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Universal Health Coverage (UHC): Making progress towards the 2030 targets

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Universal Health Coverage (UHC): Making progress towards the 2030 targets

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This special issue of the World Hospitals and Health Services (WHHS) Journal of the International Hospital Federation, features a range of country examples of Universal Health Coverage (UHC). Spending on healthcare globally now approaches US$8 trillion. Yet, according to the 2017 UHC Global Monitoring Report:

- At least half of the world's population still does not have access to quality essential services to protect and promote health.
- 800 million people are spending at least 10 percent of their household budget on out-of-pocket health care expenses, and nearly 100 million people are being pushed into extreme poverty each year due to health care costs.

How did this happen? The world committed to achieving "Free Health For All" back in the Seventies. What went wrong?

But before answering these difficult questions. Let us celebrate. This year, as we commemorate the 40th Anniversary of the Alma-Ata Declaration of "Health for All" in Almaty, Kazakhstan, 1978 and the 70th Anniversary of the UK National Health Service, 1948, we also celebrate the great achievement over the past decades in bringing access to affordable and quality health care for billions of people across the world since the 1950s. The world may have missed the global Health for All 2000 target, but the advances that have occurred are truly impressive.

Today a child in Sub-Saharan Africa has access to life saving drugs for Malaria. Mothers around the world have safer birthing environments. And even when there is a shortage of trained medical doctors, often community workers can provide the needed basic care for local populations. All of this because of the progress made over the past 50 years in both new discoveries in life science and better knowledge about how to manage health systems and health services in a more effective and efficient way.

To fully understand how to bring these benefits to all people not just those that already have access to affordable basic care, we need to understand more fully the challenges which low- and middle-income countries face, their achievements and failures, and how to slowly close the existing gap between them and the most successful of more advanced countries.

Coming back to the challenge of "Health for All", after having tried for 40 years with some success and some failure, we now understand more fully both the importance of this agenda and how hard it is to achieve. At the recent Universal Health Coverage Forum 2017 in Tokyo Japan, the international development community – including both bi-laterals and multi-laterals – committed to the Partnership for UHC by 2030 (UHC2030) through a Joint Vision..

The Joint Vision proposed a three-pronged approach:

- Strengthening governance for UHC, particularly the voice of those left behind
- Mobilizing domestic financing and improving the efficiency of collective financing for health services
- Strengthen service delivery, including Innovation for UHC

The International Hospital Federation is very excited to share with its readers' insights from round the globe on this important topic. In this issue of the Journal we have contributions from WHO, the World Bank, WHO, Results for Development and authors from around the world - both developing and western developed countries. As indicated during the Universal Health Coverage Forum 2017 in Tokyo, the Federation remains fully committed to the objectives of UHC2030 and looks forward to working with member organizations in contributing to this agenda with its international partners like WHO and the World Bank.

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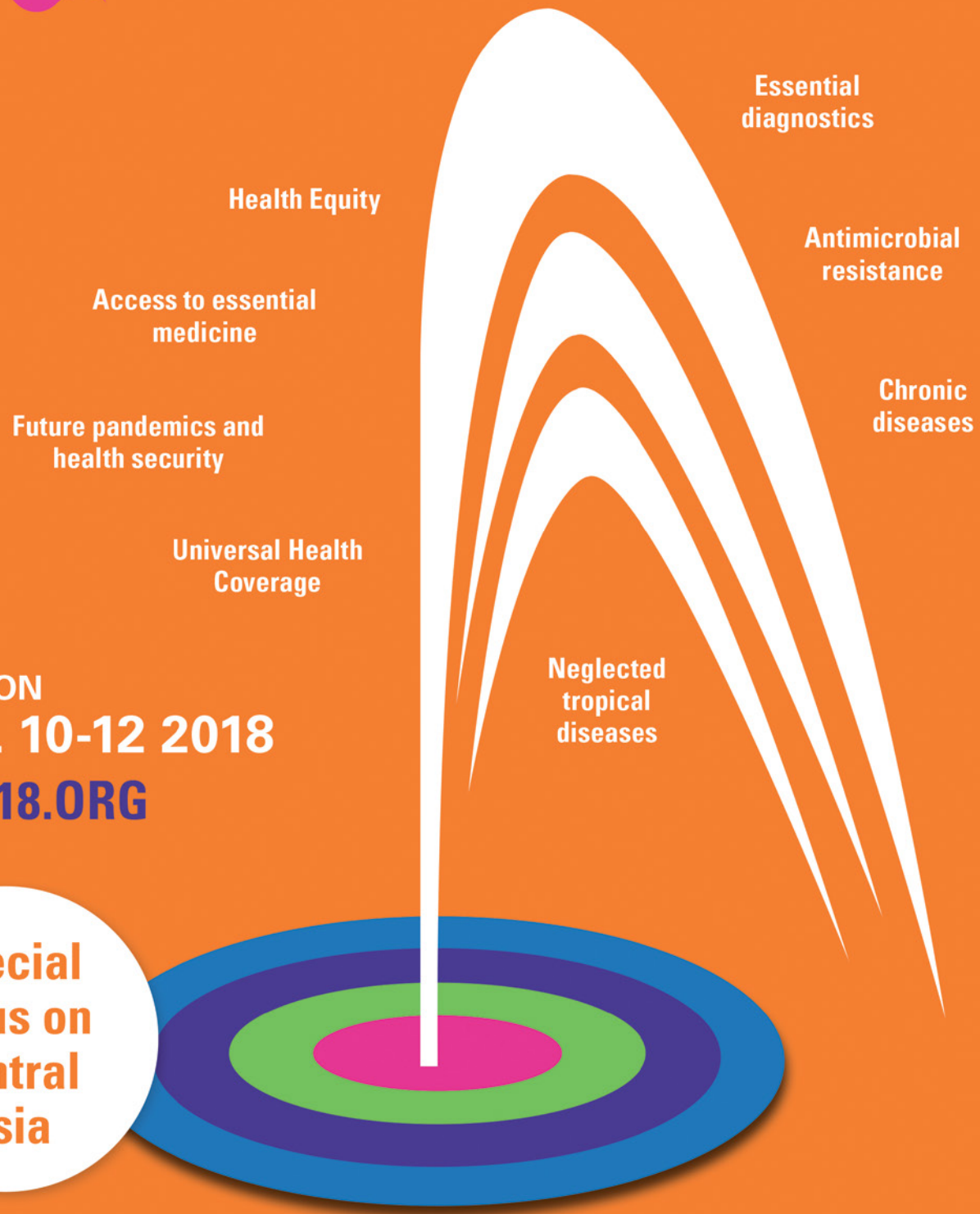

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UHC: Is this time different?

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DIRECTOR OF THE HEALTH, NUTRITION,
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WORLD BANK GROUP
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At least half of the world's population do not have full coverage of essential health services. That is a sobering conclusion from the 2017 Global Monitoring Report on Universal Health Coverage (UHC), by the World Health Organization and the World Bank. Furthermore, some 800 million people spend more than 10 per cent of their household budget on health care, and almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses. These injustices are unacceptable and have become a focus of global development policy. For example, 17 Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly in September 2015 have targets that relate to health.

Remarkably, one goal – SDG3- focuses specifically on ensuring healthy lives and promoting well-being for all at all ages. Target 3.8 of SDG3 – achieving UHC, 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 – is the key to attaining the entire goal as well as the health-related targets of other SDGs.

Securing access to needed health services for everyone – without facing financial hardship – is central to improving health. But UHC is more than that: it is an investment in the inherent value of good health, and in good health as a powerful engine of economic growth. Achieving its lofty ideals requires gritty work to ensure the convergence of: "effective coverage, i.e., coverage with quality services; the need for more countries to take true ownership of financing more of basic services from their own domestic resources; and the need for UHC to be concurrent with work on systems and institutions for public health surveillance and disease control.

Yet, the current architecture of development assistance for health is subject to gaming; in many countries, while donors emphasize basic primary health care, governments continue to lopsidedly devote their budgets to tertiary hospitals, the MOH is de facto a Ministry for Tertiary Care, and the cycle perpetuates itself. As if those weren't challenging enough, donor-funded projects do not always result in durable gains in health and institutional capacity.

There is cause for optimism. This year, as we commemorate the 40th Anniversary of the Alma-Ata Declaration of "Health for All", we also celebrate the great achievements in bringing affordable access to quality health services for billions of people across the world over the past decades. Most of all, we recommit to ensuring a better future via UHC.

To this end, the World Bank Group and many partners committed to the "Tokyo Declaration on Universal Health Coverage: All Together to Accelerate Progress towards UHC". *Inter alia*, the partners reaffirm and build on the G7 Ise-Shima Vision for Global Health, and the TICAD VI Nairobi Declaration, which acknowledges the "UHC in Africa: A Framework for Action." They also build on the G20 Berlin Declaration, which acknowledges the UHC2030 "Healthy systems for universal health coverage – a joint vision for healthy lives," as well as other regional and international declarations. They stress the need to build and strengthen resilient and sustainable health systems and prepare for public health emergencies in an integrated way. Never before has there been greater need for commitment to UHC, and never before has there been as much political momentum behind it. Is it different this time? So it seems.

Biography

Olusoji Adeyi is Director of the Health, Nutrition, and Population Global Practice at the World Bank Group. He was founding Director of the Affordable Medicines Facility-malaria (AMFm) at the Global Fund to Fight AIDS, Tuberculosis and Malaria. He has led a number of initiatives on global, regional, and country health policies, strategies and programs. He holds the degrees of MBA from Imperial College London, Master of Community Health from the Liverpool School of Tropical Medicine, and DrPH from the Johns Hopkins University.

How do hospitals fit in the UHC movement?

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While domestic politics and economics views in the United States have yet to forge a consensus on *universal health coverage* (UHC), the world as a whole has positioned it at the top of the international agenda.[1] Hospitals have played historically important roles in science and medicine, and their modern iterations are *sine qua non* components of health systems. Yet, the leadership and equities of hospitals have been absent from the global deliberations on UHC. While some authorities appreciate their importance for referrals and training in a multi-tier, many others worry hospitals may distort health financing at the expense of primary care. A win-win approach requires an understanding of the growing importance of hospitals as national economies and health systems develop.

While overseas development assistance galvanized much progress during the golden era of global health, the new world health era that follows the recent economic recession in donor countries will run on domestic resources[i] thanks to the *economic transition of health* in what used to be called the developing world. With unprecedented growth of those economies, a majority of the countries that were low-income in the year 2000 are now categorized as middle income.[2] Total Health Expenditures (THE) closely track GDP and consume an ever-growing proportion of national economies (from 3% to 12% or more – nearly 20% in the U.S.) While this is a fiscal headache for richer countries, for low-income countries it means having sufficient resources to provide essential health services.[ii]

The Lancet commission 2013 on 'Investing in Health' documented a historical reduction in poverty and the possibility of a grand convergence in life expectancy between rich and the poor countries by 2035.[v] In most 'developing' countries, however, the economic transition is accompanied by an explosion in the demand for health services often met by unregulated private provision of mixed quality and paid for out-of-pocket (OOP). Fee-for-service OOP spending is inefficient and regressive, and paying health bills is becoming the number one cause of impoverishment in countries without social protection. OOP payments account for 50% of THE in most African countries, and they reach up to 80% in large South Asian countries (vs. <20% in most OECD countries). Over 100 million families suffer catastrophic health expenditures every year.[iii]

These economic developments underscore the need and feasibility of UHC – *access for all to appropriate health services without financial hardship.*[v] Following different and often multiple approaches, one third of countries have UHC already, and another third are halfway there, with most of the remainder in Africa only starting now (early pioneers include Rwanda and Ghana).[iv] A global movement towards the progressive realization of UHC is unfolding.[v] UHC was the theme of the World Health Report 2010[vi] and became a health target of the U.N. Sustainable Development Goals.[vi] The G7 and the G20 support UHC, and a UHC Alliance has

1 http://www.ghspjournal.org/content/early/2018/03/14/GHSP-D-17-00297
2 The World Bank. Accessed in 2017: http://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?end=2015&start=1990&year_low_desc=false

been born to foster and track progress to 2030. At the Tokyo Forum of December 2017, Japan's Prime Minister Shinzo Abe pledged $2.9 Bn for UHC, while the U.N. Secretary General Guterrez announced UHC will be the subject of a high-level meeting at the U.N. General Assembly in 2019,[vii] given impetus to WHO's goal of expanding coverage to an additional one billion people in 5 years.[iv]

To realize UHC, most *financial revenues* come from government tariffs and general taxation, supplemented by private spending or insurance premiums (and foreign aid). *Risk pooling* is absent when you pay OOP, and it can take the form of public insurance, employer-based or private voluntary insurance or mixed schemes with individual mandates and subsidies as in the U.S. *Purchasing* is about which services to buy, how to do it and from whom. *Services* can be obtained through salaried providers and institutional budgets, or paid as fee-for-services, DRG or capitation. Most countries have a mix of public and private components and roles with different levels of efficiency and equity.

Hospitals are a key component of the medical services, from sophisticated tertiary care and training, to primary care networks. Quite often they account for a large proportion of THE and government budgets, and efforts to constrain that (e.g.1983 DRG introduction in the U.S.) have failed to reduce THE for various reasons. On the other hand, medical or political demand by elites may see a premature surge in urban hospitals and concentration of health workers at the expense of more efficient primary care services for the poor and in rural areas. UHC should not be about ideologically rigid positions, but budgets and political pressures are hard to balance for ministers of health. Hospital leaders should contribute to an enlightened vision for national health systems that is equitable and recognizes the progressive need and changing roles of hospitals as their economies evolve.

Biography

Dr. Ariel Pablos-Méndez is a Professor of Medicine at Columbia University in New York and former Assistant Administrator for Global Health at USAID under President Obama, driving the U.S. Government vision to end preventable child and maternal deaths and fostering global health security through innovation and health systems strengthening from 2011 to 2016. Dr. Pablos-Méndez received his M.D. from the University of Guadalajara (Mexico) and his M.P.H from Columbia University.

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An Anatomy of Progressive Universal Health Coverage Reforms in Low - and Middle - Income Countries

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ABSTRACT: By the new development agenda established in 2015, the United Nations has set "Universal Health Coverage by 2030" as a global commitment under the Sustainable Development Goals. This paper explains how this commitment is being implemented.
This paper aims to portray the policies developing countries are implementing for progressive UHC advancement. Based on a comparison across forty low- and middle-income countries, it identifies the existence of areas of policy convergence, namely areas of policy where countries have opted to use similar reform measures. It also identifies areas of policy divergence, where choices differ in significant ways. This article concludes with a summary of the main findings and with a discussion of risks and mitigation measures countries seeking to advance progressive universalism may take.

Introduction

A simple but powerful belief provides the motivation for the global movement towards universal health coverage (UHC): all people are entitled to quality essential health services, without having to suffer financial hardship to pay for health care. "UHC by 2030" is now a global commitment under the Sustainable Development Goals set by the United Nations as part of the new development agenda established in 2015. Achieving universal health coverage requires an expansion of coverage over three dimensions: population, health care benefits and affordability[1].

For many developing countries, the global commitment to UHC is not a call for new action, instead it is perceived as a reaffirmation of their line of action since around the turn of the millennium. Low- and Middle-income countries in all continents are going universal; they are reforming their health systems in ways that are massive and often transformational. Massive because they cover almost a third of the global population (over 2.6 billion people); transformational because they not only expand coverage, but also attempt to fundamentally change the way health systems function, making them more efficient and equitable.

This paper aims to portray the policies being implemented by developing countries for progressive UHC advancement. During the last five years, the World Bank has been documenting – through UNICO (the UHC Study Series) – the policies used by individual developing countries to advance progressive universalism via policies that are inclusive of the poor and low-income populations. Since 2013, UNICO, the UHC study series has published 25 country case studies and in early 2018 it published an additional fifteen studies.[2] ***Going Universal***, a synthesis book analyzing the first set of case studies, was also published.[3] These studies use a common methodology, based on a 300-question template, designed to facilitate comparisons across countries and to understand the circuitry of *UHC reforms*- the policies and institutional changes countries implement to advance UHC.

This paper is based on a comparison of the 40 UNICO series country case studies. The countries and some characteristics of the UHC reform programs are listed in Table 1. Each country is different, requiring a unique set of policies for UHC advancement. However, the systematic comparison of many countries identifies the existence of areas of policy convergence, where countries have opted to use similar reform measures. It also identifies areas of policy divergence, where choices differ in significant ways.

In the next section of this paper, we describe two features typically observed at the point of departure for many countries embarking on UHC reforms. This is followed by sections describing areas of policy convergence and areas of policy divergence. The paper concludes with a summary of some of the main findings and a discussion of risks and mitigation measures which may be taken by countries seeking to advance progressive universalism.

The point of departure of UHC reforms

Countries did not start from "zero" when they launched their UHC reforms. UHC reforms are complex, and most countries embarked on them only after achieving certain earlier objectives. The point of departure in most countries shared two characteristics:

Firstly, countries had already covered most of their population

1 WHO. 2010. World Health Report

2 World Bank. Universal Health Coverage Study Series: http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series

3 Cotlear D, Nagpal S, Smith O, Tandon A, Cortez R. 2015.

TABLE 1. COUNTRIES AND UHC REFORM PROGRAMS STUDIED BY UNICO

Country	Health Coverage Program	Creation	Coverage (millions)	Coverage (% of pop)	UNICO Round	Supply- or Demand-side reform
Argentina	Maternal-Child Health Insurance Program (Plan Nacer)	2003	1.7	4%	1	D
Armenia	Basic Benefit Package Stage Guaranteed Program (BBP)	1999	1.1	38%	2	D
Azerbaijan	State National Programs (SNP)	2008	0.3	3%	2	D
Brazil	Family Health Strategy (Programa Saúde da Família, FHS)	1994	102	51%	1	S
Chile	National Health Fund (Fondo Nacional de Salud, FONASA)	1981	13.2	78%	1	D
China	New Rural Cooperative Medical Scheme (NRCMS)	2003	832	64%	1	D
Colombia	Subsidized Regime (SR)	1993	22.3	47%	1	D
Costa Rica	Social Security of Costa Rica (CCSS)	1984	4.3	91%	1	D
Croatia	Croatian Health Insurance Fund (HZZO)	1993	4.3	100%	2	S
Dominican Rep.	Seguro Familia de Salud (SFS)	2001	6.8	68%	2	D
Ethiopia	Health Extension Program (HEP)	2003	60.9	68%	1	S
Gabon	Caisse National d'Assurance Maladie et de Garantie Sociale (CNAMGS)	2007	0.9	47%	2	D
Georgia	Medical Insurance Program (MIP)	2006	0.9	20%	1	D
Ghana	National Health Insurance Scheme (NHIS)	2005	8.2	33%	1	D
Guatemala	Expansion of Coverage Program (PEC)	1997	4.4	29%	1	S
India	National Rural Health Mission (NRHM)	2005	840	70%	1	S
India	Andhra Pradesh Rajiv Aarogyasri (RA)*	2007	70	85%	1	D
India	Rashtriya Swasthya Bima Yojna (RSBY)	2008	70	6%	1	D
Indonesia	Jamkesmas	2005	76.4	32%	1	D
Jamaica	National Health Fund (NHF)	2003	0.5	19%	1	D
Kenya	Health Sector Services Fund (HSSF)	2010	20	48%	1	S
Kyrgyz Republic	State-Guaranteed Benefit Package (SGBP)	2005	4.2	76%	1	D
Lao PDR	Health Equity Fund (HEF)	2007	0.7	13%	2	D
Malawi	Health Sector Strategic Plan (HSSP)	2011	18	100%	2	S
Malaysia	National Health Service (NHS)	1957	31	100%	2	S
Mexico	Popular Health Insurance (Seguro Popular, PHI)	2004	51.8	43%	1	D
Morocco	Subsidized Health Insurance Scheme (RAMED)	2012	6.4	19%	2	D
Nigeria	Ondo State National Health Insurance Scheme (NHIS-MDG-MCH)*	2008	0.1	4%	1	D
Peru	Comprehensive Health Insurance (Seguro Integral de Salud, SIS)	2002	12.7	42%	1	D
Philippines	National Health Insurance Program (NHIP)	1995	78.4	83%	1	D
Russia	Program of State Guarantees of Free Medical Care (SGFMC)	1993	146	100%	2	D
Senegal	Couverture Maladie Universelle (CMU)	2015	1.6	10%	2	D
South Africa	Comprehensive HIV and AIDS Care, Management and Treatment	2003	1.5	3%	1	S
Sri Lanka	National Health Service (NHS)	1930	20.5	100%	2	S
Tanzania	Community Health Funds (CHF)	2001	9	26%	2	S
Thailand	Universal Coverage Scheme (UCS)	2002	47.7	71%	1	D
Tunisia	Free Medical Assistance for Poor (FMAP)	1991	3	27%	1	D
Turkey	Green Card (Yesil Kart)	1992	9.1	12%	1	D
Uruguay	Sistema Nacional Integrado de Salud (SNIS)	2005	1.6	48%	2	D
Vietnam	Social Health Insurance (SHI)	2009	55.4	63%	1	D
TOTAL			2636.1	49%	40	

Source: UNICO, World Bank http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series

with a narrow "universal basic package" (UBP), focused on fighting communicable diseases and providing reproductive and child care. The UHC reforms in most countries aimed to expand benefits **beyond** that narrow universal basic package (UBP). This point of departure characterized middle-income countries (MICs) around the turn of the millennium, when most launched their UHC reforms, and a similar situation is found today in many low-income countries (LICs). A survey of health financing policies in 46 African countries, including LICs, found that during the MDG era, most countries established a narrow UBP, focused on fighting communicable diseases and providing reproductive and child care, for which no user fees are charged.[4] In the Africa region today, no country is starting from zero or from a blank slate.

Secondly, at the onset of UHC reforms, public health spending was significantly regressive (pro-rich) in most developing countries, with countries spending more public funds on the better off than on the lower income populations. However, there was an important caveat: services provided by community- and primary-care clinics were more accessible to the poor and low-income populations, than services provided by district and referral hospitals.[5]

This common feature led different countries to choose different paths of reform. A group of countries (including most of the LICs studied, but also countries like Brazil and Croatia) decided to expand the platforms that serve low-income populations, and chose a path that expanded community- and primary-care services. One fourth of the countries studied in the series followed this path. A second group of countries opted for a different strategy: they decided that if hospitals and higher complexity services were closed to the poor, what was needed was a reform that would open their gates to the lower income populations. The reform most commonly used to open these gates consisted of the creation of a public insurance scheme for the lower income populations; these are tax-subsidized schemes that pay providers for services delivered to low income populations which do not require payment at the point of service. Three fourths of the countries studied followed this path, which required creating the capacity to target low income beneficiaries and to realize "strategic purchasing".

The first path is a "supply-side" path, because it generally consists of investments and health care provider reforms aimed at expanding the supply-capacity in the system; while the second path is a "demand-side" path because the effort lies on providing low income populations with the capacity to exert an effective demand over existing care providers.

Policy Convergence: Explicit Promises

Advancing UHC requires progress in three dimensions and most UHC reform programs make explicit promises about the progress they expect to make in these three dimensions: what population will be covered, what benefits will be covered and how affordable health care will be.

Most UHC reforms involve explicit numerical population coverage targets. The new generation of reforms launched after 2000 explicitly identify the population they intend to cover, and by when. Many of these programs did not exist in 2000 but had grown to cover almost 800 million people by 2005 and continued to expand, reaching 2.6 billion people by 2015. On a country by country basis, programs that did not exist in 2000 had grown to cover on average almost 50 percent of the population of their countries fifteen years later (see Table 1).

To achieve progressive universalism, the countries establishing demand side reform programs generally set specific targets for the coverage of poor populations, while the supply-side programs generally reached out to poor populations, based on geographic targeting and by prioritizing the community- and primary care-platforms of delivery.

In most countries, UHC reforms aim to expand coverage beyond the narrow basic package of benefits that characterized the MDG era. This aim is often implemented by making explicit promises about what health care benefits will be provided; all but five UNICO countries (Costa Rica, India, Malaysia, Sri Lanka and Tunisia) have an explicit benefit package guiding UHC reforms. While the promise of a benefit package is now very common, the studies find that very few UNICO countries have actually developed systems capable of monitoring the fulfillment of this promise, and despite promises of a generous package of benefits, the population in many countries is not being served and in practice faces implicit rationing.

Affordability is at the core of UHC reforms. Most countries in the study aim to achieve affordability by limiting point of service payments to public providers for the expanded benefit package. An area of significant consensus across countries is that this promise must include the elimination of copayments for the poor populations. Co-payments have also been reduced or eliminated for other covered subpopulations: only a third of the programs studied involve some form of cost sharing by users (for example in Jamaica, Colombia, China).

Policy Convergence: Supply- and Demand-side Reforms

Coverage expansion requires greater public spending. Looking at the first round of UNICO countries, we find that the median annual UHC incremental program expenditure per beneficiary in 2011 across all programs was USD$39, approximately 1.4 percent of per capita GDP; and this was strongly correlated with per capita GDP. This injection of additional public funds implied a significant financial effort for most countries, but one they could manage without falling into problems of fiscal sustainability given the economic growth of those years. However, advancing UHC is not just about injecting more money into the system, it is also about ensuring that additional money is used efficiently and distributed progressively. Two groups of reforms are implemented to deliver on those aims:

Supply-side reforms aim to expand the capacity of health care providers to increase volume and quality of services. Specific reforms implemented in this path vary considerably, however among the eleven countries studied that followed this path, there are three frequent groups of reforms.

