designed with an experimental model in mind, so testing their effects with rigorous, controlled studies can be difficult. Nonetheless, a growing base of evidence has begun to show UHC's success in capturing the benefits of access and risk-pooling, which can become apparent more quickly than long-term changes in health outcomes. The following is evidence in these areas gleaned from a combination of experiences and estimates in both developing and wealthy countries.

Affordability: Access to care. One of the primary goals of UHC is to improve access to care, and most statistically robust studies find that it succeeds.¹¹ Some models perform better than others, of course. For instance, decentralized programs such as community mutual insurance have had less success reaching the poorest people.¹²

Affordability: Utilization. Utilization can be a reflection of access and affordability as well as the structure of a UHC program. In rural Rwanda, annual visits to health providers tripled after the implementation in 2007 of subsidized community-based health insurance that eliminated copayments and made coverage virtually universal.¹³ Utilization also rose dramatically in Taiwan in the late 1990s—though perhaps because of incentives more than health needs—under a UHC program that reimbursed providers for health care on a fee-for-service basis. Moral hazard affected both patients (who faced a lower price for care) and providers (who wanted higher payments from the government).¹⁴ Spikes in utilization are not uniform, however; the new scheme for rural insurance in China, for instance, has been associated with less use of traditional medicine but no increase in formal care.¹⁵

Affordability: Out-of-pocket costs. A review of studies of UHC reinforces the conclusion above that health coverage is not a guarantee of lower out-of-pocket costs or reduced financial hardship.¹⁶ Indeed, researchers have found that the interactions among patients, providers, and payers can lead to complex and unexpected results. For example, a study of UHC in the Philippines found that private providers may charge higher prices to people using government insurance so that they

generate the same revenue as people with private insurance; this practice artificially raises the out-of-pocket cost to consumers and the fiscal cost to government.¹⁷ Moreover, the continued presence of user fees and other out-of-pocket payments in some countries is pushing households into poverty and shifting the burden of paying for health-care systems to individuals experiencing poor health—essentially eliminating risk-pooling and reinstating the cycle of illness and poverty.¹⁸ But there are some bright spots; Mexico’s People’s Insurance (Seguro Popular) program, for example, led to a substantial decrease in out-of-pocket costs.¹⁹

Risk-pooling: Catastrophic spending. One of UHC’s most notable successes has been in reducing financial catastrophes resulting from health events. In Thailand, for example, the incidence of catastrophic health expenditures among both the rich and the poor dropped by roughly half in the six years following the adoption of UHC.²⁰ Even in programs that have demonstrated little or no effect on utilization and health outcomes, financial risks have fallen markedly. For instance, Seguro Popular reduced the number of Mexicans with catastrophic expenditures by a quarter from the baseline; on average, poor households spent about \$35 less during the ten-month test period.²¹ These reductions in financial risk can translate into enormous increases in well-being; a study of the first decade of Medicare in the United States suggested that the welfare gain associated with lowering financial risk could counterbalance 40 percent of the cost of the program.²²

Human capacity. Evidence here is scarcer—effects on human capacity may be only indirectly attributable to UHC—but some rigorous studies have been published. A study of the extension of national health insurance in Canada, for instance, found positive effects on both employment and wage growth.²³ In a survey of small employers in the United States, two-thirds said that health benefits enhanced workers’ productivity, and almost three in five respondents said benefits reduced absenteeism.²⁴ Other benefits can occur earlier in life. In China, for example, the extension of health coverage in rural areas was found to have little effect on child or maternal mortality but did appear to improve the school enrollment of six-year-olds.²⁵

UNIVERSAL COVERAGE IN THE FUTURE

Realizing the benefits of UHC for households is a formidable challenge. Not only do the political, legislative, and regulatory hurdles to launching a UHC program need to be overcome; the program needs to be implemented and fine-tuned in ways that respond to the behavior of the targeted population, as well as other economic and health-related trends. No one country has a UHC program that is viewed as a model for the entire world. Rather, governments and their partners seeking to implement UHC need to use a combination of insights from a collection of countries operating in similar contexts.

Evidence underlining the benefits of UHC continues to accrue, especially as the introduction of UHC is increasingly designed with controlled trials in mind. Of course, because no two systems are identical, positive results in one country will not necessarily imply success in another. Yet even the evidence collected to date makes a strong case for UHC as a way to cut costs, reduce financial hardship, and potentially improve health.

At present, countries as diverse as Cambodia and Benin are in the process of adopting some form of universal coverage. As this trend continues, questions about the reach of coverage are likely to give way to questions about the quality and cost of care. Many countries, particularly in Latin America, have had UHC for decades as a result of laws giving every citizen the right to comprehensive health care. Inequities persist, however, as the benefits accorded by UHC become an inferior good only consumed by those who have no other choice.²⁶ These same inequities may develop in countries where UHC is a more recent innovation. The Chinese government, for instance, has already perceived the need to raise subsidies for medical insurance for rural residents and the urban unemployed.²⁷

This is a critical concern, since the greatest benefits of UHC may stem from the extension of coverage to the neediest people. With this in mind, the best way to implement UHC may be to target marginalized groups such as the elderly, victims of catastrophic illness, women and their children, and the very poor.²⁸ Indeed, because of UHC's success in reducing financial hardship, it may be most effective as part of a comprehensive antipoverty program. As such, UHC can be not just a happy side effect of growth but an engine of economic development in itself.

Endnotes

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