Firstly, the creation of new coverage programs, usually at community- or primary care-levels, to increase services at health care centers. Brazil Family Health program (102 million people in 2011), Ethiopia's Health Extension Program (61 million) and India's National Rural Health Mission (840 million) are such examples.

4 Cotlear, D. and Rosemberg, N. 2018.
5 Wagstaff, Adam; Bilger, Marcel; Buisman, Leander; Bredenkamp, Caryn. 2014.

Secondly we have human resource management reforms, designed in LICs to expand the number of qualified health workers, and in all countries to confront specific bottlenecks and to align incentives with desired results. These reforms often aim to increase the density of health workers in rural and peri-urban areas. Twenty-five of the countries studied have programs that encourage or require doctors and health personnel to spend part of their career in poor and rural areas. This is often done with the use of financial incentives, which can be significant, in some countries such as in Indonesia (where the premium can be 250 percent of the base salary), Brazil and India, but is small in most other countries. Career opportunities are also often used as an incentive to overcome rural bottlenecks; in seven countries, rural service is a precondition for a career in the public sector. Many countries are expanding the use of community health workers and allowing nurses or community agents to take on new clinical roles in a team environment. Community agents are in use both in dispersed populations such as in Ethiopia and Guatemala, and in dense urban settings in Brazil, India, Nigeria and Peru.

Thirdly, financial management reforms provide flexibility in public hiring and in the management of public providers. In the past, this flexibility only existed for income obtained from user-fees, while government financing was tied by rigid rules, making provider management impossible. About 70 percent of the countries studied have attempted to provide greater autonomy and flexibility to managers, physicians and other health workers. Programs in Brazil, Kenya and Turkey allow hospitals to hire additional staff and pay extra compensation to staff working to meet production targets. India's NRHM provided facilities with flexible cash beyond what was provided by means of line-item budgets. In Indonesia and Peru, these funds can be used to purchase medical inputs and equipment; in Chile, to purchase external diagnostic services. Nevertheless, these incentives can lead to unexpected consequences, as for example in China where public hospital doctors have overtreated patients to increase their pay, in Vietnamese hospitals which have tended to focus on the most profitable services, or in Ghana, where they promoted curative and diagnostic serves over the use of preventive care.

Demand-side reforms have been followed in 80 percent of the countries studied, aiming to overcome the economic barrier restricting hospital and other service access to lower income populations. These countries introduced a purchaser-provider split, departing from the classic model of a Ministry of Health allocating inputs to public facilities that are essentially budgetary units of the ministry itself (this configuration is often called the National Health Service (NHS). In many countries, the purchaser is a new agency created to enroll certain populations and act on their behalf as third-party payor for public and sometimes private providers; examples are the Kyrgyz Republic, Thailand, and Peru. In other cases, such as the Philippines and Vietnam, new schemes were created within Social Health Insurance (SHI) agencies to provide coverage for the poor, financed by transfers from the treasury. A few countries give this purchasing role to private insurers financed with public transfers (in Colombia, Uruguay, Georgia and India RSBY).

In countries pursuing demand-side policies, the increase in public expenditures was injected through public insurers. Against frequently held beliefs, the studies found that the role of these agencies was not to replace previously existing channels of funding, but to complement traditional supply-side financing of the public health system; often public insurers are only covering flexible operating costs and incentives reflecting financing at the margin, while also serving as a powerful tool, encouraging providers and beneficiaries to change behavior for achieving desired health system outcomes. The incentives for behavior change are often strengthened by a shift from input-based financing- such as paying based on salaries, bed capacity, historical line-item budgets or simple global budgeting- to output-based payments. Payments are linked to the covered population and to the statutory benefit package.

To achieve progressivity in public expenditure, most reform programs use instruments designed to assign priority to the poor populations. Enrollment is needed in 80 percent of countries studied; most of these countries use "social registries" to ensure that the poor are not left behind. The supply-side programs achieve progressivity by investing in the type of platforms used by the lower income populations (such as public primary health care facilities) and through geographical targeting.

Policy Divergence: what and who to prioritize next?

The studies found consensus across countries regarding the components of the initial basic package, and about the need to prioritize access for the poor by eliminating user fees for them. Regarding the composition of the initial benefit package, the study of 46 African countries quantifies the level of consensus achieved in that region, finding that over 85 percent of countries offer a UBP that includes immunizations and interventions to fight HIV/AIDs, malaria and tuberculosis; and around 60 percent of countries also offer reproductive and child care as part of the UBP.[6]

Beyond this basic package, there was no consensus in MICs when they launched their UHC reforms in the early 2000s, and there is no consensus in LICs today regarding what benefits to expand next. Among the countries studied, ten countries chose to expand other primary care services, six chose to expand exclusively hospital services, and most chose different combinations of outpatient, inpatient, diagnostic and pharmaceutical benefits. There are no clear patterns regarding the inclusion of emergency services, diagnostic imaging or mental health. There are also no clear patterns regarding how to deal with secondary prevention and NCD treatment.

The lack of consensus extends to the question of how to prioritize the future expansion of benefit packages. Several countries in Asia and Latin America are creating specialized agencies to carry out health technology assessments and a few countries are experimenting with innovative forms of stakeholder involvement to improve buy-in and legitimacy of decision-making. In practice, the studies show that even if affordability and cost-effectiveness are criteria established by law in a few countries, in over half of the countries studied, no formal criteria were used to define the benefit package guiding their reforms. Also, revisions to benefit packages are rarely accompanied by an assessment of the fiscal impact of such decisions.

Another major area of divergence across countries regards

6 Cotlear and Rosemberg op. cit.

what populations to subsidize. Most countries studied have a policy regarding coverage of the civil service and of formal sector wage earners – which tends to be contributory and compulsory. At the other end of the income pyramid, all countries advancing UHC have adopted a policy to fully subsidize health coverage for the poor. There is however fierce debate related to fairness and to fiscal sustainability in many countries regarding coverage for the intermediate groups: near-poor and the non-poor informal sector workers. Many countries initially created schemes exclusively for the poor, including for example Georgia, India (RSBY), Indonesia, Peru, Tunisia, Philippines and Vietnam. Most of these countries later expanded eligibility to include the near poor, often after a period of failed experimentation with partial subsidies. In some cases, such as Peru, this decision has been reversed. It may be noted that the debate regarding the near-poor is also relevant in the USA, where some of the largest gains in coverage after the Affordable Care Act legislation were a result of allowing Medicaid to cover populations earning up to 140 percent above the poverty line and where much of the effort to repeal the law is focused on this feature. The debate surrounding coverage of the non-poor is equally fierce. Most countries have not been able to cover them to date; among those that have are Argentina, Colombia, Mexico and Thailand, which have tax-subsidized their coverage, while other countries such as Chile, Costa Rica and Turkey have instituted new tax capabilities to make it possible to enforce contributions from these non-poor populations.

Conclusions

Around the world, countries are implementing universal health coverage programs. These programs are at once new, massive and transformational. Most of the countries studied initiated and expanded their UHC reform programs after 2000; these reform programs are a defining feature of social policy in developing countries in the new millennium. They are massive because they cover more than a third of the world population. They are transformational because they do not just expand coverage but fundamentally change the way that broader health systems work, making them more efficient and more inclusive of low income populations.

Countries agree on certain things. Areas of policy convergence include the use of explicit promises regarding the three dimensions of coverage; countries promise to expand coverage of populations and of health care benefits and countries promise affordability of the benefit package. There is also convergence in health financing policies, with a transition to greater levels of expenditure financed through mandatory taxes and contributions. There is also consensus that the poor populations must be prioritized and not subject to payment at the point of service.

UHC reforms often follow two paths. Some countries focus on supply-side reforms designed to expand the capacity and flexibility of health care providers. Progressivity is ensured by prioritizing platforms such as primary health care, which have proven to be more accessible to low income populations. Other countries focus on demand-side UHC reforms designed to open the gates of hospital and high complexity services to low income populations; these usually involve the creation of public insurance agents that enroll poor and low-income populations using tax subsidies to finance their use of health care.

Countries disagree on other things. Policies diverge regarding what benefits to prioritize beyond the narrowest universal basic package. Country studies show great variation on what is covered; they also show that while on paper there is a new emphasis on the use of science and of transparent processes to choose priorities, in practice the choices are often not systematic or transparent. Countries also diverge regarding the use of subsidies to finance near-poor populations, and especially the non-poor informal sector populations.

While UHC reforms bring much promise, it is important to recognize that the reforms also bring new risks. UHC reforms transform health systems, making them more complex, both technically and politically; mitigation of this risk requires the development of new skills to deal with this complexity. Secondly, the use of explicit promises provides an opportunity for greater accountability and transparency, but the study found many broken promises – in particular, new statutory health benefits are in practice rationed. This creates problems of credibility, which may undo much of the transformational role of the reforms –the UHC movement sustainability needs governments to keep the promises they make.

Biography

Daniel Cotlear is Lead Economist with the World Bank's Health and Nutrition Global Practice. He supports countries implementing policies to advance Universal Health Coverage (UHC) and works on topics of population aging. He is manager and chief editor of the World Bank's Universal Health Coverage Study Series, which has published 40 country case studies analyzing how policy-makers in low-and middle-income countries are implementing UHC.

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How they did it? Pro-poor UHC efforts in low and low-middle income contexts

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ABSTRACT: This paper synthesizes findings from six countries in the UNICO series which have made considerable progress towards pro-poor universal health coverage (UHC), despite limited financial resources. These countries include Kenya and Ethiopia from the first round of the UNICO studies published in 2013, and Cambodia, Lao PDR, Malawi and Tanzania from the second round of case studies being published in 2018.
These programs started amidst a very challenging health system context and aimed to simultaneously address multiple constraints. Amidst these challenges, pro-poor programs were able to make significant contributions to overall health system performance. There is an emerging impact on health outcomes and on access and financial protection for the poor- but there is also a large pending agenda, including quality of services, continued equity challenges, inadequate financing and poor capacity. However, they have successfully shown innovations on purchasing, information systems and their strong pro-poor focus, a lesson for other LIC and LMIC peers.

Introduction

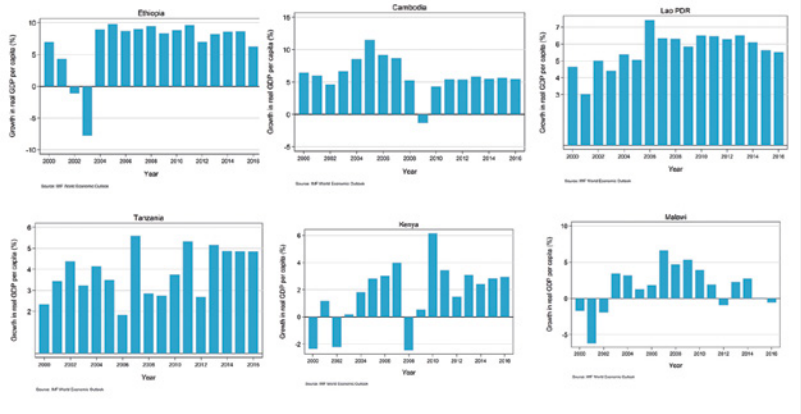
This paper focuses on findings from six countries in the UNICO series which have made considerable progress toward pro-poor universal health coverage (UHC) despite limited financial resources. These countries include Kenya and Ethiopia from the first round of the UNICO studies published in 2013, and Cambodia, Lao PDR, Malawi and Tanzania from the second round of case studies being published in 2018. It offers an in-depth examination of contextual factors, key features of their UHC programs, and important implementation trends from these countries. Despite several challenges that these programs faced and continue to face, these findings are not only enlightening and inspiring in their own right, they also hold several important lessons for other low-income and low-middle income contexts. As with other UNICO case studies, these programs were identified in virtue of their strong pro-poor UHC efforts during the 2000s, and in keeping with the 'new, massive and transformational' theme of the UNICO series.

Macroeconomic, Health System and Health Financing Context

It is not a coincidence that many of the LICs and LMICs that embraced pro-poor UHC programs in the UNICO sample were also amongst the fastest growing in their group, and in some cases, they were the fastest growing economies globally. As evident from Figure 1, Ethiopia, Cambodia and Lao PDR particularly stand out due to consistent and high growth during the 2000s, which created the fiscal space for these initiatives. Growth was consistent albeit a little lower in Tanzania, and somewhat less consistent and also lower in Kenya and Malawi.

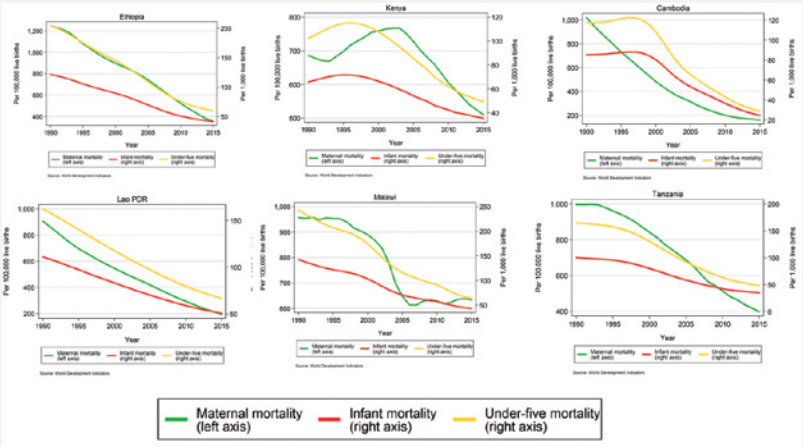
Health outcomes in these six countries with pro-poor UHC programs also tend to be better compared to their income comparators. Figure 2 shows the trends in the Millennium Development Goal (MDG) focus areas of maternal and child mortality over 1990 to 2015. All six countries recorded impressive gains over the MDG period and achieved most of the MDG targets for these key population health outcomes. For example, maternal mortality decline in Cambodia and Lao PDR was at a level close to 1000 per 100,000 live births in 1990 and was reduced to below 200 by 2015. Figure 3 plots a distribution of life expectancy by GNI per capita, and the distribution of infant mortality by GNI per capita, for all countries in the WDI database, with the six countries highlighted. Most of the UNICO countries analyzed in this paper (barring Lao PDR to some extent, which had impressive gains within its own context but also has several persisting access challenges that it is grappling with) tend to do better on these health outcomes than other countries with the same level of income per capita. While these health gains do not imply attribution to UHC efforts per se, this remains an interesting association which may have contributions from a conducive policy environment and progressive outlook on health investments, higher economic growth or inclusive approaches in health investments, among others.

FIGURE 1: GROWTH TRENDS IN GDP PER CAPITA ACROSS THE SIX SELECTED COUNTRIES, 2000-2016



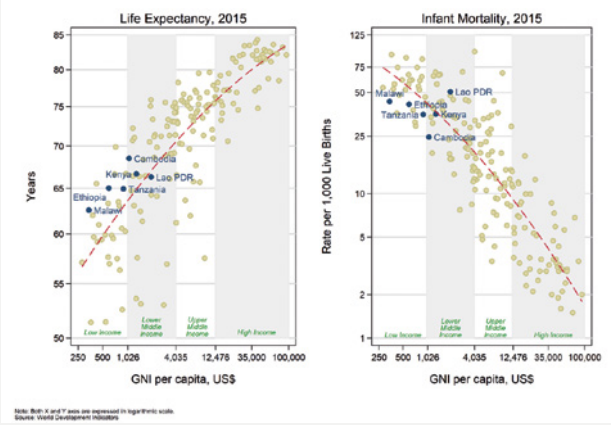
Source: IMF World Economic Outlook

FIGURE 2: TRENDS IN MATERNAL, INFANT AND CHILD MORTALITY ACROSS THE SIX SELECTED COUNTRIES, 1990-2015



Source: World Development Indicators

FIGURE 3: LIFE EXPECTANCY AND INFANT MORTALITY VIS-À-VIS GNI PER CAPITA IN THE SIX COUNTRIES, 2015

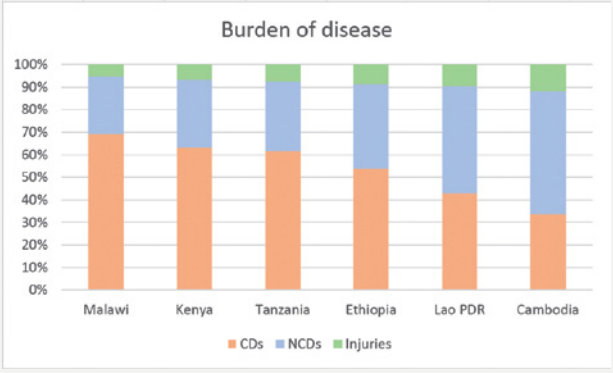


Source: World Development Indicators

Between 1990 and 2016, epidemiological profiles have changed across all six LICs and LMICs, though the relative situation in Africa and East Asia seems different currently. Generally, the countries analyzed in this study have followed the global trend, with reducing disease burden from most communicable diseases (barring exceptions such as HIV/AIDS) and from maternal, neonatal and child health causes, while increasing the relative share of disease burden from non-communicable diseases and injuries. However, the patterns differ between the four African LICs and LMICs in the UNICO sample, and the two Asian countries, as evident in Table 1. The reduction in the relative burden of communicable diseases, maternal and child health issues was far steeper in the East Asian countries of Lao PDR and Cambodia, where NCDs moved to a clear majority of the disease burden. Interestingly, despite following the same trend, this transition is slower in the four African countries where CDs and MCH burden continues to be the majority, even in 2016.

TABLE 1 AND FIGURE 4: DISTRIBUTION OF BURDEN OF DISEASE IN THE SIX SELECTED COUNTRIES (IN PERCENT), 2016

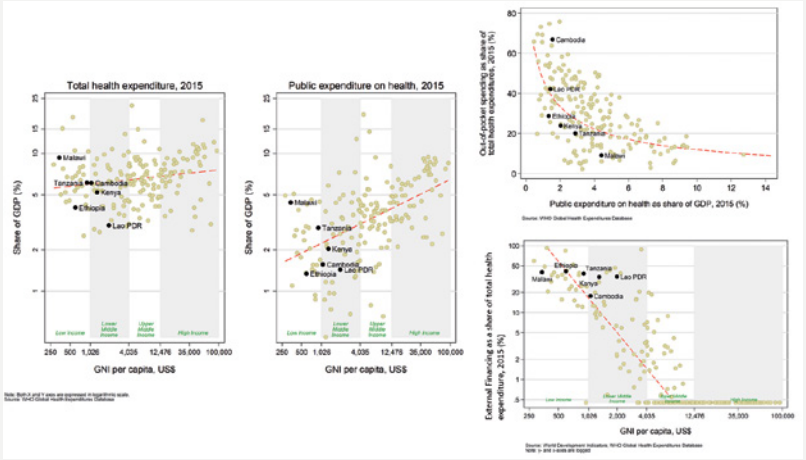
Country	NCDs	CDs	Injuries
Cambodia	54.6	33.6	11.8
Ethiopia	37.6	53.9	8.5
Kenya	29.9	63.4	6.8
Lao PDR	47.4	42.9	9.7
Malawi	25.7	69.1	5.2
Tanzania	30.8	61.6	7.6



Source: IHME
Note: NCDs = Non-Communicable diseases; CDs = Communicable diseases

With the exception of Malawi and to some extent Tanzania, the total health expenditure as a share of GDP, as well as public health expenditure as a share of GDP, remained low in the LICs and LMICs, often even lower compared to their peers with the same level of income. This also reflected as a relatively high out-of-pocket share in total health expenditure (Figure 5), with the two Asian countries demonstrating a much higher out of pocket share than the four African countries in this group. In the case of Cambodia, this may partly be due to the relatively low share of external assistance of health in total health expenditure, as compared to the other five countries in the LIC/LMIC group.

FIGURE 5: HEALTH FINANCING IN THE SIX COUNTRIES, 2015: TOTAL HEALTH EXPENDITURE AND SHARE OF PUBLIC, EXTERNAL AND OUT-OF-POCKET FINANCING VIS-À-VIS GNI PER CAPITA



Sources: WHO Global Health Expenditures Database

Key Program Features and Common Trends

The following section describes key program features and trends observed in these countries. Given that the data periods and information for the two UNICO rounds are not comparable, the first round of UNICO countries (Kenya and Ethiopia, with information collected in 2011) are not part of the comparison made in this section. There are five pro-poor health coverage programs described in these four case studies (including two programs from Malawi) from the second round of UNICO studies that are discussed here. While these programs focus on different aspects of the health system (two use demand-side and three use supply-side approaches), a more detailed analysis reveals several commonalities in their implementation arrangements, program design and emerging evolutionary trends.

Benefit Package, Scope and Service Provision

With the exception of CHAM in Malawi, pro-poor programs in lower resource contexts were seen to operate mostly through the public sector, and the private sector plays a relatively limited role in all countries. This is particularly evident for primary health care service provision, where services are predominantly delivered through public providers. Private facilities provide a more significant share of services at higher levels of care. Patients may still be able to choose within public facilities; gatekeeping and referral requirements were weak.

T**he programs are targeting specific levels of care, and also have undertaken efforts to explicitly define benefit packages.** There are no detailed positive or negative lists in use yet, instead these programs cover broad categories of services at the defined levels of care. Also, all countries do not have fully institutionalized processes to establish which services should be covered by the program. Only two countries had explicit criteria to select health services, and in all cases, affordability was the main guiding principle. The Ministry of Health was seen as the main stakeholder in the determination of the benefit package.

Programs generally covered primary care services and pharmaceuticals well, but varied in their coverage for hospital care. As table 2 summarizes, in Lao PDR and Cambodia, pro-poor programs offered a comprehensive benefit package with coverage for all levels of service delivery (though limited by service availability at each level of care). In Tanzania, most programs focused on primary health care services (e.g. CHF), and in Malawi, CHAM has targeted secondary care level through service agreements with faith-based (church-run) hospitals. Pharmaceuticals are covered by all programs. Formal efforts for quality improvement are only starting now, and only one of the five programs (the program in Malawi that used faith-based providers) required accreditation as a prerequisite. While the quality of primary health care services was comparable for the poor and the rich in all countries, half of the countries indicated that for secondary and tertiary care, the poor may consume a different quality of services than what may be sought by the higher income groups (which may be in completely different health facilities that the poor remained unable to access, such as private or overseas hospitals). In three countries (Cambodia, Lao PDR and Malawi), public hospitals had private wards or rooms that offer a differential level of services to paying patients, indicating some differential level of services even within the same public facilities.

Program Financing and Governance

In all the programs analyzed, central government and external donors were the main sources of funding. In Lao PDR and in Tanzania, sub-national governments also contribute to the program's funding. In Tanzania however, districts often failed to pay their share and funding relied on the central government and contributions from beneficiaries (the rural poor). This was reported as the only example in which poor households are required (de facto) to pay contributions. In all other programs, the poor are eligible to receive all the services

TABLE 2: SCOPE OF SERVICES AND COPAYMENT REQUIREMENTS ACROSS THE FOUR UNICO2 COUNTRIES, 2017

	Outpatient Services	Secondary-level Inpatient hospital services	Tertiary/Super specialty inpatient services	Emergency Services	Clinical laboratory tests for outpatient services	Pharmaceuticals
Covered by the program	100%	75%	75%	75%	75%	100%
Requires copay by beneficiary at point of service	0%	25%	25%	0%	25%	0%
If not covered by HCP, is it available with no copay to the HCP population outside the program?	0%	0%	0%	0%	0%	0%

Source: Authors' Elaboration based on UNICO Questionnaires for the respective countries

offered by the programs, with no contribution or co-payment, and this was also achieved in practice. Anecdotal evidence suggests that while informal payments may still be an issue in some of these countries, the likelihood was considered low. However, it is important to remember that incidental costs, such as travel and loss of wages, remain possible barriers to access by the poor, even when health services were available at no cost.

HEF in Cambodia and EHRP in Malawi are adequately funded. In the other three programs, it was reported that funding was insufficient. Programs have adopted different strategies to cope with the limited availability of funds. The most common impact of inadequate funding has been the provision of an incomplete set of services, or requesting patients to buy certain commodities. Other coping strategies include targeting specific sectors of the population (therefore not meeting the program's stated population target) or accumulating arrears. This inadequacy of funds is despite the fact that these programs do not represent the full cost of services delivered. In most cases, these programs provide additional or supplementary sources of financing, over and above the supply side funding to the health system which continues (even if inadequate by itself). In some cases, this may be an unfunded or underfunded mandate, so that health facilities that offer services to the poor under these programs must bear some of the financial burden of doing so, and subsidize it from other sources of income, such as user fees for paying patients.

These programs are contributing to important improvements in the way the overall health system works. While the main goal of these programs is to increase access to health services to the poor, all programs have indicated having a broader impact. To illustrate this, all programs have reported strengthening local government authorities' (LGAs) and/or service providers' autonomy. Improved availability of flexible cash resources is the most frequent area in which these programs increase providers' and LGA's autonomy. In many cases, service providers were also allowed to purchase drugs outside the public system, to prevent stockouts and improve service availability. Performance linkages inherent in the design of some of these programs have also meant that a small top-up payment is improving results being achieved from the larger underlying public investment in health services.

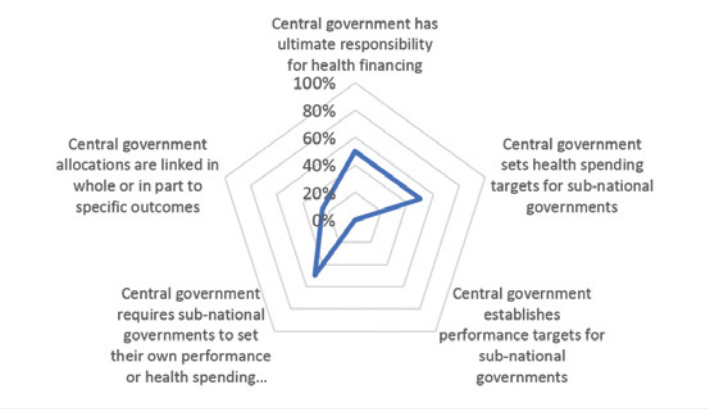
Incidentally, three countries (Cambodia, Laos and Tanzania) of these four have also introduced parallel social health insurance programs. These schemes were not linked to or featured as pro-poor health coverage programs for the UNICO analysis, as they predominantly cover civil servants and/or the private formal sector, and have a very limited contribution to the expansion of coverage to the poor. Furthermore, redistribution mechanisms were not in place in any of the sample countries to cross-subsidize pro-poor health coverage programs and these SHI initiatives. In all cases, there is a purchaser-provider split, and SHI is managed by a separate or autonomous agency.

All countries in the sample have embarked on the process of decentralization. Sub-national authorities, to varying extents, play an important role in the design and/or implementation of these programs. Even though all countries indicated that the health system is decentralized, central governments seem to have a significant influence that goes beyond steering the sector and monitoring the performance of sub-national authorities (Figure 6). This suggests that while decentralization is widespread, it is still an unfinished agenda and the level of balance between national influence and decentralized decision-making autonomy also remains an open question.

Country UHC Monitoring Status and MDG Performance

The recently released SDG UHC indicator status for these six countries from the Global UHC Monitoring report, 2017[i] is summarized in table 3. The cou-ntries show modest performance on both service coverage and financial protection indicators, though seemingly better than other low income countries in the list. As further research, it may be a useful exercise to compare this performance systematically to their economic comparators, with more detailed data from the UHC monitoring report. Within

FIGURE 6 – TRENDS IN DECENTRALIZATION: EXPERIENCES FROM CAMBODIA, LAO PDR, MALAWI AND TANZANIA



Source: Authors' Elaboration based on UNICO Questionnaires for the respective countries

the detailed calculation of the UHC service coverage index, it is not surprising that these six countries are particularly pulled down by indicators around specialized human resources, and socioeconomic determinants exemplified by sanitation status. For example, Cambodia in East Asia, and Ethiopia, Malawi and Tanzania are among the countries that managed to achieve the Millennium Development Goal (MDG) target of reducing under-five mortality by two-thirds, outperforming many of their comparators. Likewise, Cambodia and Lao PDR also attained the MDG target of reducing maternal mortality by three-fourths.

TABLE 3: SDG-UHC INDICATORS FOR SIX SELECTED COUNTRIES FROM GLOBAL UHC MONITORING REPORT, 2017

Country	SDG-UHC indicator 3.8.1: Service coverage index, 2015	3.8.2: Incidence of catastrophic expenditure at 10% of household total consumption or income	3.8.2 Incidence of catastrophic expenditure at 25% of household total consumption or income	Data availability for 3.8.2 (Year)
Cambodia	55	19.97	5.64	2009
Ethiopia	39	0.82	0.18	2004
Lao PDR	48	2.98	0.26	2007
Kenya	57	5.83	1.51	2005
Malawi	44	1.64	0.1	2010
Tanzania	39	9.87	2.48	2012

Source: Global UHC Monitoring Report, 2017

Discussion and Synthesis

Several interesting insights emerge from the evolution and implementation experiences of the pro-poor UHC programs in low-resource contexts. Some of these are discussed in this section.

These programs were generally designed with an aim to mitigate the effects of user fees on the poor who were disproportionately affected by said fees. It was increasingly realized that unfunded mandates of 'exemption' from user fees were a less attractive solution (in view of the perverse incentives that they created for the health facilities) than programs that provided some resources to health facilities on behalf of the poor. Many of the programs, such as Health Equity Funds (HEFs) in Cambodia and Lao PDR, and the Community Health Fund (CHF) in Tanzania, represented these responses which compensated health facilities while reducing any out of pocket payment burden on the poorest population groups. It is also interesting that these programs targeted their benefits towards the poorest, in a context when the country itself was low-income and had high levels of poverty. In the evolutionary choice they faced between having wider population coverage or a deeper benefit package for the poorest, the latter seems to have been a preferred choice.

These programs started amidst a very challenging health system context, trying to address multiple constraints at the same time. These challenges were not dissimilar to other low-income contexts. These pro-poor UHC programs evolved in a context of limited fiscal space, high levels of poverty, fragmented donor support, low levels of public financing for health and amidst severe shortage of core health workers (who were also poorly paid). There were also severe challenges of supply side readiness, especially in the quality of health services, further accentuated by low levels of facility autonomy and hugely inadequate commodity supply and financial resources at facility level. There remained continued physical and financial barriers to access (particularly pronounced for the poor), and very poor health outcomes during the 1990s across all these countries.

Amidst these challenges, pro-poor programs were able to make significant contributions to their respective health systems. Significant additional resources were provided to health facilities, including incentives and salary top-ups which were often results-based. These filled in critical funding gaps, improved facility maintenance and availability of commodities, and in many ways helped improve the performance of underlying public investments. They introduced innovations in purchasing (both from within the public sector, and to some extent also involving the private sector in Malawi), while also improving information systems, changing the accountability paradigm and thereby better aligning incentives of health providers to those of the policymakers. Close involvement with communities, a common accountability feature across these programs, also helped foster improved linkages and responsiveness to community needs.

The programs had a strong primary care focus- especially

on maternal and child care. Several of these programs primarily focused on primary care facilities, while de facto utilization was predominantly on maternal and child care services, except for in programs explicitly focused on higher levels of care (service level agreements with faith-based providers in Malawi being such an exception). They predominantly used public facilities, but there was experimentation with the private sector in at least one case, even within their own challenging contexts.

There is an emerging impact on health outcomes and on access and financial protection for the poor- but there is also large pending agenda. The quality of services remains a pending agenda, as do the continued equity challenges between geographies and between ethnic and socioeconomic groups, despite their pro-poor focus and achievements. The sobering reality remains that these programs still face several challenges, not least inadequate financing and poor capacity. A consequence of these challenges is that the full promised benefit package is not available in reality, and this is yet another pending agenda. However, these programs have successfully shown innovations on purchasing, information systems and pro-poor focus that are well ahead of their peers and lay a promising foundation for these countries, constituting a lesson for other LIC and LMIC peers. This lesson seems to be that progress towards Universal Health Coverage is a lot more about willingness to do better, even if resources are constrained.

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Biographies

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Faster, higher, leaner, but not further: Sri Lanka and Malaysia's expansion of Universal Health Coverage (UHC) using an integrated NHS

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ABSTRACT: This paper focuses on the characteristics of integrated national health services (NHSes), as exemplified by Sri Lanka and Malaysia, as it relates to their successful expansion of Universal Health Coverage (UHC) for maternal and child health (MCH). Both countries attained high and equitable MCH outcomes, with strong financial protection, faster and to a higher degree than economic comparators. However, the challenges faced by both countries with noncommunicable diseases (NCDs) indicates the limitations of unreformed integrated NHSes and the imperative for reforms. As Malaysia has a GNI per capita three-times that of Sri Lanka, and is currently facing stagnation with MCH outcomes and acute challenges with NCDs, we postulate that such reforms should be timed around graduation from lower-middle income to upper-middle income status, equating approximately a GNI per capita of US$ 4,000.

Introduction

Middle-income countries (MICs) have generally addressed the coverage of basic health services but increasingly face challenges with financial sustainability and continued effectiveness in improving health outcomes beyond maternal and child health (MCH). Health outcomes for noncommunicable diseases (NCDs), such as cardiovascular diseases and cancer, are increasingly relevant given the epidemiological and demographic transition, rising middle-class expectations, and high-cost health technologies. Although MICs use a variety of health financing schemes – general tax-financed national health services (NHSes), social health insurance (SHI), private health insurance (PHI), and gradations in-between, which coexist with private out-of-pocket (OOP) funded health services – they share a common imperative to improve efficiency while preserving and enhancing equity and financial protection (Gottret and Schieber, 2006), as universal health coverage (UHC) is expanded to services beyond MCH. The 'depth' of services covered and the 'height' of financial coverage for health services, are two critical dimensions of the UHC 'cube', in addition to the third dimension which is the 'breadth' of population coverage (World Health Organization et al., 2010).

MICs are a large and diverse group of countries which together account for one-third of global GDP and 5 billion people (World Bank, 2018a). They are subdivided into lower-middle income countries (LMICs) and upper-middle income countries (UMICs), with income thresholds of $1,025 to $4,035 and $4,036 to $12,475 respectively (World Bank, 2018b). Incomes are higher in MICs than low-income countries (LICs) and the basic institutions and capacity of the government to administer and deliver services is stronger, but inequality and poverty are far from being eradicated - 73 percent of the world's poor live in MICs.

This paper describes the successful expansion of UHC for MCH in Sri Lanka and Malaysia, respectively a LMIC and a UMIC, by means of integrated NHS. The key characteristics of this high-performing scheme have enabled both Sri Lanka and Malaysia to attain the coveted triad of high and equitable MCH health outcomes, strong financial protection, combined with low-cost leanness; all this faster and to a higher degree than economic comparators in the past. However, this same unreformed scheme is now constraining progress in expanding UHC beyond MCH, as the chronicity and complexity of diseases change, expectations rise, and effective but costly health technologies become available. Malaysia has approximately three times the GNI per capita of Sri Lanka, but the integrated NHS of both countries remain unreformed, therefore the relative performance of these two countries over time can indicate the desirable timing for health financing reforms.

The characteristics of an integrated NHS

NHSes are funded through unearmarked (neither to health nor specific covered individuals) general taxes and other public revenue (Gottret and Schieber, 2006), with no opt-out for nonusers, and provide health services for free (or nearly free) at point of care based *'on clinical need, not an individual's ability to pay'* (Department of Health UK, 2015). By definition, an NHS covers the full breadth of UHC – all citizens. *Integrated* NHSes integrate financing and provision, but are not to be confused with integration used in other contexts, such as vertical integration across hospitals and clinics. Integrated NHSes anchor but do not equal the whole health system, as they coexist in equilibrium with other health financing and provision schemes, particularly the private sector. The latter can absorb excess demand and, through dual-practice, supplement public salaries.

These schemes owe their genesis to country-specific historical contexts which evolved according to the culture and character of each country, its institutions, and external forces. Two health systems are noteworthy predecessors – the Semashko centralized healthcare system of 1918 which developed in the former Soviet Union and the Beveridge NHS of 1948 which developed in post-war United Kingdom. The latter, however, is not an integrated NHS, due to its internal market. Several characteristics of integrated NHSes are clustered together, which contribute to its performance in expanding UHC and color future reform options, and are described below.

Revenue mobilization

As resources are mobilized through general taxation, fiscal space provided to integrated NHSes can permit the expansion of health coverage, even despite labor informality and inequality, at a pace permitted by economic growth. Even if wealth is not held by households, for example in natural resource-rich countries, well designed and implemented taxation policies can finance health progressively and enable a country's wealth to be prioritized toward healthcare. Integrated NHSes are less complex to administer, as they do not require a separate financing institution besides the treasury. Health financing through general taxation is also single-payer by default – allowing the market power of a monopsony to centrally procure health supplies such as pharmaceuticals efficiently, although this default is not always used, for example in decentralized countries.

Pooling

Compared to individual medical savings accounts, overly segmented SHI, or underregulated PHI schemes, pooling across an integrated NHS is in theory very large – national-level risk pools (or subnational risk pools in large decentralized countries). There is no direct link between an individual's contributions to and access to the scheme. Hence, if resources are well-allocated, access can be based purely on 'clinical need', with the healthy and rich cross-subsidizing the unhealthy and poor. This access is 'universalist' – having an intent to be universal, even if effective access is dependent on local supply.

Where local supply is adequate, a high degree of equitable access can be provided with strong financial protection. However, where local supply is inadequate, as evidenced by queues and/or foregone care (for example, undiagnosed or sub-optimally managed NCDs), access is compromised. Health coverage in the context of an integrated NHS is hence essentially a function of the services that can be supplied in sufficient quantity to meet local demand.

Resource allocation and purchasing services

Resources allocation, across geography, health programs and facilities, and composition of spending, is centrally- or regionally-planned and determined bureaucratically, rather than demand- or market-driven. Where the government prioritizes MCH, and rural and/or poor populations, the performance of such a scheme in attaining those relevant outcomes can be stellar, as exemplified by Sri Lanka and Malaysia (Box 1). However, if urban areas or tertiary care is favored, or if there are failures in governance, the scheme would fail to attain desired health outcomes equitably.

By definition, integrated NHSes do not separate purchaser from provider. Both are the same government legal entity, in contrast with health insurance schemes and even non-integrated NHSes such as the UK's NHS, where health services are purchased from hospital trusts and private GP contractors. The government, as purchaser, controls the provider directly, rather than through strategic purchasing or incentives. Direct budgetary control is expressed as historical line items budgets, which deny providers autonomy to respond to local needs and conditions, and disincentivizes efficiency improvements. Providers merely administer resources as centrally-planned and determined.

Box 1: Faster, higher, and leaner: How Sri Lanka and Malaysia expanded UHC using an integrated NHS

Sri Lanka and Malaysia are MICs which share a history of British colonial administration and an integrated NHS. Both countries expanded UHC to attain strong and equitable (O'Donnell et al., 2005) MCH health outcomes and financial protection *much faster* and to a *higher degree* than economic comparators. These schemes are *lean* - general government expenditures on health at 1.6 and 2.1 percent over GDP respectively in 2015 (World Health Organization, 2018) – but as fast growing economies[1], these general taxation funded schemes benefited from an increase in real per capita general government consumption of 303 and 246 percent respectively in Sri Lanka and Malaysia (World Bank, 2018a). Although both are MICs, Malaysia has approximately 3 times the GNI per capita of Sri Lanka, and hence the successes and limitations of integrated NHSes at different stages of economic development are notable. Malaysia's progress in improving MCH outcomes has slowed to the extent that it failed to attain the maternal health Millennium Development Goal #5 (United Nations Malaysia, 2015).

As universalist integrated NHSes, both Sri Lanka and Malaysia include the full population breadth – all citizens. Healthcare is provided for free (in Sri Lanka, for drugs

1 Real GNI per capita grew 3.1 and 2.5 times in Sri Lanka and Malaysia respectively from 1990 to 2016 (World Bank, 2018a).

deemed essential) or nearly free (in Malaysia), thus ensuring high financial coverage. Informal payments to public providers and absenteeism in Sri Lanka and Malaysia is insignificant, given strong governance and the intrinsic motivation of health workers. No special institutions or health insurance mechanisms, which may add to administrative overheads, are needed to implement the integrated NHS. Revenue is mobilized from the existing general taxation system and delivered directly through the public sector. Formal enrollment of the eligible population to specific providers is *not* required of users and eligibility is easily verified through proof of identity and citizenship using the national identity card.

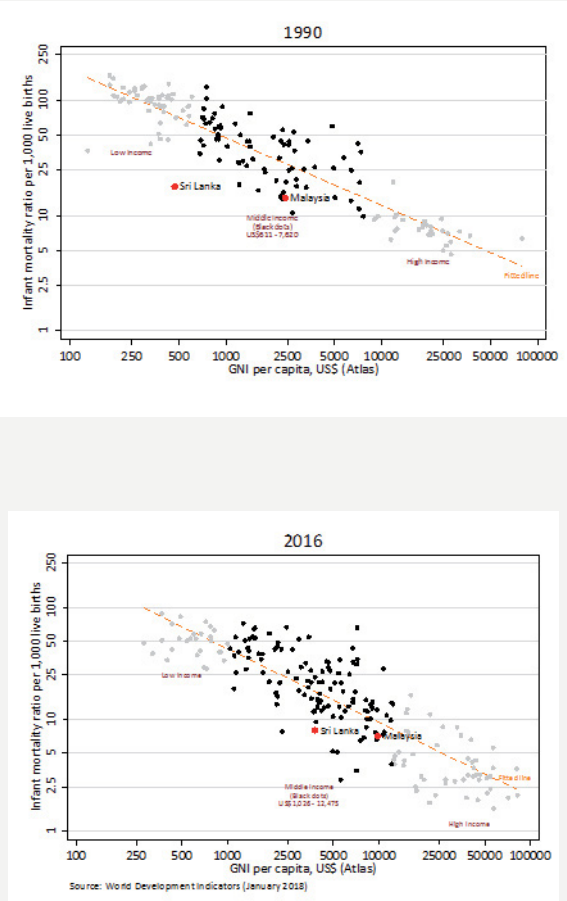
However, demand outstrips supply when services are free of charge for every citizen, resulting in overcrowding and implicit rationing through queues, and decreased consumer responsiveness. The rich then opt-out by paying privately for health services, leaving publicly-financed services for the poor. Dual-practice, where public doctors work privately during allowable hours, is common in Sri Lanka and increasingly common in Malaysia[2]. This further allows the rich to bolster the salaries of public doctors, who are generally paid less than their private counterparts. These features account for the pattern of relatively high OOP expenditures in both Sri Lanka and Malaysia, at 38 and 37 percent of total health expenditure in 2015 respectively (World Health Organization, 2018), despite strong financial protection[3] and progressive benefits incidence in the public system, within universalist schemes which do not explicitly target. OOP expenditures are instead concentrated among the rich and/or for low-cost outpatient services.

On the supply-side, priorities such as MCH are strongly governed and well-funded through investments which favor rural communities. In Sri Lanka, these have led to coverage for antenatal care, institutional deliveries, childhood immunizations for nearly 100 percent, leading Sri Lanka to the *'global frontier for indicators such as infant mortality'*, indeed *'no other country with a similar income to Sri Lanka has better MCH outcomes'* (Owen Smith, 2018). Similarly, Malaysia has built 2,227 new clinics over the 23 years after independence, explicitly prioritizing rural areas and MCH (Pathmanathan and Liljestrand, 2003; Safurah Jaafar et al., 2012). Antenatal care is ubiquitous and equitable, resulting in strong MCH indicators (Figure 1). Indeed, some commentators consider Malaysia to have attained UHC, at least for MCH, already by the 1980s (Savedoff and Smith, 2011) when GNI per capita was just US$ 1,790[4] (World Bank, 2018a).

The year-on-year affordability of the integrated NHS is assured through the line-item budgeting system, where high demand results in shorter visits and longer queues which ration and limit demand, but do not create the deficits seen in health insurance schemes, as financial stresses are borne by providers. The supply-side can be further used to ration the depth of services covered, as effective access is in practice limited to services provided locally by integrated NHS facilities. However, if this comes at the expense of the diagnosis and early management of NCDs, this can lead to poorer outcomes and higher expenditures in the future.

LICs should be aware that Sri Lanka's low infant mortality was achieved before 1990, when GNI per capita was around US$ 500, as this indicates that UHC for MCH can be attained quite cheaply. However, the decline in both Sri Lanka and Malaysia's relative performance from 1990 to 2016 (Figure 1) indicates the limitations of an unreformed integrated NHS, not just for NCDs but even for MCH.

FIGURE 1: INFANT MORTALITY RATIO, 1990 & 2016



Source: World Development Indicators (January 2018)

2 In Malaysia, the Full Paying Patients scheme allows public doctors to practice privately at designated 'private' wards in some public hospitals. Furthermore, specialists have recently been allowed one day per week to work or teach in the private sector - *Good news for medical specialists in govt service* - Nation | The Star Online [WWW Document], 2018. URL https://www.thestar.com.my/news/nation/2018/01/07/good-news-for-medical-specialists-in-govt-service/ (accessed 1.12.18).

3 Only 1.5 and 0.3 percent of households in Sri Lanka and Malaysia respectively spent more than 25 percent of total expenditures on health out-of-pocket expenses (Owen Smith, 2018; IHSR, 2013).

4 Current US dollars; Atlas Method.

The constraints of an integrated NHS

The characteristics of integrated NHSes and the experience of Sri Lanka and Malaysia point to four inherent constraints.

Sustaining and coopting additional health financing sources. General taxation has strengths, but is vulnerable to three important variables: (i) macroeconomic conditions; (ii) the ability of the government to collect tax; and (iii) the willingness and ability of the government to prioritize health spending – i.e., political and bureaucratic processes and their vagaries. These temperamental factors result in year-by-year budgets, fought through the political system, which do not facilitate long-term planning and investments, for example, in the prevention of NCDs. Furthermore, coopting private OOP and payroll contributions is constrained in an integrated NHS. Neither the rich nor formally employed may be minded to contribute without assurance of defined benefits, even if organizing private OOP into a strategic purchaser with large market power (such as a single payor) would be more efficient. By contrast, earmarked taxes or SHI contributions, if managed by trusted institutions and linked to defined benefits, receive more political support from the population as these finances are committed to health.

Increasing health resources, using a balance of general taxation and health-specific contributions such as insurance premiums, would be important to support investments in preventing and managing NCDs. In its absence, Sri Lanka has prioritized the purchasing of essential drugs covering MCH but implicitly accorded a *'lower priority'* to NCDs such that *'the population regularly pays out-of-pocket for drugs, including when seeking care at public facilities'* (Owen Smith, 2018). Suboptimal treatment of NCDs at an early stage of the disease results in costly complications which becomes unaffordable later.

Implicitly-rationed universalist health coverage, instead of transparent explicitly-defined benefits. Universalist integrated NHSes deny instruments to explicitly ration and explicitly target health services. As resources are constrained, implicit rationing is ubiquitous in integrated NHSes, which promise almost all health services, including cancer treatment and cardiac surgery, to every citizen. This results in allocative inefficiencies, opportunities for rent seeking, and an 'unfair' system. Waiting lists, queues, and nonfinancial barriers (such the comfort of surroundings and friendliness of health workers) serve as de facto but suboptimal and implicit surrogates to ration and target health services.

These implicit rather than explicit mechanisms come at a cost. Although preferable to rationing by price, targeting the poor by limiting comfort can be perceived as being deeply discriminatory and queues impose substantive opportunity costs on users and, in case of weaker governance, encourage informal payments. This also discourages preventive care, especially for those who cannot afford private care. Instead, formal health technology assessments (HTAs) directly linked to the benefits package, should transparently determine resource allocations - the most cost-effective services should be funded-fully first, for all those with 'clinical needs' not just those who are able to arbitrage an implicitly rationed system.

Lack of provider-purchaser separation. Efficiency is increasingly paramount for MICs, but the line-item budgeting system used by integrated NHSes constraints the ability of local providers to respond to local needs and disincentivizes savings, even if these line-item budgets were previously adequate for simple MCH services. Provider-purchaser separation, accompanied by increasing autonomy in public facilities, will enable strategic purchasing to be used to increase the accountability, efficiency, and quality of services, and to purchase from both private and public providers (Cotlear et al., 2015).

Un-modernized delivery. NCDs, for which patients may have no apparent symptoms initially, are more complex and chronic than MCH or CDs, but lead to costly complications if untreated or undertreated. These place individualized demands on the delivery system outside the comfort zone of integrated NHSes. For example, as every citizen is eligible, these schemes do not enroll or track individuals preemptively for risk factors of NCDS, until they use health services, unless outreach or alternative demand-side interventions are effective. Resources are allocated bureaucratically to facilities, not to individuals according to their needs. Primary health care for NCDs, which require greater coordination and continuity of care, is not strong in Sri Lanka. Information systems do not require sophistication and hence in Sri Lanka, this remains *'paper-based'* (Owen Smith, 2018). In Malaysia, even with a GNI per capita three times that of Sri Lanka, the delivery system struggles to preemptively manage NCDs and their risk factors, resulting in a high prevalence of diabetes mellitus (18 percent) among adults, half of which are undiagnosed (Institute for Public Health, 2015).

Conclusion

Integrated NHSes in MICs, as exemplified by Sri Lanka and Malaysia, have attained high and equitable MCH outcomes with strong financial protection and progressivity, as OOP expenditures are concentrated among the rich, and at relatively low-cost to taxpayers, without health financing reforms. This performance was attained faster and higher than most economic comparators, and hence can serve as a benchmark and resource for countries desiring such performance. However, Malaysia, and to a lesser degree Sri Lanka, already struggle with NCDs, indicating the limitations of unreformed models. The specific reform pathways appropriate for each country is beyond the scope of this case study, but such reforms should address the critical constraints described above. As these schemes have clear historical successes, an important question which remains is: *'When to embark on health financing reforms?'*

Sri Lanka, as a LMIC, may not have an adequately large and wealthy formal sector, nor a sufficiently diversified economy to afford an expansion in its priorities to cover NCDs. For example, many NCDs require long-term medications which may be genuinely unaffordable without compromising cost-effective and critical MCH services. Furthermore, the administrative and governance simplicity of an integrated NHS may be too compelling given Sri Lanka's current economic status and performance, and hence financing reforms may lack immediacy and enabling reform factors. On the other hand, while Sri Lanka cannot afford to reform, Malaysia probably cannot afford not to reform as the epidemiological transition is well underway. As

a UMIC with a diversified economy and decent administrative capacity, such reforms are technically feasible although political expediencies may dictate the exact timing. We hence postulate that an appropriate period for integrated NHSes in MICs to embark on health financing reforms is just after graduation into UMIC status at a GNI per capita of US$4,035.

Having attained much *faster, higher,* and *leaner* UHC than comparable countries, Sri Lanka, Malaysia, and similar MICs with integrated NHSes must now go *further* to ensure that their health systems dynamically meet current and future challenges, rather than serve as cautionary tales for other countries.

Biographies

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UNICO: Demand Side Strategies for Universal Health Coverage (UHC)

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ABSTRACT: This article aims to enable a better understanding of the design and implementation of demand-side programs developed in middle-income countries documented by the World Bank through UNICO, with a focus on the progress achieved in identifying beneficiary populations and separating financing from provision.
The article concludes that these programs increased insurance coverage and often also the utilization of key health services. However, their design and implementation faced challenges. The split between financing and provision remained incomplete, since in most cases a large share of the funds financing public providers remain supply-side subsidies and not the funds provided by these demand-side programs. Other challenges remain such as weaknesses in the design of benefit packages and provider payment mechanisms, in the autonomy of providers, in the quality of care, and in ensuring the long-term financial sustainability of these programs.

Introduction

In the quest towards universal health coverage, several middle-income countries have developed demand-side programs aimed at increasing service coverage and financial protection in case of illness. These programs create or extend previous mandatory health insurance programs, providing coverage to groups that had remained uninsured: the poor, the vulnerable living close to the poverty line, and non-poor/vulnerable informal sector workers.

Based on a review of some of these experiences, this article aims to enable a better understanding of the design and implementation of these programs, with a focus on the progress achieved in identifying beneficiary populations and separating financing from provision. This review is not meant to be exhaustive; it only covers countries whose experiences have been documented by the World Bank through UNICO (the UHC Study Series). Despite the fact that all countries included are middle-income countries, there are significant variations in their level of income, the functioning and organization of their health system. In 2016, GDP per capita in the countries reviewed varied from US$ 1,708 per capita (in constant 2010 US$) in Ghana to US$ 14,465 in Croatia.[1] In addition to these two countries, the review also included: Argentina, Armenia, Colombia, Dominican Republic, Indonesia, Kyrgyz Republic, Mexico, Morocco, the Philippines and Vietnam.

Demand-side programs: parallel vs. integrated schemes to insure the poor and vulnerable

Many of the countries reviewed had insurance schemes that already covered formal sector workers and thus designed strategies aimed at identifying the poor and vulnerable, fully subsidizing their coverage within a pre-existing scheme, or within a parallel one created to provide coverage to these population groups.

Croatia, Kyrgyz Republic, the Philippines, Ghana, and Vietnam[2] subsidized the insurance of the poor and vulnerable within existing national health insurance schemes, without generating a parallel program, thus avoiding additional fragmentation. Similarly, Armenia covers the entire population with a basic package of free primary care services through the State Health Targeting Program Law (which generated a split between financing and provision) and different ranges of co-payments for inpatient care, subsidizing the poor and vulnerable.[3]

The Dominican Republic created Family Health Insurance with different financing mechanisms and strategies to cover formal sector workers and their families ("contributive regime"), the poor ("subsidized regime", fully financed by general taxation) and informal sector workers ("subsidized contributive", which was intended to be partially financed by general taxation and household contributions). Similarly, Colombia also created a scheme that originally consisted of different financing mechanisms and strategies to cover different population groups, with "contributive" and "subsidized" regimes, but they were unified in 2012.

1 World Bank World Development Indicators data base.

2 In Vietnam, the 2009 Law on Health Insurance merged all the different programs into one, those covering the formal sector and the poor and informal sector workers (Somanathan, 2013).

3 Rousell, F. et al. 2017.

Two of the upper-middle income countries reviewed created a health insurance scheme to cover all informal sector workers: the Social Protection System in Health (and its main pillar Seguro Popular) in Mexico and Plan Nacer (now known as Programa Sumar) in Argentina. These schemes run parallel to those that cover formal sector workers.

Other countries created parallel schemes to cover the poor and vulnerable but not informal sector workers. This was initially the case in Indonesia with Jamkesmas, and Morocco with RAMED.[4] These schemes ran in parallel to those that covered formal sector employees. Nevertheless, in the case of Indonesia, Jamkesmas merged with two other pre-existing schemes to form the Indonesian national health insurance, Jaminan Kesehatan Nasional or JKN.

Identifying and enrolling the beneficiary population

Since most of the programs reviewed aimed to increase health insurance coverage for the poor and the near-poor in a few cases, these programs developed complex mechanisms to identify and enroll beneficiaries. These mechanisms evolved over time, but they were mainly based on proxy means tests and validation/certification at community level. Systems used to identify the poor have been increasingly centralized and tend to use a unified registry of social program beneficiaries, to reduce space for exclusion and or inclusion errors. This is the case for SISBEN in Colombia, the SIUBEN in the Dominican Republic, the National Targeting System- Poverty reduction list managed by the National Government Department of Social Welfare in the Philippines, and the National poverty list in Indonesia. In addition to proxy means test, other countries also used categorical criteria such as older population and/or children (e.g. Kyrgyz Republic, Ghana, and Vietnam) and other categories, such as people with certain medical conditions or disease, such as Armenia and Kyrgyz Republic.

Explicit entitlements

In addition to mechanisms for identifying and enrolling the beneficiary population, the development of explicit benefit packages and the split between financing and provision of services were also central issues for these programmes. With only a few exceptions, such as Colombia, Croatia, and Mexico, there were weaknesses in the definition and costing of benefit packages. In many instances, these packages were meant to include cost-effective interventions aimed at preventing or treating the main causes of the disease burden of the population that could be fully funded with available resources. In practice, in many instances this was not the case; the criteria for selecting interventions to be included in the package were not always clear or transparent, often following historical expenditure trends and political decisions.

Croatia has a generous package for the entire population, explicitly defined for primary care but with a negative list for remaining services. New services and medicines to be included are decided by technocrats, based on their knowledge, taking into consideration scientific evidence and cost implications. Mexico was another example of a country that progressed significantly in the design and costing of a benefit package and in fully funding its provision.[5] Other countries, such as the Dominican Republic, have explicit packages that were well defined and costed at the beginning but lacked a proper evidence-based system for ongoing revision, which enabled political influences and lack of decision-making transparency to creep in.[6]

Plan Nacer in Argentina also had a well-defined package of services. However, this package was not fully funded by the program, it only provided a top-up for participating provinces. Indeed, its original costing only included the costing of the gap to increase coverage of selected services.[7] In some of the other countries reviewed, no specific and transparent criteria were used to design the package of services, as was the case in Vietnam.[8]

Separation between financing and provision

In many of these countries, the financing and purchasing split was justified by the need to introduce efficiency gains through competition among providers, and in a few cases also among insurers (Colombia, Dominican Republic, Morocco), all with the idea of fostering strategic purchasing. In some cases, one of the main objectives of the split was to optimize a large and inefficient delivery network, by generating competition between public and private providers: this was the case in Croatia, Armenia and the Kyrgyz Republic. In other cases, an important objective of the reform was to increase allocative efficiency through the development of an explicit and prioritized package of services aimed at preventing and controlling the main burden of disease in these countries (e.g. Mexico, Argentina, Philippines, Colombia, Dominican Republic). This package of services was supposed to be "purchased" from existing providers, who would then become accountable for its provision to the beneficiary population. By attempting to develop an explicit package of services and funding it, these programs aimed to eliminate informal payments, implicit rationing and insufficient drugs and supplies. The new provider-payment mechanisms also aimed to generate incentives for providers for improving efficiency and overall performance.

Despite these efforts, in most examples reviewed in the UNICO series, the purchaser/provider split remained incomplete. The demand-side programs only financed part of the cost of providing the package of services. Countries continue to pay most costs (usually payroll, often other things too) through line-item budgets, with only a part of variable costs covered by the payer.

Only some upper-middle income countries were able to achieve a more complete separation between financing and provision, as was the case in Colombia, Morocco, Dominican Republic and Argentina[9], but only in the schemes that cover formal sector workers (usually with private providers), not in the programs covering the poor and uninsured, where the split remained incomplete.

In Argentina, Plan Nacer, today Programa Sumar, only pays a top-up that serves as an incentive to health facilities to provide services included in the benefit package. Health facilities continue to be paid by provinces through line-item budgets that

4 Harimurti et al., 2012 and Dorothee Chen, 2017.

5 Bonilla-Chacin and Aguilera, 2013.
6 Rathe, Magdalena. 2018.
7 Cortés y Romero. 2013.
8 Somanathan et al. 2013.
9 World Bank, 2018.

include salaries, drugs, medical supplies, equipment and capital goods. The resources received by Plan Nacer are small, but in contrast to all other funds financing health services, the facility has the autonomy to decide how to use these resources.[10] In Croatia, even though most health care resources are managed by the Croatian Health Insurance Fund (HZZO) via demand-side financing, local governments (counties) are responsible for the maintenance of infrastructure and capital investments in primary health care centers and minor local public health programs. In Indonesia, it was estimated that the premiums paid by Jamkesmas were not reflective of the true cost of care. It was estimated that over 2/3 of the average costs of care were covered by supply-side subsidies.[11] Salaries, capital and some operational costs continued to be paid by different levels of government (central, provincial, district depending on the type of facility). Also in Vietnam, the government continues to pay supply-side subsidies based mainly on historical norms which are channeled through the Ministry of Health and the Provincial Health Bureaus; supply-side subsidies mainly remain grounded in historical norms.[12] In Ghana, the MOH still pays some supply-side subsidies to health facilities. It pays about 95% of all personnel compensation, but a negligible share of non-salary recurrent expenditures for front-line health care workers.[13] Similarly, in the Dominican Republic, within the subsidized regime, the most important source of funds for service provision are supply-side subsidies, not funds from SENASA, the purchaser agency.[14]

In Mexico, even though Seguro Popular fully funded the premiums for the uninsured, the split remained incomplete since there was no significant change in provider payments. Only in the Fund for Protection against Catastrophic Health Expenditure did the split advanced significantly, but this fund only finances a few high-complexity services; most services financed by Seguro Popular are provided by the States and financed mainly through line-item budgets.[15] In the Philippines, even though resources were mainly financed by the demand-side scheme, the split remained incomplete since PhilHealth did not hold providers accountable for performance, and many did not have the necessary autonomy to retain the received resources. Resources were managed by the LGUs (local government units) for LGU hospitals , since very few of them could retain income and thus the resources they received went back to the LGU who then paid them through line-item budgets.[16]

In some cases, the idea of only providing a top-up inspired the objective of generating performance improving incentives to providers, as was the case in Argentina and Armenia. Prior to reforms, providers mainly received resources through line-item budgets. These top-ups were meant to be received and managed by the facility level and used to change behavior to improve the provision of services included in the benefit package. In some cases, this was not fully achieved, since providers did not have the necessary autonomy, or the rules did not allow them to retain and manage resources. This limited the possibilities for improving performance, as was the case in the Philippines.

10 Cortes et al, 2012 and World Bank, 2018.
11 Harimurti et al., 2012.
12 Somanathan et al., 2013
13 Wang et al., 2017.
14 Rathe, 2018
15 Bonilla-Chacin and Aguilera, 2013.
16 Chakraborty, 2013.

Demand-side schemes in a decentralized context

Many of these demand-side programs were implemented in highly-decentralized health systems, where lower levels of government are responsible for public service provision. In some cases, the programs tried (not always successfully) to reduce the inequalities in health expenditure and service provision, by changing the allocation of funds across geographic areas, by making resources follow the patient (e.g. Mexico, Argentina, Indonesia, Philippines, Vietnam, Colombia). However, these decentralized contexts also generated extensive implementation challenges. These programs were often developed by the central government but required joint implementation in conjunction with lower levels of government, that not only were in charge of delivering services, but in a few cases also of identifying and enrolling beneficiaries and financing part the scheme. For example, in the Philippines, the identification of the poor was originally supposed to be verified and the final decision made by the local government units. Given various loopholes in the means tests and capacity to verify at that level in 2009, the National Government announced it would pay for the Sponsored Program only if households were on the National Targeting System-Poverty reduction list of households, managed by the National Government Department of Social Welfare, centrally managed to control any manipulation of the list (only 15% of the original beneficiaries cross-matched in the first list of 2010).[17]

Progress achieved by these programs and ongoing challenges

All countries which adopted demand-side strategies for UHC increased the coverage of health insurance to a large percentage of the population that had remained uninsured. However, since often this increase in insurance coverage was done through the development of a new insurance scheme, few countries were able to eliminate or even decrease the fragmentation of the resource and risks pools. Most countries increased coverage for the poor and vulnerable, and a few also for informal sector workers. For instance, Seguro Popular beneficiaries went from 11.4 million in 2005 to 52.5 in 2012; by 2014 the Ghanaian national health insurance covered 40% of its population.[18] In the Dominican Republic, insurance coverage went from 870 million in 2007 to 7 million in 2016 (70% of the population), with almost 100% of the poor population already affiliated.[19] As a result, most countries have seen an increase in the utilization of health services, particularly among the poor and previously uninsured population. For instance, Plan Nacer in Argentina increased utilization of services, and there is also evidence that it has improved birth outcomes among those not covered by contributed health insurance.[20]

Many of these demand-side programs were able to mobilize additional resources for health. Most of these resources came from general taxation, although some countries used innovative sources of revenue, as was the case in Ghana where part of VAT was earmarked to fund the National Health Insurance Scheme

17 Chakraborty, 2013.
18 Bonilla-Chacin and Aguilera 2013; Wang et al. 2017.
19 Rathe, Magdalena. 2018.
20 World Bank, 2018.

(NHIS), and the Philippines, with the earmarking of sin taxes to partly fund the Sponsored program.[21]

There were also benefits to the adoption of explicit packages and the split between provider and purchaser, establishing the basis to strategic purchasing. Even when these strategies were not fully, they contributed towards efficiency with the introduction of innovative payment mechanisms and incentives.

All countries still present important challenges in their path to UHC. As an example, the large differences in health service utilization between geographical regions and income levels have not disappeared. This issue remains a challenge in many of the countries reviewed: Argentina, the Philippines, Vietnam, Ghana and others. In addition, it is not clear to what extent these programs were able to increase effective coverage of health services, since quality of care remains a challenge.

Supply-side capacity restrictions were one of the main challenges faced by most demand-side programs. In many cases, supply did not have the capacity to offer all the services included in the benefit package to all the population groups (e.g. Colombia, Indonesia, the Philippines). In others, providers did not have the necessary autonomy to respond to new incentives generated by different provider payment mechanisms, in some cases they were not able to retain resources obtained from services provided to program beneficiaries. Regulated competition of insurers was not achieved, and governments did not enforce adequate plan supervision (Colombia, Dominican Republic and Morocco), contributing to the system's fragmentation and causing difficulties in ensuring transparency in the design and costing of the benefit package.

Financial sustainability of these schemes remains a challenge: Premiums are not always actuarially based (e.g. Indonesia) and there are no risk-adjustment mechanisms in place in most of the countries. Not all benefit packages are fully financed via demand-side: the supply-side subsidies often hide insufficient resources to fund these programs and persist implicit rationing (e.g. Indonesia, Dominican Republic).

Some of these programs have been facing issues in controlling the cost of provision, partly due to provider payments that incentivize the oversupply of expensive services (e.g. Vietnam).

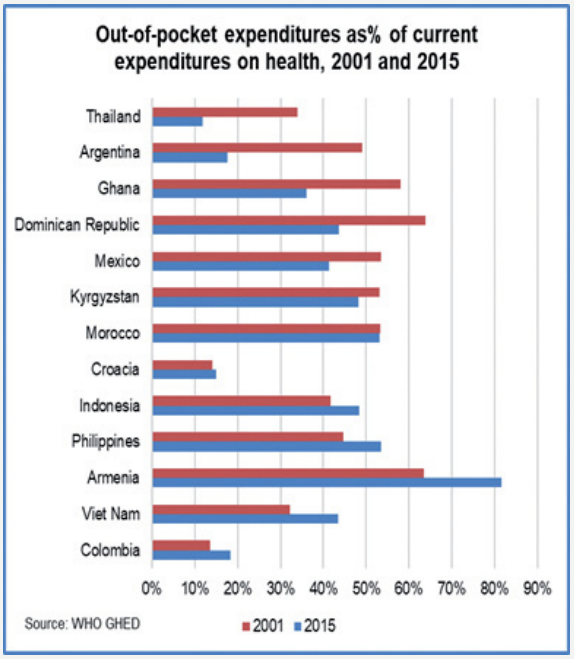
In addition, with demographic and epidemiological transitions, these countries are facing an increasing burden of disease coming from non-communicable diseases, which need long-time contact with the health system and if not controlled, can result in complications and hospitalizations. Technological changes coupled with increasing citizen expectations and demands are also likely to increase health care costs.

In view of these fiscal pressures, some countries place caps on hospital payments, others introduce co-payments or leave complex procedures to be paid out-of-pocket (Armenia, Kyrgyz Republic), with the result of very high direct payments by users; therefore financial protection remains a challenge.

As can be seen in the graph, some countries were able to substantially reduce out-of-pocket payments from 2001 to 2015 and were therefore more likely to offer increased financial protection for their populations. Other countries increased such payments (Armenia substantially, Indonesia, Vietnam, Philippines); Colombia increased them despite its relatively low percentage; Croatia maintained the same low proportion; and Morocco remained the same at a relatively high level.

21 Wang et al., 2018 and Chakraborty, 2013.

FIGURE 1



Conclusions

In their efforts to progress towards UHC, many middle-income countries have developed demand-side programs which aim to provide increased coverage to the poor and vulnerable to a package of health services, while also improving financial protection in case of illness. These programs have increased insurance coverage for their target population groups and in some cases, the utilization of key health services too.

These programs aim to improve allocative efficiency by designing an explicit package of services for preventing and controlling the main causes of the burden of disease in the countries, and funding it. They also aim to increase the efficiency and overall performance of providers by trying to separate financing from provision and setting the stage for strategic purchasing of services.

However, with only a few exceptions, these reforms have not been fully developed and continue to be a work-in-progress. There are weaknesses in the design of the benefit package, since the inclusion of services did not always follow a pre-established transparent criterion. The split between financing and provision has also remained incomplete, since in most cases a large share of the funds financing public providers does not come from these demand-side programs but from supply-side subsidies. Most countries also struggle with changing payment mechanisms or ensuring more autonomy of public providers in responding to new incentives. The financial sustainability of schemes remains

an issue in many cases.

In addition, some of these demand-side schemes have been developed as parallel schemes, maintaining and sometimes exacerbating the existing fragmentation of the resource and risks pools (e.g. Mexico, Argentina, Morocco). Others, while developed as part of a strategy directed at the whole population, have come up against political restrictions which prevent, at least temporarily, the elimination of fragmentation (Dominican Republic, Colombia). Some countries attempted to eliminate this fragmentation, as was the case in Croatia, Philippines, Kyrgyz Republic, Vietnam, Indonesia, but a few found this difficult to achieve. For example, in Vietnam even though a unique insurance scheme was used to extend service coverage, the capitation formula used to distribute resources across districts preserves the fragmentation of the resource pools.

The challenge of increasing coverage of these programs to the non-poor informal sector workers remains. Some countries have decided to fully subsidize them, for example Argentina and Mexico, but this mostly remains a financially difficult option.

Despite the challenges and the need to improve or even change some of their policies based on experience, most countries seem committed to continuing their exploration into improving the implementation of these demand-side strategies, along a path towards universal coverage.

Biographies

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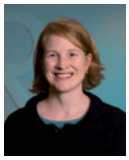
Solving Universal Health Coverage Challenges through Joint Learning



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ABSTRACT: As universal health coverage (UHC) gains momentum in more countries, the need for practical information on how to strengthen health systems and expand coverage has emerged as a vital global priority. The Joint Learning Network for Universal Health Coverage (JLN) convenes practitioners and policymakers virtually and in-person for intensive learning exchanges on shared technical barriers to UHC. During the process, members co-produce practical tools on the how-to's of designing and implementing efficient, equitable and sustainable health care systems. This article explores how Ghana and the Philippines, two JLN member countries, have leveraged practitioner-to-practitioner learning to address common challenges in their pursuit of UHC.

The Global UHC Movement

The inclusion of Sustainable Development Goal (SDG) 3.8 in the UN Sustainable Development Goals both spurred and invigorated an unprecedented effort by countries across the globe to strengthen their health systems in pursuit of universal health coverage (UHC) for all their citizens.

SDG 3.8 calls for countries to "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," not only to work towards healthy and sustainable populations, but also to meet other global health development goals.

Global health coverage, measured across a series of essential services indicators, has risen nearly 20 percent from 2000-2015, as documented by the World Bank and World Health Organization in their recent report, *Tracking Universal Health Coverage: 2017 Global Monitoring Report.*

Yet serious gaps in realizing universal health coverage remain. According to the *Tracking Universal Health Coverage* report, more than 800 million people worldwide still spend more than 10 percent of their household budget on health care and 100 million people sink into poverty because of health expenses every year.

Beyond the public health implications of citizens lacking essential health coverage, barriers to health services impact other vital global development goals, including rates of educational attainment, labor participation and economic development.

Even though low and middle-income countries benefiting from strong political support, like Ethiopia, Ghana, Indonesia,

Kenya and Malaysia, have made significant strides in committing resources and designing policy reforms to advance UHC, they continue to grapple with implementation challenges due to tough on-the-ground realities, such as limited resources for revenue generation, a large informal population sector and the unavailability or unreliability of data. Meanwhile, developed countries like South Korea and Japan, considered global leaders in UHC having achieved universal coverage decades back, are now facing new challenges caused by aging populations and rising health expenses.

Designing and implementing the reforms needed to make UHC possible is a formidable goal for a country at any income level. As UHC has gained momentum in more countries, practical information on how to strengthen health systems and expand coverage is now perceived as an increasingly pressing need. While a large body of theoretical knowledge exists from global experts on what actions can drive UHC forward, there is little knowledge on the "how-to" of implementing those actions, particularly in developing countries, where imperfect conditions present unique challenges for building strong health systems.

The Joint Learning Network for Universal Health Coverage

Eight years ago, a group of national health and finance practitioners from Ghana, India, Indonesia, the Philippines, Thailand, and Vietnam and their development partners gathered in a small town in northern India to learn from their peers' experiences on UHC strategies in the context of low- and middle-income countries.

The meeting sparked the development of the Joint Learning Network for Universal Health Coverage[1] (JLN), a community of policymakers and practitioners from government agencies around the world that engages in practitioner-to-practitioner learning and translates combined tacit knowledge and shared expertise into actionable knowledge that can accelerate country progress towards UHC.

Through the JLN, policymakers and practitioners from member countries, predominately low- and middle-income countries – with some high-income countries further along their UHC journeys – convene virtually and in-person throughout the year for intensive learning exchanges on shared technical barriers to UHC and in the process, co-produce practical tools on the how-to's of designing and implementing efficient, equitable and sustainable health care systems.

The network initially consisted of nine member countries in 2010 and has since grown into a community of 30 actively engaged countries spanning Asia, Africa, Europe and Latin America, providing a platform for policymakers and practitioners to connect with their peers and leverage experiences of other countries to learn from and innovate within their own countries.

The secret has been creating a neutral space for practitioner-to-practitioner learning that is country-led and country-driven, to ensure that learning outcomes are aligned with countries' priorities and well positioned for application in-country. A member base of committed policymakers and practitioners steer, lead and participate in learning activities to jointly tackle their real-world challenges as they strive toward UHC.

Country Progress through Joint Learning

Eight years into the JLN's evolution and expansion, last year the network began connecting the dots from joint learning to outcomes - if any - in countries, and assessing whether the knowledge gained is translating into on-the-ground action for UHC advancement.

In 2016, an independent qualitative case study[2] completed by Mathematica assessed the efficacy of the model and the extent of its impact at country level. The study found a vibrant community that grew out of an iterative process and several instances of countries having leveraged JLN tools and resources to advance UHC-oriented programs and reform efforts through design interventions and/or advocacy.

At a more in-depth level, the network's technical facilitators, country coordinators and members have recounted more than 20 instances of outcomes in countries based on their engagement with the JLN, including in Estonia, Ghana, Indonesia, Kenya, Malaysia, Nigeria, the Philippines and Vietnam, with a myriad of different actions and forms, such as adopting another member country's e-claims standard; the introduction of a pilot primary health care (PHC) capitation payment system using international best practices; the alignment of a financing approach and service delivery goals leading to increased engagement of private sector providers in promotive and preventive care; and the development of provider payment mechanisms for PHC benefits using the JLN's Costing of Health Services for Provider Payment Manual.

In the JLN's experience, the key to success of its approach lies in engaging the "right" government officials in charge of, or well-positioned to champion UHC efforts in their countries and designing learning exchanges that reflect national priorities and that are common across multiple countries, as the following examples of Ghana and the Philippines demonstrate.

Ghana Aligning Health Financing with Primary Health Care

Ghana's National Health Insurance Scheme (NHIS) has been praised globally as an example of how government can implement UHC in low- and middle-income countries. However, the system has not been without challenges. Ghana's Community-based Health Planning and Services (CHPS) – a successful primary health care program that relocates health workers into communities to deliver preventive and promotive services, as well as the treatment of minor ailments – was facing a significant bottleneck. There was no provision for reimbursement of community-based care in Ghana's NHIS, which was largely designed to protect Ghanaians from catastrophic health expenditures

1 Joint Learning Network for Universal Health Coverage. http://www.jointlearningnetwork.org/

2 Reference: Rockefeller Foundation Joint Learning Network Case Study https://www.rockefellerfoundation.org/report/ths-joint-learning-network-brief/

and improve access to curative care in clinical settings.

As an active participant in the JLN's Primary Health Care technical initiative, Ghana members suspected that their health financing approaches did not always support the country's PHC goals. The Ghana team piloted the initiative's co-produced UHC Primary Health Care Self-Assessment Tool in collaboration with the NHIS and its Regional Health Directorate in the Upper East Region of the country in late 2014.

The pilot helped Ghana identify key areas of misalignment that worked against the very foundation of universal health coverage, for example: delays in reimbursements of claims for services provided by health care providers at the PHC level, which serves as a disincentive in support for the NHIS; inadequate coordination among stakeholders in PHC delivery; inadequate funding for PHC; and non-reimbursement by the National Health Insurance Agency (NHIA) for preventive and promotive services.

The exercise indicated that despite Ghana's progress since establishing the CHPS, and later the NHIS, there were still significant gaps that needed to be addressed to reach their UHC goals. A presidential-level technical review of the NHIS in 2016 concluded that the insurance scheme should be revamped to focus on ensuring access to PHC services for all Ghanaians – with a new PHC-oriented benefits package, provider payment mechanisms that incentivize preventive and promotive care, and automatic enrollment based on residence, rather than voluntary enrollment based on premium payment or exemptions.

Applying the UHC Primary Health Care Self-Assessment Tool[3] also gave health service providers and stakeholders in Ghana's Upper East Region an opportunity to communicate their concerns regarding NHIS implementation. This led to further integration of Ghana's health financing and primary health care. There are plans to extend the application of the self-assessment tool to other regions and nationally.

The Philippines Strengthening its Medical Audit System

The Philippine Health Insurance Corporation (PhilHealth) developed a health care provider performance assessment system around the same time that the JLN's Medical Audits collaborative was launched in 2015. The new PhilHealth monitoring system was designed to enforce performance standards among health care providers across different regions of the country. While the policies, processes and systems were put in place, monitoring and evaluation (to check if the intended objectives were being met) needed work – a gap where the Medical Audits learning collaborative proved useful for the PhilHealth officials.

A medical audit system is an iterative quality-improvement process that seeks to improve patient care and outcomes by systematically reviewing care against explicit criteria and the implementation of change. For the Philippines, this meant revisiting the control indicators and developing triggers for audits to ensure cost containment and quality improvement.

3 Joint Learning Network for Universal Health Coverage; UHC Primary Health Care Self-Assessment Tool http://www.jointlearningnetwork.org/resources/uhc-primary-health-care-self-assessment-tool

JLN's Medical Audits collaborative leveraged the experience of South Korea, a country with a mature health care system, advanced provider performance and medical audit systems in place. A mix of virtual learning through webinars, email exchanges and WhatsApp chats, enriched with a series of site visits to South Korea in 2016, enabled participating JLN member countries to learn from each other and receive first-hand exposure to the established medical audit system in South Korea.

The participating PhilHealth members shared their experiences and reviewed their performance indicators for quality of care, patient satisfaction, financial-risk protection and fraud detection. Based on findings from analytics on claims in the database, the team found that some claims for conditions, such as pneumonia, had a length of stay below the recommended standard, which affected the quality of health care provided. PhilHealth decided to incorporate recommended length of stay as a control indicator for the reimbursement of claims. PhilHealth is considering bringing back pre-payment medical review to catch these inconsistencies.

Furthermore, a shift in PhilHealth's payment system, from the fee-for-service system to bundled case payments, has enhanced claims processing efficiency, while also compromising the rigor of the medical review process. In some cases, the removal of some controls led to an unintended increase in benefit payouts. Insights from the experienced medical audit system of countries like South Korea allowed the Philippines' participating team to contribute to the development of medical review criteria for ranking conditions among the paid claims, which strengthened controls in the pre-payment review process.

Aside from improving their monitoring system, participation in the collaborative helped PhilHealth build the capacity of its staff and instill the importance of data quality, the need for standardization and the use of indices to ensure that changes introduced in the system are determined by the use of thresholds.

PhilHealth continues to work with research and development partners to determine thresholds for triggers of adverse practice and fraud identification and explore the use of machine learning and artificial intelligence to identify unusual patterns.

Vertical Integration with Expanded Roles for Hospitals: A New JLN Priority

For the global UHC community, the idea of people-centered integrated health services has resonated widely as being pivotal to achieving UHC and to truly ensuring that no one is left behind. The entailing shift from health systems designed around diseases towards health systems designed around the needs of people places a heavy demand on care coordination strategies that cut across all actors on the care continuum, including care providers, hospitals, community agencies (e.g., social services) and home care providers. Most countries, however, struggle with fragmented delivery systems, which are increasingly becoming a roadblock in the

context of the rise in non-communicable diseases.

Last year, a group of JLN countries prioritized vertical integration accordingly, with the aim of enabling care models that are organized around the health care needs of populations. Under the newly launched JLN initiative, Indonesia, Malaysia, the Philippines, Sudan and Vietnam, have set out to jointly examine existing vertical integration initiatives and potential new roles for hospitals as a means to addressing the onslaught of non-communicable diseases.

Vertical integration is part and parcel of a broader "care coordination" strategy that aims to provide support to patients through the "*deliberate organization of patient care activities between two or more [providers] involved in a patient's care to facilitate the appropriate delivery of health care services*" (McDonald et al., 2007:5).

During the initial scoping phase held between July and September 2017, country participants mentioned several recurring themes, including a lack of care coordination across providers resulting in poor quality, higher costs and patient dissatisfaction, and patients' bypassing primary care units to seek care in overcrowded hospitals. Broadly, vertical integration was widely understood as confined to referral systems which existed on paper but were rarely used. For example, country teams reported that there were no standard procedures for tracking patients once they were referred to or discharged from hospitals. Also, addressing non-communicable diseases through better care coordination and provider interaction emerged as a major priority, as aging populations, rising incomes and urbanization contribute to an already heavy burden.

Participating countries agreed to co-produce a diagnostic and readiness assessment tool during a facilitated learning exchange planned for early March 2018. Small-scale vertical integration initiatives exist in most of the participating countries, but there is no information on their features, lessons or impacts. The proposed tool will assess current local vertical integration initiatives while also appraising financial and institutional enablers and barriers to vertical integration. The tool will focus on integration strategies and operations along three major patient transition domains: between primary care and specialty care, between hospital and primary care, and between hospital to home or community-based care. As part of the learning exchange, each country will share their experience and the areas it considers most critical, to establish an enabling environment for integration across all levels of care. The tool will entail common components to measure initiatives and assess preparedness across all countries, as well as a country-specific component which will be adapted to each country's context.

JLN Model and Technical Scope

Country-Led Joint Learning Approach

The core strength and sustainability of the JLN lies in its country ownership, which allows the network to articulate country demand and co-create responsive products. To this end, a pivotal role is played by country core groups or CCGs – in-country stakeholder groups with representatives from key institutions supporting a country's UHC efforts. CCGs define and channel their country's learning priorities into the network. They also take back global learnings from the network to their country for dissemination and application.

Comprised of practitioners who are often recognized as UHC champions in their countries, CCGs are helping to drive greater engagement with the network's learning and maximizing the resulting benefits at the country level. Furthermore, the World Bank has been leveraging its country teams around the world to actively engage CCGs and foster country ownership, along with playing an increasingly important role in facilitating participation from relevant UHC stakeholders, as well as the adaptation and use of JLN products.

JLN's Technical Initiatives

Joint learning is targeted to bridge the knowledge gap between theory and practice and is structured around helping countries to: i) identify and frame priority issues; ii) systematically assess technical and organizational needs; iii) exchange ideas and experience with peers on shared challenges; iv) co-develop practical tools and solutions; and v) adapt and apply the tools and knowledge acquired through the JLN in their UHC efforts.

The topics for JLN's joint learning are based on priorities identified by its member countries and are broadly structured across six broad themes or "technical initiatives." Under the umbrella of these technical initiatives, interested country members come together in learning exchanges and collaboratives to focus on more specific technical challenges.

The focus of each of the technical initiatives allows practitioners and policymakers to focus on the nuts and bolts of implementing UHC:

Primary Health Care (PHC) technical initiative focuses on several interrelated PHC areas, including benefits policy design and implementation, leveraging the private sector, aligning financing mechanisms and measurement for improvement to enable effective delivery and utilization of preventive, promotive and curative care.

Provider Payment Mechanisms technical initiative aims to help countries enhance financial sustainability, efficiency and quality of care through developing robust provider payment mechanisms.

Information Technology (IT) technical initiative supports countries to develop virtual communication and data platforms for UHC, enabling interoperability across ministries of health and national health payers for knowledge sharing, promoting high quality care and ensuring responsible financial management.

Quality of Health Care technical initiative focuses on how to incentivize and catalyze providers to continuously improve quality through use of financial levers, effective organization and governance of quality functions, and implementation and use of medical audits systems.

Revisiting Health Financing technical initiative aims to

help countries effectively navigate the balance of resource needs, resource availability and resource utilization by innovating their own past practices to meet the critical and complex health financing challenges posed by the pursuit of UHC. The initiative focuses on the topics of domestic resource mobilization and health financing efficiency.

Population Coverage technical initiative supports efforts to extend equitable health coverage to population groups, particularly the poor and informal sector.

The spread of topics stems from JLN's rapidly expanding learning portfolio, reflective of a tremendous appetite of countries seeking to address their UHC implementation challenges through joint learning. Today there are a total of 13 learning exchanges and collaboratives – a sharp rise from four in 2014 – each one having its own group of participating countries, reflective of their interests.

UHC How-To's: JLN Knowledge Products

JLN member countries have co-produced and have begun adapting and using 18 global UHC knowledge products through learning collaboratives to date, available free of cost online as international public goods that any country can use to adapt, innovate and develop solutions suited to their context.[4]

These knowledge products, spanning JLN's technical areas of focus, are examples of tools that are equipping countries with the how-to's of designing more robust and efficient PHC systems, key to advancing UHC:

- **Costing of Health Services for Provider Payment: A Practical Manual**[5]: Practical step-by-step guidance on how to address challenges related to costing for provider payment in low- and middle-income countries (includes a workbook, templates and an e-learning course[6])
- **Engaging the Private Sector in Primary Health Care to Achieve UHC: Advice from Implementers to Implementers**[7]: A practical manual that contains step-by-step guidance along with real-world examples and case studies to help facilitate public-private sector engagement around primary health care
- **UHC Primary Health Care Self-Assessment Tool**[8]: A rapid diagnostic instrument for identifying practical policy opportunities in the health system to improve the relationship between health financing and PHC efforts
- **Connecting Health Information Systems for Better Health**[9]: A guide for decision-makers and health system planners on use of information and computer technology (ICT) to support care delivery and provider payment workflows and generate health system metrics and indicators (includes norms and standards needed for national-scale system-to-system connectivity)
- **Closing the Gap: Health Coverage for Non-Poor Informal Sector Workers**[10]: A synthesis of experiences of five countries (China, Mexico, the Philippines, South Korea, and Vietnam) covering the non-poor informal sector to achieve UHC

Aside from these tools, the JLN houses an online library with over 60 resources synthesized from country experiences, such as country assessments, case studies, best practices, policy frameworks and performance evaluations. By documenting their experiences and lessons learned, JLN countries are bridging the global knowledge gap in critical areas of service delivery, health financing and provider payment, data and information systems, and quality of care, so other countries don't have to reinvent the wheel.

Joint Learning for UHC: A Catching Trend?

As the momentum picks up for countries to meet the UHC2030 goal of achieving universal health coverage by 2030, more countries are joining the JLN. JLN membership tripled from nine countries in 2014 to 27 in 2017. Three new countries, Lao PDR, Lebanon and South Africa, joined the network at the end of 2017, bringing the membership to a total of 30 countries with more expressing interest.

Furthermore, JLN members are sharing the knowledge from cross-country joint learning with stakeholders within their countries, creating a ripple effect that is generating interest in joint learning at the state and regional levels within the countries. In some of the larger JLN countries that have highly decentralized contexts, the interest has evolved and subnational joint learning networks are coming together.

For example in 2017, Nigeria launched a subnational JLN to cascade joint learning at the federal and state levels, with 22 states participating in two joint learning collaboratives, and plans to scale to all 36 states. An active member since 2011, the new initiative aims to provide a platform for states to access global learnings from the JLN as well as share experiences across states, focusing on operationalizing state-supported health insurance, strengthening PHC systems, and raising domestic resources for health.

In India, the longstanding Government-Sponsored Health Insurance Forum, facilitated by the World Bank and Indian Ministry of Health and Family Welfare, has played the role of bringing together policymakers and practitioners from across the states to discuss the how-to of implementing tax-funded health insurance programs. The forum is now linking national and state stakeholders with the JLN, with the aim of improving coverage for over 500 million beneficiaries.

Among the many global initiatives working with countries to advance the goal of UHC, learning from peers in other countries with similar challenges has gradually but unmistakably taken root. Initiatives, such as the World

4 http://www.jointlearningnetwork.org/resources
5 http://www.jointlearningnetwork.org/resources/costing-of-health-services-for-provider-payment-a-practical-manual
6 http://www.jointlearningnetwork.org/resources/costing-emodule
7 http://www.jointlearningnetwork.org/resources/PHC-Engaging-the-private-sector-in-PHC-to-Achieve-UHC
8 http://www.jointlearningnetwork.org/resources/uhc-primary-health-care-self-assessment-tool
9 http://www.jointlearningnetwork.org/resources/connecting-health-information-systems-for-better-health
10 http://www.jointlearningnetwork.org/resources/closing-the-gap-health-coverage-for-non-poor-informal-sector-workers

Health Organization's Global Learning Laboratory (GLL) for Quality Universal Health Coverage, Health Systems Global, P4H Network and Asia eHealth Information Network (AeHIN) are similarly pushing forward the agenda of stronger and equitable health systems through knowledge sharing and actionable learning. In an unprecedented push for UHC, these initiatives along with the JLN are combining forces under the newly launched UHC2030 global partnership, which calls for country access to relevant and timely actionable knowledge as a key strategy to accelerating UHC in countries.

For its part, the JLN has found its model of providing a haven for country-led and country-driven joint learning to be its biggest value proposition, as countries navigate a web of technical and implementation challenges on the path to UHC, often amid a rapidly changing political and economic landscape.

The JLN receives financial and in-kind support from JLN member countries and a host of development partners, including the Bill & Melinda Gates Foundation, German Development Cooperation (implemented by GIZ), Government of Japan (through the Japan-World Bank partnership program), Korean institutions (Korea Development Institute, National Health Insurance Service and Health Insurance Review and Assessment Service), Rockefeller Foundation, USAID and the World Bank.

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The National Health Service in England: Achievements, Challenges and Prospects as it approaches its 70th Anniversary

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ABSTRACT: The article examines the history, achievements, challenges and prospects of the NHS in England, as of early 2018. The article starts by examining health outcomes, distinguishing between absolute and comparative ones. It then considers the impact of the Global Economic Slowdown and Brexit, staffing, operational and financial pressures on the NHS. The article then summarizes and comments on the House of Lords 2017 Select Committee Report *The Long-term Sustainability of the NHS and Adult Social Care*. The article concludes that the NHS in England is sustainable only if ministers have the political stomach to enact necessary fiscal and re-distributive prerequisites. The article ends by asking a bigger underlying question: to what extent can current, or successor, UK Governments, as a whole, acquire the skills and pace to adapt to "The Age of Accelerations."

Introduction

The National Health Services (NHS) of the United Kingdom all began their work on the "Appointed Day" of 5th July 1948. The Services of England, Scotland and Northern Ireland have always been operationally independent, separately accountable to the Government and distinct in terms of policy and legislation. The Welsh Service originally administratively combined with England but transferred in 1969 and devolved in 1999[i].

Similarly, the NHS, in England in particular, is not a single organization but a network of national and local organizations (mainly public but also including businesses and charities), all operating to provide NHS-funded services under the NHS "brand".

For the sake of clarity, this article focuses mainly on the NHS in England, even though the four Services have much in common and were described collectively at the Opening Ceremony of the 2012 Olympics in London as "the institution [sic] which, more than any other, unites our Nation [i.e. the United Kingdom]." For this reason, the NHS is never an easy subject to evaluate dispassionately.

Nonetheless, this article seeks to guide readers towards the commentators and issues that the author has recently found must useful in offering concise, accurate and relevant insights into the history, achievements, challenges and prospects of the NHS in England, as of early 2018.

History and achievements

The history and evolution of the NHS has been, and continues to be, described accurately and magisterially, online by Geoffrey Rivett[ii]. Bancroft and Ellison have recently offered an elegant, wide ranging yet concise summary of the current English health and social care system as a whole and from a legal perspective.[iii] The European Observatory on Health Systems and Policies published its latest Health System Review of the United Kingdom in 2015, which is detailed, systematic and authoritative.[iv]

Both the Observatory Review and Rivett paint a very mixed picture of NHS performance (across the UK as whole, but mainly focused on England) in recent decades compared to other European countries. As the Observatory Review states, "For the United Kingdom as a whole, life expectancy increased between 1980 and 2013 from 73.7 to 81 years (slightly above the EU average of 79.9 years), and mortality rates from most cancers and circulatory diseases have decreased. However, chronic disease and disability have not declined as much as in other western European countries; thus while individuals live longer on average, they do so in relatively poor health. These averages across the United Kingdom also mask considerable variation, both geographically (Scotland has poorer health than the rest of the United Kingdom) and between socio-economic groups."

It is important to note that the NHS does not constitute the entire healthcare system in the UK, particularly in England. Public (General Government) healthcare expenditure (almost all through the NHS) does however represent about 83% of total expenditure[v].

The persistence of substantial geographic and socio-economic differences in life expectancy across the UK, despite the constrained nature of co-payment at the point of use in the NHS, has been a cause of political and professional concern and frustration. In 2008 Professor Sir Michael Marmot was commissioned to review health inequalities by Prime Minister Gordon Brown and make recommendations. Sir Michael's conclusion was that disparities in income and education would need to be reduced, if continued efforts to reduce health inequalities in the UK are to succeed.[vi]

It is important to make the distinction between comparative and absolute performance. Table 1.5 of the Observatory Review, for example, highlights a fall in Standardized Death Rates (per 100,00 population) in the UK from diseases in the circulatory system across all ages, from 475 in 1980 to 164 in 2010. Improvements in other disease areas are generally less remarkable but still mostly positive, with the notable exception of mental disorders, diseases of the nervous system and sense organs.

Nonetheless, measures of comparative performance and cost are important indicators of "value" and scope for improvement in policy, strategy and performance – from both economic and clinical perspectives.

Given that Total Healthcare Expenditure of the UK, which stands at approximately 10% of GDP, is unexceptional for a country of such economic status and demography, the Observatory Review in particular implies that the health and care system of the UK in general, and the NHS in particular, could in theory do better in terms of outcomes and efficiency.

Such an assertion would doubtlessly be received with dismay, and possibly derision, by many working in the NHS and would also be challenged by many of the thousands of patients who receive outstanding, dedicated and sometimes world-leading treatment and care from the NHS every single day.

Many would probably point to the 2017 evaluation of the Commonwealth Fund in New York, which again judged the NHS as the top performing system out of eleven high-income countries compared.[vii] However, even the Commonwealth Fund review ranked the UK tenth out of the eleven countries evaluated in relation to overall health outcomes (the USA came last). This was despite the fact that the UK ranked first on the related indicator of rate of reductions in amendable mortality over the past decade. The UK also came first in relation to care process and equity, and third in relation to access and administrative efficiency.

The methodological approach of the Commonwealth Fund evaluation is transparent and empirical. It attaches equal weight to the five domains it analyses, using a total of 72 indicators. However, the Appendix on methods records that "In the past some have argued there are other important elements of system performance that should be considered as well, such as innovativeness or value. After consideration, and based on discussions with our advisory panel, we decided not to add new domains to the report. We believe our current five domains capture a sufficiently broad and comprehensive view of health system performance. In addition, there was a lack of meaningful data to assess these new domains."[viii]

Challenges

The greatest challenges that the NHS has confronted in recent years have been the Global Economic Downturn since 2008, and Brexit since 2016. Both of these events have hit the UK economy hard and continue to affect UK economic performance, and consequently the scope for public expenditure growth.

UK GDP in current prices decreased during the global financial crisis of 2007–8, falling 4.3% in 2009 and returning to only weak positive growth from 2010 through to 2013. The United Kingdom experienced the highest fall in GDP per head of any EU country between 2007 and 2009 (24.3%, compared to the EU average of 5.8%).

The financial crisis has had important implications for UK public finances. While government revenues as a share of GDP remained relatively stable, central Government debt rose from 43.9% of GDP in 2005 to 97.2% in 2012.[ix]

In 2017 Goldman Sachs predicted UK GDP growth in 2018 to be 1.6% compared to an EU average of 1.8%, a developed markets average of 1.9% and an emerging markets average of 5.9%.[x]

On 11th January 2018 the Mayor of London Sadiq Khan published a report prepared for him by Cambridge Economics, entitled *Preparing for Brexit* and which examines the economic impact on the UK, to 2030, of four clearly defined scenarios, against the baseline of remaining in the Single Market (SM) and Customs Union (CU).[xi] Investment would be particularly affected, down 6.7% (£20 billion) in the best scenario (UK in EEA but not CU) and down 15.4% (£ 46.7 billion) in the worst scenario (WTO rules). Reduced investment would have negative effects on population, employment, productivity and Gross Value Added (broadly indicative of gross incomes to businesses) down between 1% and 3% by 2030.

Another direct and more immediate concern is the potential impact of Brexit on NHS staffing. As of March 2017, there were a reported 61,934 EU staff working in NHS hospitals and community services alone in England (i.e. excluding primary care). This included 10,668 doctors, 22,232 nurses and health visitors, 1,384 midwives, and 7,383 scientific, therapeutic and technical staff. In addition, over 90,000 EU nationals are estimated to work in the social care sector in the UK, comprising 7% of its total workforce.[xii]

The NHS is already facing a looming crisis regarding medical general practitioners (GPs). In July 2017 Professor Azeem Majeed, who holds the chair in primary care at Imperial College, published estimates indicating that

the NHS was currently short of about 6,500 GPs, set to increase to a shortage of 12,100 GPs by 2020.[xiii] This is important because the UK, and England in particular, is heavily reliant on GPs delivering family medicine and acting as gatekeepers to hospital care.

The NHS already has a nursing crisis. 33,500 left NHS England in the year to 2017, 10% of all nurses employed by that organization, and 3,000 more than those who joined. Over half the leavers were under 40, and only 21% over 55. The figures suggest Brexit may be having an impact, with more nurses from the EU leaving than joining in recent years. Last year, 3,985 EU (excluding the UK) nurses left, compared to 2,791 who joined.[xiv]

Operational pressures often hit the NHS hardest in winter, particularly if accompanied by a flu epidemic. As Nigel Edwards of the Nuffield Trust has recently reported,[xv] "This year, a new system has been introduced which permits a little more analysis of the operational pressures facing NHS hospitals in winter. Trusts have been required to record any days on which they have reached any of four different Operational Pressures Escalation Levels, known as OPELs….OPEL 1 involves 'meeting anticipated demand within available resources', and OPEL 2 denotes a trust 'starting to show signs of pressure'. Levels 3 and 4 correspond more closely to the old terms such as 'black alert' or 'major incident'."

Edward continues " The figures published by NHS England for the period 1st-27th December show that: around a third (50) of the 152 trusts that sent data into NHS England declared an OPEL 3 or 4; of these, seven were OPEL 4s; in total, 201 OPEL 3 or 4s were declared between 1st-27th December, of which 15 were OPEL 4s; the worst day in this period was Tuesday 13th December, with 23 trusts at the highest levels, including four at OPEL 4.

NHS England Chief Executive Simon Stevens has used great ingenuity to keep his organization technically solvent in recent years. Even so he has not escaped censure from the UK National Audit Office. Reporting on the financial sustainability of the NHS in the period 2015 to 2016, in November 2016 NAO Chief Executive Sir Amyas Morse stated "With more than two-thirds of trusts in deficit in 2015-16 and an increasing number of clinical commissioning groups unable to keep their spending within budget, we repeat our view that financial problems are endemic and this is not sustainable……The Department, NHS England and NHS Improvement have put considerable effort and funding toward stabilising the system, but have a way to go to demonstrate that they have balanced resources and achieved stability as a result of this effort."[xvi]

In their covering statement to the above report NAO also stated:

"In 2015-16, NHS commissioners, NHS trusts and NHS foundation trusts reported a combined deficit of £1.85 billion, a greater than three-fold increase in the deficit position of £574 million reported in 2014-15. Provider trusts' overall deficit grew by 185% to £2.45 billion, up from £859 million in 2014-15, against total income of £75.97 billion.

NHS trusts and NHS foundation trusts under financial stress continue to rely on financial support from the Department and NHS England. The total amount of financial support funding provided by the Department and NHS England in the last financial year was £2.4 billion…..The Department has transferred £950 million of its £4.6 billion budget for capital projects, such as building works and IT, to funding for day-to-day spending. While this helped it to manage the NHS' financial position in 2015-16, it could threaten the ability of trusts to achieve sustainable service provision.

There are indications that financial stress is having an impact on access to services and quality of care. Trusts' performance against important NHS access targets has worsened, and the NAO found an association between trusts' financial performance and their overall Care Quality Commission rating, with those that achieved lower quality ratings also reporting poorer average financial performance. The 14 trusts rated 'inadequate' had a net deficit amounting to 10.4% of their total income in 2015-16."

In addition, on 25th May 2016, the House of Lords appointed a Select Committee to investigate the financial sustainability of the NHS. On 5th April 2017 the Select Committee published its report entitled: *The Long-term Sustainability of the NHS and Adult Social Care*.[xvii] The Report concluded:

"A culture of short-termism seems to prevail in the NHS and adult social care. The short-sightedness of successive governments is reflected in a Department of Health that is unable or unwilling to think beyond the next few years. The Department of Health, over a number of years, has failed in this regard. Almost everyone involved in the health service and social care system seems to be absorbed by the day-to-day struggles, leaving the future to 'take care of itself'. A new political consensus on the future of the health and care system is desperately needed and this should emerge as a result of Government-initiated cross-party talks and a robust national conversation.

To build on this consensus, we recommend the establishment of an Office for Health and Care Sustainability. It should play no part in the operation of the health and care systems, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should look 15–20 years ahead and report to Parliament, initially focusing on: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. The body should be established in statute before the end of this Parliament."

In addition to the above comments the Report recommended:

"A more integrated health and social care system…..

[and] that NHS England and NHS Improvement are merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government."

Importantly, the report also stated:

"We are clear that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for the delivery of sustainable health services. In coming years this will require a shift in government priorities or increases in taxation…. We recommend that the budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the 'Department of Health and Care'. This should allow money and other resources to be marshalled within a unified policy setting at national level. We acknowledge the difficulties with integrating budgets at a local level but this is achievable…. We support a funding system for social care that enables those who can afford it to pay for the care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission. We also call on the Government to implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms to make it easier for people to save and pay for their own care."

Lastly, the Report concluded:

"We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10–15 years. In our view this represents the biggest internal threat to the sustainability of the NHS….. Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce…… We [also] heard repeatedly of the linkage between over-burdensome regulation, unnecessary bureaucracy, a prolonged period of pay restraint, low levels of morale and retention problems. We call on the Government to bring forward legislation to urgently reform the system regulators and the system of regulation for health and social care professionals."

The report also offered the following final consideration:

"Currently, leaders in the NHS seem to be incapable of driving the much needed change in levels of productivity, uptake of innovation, effective use of data and the adoption of new technologies. Understandably, too much management and clinical attention is focussed on the here and now and there are too few incentives to look ahead to the longer term….. Unwarranted levels of variations in patient outcomes are unacceptably undermining the effectiveness and efficiency of the NHS and there is no plan to bring about a greater consistency in levels of performance….Greater levels of investment and service responsibility should be given to those who improve the most.

Importantly, the Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted and re-launched with a greater emphasis on these often overlooked individual responsibilities."

Conclusions

It is revealing and significant that eight months later, the Government is yet to fulfil its constitutional responsibility of responding to the Lord's Select Committee Report.[1] Whether this is because it lacks the power in Parliament to do so, or simply lacks the necessary consensus and energy at Ministerial level, is unclear. In any case, prime responsibility for any resulting NHS failure must lie with Government itself until it responses effectively.

In November 2017 Simon Stevens, the NHS England Chief Executive gave public notice that "the NHS can no longer do everything that is being asked of it."[xviii] As The King's Fund has observed, "Stevens' decision to speak out might yet have consequences for his position, although as a public official accountable to an independent board he cannot be directly removed by politicians."

So given all these challenges and turmoil – is the NHS sustainable?

In the House of Lords Select Committee report Ministers have been presented with a clear and plausible Roadmap for sustaining the NHS. So the answer to the question must be:

"Yes Minister…. if you have the political stomach for the necessary fiscal and re-distributive prerequisites." So, a definite maybe.

Are there any grounds for hope? Perhaps in one sense.

In January 2018 the current, and now very experienced, Secretary of State for Health, Jeremy Hunt, persuaded Prime Minister Theresa May to allow him to continue with his current portfolio, to rename him Secretary of State for Health and Social Care, and let him take responsibility for a forthcoming Green Paper on Social Care.[xix] It cannot be said that the man lacks courage or resilience. Can he fashion an adequate political and policy strategy and sell it to his Cabinet colleagues? If so, can Government as a whole, not just DH and NHS England, execute it successfully?

Perhaps the bigger underlying question is: to what extent can current, or successor, UK Governments, as a whole, acquire the skills and pace to adapt to "The Age of Accelerations,"[xx]? Only time will tell.

Biography

Mark Bassett is an independent management consultant, with over thirty years experience, specializing in international health policy and management. He has worked for the National Health Service (NHS) (England), NHS Overseas, Department of Health (England), Bupa Group; and as a consultant for The World Bank Group, Hospital Corporation of America (HCA) International and the World Health Organization.

1 The Government eventually published its response on 20 February 2018, after this article was submitted. The response can be found at https://www.parliament.uk/nhs-sustainability . The response is "a curates egg", good in parts. It avoids engaging fully with some of the bigger questions raised.

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The "Bismarck-Model" Germany's health insurance system in its historical context[1]

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ABSTRACT: The German system of statutory health insurance, commonly referred to as the Bismarck model, has developed during its 135 years of existence from a compulsory workers' insurance to a system that provides universal population coverage, a generous benefit basket and low cost-sharing arrangement. This article gives a short account of German health insurance history on its way to universal health coverage along the country's historical and political periods, as well as an overview of its current operation.

Introduction

The German health system, or more specifically its statutory health insurance (SHI) system, has been hallmarked as one of the prototypes of health system configurations. Since the system's legal introduction in 1883, solidarity among the insured has been its guiding principle. Solidarity affects both the income- and provision-side of SHI: every insured person pays an income-dependent contribution, which is proportional to income (up to a certain limit), but irrespective of health risk. This earmarked contribution provides entitlement to benefits according to health needs, mostly irrespective of the socio-economic situation, based on the ability to pay or geographic location (Meulen 2016). This "Bismarckian"-style system is often contrasted by systems based on a tax-financed National Health Service ("Beveridge"-style) and those based on market principles (Bohm et al. 2013; Wendt et al. 2009). However, health system types have evolved over time and do not longer conform to this stereotype classification (Greer et al. 2016).

Universal health coverage is a key objective for all health systems, regardless of the underlying health system model, as reflected in solutions of the World Health Organization and in the United Nations General Assembly's 2030 Agenda for Sustainable Development (World Health Organization 2010; United Nations 2015). Due to differences in health financing arrangements, NHS countries traditionally provide access to a set of basic health care services for a broader population. In contrast, coverage gaps exist in SHI systems, as eligibility to health insurance is linked to the individual's occupational status (Kutzin 2013; Cotlear 2015). Generalized access, irrespective of the individual's economic circumstances, was adopted early on in Germany and incrementally expanded over time (Savedoff et al. 2012; Evans et al. 2012). However, universal health coverage was not provided from the beginning and became fully implemented only a decade ago in 2007.

This article analyses the development of Germany's health insurance system alongside the country's political history, with a focus on the evolvement of the three dimensions of UHC: (1) population coverage, (2) the scope of covered services, and (3) the proportion of the covered costs (World Health Organization 2010).

Legal introduction of Statutory Health insurance in 1883

The German SHI system came into being in 1883 with the Health Insurance Act (*Krankenversicherungsgesetz*). At that time, the Chancellor ("*Reichskanzler*") Otto von Bismarck "invented"

1 This paper is based on an article published in The Lancet (Busse R, Blümel M, Knieps F, Bärnighausen T (2017): Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition. Lancet; 390(10097):882-97.).

the welfare state based on solidarity as part of a political response to the emerging workers' movement (Tennstedt 1976). The implementation of comprehensive health coverage for workers removed fertile ground for the social democrats and labour unions, supporting Bismarck's idea of German unification (Knieps 2015). Although often portrayed as the originator of SHI, Bismarck built on traditions and previously existing structures, particularly with regard to the five types of solidarity-based relief funds (for journeymen, craftsmen, factory workers, workers or trades people, and community funds) whose origins can partly be traced back to the middle ages (Bärnighausen & Sauerborn 2002).

The 1883 law had already defined the basic principles of today's SHI. Firstly, according to the principle of solidarity, the amount of contributions was (and is) based on the ability to pay; in turn, the insured persons were (and are) entitled to benefits according to need. Secondly, SHI was (and is) conceived as compulsory insurance, in which the employers take part in financing. Thirdly, statutory health insurance is based on self-governing structures, which means that competencies are delegated to membership-based, self-regulated organisations of sickness funds and health-care providers.

However, the initial organization of SHI was very different from the system as we know it today. SHI continued to focus on the expansion of universal health coverage, both with regard to population coverage and to the benefit basket. Continuous development continued during different political ages, and despite historical breaks as shown in figure 1.

Early extension of population and benefit coverage during the German Empire

In the beginning, health insurance coverage was restricted to blue-collar workers only. In 1885, 10.3% of the population was insured in one of the then 18,776 sickness funds. The number of contributing members tripled between 1885 and 1914 from 4.3 million to 13.6 million, and the total number of insured even quintupled from 4.8 million to 23 million (Alber 1992) because of the rapid growth of German industry (which at that time inevitably went hand in hand with the expansion of SHI). Between 1883 and the beginning of the First World War in 1914, SHI became mandatory for transport workers, commercial office workers, agricultural and forestry workers, domestic servants, itinerant workers and finally white-collar workers (e.g. persons employed by lawyers, notaries, bailiffs, industrial cooperatives

FIGURE 1: GERMAN SHI IN A HISTORICAL CONTEXT

1871-1918 German Empire and World War I	***Extension of population and benefit coverage*** **1881:** Kaiser Wilhelm I's „Royal Proclamation on Social Policy" **1883:** Establishment of SHI by Bismarck's „Health Insurance Act", covering initially 10% of population **1911:** Health, pension and accident insurance became integrated into the „Imperial Insurance Code" (in force from 1914) **1913:** Berlin Convention on Ambulatory Care, the first step towards joint self-governance in SHI system **1913:** 35% of population are covered by SHI	
1919-1933 Weimar Republic	***Strengthening of medical profession*** **1923:** Imperial Committee of Physicians and Sickness Funds **1925:** Majority of population (51%) is covered in SHI **1931-1933:** Special presidential directives on ambulatory care; create regional associations of SHI physicians and a "total payment" for ambulatory care	
1933-1945 Nazi regime and World War II	***Fundamental structures of SHI remained****, but* **1933:** Withdrawal of self-administration and exclusion of socialist and Jewish workers from the committees of the sickness funds **1933-1938:** Work prohibition for Jewish physicians; denied access to health care for Jews and other minorities **1934:** regional associations of SHI are merged into one National Association of SHI Physicians **1934-1935**: Redefining organizational framework along the rules of Nazi-dictatorship: centralization of sickness funds, welfare organizations, and community health services by the Nazi Party **1941:** SHI coverage for retired persons	
1945-1989 German Separation	**West:** ***Continuation of SHI system in the Federal Republic of Germany (FRG)*** **1955:** Restoration of self-administration of sickness funds **1960-1964:** Failed reform acts **1972:** Hospital Care Financing Act **1972/1975/1981:** SHI coverage for farmers, students, disabled and artists **1977:** First Cost Containment Act **1988:** Health Care Reform Act: Transformation of the „Imperial Insurance Code" of 1914 into the „Code of Social Law" (*Sozialgesetzbuch* – SGB), divided into books; the fifth book (SGB V) covers SHI	**East:** ***Strong focus on public health in the German Democratic Republic*** **1945:** Establishment of the Central administration for the East German health care system **1950:** "Central Planning Act" - introduction of universal health coverage, managed by two national social insurance agencies **1974:** Introduction of disease management programs **1989:** Only few weeks before the fall of the Berlin wall, a „National Health Conference" decided to implement substantial health care reforms with increased investment
1990-today Unified Germany	***Transfer of the FRG health care system to the eastern part of Germany*** **1990:** Re-unification Acts; application of SGB V is extended to the Eastern parts **1992:** Health Care Structure Act: free choice of sickness funds, introduction of risk-structure compensation mechanism among competing sickness funds **1994:** Statutory Long-Term Care Insurance Act **1996/97:** reduction of certain benefits (but introduction of hospice care), increased copayments **1998:** Act to Strengthen Solidarity in SHI: dentures for persons bon after 1978 reintroduced; several copayment rates lowered **2003:** Statutory Health Insurance Modernization Act: certain benefits excluded (esp. OTC drugs), creation of Federal Joint Committee, shift away from 50:50 split of contributions between employer and employee **2007:** Act to Strengthen Competition in SHI: legal mandate for health insurance results in universal health coverage	

Source: authors' own compilation

and insurance funds). The inclusion of the latter group had three visible effects: (1) White-collar workers were given certain extra rights, e.g. to maintain separate sickness funds, giving them a certain choice between "primary" (mainly for blue-collar workers) and "substitute" funds, or to opt-out of the system if their income was above a certain threshold – inequities which were only abolished 75 years later. (2) From that moment on, a clear distinction between private and statutory health insurance emerged. Persons not covered by SHI, e.g. civil servants, teachers and clerics, could purchase private insurance. (3) The number of insured persons became so large that physicians feared for their income.

Just as population coverage increased, so did the scope and scale of covered benefits. The Health Insurance Act of 1883 constituted the insureds' entitlement to cash-benefits in case of illness (amounting to 50% of wage for a maximum of 13 weeks), death and childbirth. In addition, it granted in-kind services such as free medical treatment and medicinal products. Alternatively, sickness funds could offer their members coverage for inpatient treatment. The 1883 law also defined the areas in which individual sickness funds could extend benefits, such as higher cash benefits, extending the maximum duration of sick pay to as much as one year, and offering additional benefits in kind, including what today would be classified as complementary and alternative remedies (Alber 1992). In 1903, the duration of sick-pay was doubled to 26 weeks.

The passing of the "Imperial Insurance Code" (Reichsversicherungsordnung) in 1911 was a milestone in the history of social insurance in general and health insurance in particular. It bundled together all previous individual laws and regulations. Until the late 1980s, it remained the centrepiece of German social law and can still be described as the legal base of today's welfare state.

Health Insurance during two World Wars

In the aftermath of World War I (1914-1918) and ensuing political instability during the Weimar Republic, no extensive legislative changes regarding the health insurance system were made. However, after the early extension of SHI coverage to the sector of work and occupational groups, there were two further major coverage extensions in the period of the Weimar Republic: (1) the unemployed after the First World War in 1918, and (2) non-earning wives and daughters in 1919. By 1925, the majority of the population (51%) was covered by SHI (Bärnighausen & Sauerborn 2002). In terms of benefits coverage, the introduction of maternity-pay as a standard SHI benefit in 1919 was a major step.

During the period of National Socialism (1933–1945), the fundamental structures of the social insurance system, including those related to health care financing and delivery, remained unchanged. Despite this structural continuity, the principles of the social insurance system were grossly violated. Access to medical and cash benefits from SHI, accident and old age insurance was restricted or denied to the Jewish population and other stigmatized minorities. However, an important step was taken in 1941: all pensioners were included in the SHI system. The National Socialists extended benefits to all primary dependents in the same year (Busse et al. 2017).

Two systems in a divided Germany

After the end of World War II, the Soviets took an authoritarian approach in East Germany to controlling infectious diseases and despite protests from many doctors, gradually moved towards a centralised, state-operated health system in the German Democratic Republic (Busse and Blümel 2014). However, despite socialist ideology, the health system retained important features of the Bismarck model. Although the Central Planning Act of 1950 put the system under central state control, the principle of social insurance—with employers and employees sharing the cost of insurance contribution amounting to 60 Marks a month—was maintained by law. Insurance was made universal and administration was concentrated in just two large sickness funds: one for workers (89%) and one for other occupational groups, including members of agricultural cooperatives, artists, and the self-employed (11%) (Lüschen et al. 1997).

West Germany continued to adhere to the SHI system and strengthened the quasi-abolished self-administration of sickness funds after a long and fierce debate. Regarding the expansion of population coverage, insurance became mandatory for four other population groups in 1972 (farmers), 1975 (disabled persons and students) and 1981 (artists). By 1987, 76% of the population was obliged to be covered under SHI. In addition, just over 10% of the population, mainly self-employed, as well as white-collar workers earning more than the income threshold, were insured with the SHI on a voluntary basis, so that total population coverage was 88% in 1987 (Alber 1992). The size of the voluntarily insured is an important litmus test for the sustainability of the SHI system, as most of this category pay the maximum contribution to the SHI system, based on their relatively high incomes and could also seek private insurance coverage.

In 1969, the government granted blue-collars up to six weeks on full salary when sick, a regulation that applied to white-collars already since 1930. In 1970, preventive medical check-ups and paediatric screening were included in the benefit basket. Around the same time, the provision of immunizations was shifted from the public health offices to office-based physicians, especially paediatricians, which further diminished the role of public health actors. The Act to Improve Services of 1973 removed the time limit of hospital care and introduced a sick pay to compensate for wages lost while caring for a sick child. Furthermore, the Act granted domestic aid during inpatient stays and extended the coverage of rehabilitation services as well as dental and orthodontic services. As a result, SHI expenditures shot up in the following years. SHI expenditure, as a share of GDP, increased from 3.5% in 1965 to 5.9% in 1975, with a growth of 2.1% points between 1970 and 1975 alone (Alber 1992), resulting in an explosion of the concept of "*Kostenexplosion im Gesundheitswesen*" (cost explosion in healthcare) (Braun et al. 1998).

Focus on cost containment in a reunited Germany

After Germany's reunification in 1990, the structures of the West German SHI system were almost completely and immediately transferred to the former East Germany (Knieps

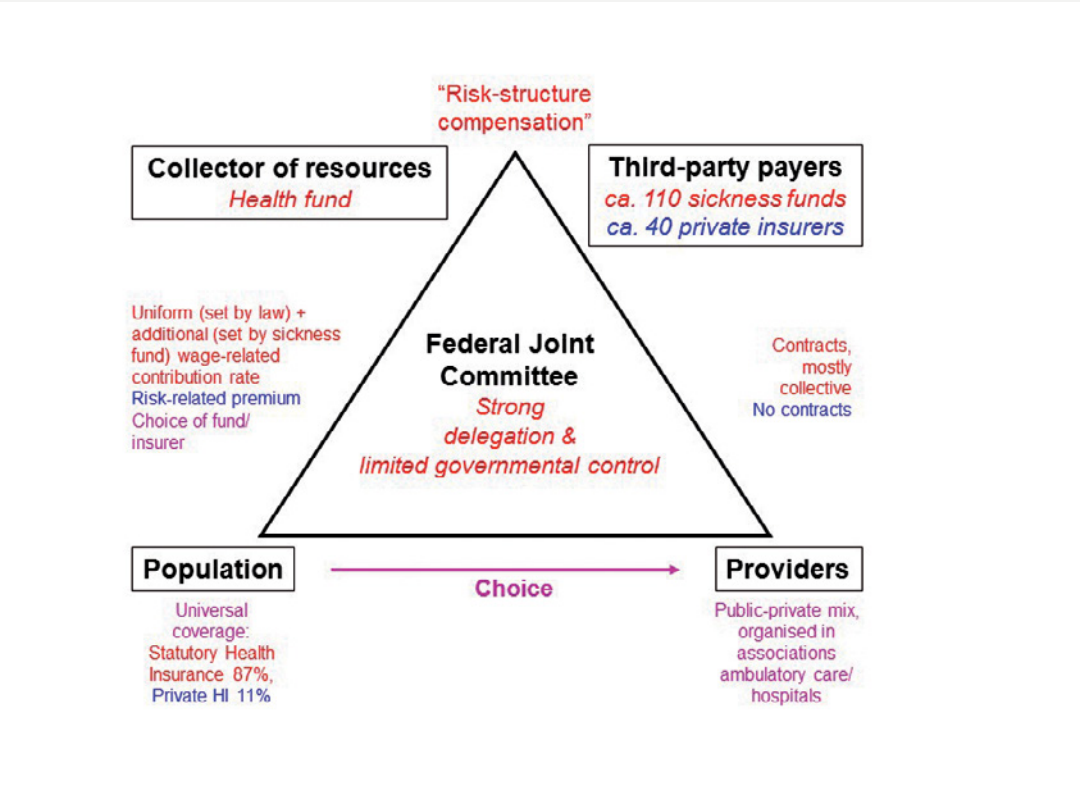
and Reiners 2015). In addition to the main task of bringing together the health systems of the western and the eastern parts, Germany was faced with the challenge of rising health care costs due to population aging, growing healthcare demands and progress in medical technology. This led to recurrent deficits and increasing debts in the SHI, even as sickness funds raised their contribution rates. In 1992, €108 billion in SHI expenditures stood in contrast with €105 billion revenues (Busse and Riesberg 2004). Rationalization was given priority over rationing and few items were removed from the SHI benefit basket (Lisac et al. 2010).

Health care reforms through the mid-1990s were characterized by increased government intervention for limiting expenditure in all sectors of care. Indeed, new benefits were added in order to more adequately meet the population's health needs and to provide more efficient care. Access to long-term care services was expanded substantially by introducing a statutory long-term care insurance scheme as a new, fifth pillar to the German social insurance system. However, the period between 1990 and the 2000s was also characterized by many cost-containment measures. Some of them were unpopular attempts at reducing benefits, such as the exclusion, in 1996-97, of certain rehabilitative benefits and, controversially, of dentures for those born after 1978 (denture coverage was reintroduced in 1998). In 2004, a second wave of cost-containment measures removed insurance coverage for OTC drugs and prescription eyeglasses, and shifted costs to private households through out-of-pocket payments (Busse and Blümel 2014).

In general however, instead of removing benefits, legislators preferred a cost containment approach that set budgets or spending caps for entire sectors, such as hospitals, ambulatory care and pharmaceuticals. Budgets helped to keep SHI expenditure slightly above 6% of GDP, while overall health expenditure rose moderately from 9.0% in 1992 to 10.3% in 2003 (Busse and Riesberg 2004).

Population coverage was expanded further with the inclusion in 2008-09 of persons on welfare, culminating in the almost accidental achievement of "completely universal" health coverage (from already near-complete levels). The original intention was to ensure that persons would not lose their private insurance coverage through no fault of their own, but it turned out that this was only possible by mandating health insurance for everybody,

FIGURE 2: SCHEMATIC ILLUSTRATION OF ACTORS AND RELATIONSHIPS IN THE GERMAN HEALTH SYSTEM



Source: authors' own compilation

either through membership in the SHI scheme or through private health insurance (Busse et al. 2017).

As of 2007, a step towards introducing more competition in SHI consisted of enabling sickness funds to offer a choice of tariffs, previously limited to private health insurance companies. Different benefit baskets and pricing allowed the funds to better meet the individual needs of their members, for instance through offering plans with a higher-than-standard cost-sharing requirement, which makes SHI more attractive to people with higher incomes and lower service utilization. Tiered rates in SHI are therefore a tool that can both strengthen competition between sickness funds and prevent the opting out of "low risks" from the solidarity system.

Germany's health system today

In 2018, there is universal health coverage in Germany and people have free choice of health care providers. SHI is provided by 110 (as of January 2018) competing, not-for-profit, self-governmental sickness funds (GKV-Spitzenverband 2018). All employed citizens (and other groups such as pensioners) earning less than the opt-out-threshold (€ 59 400 per year in 2018) are mandatorily covered by SHI, and their non-earning dependents are covered free of charge. Individuals whose gross wages exceed the threshold and the previously SHI-insured self-employed can remain in the SHI on a voluntary basis, or purchase substitutive PHI. About 87% of the population receives primary coverage through SHI and 11% through substitutive PHI. The remainder (e.g., soldiers, police officers or refugees) are covered by specific governmental schemes. People covered by SHI have free choice of sickness funds and people covered by PHI have free choice between 40 private health insurers. SHI is mainly financed through a contribution rate of 14.6% of wage-related income, which is paid equally by the employee and the employer. These SHI contributions are collected in the Central Reallocation Pool (*Gesundheitsfonds*), which reallocates them among the sickness funds according to a morbidity-based risk-adjustment scheme (Busse et al. 2017; Blümel and Busse 2017). Each sickness fund charges an additional contribution rate from its insured to cover total expenditure, approximately 1.0%; these rates currently vary from 0.3% to 1.7% (GKV-Spitzenverband 2018). While SHI is financed on a pay-as-you-go basis, financing PHI is based on capital cover and premiums vary according to age, sex and medical history.

The conclusion of collective contracts is the predominant method of purchasing outpatient and inpatient providers for SHI, i.e. scope and (in principle) payment for services is equal for all providers in a region. Private health insurers do not conclude contracts, instead they pay providers directly. Although SHI and PHI are organized and financed differently, they use the same providers, i.e. hospitals and physicians treat both SHI as well as PHI patients, which differs from the situation in many other countries.

A key characteristic of the system is limited state control and extensive delegation to self-governing associations of payers and providers. The highest self-governing body is the Federal Joint Committee, which consists of representatives of the different associations and decides on benefit coverage, reimbursement systems and quality assurance within SHI. Using the triangle as a basis, figure 2 illustrates the key organizational and financial elements of the German health system with respect to the co-existence of SHI (red) and PHI (blue), with purple indicating that it is valid for both.

Discussion and Implications

The "Bismarckian" health system is the oldest social health system in the world and is still referred to as a prototype of health systems. It was initiated in 1883, survived the German Empire and the First World War (until 1918), the Weimar Period (1919-1933), the Nazi dictatorship, the Second World War (1933-1945), and German Separation (1949-1989). It evolved into the current system, implemented within a reunified Germany. Innumerable reforms had taken place over these 135 years, however, from a historical point of view, the system is characterized by a high degree of structural continuity (Alber 1992).

Today, the German health system provides its population universal health coverage either under SHI or PHI. It offers a generous benefit basket with relatively low cost-sharing. This fact is also reflected in the comparatively low share of people who report an unmet medical need (Organisation for Economic Co-operation and Development 2017). However, universal health coverage was not given from the outset, but has incrementally expanded over the years.

An ever-recurring point of contention is the opportunity for self-employed and high earning people to leave the SHI system and to choose substitutive PHI. This unusual co-existence of SHI and PHI raises concerns about the preservation of solidarity and increases the (already existing) complexity of the system. Furthermore, it has an impact on actual health care coverage: despite the legal mandate to have health insurance, an estimated share of 0.1% of the population did not have any health insurance coverage in 2015 (Statistisches Bundesamt 2017). As the European Commission recently stated in the health profile for Germany, these individuals fall between the cracks of the system either because of administrative hurdles or because they have problems paying PHI premiums or SHI contributions (for example: low-income self-employed) (OECD/European Observatory on Health Systems and Policies 2017).

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The french health care system

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ABSTRACT: The French health care system is a model of national health insurance (NHI) that provides health care coverage to all legal residents. It is an example of public social security and private health care financing, combined with a public-private mix in the provision of health care services. The French health care system reflects three underlying political values: liberalism, pluralism and solidarity. This article provides a brief overview of how French NHI evolved since World War II; its financing health care organization and coverage; and most importantly, its overall performance.

Introduction.

The French health care system is a model of national health insurance (NHI) that provides health care coverage to all legal residents. It is not an example of socialized medicine, e.g. Cuba. It is not an example of a national health service, as in the United Kingdom, nor is it an instance of a government-run health care system like the United States Veterans Health Administration. French NHI, in contrast, is an example of public, social security and private health care financing, combined with a public-private mix in the provision of health care services.

The French health care system reflects three underlying political values (Rodwin, 1981):

1. liberalism, in the sense of giving patients free choice of doctors and hospitals;
2. pluralism, in offering diverse health care delivery options ranging from private fee-for-service practice, health centers and outpatient hospital consultations for ambulatory care, through a range of public, non-profit and for-profit hospitals;
3. solidarity, in the sense of having those with greater wealth and better health finance services for those who are less well-off and in poorer health.

In practice, the French health system represents a delicate balance between NHI and private fee-for-service practice – *la médecine libérale* (Rodwin, 2003; Rodwin and LePen, 2004; Steffen, 2010). The tensions involved in achieving universalism, respecting liberalism and meeting the challenge of rising inequalities are often highlighted in attempting to characterize the distinguishing features of French NHI (Nay et. al. 2016; Steffen 2016). Also, the question of whether the system is sustainable, recurs with regularity (Rodwin and contributors, 2006).

In this article, I provide a brief overview of how French NHI evolved since World War II; its financing, health care organization and coverage; and most importantly, its overall performance.

Evolution, coverage, financing and organization

Evolution: French NHI evolved in stages and in response to demands for extension of coverage. Following its original passage, in 1928, the NHI program covered salaried workers in industry and commerce whose wages were under a low ceiling (Galant, 1955). In 1945, NHI was extended to all industrial and commercial workers and their families, irrespective of wage levels. The extension of coverage took the rest of the century to complete. In 1961, farmers and agricultural workers were covered; in 1966, independent professionals were brought into the system; in 1974 another law proclaimed that NHI should be universal. It wasn't until January 2000 that comprehensive first-dollar health insurance coverage was granted to the remaining uninsured population, on the basis of residence in France (Boisguerin, 2002).

NHI forms an integral part of France's Social Security system, which is typically referred to by means of an agrarian metaphor, as a set of three sprouting branches: 1) pensions; 2) family allowances; 3) health insurance and workplace accident coverage (Damon and Ferras, 2015). The first two are managed by a single national fund whereas the third branch is run by three main NHI funds: for Salaried Workers (CNAMTS); for farmers and agricultural workers (MSA); and for independent Professionals (RSI) (Bras and Tabuteau, 2015). In addition, there are eleven smaller funds for specific occupations and their dependents, each defending their "rightfully earned" entitlements. The CNAMTS covers 86 percent of legal residents in France which includes salaried workers, those recently brought into the system because they were uninsured, and the beneficiaries of seven of the smaller funds administered by CNAMTS.

All NHI funds are legally private organizations responsible for the provision of a public service. In practice, they are quasi-public organizations supervised by the government Ministry that oversees French Social Security. The main NHI funds have a network of local

and regional funds that process reimbursement checks for health care providers and/or patients, look out for fraud and abuse, and provide a range of customer services for their beneficiaries.

Coverage and Benefits: French NHI covers services ranging from hospital care, outpatient services, prescription drugs (including homeopathic products), spa treatments, nursing home care, cash benefits, and to a lesser extent, dental and vision care. Small differences in coverage remain among different NHI funds. Smaller funds with older, higher-risk populations, e.g. farmers, agricultural workers and miners, are subsidized by the CNAMTS, as well as by the state, on grounds of what is termed "demographic compensation." Retirees and the unemployed are automatically covered by funds according to their occupational categories.

Financing: As of 2016, public health care expenditures accounted for 79 percent of total health care spending (DRESS, 2016). Private voluntary health insurance (VHI) accounted for another 13 percent and out-of-pocket payments around 8 percent. Of the total public portion, social security payroll taxes accounted for 64 percent of the total. The remainder was financed by a national income tax on all earnings, including dividends and interest from capital (16%), revenues from a tax on tobacco, alcohol, the pharmaceutical industry and private voluntary health insurance (VHI) (12%), state subsidies (2%) and contributions from other branches of social security (6%).

Health Care Organization: Liberalism is correctly invoked as underpinning the medical profession's attachment to cost-sharing and selected elements of *la médecine libérale* (private fee-for-service practice): selection of the physician by the patient, freedom for physicians to practice wherever they choose. Likewise, the diverse forms of practice in ambulatory care – private office-based arrangements that still prevail, along with growing numbers of health care centers and hospital-based consultations – reflect the importance of pluralism in French medical practice. As for hospitals, most acute beds are public (two-thirds), with the remaining third consisting of private beds divided among commercial for-profit and private not-for profit, usually affiliated with the public hospital service.

Performance

The French health care system is worthy of attention from health policymakers worldwide, for three reasons. First, France is among those countries that enjoy the highest levels of population health among wealthy nations. Second, France ranks #1 among OECD nations on an important indicator of health system performance – avoidable mortality. Third, the French have easy access to primary health care, as well as specialty services, at less than half the per capita cost (Table 1) of what is spent in the U.S.

Population health status

Health systems are often compared and ranked, based on their population's health status. Insofar as access to public health services and medical care can significantly improve a population's health, this is a good starting point in evaluating a health system.

Whether one compares life expectancy at birth, life expectancy at 65 years, infant mortality rates, or years of life lost due to premature death, France performs better than the U.S. (Table 1). France is also noted for having the highest longevity for women, after Japan. These indicators, however, are not sufficient for assessing the system's performance, because they reflect many other important determinants of health, e.g. poverty rates (Figs. 1-2); other socio-economic disparities; maternal and child health programs; work and family policies; and nutrition. Although the U.S. spends more on health care as a share of GDP, than any other nation, France spends a significantly higher share of its GDP on social service programs, particularly on family support and employment training programs (Fig. 3). An important hypothesis to investigate is whether France's government spending on these programs contributes to the population's impressive population health status.

Health system indicators

France's claim to fame with respect to health system performance is its top ranking among wealthy OECD nations, based on its success in averting deaths from a range of curable cancers, pneumonia, ischemic heart disease, maternal deaths in childbirth, and a host of other causes of mortality considered to be "amenable to health care interventions." Avoidable mortality (AM) attempts to capture the extent to which deaths under the age of 75 years would *not* have occurred, had the population benefitted from access to effective disease prevention programs, primary care, as well as specialty services.

Based on a comparison of avoidable mortality among 19 OECD nations, France has the lowest rate (ranks #1) and the U.S. has the highest rate (ranks #19) (Nolte and McKee, 2008). Moreover, between 1999-2007, the percentage decline in AM in France (27.7%) was higher than in the U.S. (18.5%) (Nolte and McKee, 2012). Based on these findings, Nolte and McKee estimate that if the U.S. were to achieve levels of AM of the three top-performing countries (France, Japan and Australia), about 101,000 deaths could be avoided.

An exclusive focus on AM does not allow one to disentangle the consequences of poor access to disease prevention versus primary or specialty health care services. Thus, it is useful to consider other indicators that capture the consequences of barriers in access to primary and specialty care (Gusmano and Rodwin, 2010). The first is well-established – hospital discharges for ambulatory care sensitive conditions (ACSC). It measures hospitalizations for exacerbations of conditions (e.g. asthma, diabetes, and hypertension) that are less costly and less painful to treat in community-based medical settings (Milman, 1993). The Agency for Healthcare Research and Quality (AHRQ) currently devotes part of its efforts to tracking access to primary care by examining rates of ACSC. Likewise, the Commonwealth Fund monitors ACSC as a measure of access across states. The second indicator is less well known. It concerns access to specialized cardiac care for those patients who require revascularization – coronary artery bypass surgery or angioplasty.

Comparative analysis of ACSC rates in the U.S. and France indicates that the U.S. rate is almost twice that of France, whether one examines national-level data or compares New York City and Paris. This demonstrates that access to primary care is significantly worse in the U.S. than in France, leading to many more hospitalizations that could be avoided if our health care system were improved (Gusmano, Rodwin Weisz, 2013; Gusmano, Rodwin, Weisz, 2014). With respect to cardiac services, contrary to conventional views that the U.S. makes available greater access to

life-saving medical technologies than other nations, after adjusting for the fact that the French have less heart disease than Americans, it appears that the rate of revascularization in the U.S. is not as high as in France – neither for adults (35-64 years) nor for older persons (65+) (Gusmano et. al. 2007). This supports the claim that the French health care system provides relatively easy access to specialized health care services.

Along with access to primary and specialty care, there is another important dimension of health system performance that merits attention – satisfaction with the health care system as reported in comparative surveys not only of the adult population, but also by chronically ill patients and physicians. Although comparisons of

TABLE 1. BASIC INDICATORS: FRANCE, U.S., GERMANY, NETHERLANDS, SPAIN, UNITED KINGDOM (2013-2016)

	France	United States	Germany	Netherlands	Spain	United Kingdom
Demographic and economic characteristics						
Total population	66,760,000 (2016)	323,127,500 (2016)	82,175,700 (2016)	16,979,100 (2016)	46,445,800 (2016)	65,382,600 (2016)
Percent of population >65 yr of age	17.9 (2013)	14.5 (2014)	21.4 (2014)	17.1 (2013)	18.3 (2014)	17.3 (2014)
Gross domestic product (GDP) per capita ($)	41,364.40 (2016)	57,591.20 (2016)	48,947.10 (2016)	50,539.60 (2016)	36,317.70 (2016)	42,622.20 (2016)
Health care system						
Heath care expenditures as percent of GDP	11.0 (2016)	17.2 (2016)	11.3 (2016)	10.5 (2016)	9.0 (2016)	9.7 (2016)
Per capita health expenditures in $PPPs	4,600.4 (2016)	9,892.3 (2016)	5,550.6 (2016)	5,385.4 (2016)	3,248.4 (2016)	4,192.5 (2016)
Public expenditures on health as % of GDP	8.7 (2016)	8.5 (2016)	9.5 (2016)	8.5 (2016)	6.3 (2016)	7.7 (2016)
Practicing physicians per 1,000 population	3.3 (2015)	2.6 (2014)	4.1 (2015)	3.3 (2013)	3.9 (2015)	2.8 (2015)
Physician consultations per capita	6.3 (2014)	4.0 (2011)	10.0 (2015)	8.2 (2015)	7.6 (2014)	5.0 (2009)
Average length of stay in hospitals (Acute Care)	5.7 (2014)	5.5 (2014)	7.6 (2015)	6.2 (2015)	5.9 (2015)	6.0 (2015)
Acute care beds per 1,000 population	4.1 (2015)	2.5 (2014)	6.1 (2015)	3.6 (2013)	2.4 (2015)	--
Health status						
Infant deaths per 1,000 live births	3.7(2015)	5.8 (2014)	3.3 (2015)	3.3 (2015)	2.7 (2015)	3.9 (2015)
Maternal deaths per 100,000 live births	5.1 (2014)	12.7 (2007)	3.3 (2015)	3.5 (2015)	3.6 (2015)	4.5 (2015)
Life expectancy at birth	82.4 (2015)	78.8 (2015)	80.7 (2015)	81.6 (2015)	83.0 (2015)	81.0 (2015)
Female Life expectancy at 65 yrs	23.5 (2015)	20.6 (2015)	21.0 (2015)	21.1 (2015)	23.0 (2015)	20.8 (2015)
Male Life expectancy at 65yrs	19.4 (2015)	18.0 (2015)	17.9 (2015)	18.4 (2015)	19.0 (2015)	18.6 (2015)
Female Life expectancy at 80 yrs of age	11.4 (2015)	9.8 (2015)	9.4 (2015)	9.6 (2015)	10.7 (2015)	9.5 (2015)
Male Life expectancy at 80 yrs of age	9.2 (2015)	8.4 (2015)	8.1 (2015)	8.1 (2015)	8.8 (2015)	8.4 (2015)
Years of life lost per 100,000 population due to death before 70 yrs of age	3,130.4 (2013)	4,610.7 (2014)	2,880.1 (2014)	2,540.0 (2014)	2,397.9 (2014)	2,995.8 (2013)

Source: OECD Health Data. Data in this Table were assembled by Ekemini Isaiah

consumer satisfaction are often inconsistent, there was evidence in 2007-8 across Europe, that France was first among those nations with the highest rates of consumer satisfaction (HI Europe, 2007). In June 2008, Harris Interactive, France 24 and the International Tribune collaborated on a survey that placed France at the top with 55 percent of respondents "satisfied" in contrast to the 28 % in the U.S. (HI, 2008).

Results of the 2008 Commonwealth Fund International Survey of Sicker Adults are consistent with these positive views of the French health system (Schoen, 2008). For example, with regard to "overall health system" assessments, sicker French patients (41%), along with their Dutch counterparts (42%), had among the highest rates of persons who felt that "only minor changes (were) needed."

Beyond measuring satisfaction, a number of other questions in the Commonwealth Fund Survey provide further evidence that the French have relatively easy access to health care. For example, on the question of medical homes – "do you have a doctor you usually see" – 99% of sicker adults, in France, answered "yes." Finally, the percent of sicker adults with out-of-pocket expenses over $1000, in the past year, was among the lowest in France (5%).

French policymakers assume that their NHI system is a realistic compromise between Britain's national health service, which they believe requires too much rationing and offers insufficient choice, and the mosaic of subsystems in the U.S., which they consider socially irresponsible because of the large share of the population that remains uninsured, under-insured or even forced to declare bankruptcy after a serious episode of illness.

Lessons from the French health system

Health systems cannot be transplanted from one country to another; nor should they be. Looking abroad, at best, can inform policy debates at home. Beyond France's impressive population health status and health care system performance, there are some distinctive features of the system that raise important questions for health policy, in general.

1. **There is no choice of insurance plan for standardized benefits**: The French health system differs from most other European health systems in its strong resistance to the most recent wave of reform efforts that have sought to introduce a dose of competition and market forces within a social context that maintains its commitment to national solidarity (Oliver, et. al., 2005). In France, American nostrums of unleashing market forces under the banner of "consumer-directed health care," and selective contracting by private health insurers, have gained little traction (Rodwin and LePen, 2004). French NHI does not allow a choice among health-insurance plans for the essential benefits covered under the program. Nor does it allow local health-insurance funds to engage in selective contracts with "preferred providers." The competition occurs among health care providers, not among the small number of insurers to which beneficiaries are assigned based on their occupation.
2. **All insurers reimburse providers according to nationally set rates**: In France, all insurers pay the same price for hospital services. Likewise, all physicians receive the same reimbursement under a national fee schedule that is negotiated every year. Approximately one-quarter of all physicians (12% of general practitioners) have opted for what is called "sector 2" and are entitled to balance bill their patients, i.e. to set fees above the national fee schedule. In these cases, physicians lose their own health insurance benefits and must pay for their own insurance like all others who are self-employed. Health centers and public hospital outpatient departments (where the most prestigious specialists work) may only charge patients national rates.
3. **There are no physician gate-keepers**: French NHI allows patients the freedom to consult general practitioners, specialists and hospitals of their own choosing. There are no restricted networks, no concept of out-of-network surcharges. Since 2005, policymakers have imposed a soft gate-keeping system by requiring French residents to sign up with a primary care doctor (*médecin traitant*). It is still easy, subject to a slightly higher co-insurance payment, to have direct access to a specialist without a referral (Dourgnon and Naiditch, 2010).
4. **There is extensive co-insurance and voluntary health insurance coverage**: In France, co-insurance (the so-called *ticket modérateur*), remains a component of the reimbursement system. Almost the entire population choose from a wide range of VHI products covering portions of co-insurance, extra-billing and supplementary benefits beyond the basic plan (mainly dental and optometry services). Most of the remaining population has free voluntary health insurance provided by the NHI fund or the government.
5. **Sicker patients have better insurance coverage**: In France, when patients become severely ill, their health insurance coverage improves. Although co-insurance and direct payment are symbolically an important part of French NHI, patients are exempted both when: 1) expenditures exceed approximately $100 per month; 2) hospital stays exceed 30 days; 3) patients suffer from serious, debilitating or chronic illness (e.g. cancer, heart disease, diabetes…); or 4) patient income is below a minimum ceiling, thereby qualifying them for exemption from co-insurance payments.
6. **Parliament sets annual health care expenditure targets**: All of the features noted above operate within a system in which Parliament approves an annual health care expenditure target for the coming year. This includes spending targets for specific components of health care (hospitals, community-based physician services and other sub-sectors). If hospitals and physicians exceed their targets by billing for higher than the projected volume of services, prices are negotiated downward the following year.

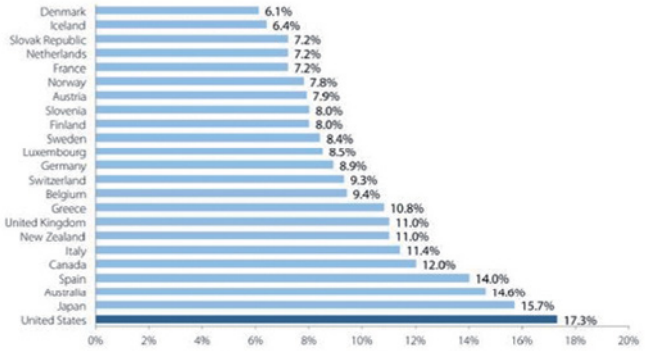
Biography

Victor G. Rodwin is Professor of Health Policy and Management, Wagner School of Public Service, New York University (NYU) and Co-Director (with Michael Gusmano) of the World Cities Project, a collaborative venture that studies health systems and population aging among, and within, New York, Paris, London, Tokyo and Hong Kong.

FIGURE 1

U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries
Economic Policy Institute, Issue Brief, 7/24/2012

Relative poverty rate in the United States and selected OECD countries, late 2000s



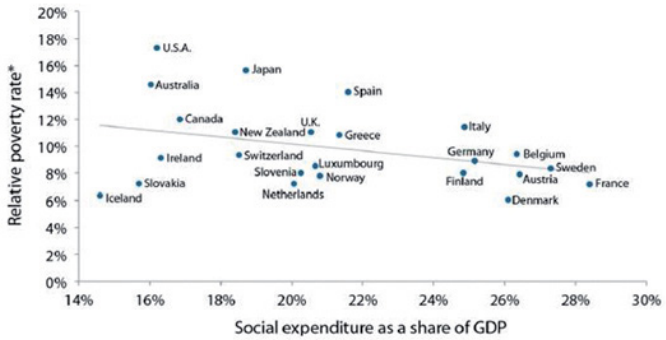
Note: The relative poverty rate is defined here as the share of individuals living in households with income below half of household-size-adjusted median income. Poverty rates are based on income after taxes and transfers.

Source: Authors' analysis of Organisation for Economic Co-operation and Development *Stat Extracts* (data group labelled "late 2000s")

FIGURE 2

U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries
Economic Policy Institute, Issue Brief, 7/24/2012

Social expenditure and relative poverty rates in selected OECD countries, late 2000s



* The relative poverty rate is the share of individuals with income below half of household-size-adjusted median income. Poverty rates are based on income after taxes and transfers.

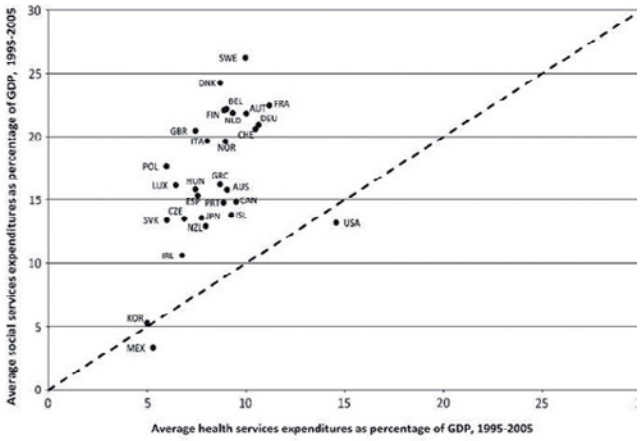
Note: Social expenditure is government expenditure on social programs, such as Social Security and Medicare in the United States. The equation for the trend line is $y = -0.2559x + 0.1528$ and the $R^2 = 0.1266$.

Source: Authors' analysis of Organisation for Economic Co-operation and Development *Stat Extracts* (data group labelled "late 2000s")

FIGURE 3

Health and social services expenditures: associations with health outcomes

Figure 2 Average social-services expenditures versus average health-services expenditures as percentages of gross domestic product (GDP) from 1995 to 2005, by country. *Social services expenditures Hungary are missing for 1995–1998, and for Portugal for 2005; health-services expenditure data are missing for the Slovak Republic for 1995–1996. Source: *OECD Health Data 2009* (accessed June 2009); *OECD Social Expenditure Dataset* (accessed December 2009); authors' calculations.



Bradley EH, Elkins BR, Herrin J, *et al. BMJ Qual Saf* (2011). doi:10.1136/bmjqs.2010.048363

FIGURE 4

In Amenable Mortality – Deaths Avoidable through Health Care – Progress in U.S. Lags that of 3 European Countries

Nolte, E. and M. McKee. *Health Affairs.* 2012; 31(9):2114-2122.

Age-Standardized Mortality Rates From Selected Causes In Four Countries, 1999 And 2006/2007

	Mortality rates per 100,000 people ages 0–74, 2006/2007				Percent change from 1999 to 2006/2007			
Country	Amenable causes	Heart disease (50%)	Other causes	All causes	Amenable causes	Heart disease (50%)	Other causes	All causes
MEN								
France	60.97	13.67	326.96	401.60	27.7	30.7	16.9	19.2
Germany	90.29	30.45	286.32	407.05	24.3	33.2	15.3	19.0
UK	91.27	34.47	253.76	379.51	36.9	41.7	8.4	21.1
US	106.90	37.18	328.20	472.26	18.5	32.6	8.8	13.6
WOMEN								
France	49.39	2.84	126.88	179.10	23.4	37.9	11.2	15.5
Germany	65.87	9.23	133.06	208.15	22.7	37.9	11.3	16.8
UK	74.14	10.82	153.81	238.76	31.9	47.8	6.0	18.6
US	84.50	14.52	191.47	290.49	17.5	35.8	6.1	11.7

SOURCE Authors' calculations based on data from the World Health Organization mortality database (Note 15 in text) and Centers for Disease Control and Prevention vital statistics data (Note 16 in text). **NOTES** Data for Germany for 2007 were not available; we used data for 2006 instead. As explained in the text, we assumed that 50 percent of deaths from heart disease were amenable deaths. Numbers may not sum to the total because of rounding.

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Universal health insurance coverage in Switzerland – yes, but …

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ABSTRACT: This article argues that in the case of Switzerland, financial incentives for signing up with social health insurance were so strong as to obviate the mandate imposed by a reform in 1996. That reform introduced premium subsidies paid to those whose health insurance premium exceeded a certain percentage (depending on the canton) of taxable income. The subsidies would have permitted to expose health insurers to full competition, rather than maintaining and even tightening existing regulation. With sufficiently high premiums obtained from high risks (lowered by the subsidy), competing insurers would not have any incentive to prefer them to favorable ones. Therefore, regulation intended to prevent cream skimming, in particular a risk adjustment scheme and a premium surcharge on no-claims bonus options could have been avoided. In this sense, the reform 'missed the boat', i.e. an enhancement of efficiency in social health insurance.

Background

The beginning of social health insurance dates back to 1911, when Swiss voters approved a federal law, modeled after the earlier Bismarck reforms in Germany, by means of popular referendum. Thus, health care insurance remained voluntary, except in a few (especially urban, industrialized) cantons, who exercised the option of imposing a mandate on low-income and foreign workers. The law fostered rather than constrained already existing private mutual funds, which were used to insure mainly blue-collar workers against short term disability.

Several attempts were undertaken in the years to come to further expand health insurance to cover medical treatment. One attempt was to implement federal subsidies. Since 1911, the funds were given the opportunity to ask for a subsidy for each enrolled person; in turn, they were to charge premiums according to age at entry, rather than current age, in order to encourage lifetime enrolment (Bundesamt für Sozialversicherung BSV, 2013a). This motivated middle and high-income taxpayers in particular, who realized that signing up for social health insurance was a good way of getting something back for their money. Another relevant attempt occurred in 1962 - reflecting the post-war economic boom - when copayment on ambulatory care was reduced from 20 to 10 percent, and restricted to a total of 700 CHF annually (some 2,800 USD at the time), while treatment and accommodation in the public ward of hospitals continued to be free of charge. By the mid-1990s, an estimated 97 percent of the population was covered (BSV, 2013a). Not surprisingly, cost inflation in the Swiss healthcare sector started to pick up, triggering several attempts at reform that failed already at Parliament level (BSV, 2013b). The politicians' primary motivation was to relieve the increasing burden of the premium subsidy on the federal budget.

The one reform that passed Parliament dates back to 1994. It was both pro-competition and pro-regulation (Bundesgesetz über die Krankenversicherung). The law was pro-competition mainly because of the following three reasons. Firstly, the premium subsidy was to be paid directly to low-income consumers, with implementation left to the cantons, who were free to determine both the maximum allowable income and the amount of the subsidy. Secondly, in order to ease change between insurers and thus increase competitive pressure, premiums were not to be scaled to age at entry anymore. Thirdly, insurers were given the right to innovate, provided a new product held the promise to reduce healthcare expenditure (HCE) – and with it, the burden of subsidies falling on the federal budget. Insurers were expected to launch Managed Care-type contracts in particular; for these policies, they were exempted from the any-willing-provider clause forcing them to accept all physicians in the country as contractual partners. On the other hand, the law was pro-regulation because the federal government obtained new regulatory power. Dissatisfied with 97 percent enrolment, it declared social health insurance mandatory, following the example of most industrial countries. Premiums had to be uniform for members of a given insurer living in one of three 'premium regions' characterized by differences in HCE. The only other premium differentiation was set for children (aged <18), young adults (ages 18 to 25), and older adults (aged >25). Additionally, a risk-adjustment scheme consisted of making insurers with an above-average share of young and male share of enrollees pay into the scheme, to be used for subsidizing insurers with a below-average share of these favorable risks. The federal government also obtained the authority to impose a uniform nationwide structure of hospital payment (in spite of the fact that up to 55 percent of their operating costs are covered by the canton of their residence), as well as a uniform nationwide fee schedule for ambulatory care, should negotiations between health insurers and

the medical association fail [for a detailed description and comparison with the United States, see Zweifel and Tai-Seale (2009) as well as Kreier and Zweifel (2010)].

Physicians in particular opposed the new legislation and encouraged their patients to sign their support for a referendum against it. To their surprise, the referendum was defeated in the popular vote of December 1995, so the law became effective in January 1996. Since Parliament had extended the list of benefits considerably, HCE and hence premiums and federal premium subsidies continued to rise, contrary to the promise that increased competition between insurers would cause them to fall. This failure (to be expected also in view of costly medical innovation), gave politicians reason to undermine and challenge the pro-competitive features of the new law. In particular, the Federal Office of Social Insurance (of Health at present) issued an ordnance mandating insurers to slash a ten percent 'solidarity surcharge' on premiums for no-claims bonus policies. It feared that this innovation might be used for attracting favorable risks – although the risk adjustment scheme, designed to prevent cream skimming, was already in place.

After 1996, the federal government did not hesitate to use its newly-won power. Already in 2000, it promulgated the nationwide uniform fee schedule TARMED, applicable to ambulatory care services [see Zweifel and Seale (2009) for a description and critique]. Social health insurers did not resist TARMED and failed to fight for the right to negotiate payment with (groups of) service providers in the interest of their members, as any prudent private-sector purchaser would do (imagine a high-scale fashion store striking the same contracts with its suppliers as a competitor catering to low-budget customers). In 2004, insurers also supported the nationwide transition to DRG-based hospital financing, in order to increase hospital efficiency. The reform was passed in parliament in 2007 and became effective in 2012, even though it was not clear at the time whether DRG-based payment dominated its alternatives in terms of efficiency (previously, *per diems* had been the norm, and there had been experiments with prospective budgeting). Moreover, some types of patients with an interest in avoiding early discharge (e.g. because of a lack of family support) might be better served by *per diem* financing [see Widmer (2014) for the ambiguous efficiency effects of DRG-based payment]. In 2006, Parliament also decided to increase copayment from 10 to 20 percent on prescription drugs, provided there is a generic that is at least 20 percent cheaper. In 2011, this regulation was extended to all drugs that can be substituted by a lower-priced equivalent alternative.

The major challenge to the existing system was a popular initiative calling for the abandonment of competitive social health insurance in favor of a uniform national scheme. Inspired by Quebec with its tightly run Canadian national health insurance, it was mainly supported by politicians from the French-speaking part of Switzerland. Since per-capita HCE in Geneva is far higher than in German-speaking cantons, they saw an opportunity for obtaining more funding through a federal monopoly. However, the initiative was overwhelmingly defeated in another popular referendum held in 2007 by 71 percent of voters (especially in the German-speaking cantons). A second attempt failed in 2014, garnishing 63 percent of no-votes this time. Finally, in its quest for reducing HCE and with it, its premium subsidy burden, federal government triggered a referendum against a proposed change in the law of 1996 that would have made Managed Care the default option of social health insurance. Consumers who prefer conventional fee-for-service policies were to pay an extra premium and a rate of copayment on ambulatory care of 20 rather than 10 percent. In 2012, this referendum was supported by 76 percent of voters, resulting in the proposal's rejection. According to experimental evidence cited in Zweifel (2013), consumers were not willing to bear the cost of information caused by a change reflecting governmental impatience (the market share of Managed Care-type contracts had grown to 47 percent by 2010 anyway).

Insights from the Swiss experience

Insight No. 1: *Policy may not address the most urgent issues*. Evidently, almost universal health insurance coverage was achieved in Switzerland, mostly without a national mandate. The few percent of the population not covered before 1996 mainly consisted of rich individuals who were willing and able to bear the cost of medical treatment themselves. Yet, replacing the old per-capita premium subsidy by a personal subsidy targeted to low-income individuals made sense because by the 1970s the sick funds also enrolled many well-to-do persons. The catch is implementation by the cantons. For instance, in generous Geneva, the subsidy kicks in at a taxable income as high as CHF 38,000 (1 CHF = 1 USD at present) for a single person (Mon subside d'assurance maladie 2017); in stingy Appenzell, a beneficiary has to be far poorer, earning CHF 12,000 (Merkblatt für die individuelle Prämienverbilligung 2017). However, several 'stingy' cantonal governments, fearing the backlash of higher-income voters who lost the benefit of the indiscriminate subsidy with the new law of 1996, simply redefined 'taxable income' in a way that up to 30 percent of the local population became entitled to the subsidy. The burden on their budget was limited because the subsidy is mainly financed at the federal level of government.

Insight No. 2: *Risk selection is a major issue because of premium regulation.* More than thirty years ago, Mark Pauly (1984) argued that risk-based premiums would dispel any incentive for risk selection on a competitive market for health insurance. High risks would have to pay a high premium (rendered affordable for the poor by a targeted subsidy), while low risks would search for an insurer offering a low premium. Contribution margins would become equal across types of risk, equally welcome by health insurers. By way of contrast, consider community rating: A health insurer will always have enrollees whose expected future HCE exceeds the revenue from uniform premiums. In order to avoid bankruptcy, it needs to attract low risks to make up for the deficit, and of course enrolling many low risks is better than few low risks. In this way, premium regulation induces risk selection efforts among health insurers. Risk adjustment amounts to artificially increasing the cost of enrolling a low risk to the insurer while artificially lowering the cost of enrolling a high risk. Economic theory and empirical evidence show that the objective of neutralizing incentives for selection both among insurers and enrollees (Zweifel and Frech, 2015) cannot be achieved in this way. Therefore, premium regulation induces a regulatory spiral: It has to be complemented by imperfect risk adjustment, followed by restrictions on product innovation (recall the fate of bonus options for no-claims mentioned above; in addition there is political pressure to eliminate the choice of higher deductibles, in exchange for lower premiums), and given little product innovation, consumers do not see much benefit in competitive health insurance anymore (recall the popular initiatives in favor of a public monopoly).

Insight No. 3: *The health share in GDP is a red herring.* The policy debate continues to revolve about the fact that Switzerland spends 11 percent of its GDP on health care, not far below the 16.4 percent of the United States (OECD, 2015). Yet, whenever consumers as voters decide about the modernization of a public hospital in their community, they support the proposal with clear majorities. Most of them know full well that increasing the cantonal rate of income taxation will finance one-half of higher operating cost, and the other half must come from their insurance premium. Indeed, experimental evidence suggests that the Swiss are willing to pay for having immediate access to costly medical innovation, even in the face of imminent death (Fischer et al., 2017). Of course, the media publish soul-searching articles every time higher health insurance premiums are communicated, but interest in the topic ebbs within weeks. The continuing cry for reform comes from politicians, especially at federal level, who dislike the inexorable rise in the budget item 'premium subsidies', which are growing at a rate of 4.1 percent, compared to about 3 percent for total federal expenditure (Gottwald, 2015). They prefer allocating funds in favor of voter groups who are crucial for their (re-)election (this may also be true of U.S. politicians, who need to reserve funds for Medicare and Medicaid).

Conclusion

In Switzerland, social health insurance dates back to 1911, when sick funds obtained a subsidy per enrollee, designed to render premiums affordable for blue-collar families. This financial incentive proved so powerful as to cause a voluntary expansion of coverage, leaving only a few rich citizens uncovered. Therefore, the mandate imposed by the reform in 1996 was not necessary; moreover, it missed the opportunity to expose social health insurers to full competition. The new targeted subsidy would have enabled unfavorable risks who are also low-income to pay a high premium, voiding any insurer incentive to eschew them. Rather, premium regulation was continued and complemented with a risk adjustment scheme (which has developed into a redistributive mechanism of its own at five percent of GDP). In sum, while achieving full coverage, the 1996 reform has opened the door to ever more public regulation, contravening its original purpose, which was to increase efficiency in the interest of consumers through encouraging competition.

Biographies

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Universal Health Coverage in Israel: Going Beyond the Number Covered

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ABSTRACT: The health indicators of Israel are high, while relative spending on healthcare is low. The enactment of the National Health Insurance Law (NHIL) in 1995 entitled all Israeli residents to free or nearly free health coverage via access to a socially determined "basket" of medical care. However, the NHIL recognizes that universal health coverage (UHC) transcends "the numbers," or shares of population coverage. According to this law, UHC also embodies a series of qualitative attributes.
This paper highlights the UHC attributes achieved in the Israeli healthcare system, beyond population coverage: equitable coverage, progressive contributions, access depending solely on medical need, accountability, and free choice. It also demonstrates particular implementation and continuance challenges: the lack of a firm state commitment to equitable UHC, leading to persistent disparities across Israel.

Introduction

Israel secured universal healthcare coverage (UHC) for its residents upon enacting the National Health Insurance Law (NHIL) in 1995.[1,2]

The law is based on principles of justice, equity and mutual support that aim first and foremost to (a) guarantee every resident free or nearly free access to a socially determined "basket" of medical care, and (b) protect household non-medical consumption from unacceptable spending on such care. In addition to the aforementioned, the law also stipulates a managed competition system to assure quality care and patient satisfaction efficiency and cost controls.

This Israeli legislation aimed to epitomize the full meaning and nature of universal health coverage. Prior to its enactment, Israel already had near-universal (95%) coverage; therefore, the opponents of the law argued that this legislation would be redundant, and that "minor change" was all that was required to make insurance mandatory for the 5% non-insured.

However, the NHIL recognizes that universal health coverage goes beyond "the numbers," or shares of population covered. By this law, UHC also embodies a series of qualitative attributes.

Background

As of 2017, Israel has a population of 8.79 million. Life expectancy at birth is 82.1 years and the infant mortality rate is 3.1 per 1,000 births—these outcomes are higher than for the U.S. and other OECD countries (Table 1).

Simultaneously, Israel spends considerably less per capita and a lower percentage of its gross domestic product (GDP) on healthcare than the U.S. and the OECD average: approximately 7%, as opposed to about 17% and 12%, respectively. Also in contrast

1 The Israeli law makes a distinction between 'citizens' and 'residents'. The NHIL applies to residents, some of whom are not citizens (Chernichovsky, 2009), (Chernichovsky, 2013), (Rosen & Samuel, 2009).

2 There can be entitlement by virtue of other statutes. The latter includes, as key examples, entitlement of those serving in the military, individuals covered by car and other insurance for particular injury requiring medical attention. Regardless of this the principle that every resident is covered for "necessary treatments" is maintained.

to the trend of rising healthcare spending as a share of GDP in other developed countries, spending in Israel has remained fairly stable over the 20 years between 1996 and 2016.

TABLE 1. HEALTH OUTCOMES/SPENDING IN ISRAEL, COMPARED TO THE U.S. AND OECD AVERAGE

Health Outcomes/Spending	Israel	United States	OECD Average
Life expectancy at birth (2015)	82.1 years	78.8 years	80.8 years
Infant mortality rate (2015)	3.1 per 1,000 births	5.8 per 1,000 births	4.2 per 1,000 births
Population above age 65 (%)	11.33%	14.5%	18.05%
Healthcare spending (Per capita)	$2,822 (USD)	$9,892 (USD)	$4,708 (USD)
Healthcare spending (% of GDP)	7.3%	17.2%	12.3%

Source: OECD Data, The World Bank Data

Medical Benefits

Entitled benefits

Israelis have been entitled to maternal, child, obstetric, and mental health care since the State of Israel was established in 1948, and to state-subsidized long-term care in the community and institutions since the mid-1950s. Under the NHIL enacted in 1995, residents of Israel became entitled to additional medical benefits: general preventive, acute, and chronic care delivered in the community and in hospitals, hereinafter referred to as "general care".

Prior to the NHIL, this care was secured by four sickness funds: Klalit Health Services, Maccabi Healthcare Services, Leumit Health Fund, and Meuhedet Health Fund. These funds covered about 95% of the population prior to the law, operating fairly independently from the state. The law then adopted the funds as arms of the state.

Quasi-private and private benefits

Each sickness fund also offers supplemental insurance to its members at community-rated premiums and with no underwriting.[3] Approximately 80% of Israelis hold this supplemental insurance—a dramatic increase from about 20% in 1998.

These funds have been regulated to pay for care and treatment in "private" provider facilities not funded by tax money, and do not monetarily reimburse its members, in contrast to commercial insurance reimbursement.

Israelis also have the option of purchasing wholly commercial insurance; currently, around 30% of Israelis hold this coverage.

In spite of legislation and regulation to the contrary, there is considerable duplication of benefits among all three insurance schemes; however, Israelis purchase voluntary insurance primarily to reduce waiting times and a wider choice of physicians.

3 Some elements of the insurance may stipulate a "waiting period," after which the benefits become effective. This is not underwriting.

The System

The organization of the Israeli system is depicted with the aid of Figure 1 according three functions: funding, fund holding, and care provision.

Funding

In line with the NHIL's principles, universal coverage in Israel is funded by general taxes plus an income-based health tax. The two taxes also replaced mandated employer contributions in 1998. However, these taxes only finance universally-entitled general care originally granted in 1995 (Figure 1 - a). They do not pay for maternity expenses or community long-term care, which are financed through the National Insurance Institute (NII), Israel's social security agency (Figure 1 - b). Nor do they pay for entitlements to maternal and child health, obstetric, or institutional long-term care, which are financed directly through the state budget of the Ministry of Health (Figure 1 - c).

Health tax collection and the share of the state budget allotted to general care are pooled through a special fund managed by the NII. The pooled contributions, about 80% of the public budget allotted to healthcare, are distributed nationally to the four competing sickness funds according to criteria of need, defined by an age-gender risk-adjusted (capitation) mechanism with an adjustment for disparities associated with the "social periphery."

In addition, the cost of five "severe diseases"—Gaucher disease, hemophilia, HIV, Thalassemia, and chronic kidney failure—are paid on a per-treatment basis, according to a Diagnostic Related Groupings method.

The remaining 20% of the public budget finances the healthcare activities overseen by the state and the NII.

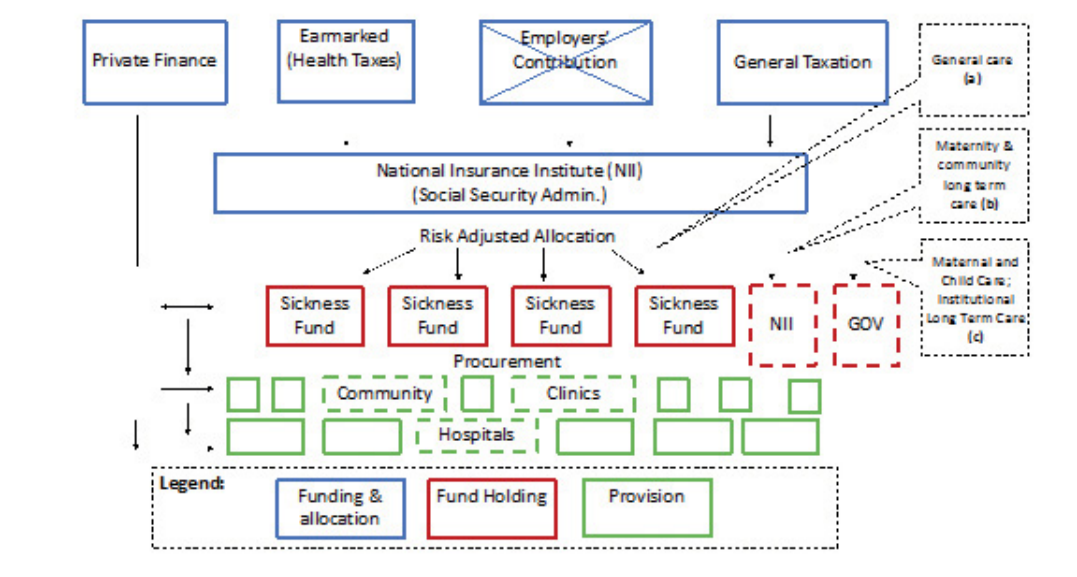
Budget Holding

The four competing sickness funds organize, manage, and procure care for their membership in a variety of ways. The largest fund, Klalit Health Services, is also the largest care provider, owning and operating its own clinics and hospitals. The second-largest fund, Maccabi Health Services, contracts almost all care from private clinics and from hospitals that it does not own (including those owned by Klalit). The two smaller funds, Mehuhedet and Leumit tend to provide primary care in their own clinics and purchase specialized care and hospitalization from institutions they do not own.

Provision of Care

Provider organizations may be public, wholly privately owned, or non-governmental not-for-profit. Public funds can only be used in facilities that do not provide care paid by supplementary or commercial insurance and out-of-pocket pay.

FIGURE 1. THE ORGANIZATION OF THE ISRAELI HEALTH SYSTEM



Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel
Note: This depicts the organization of the Israeli Health System following the enactment of the NHIL in 1995.

The Attributes of Universal Health Coverage in Israel

The right to equitable medical care

The NHIL recognizes access to equitable, basic medical care as a fundamental right to be supported by the public, regardless of one's employment status, place of work, or the level of one's contributions to the system.

Equitable care

The NHIL established a standard "basket" of care financed by taxes that each sickness fund must provide to its members. This standard basket of care was made possible by pooling all income-based tax contributions. Prior to the NHIL, contributions to the sickness funds were already income-based; however, this legislation made them more progressive, thus providing even more protection to household income from "undue" catastrophic medical expenditures.

The allocation of the pooled funds to the sickness funds is done through universal risk-adjusted capitation based on members' expected cost of care or need, and not their tax contributions.

Free choice and accountability

To foster transparency and accountability in the healthcare market, the NHIL granted Israelis the right to switch their sickness fund periodically if they choose—which they could not exercise before 1995—and mandated the sickness funds to maintain open enrollment. According to the NHIL, each sickness fund must accept all applicants who want to join or switch from their current fund, and similarly, participating providers must accept all patients, in accordance with the fund's provisions. These stipulations have increased the sickness funds' and providers' accountability to residents.

Efficiency

To reduce labor costs and boost employment, an employers' tax for funding medical services was abolished in 1988 and was replaced with funding from additional general revenues. This measure also makes contributions more fair and equitable than under the regime with employers' contributions. Additionally, the centralized collection of funds through the tax system significantly reduced financial management cost associated with collection.

While increasing accountability to enrollees, the risk-adjusted allocations forced the sickness funds to improve the efficiency of operations as a means to making them more attractive to enrollees on the managed competition market.

Outstanding and Emerging Challenges

Israel's health reform is incomplete in several major regards, and new challenges to universal coverage as defined here have also emerged. These include: a lack of complete integration of

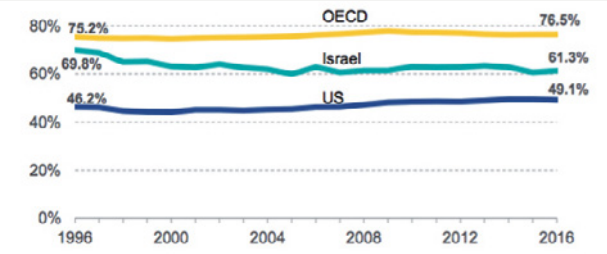
entitlements under sickness funds, uncertain state commitment and funding, an outdated allocation mechanism, and poor regulation of the public/private elements of the health system.

A lack of complete integration

As outlined above, the state oversees entitlement to preventive care, maternal and child care and institutionalized long-term care, while the National Insurance Institute oversees maternity benefits and community long-term care from a separate budget.

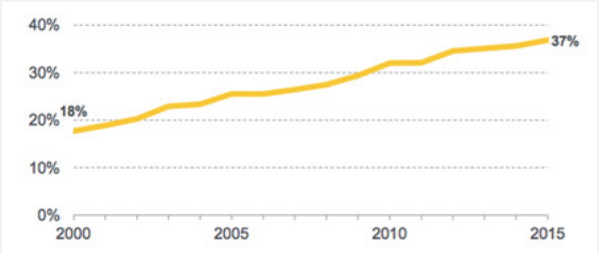
Thus, Israeli policymakers still face the challenge of integrating all entitlements under the institutional umbrella of the sickness funds. This would make the system more efficient, improve quality of care (through integration of treatment), and reduce waiting times, most notably with maternal and child care in the community, as is now the case with mental health.

FIGURE 2. PERCENTAGE OF PUBLIC EXPENDITURE OUT OF NATIONAL EXPENDITURE ON HEALTH



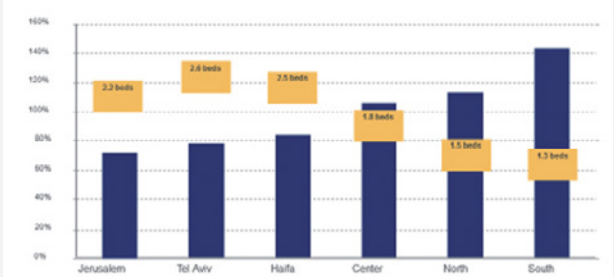
Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel, 2017
Data: OECD, Health spending indicator, 2017

FIGURE 3. EXPENDITURE ON PRIVATE INSURANCE OUT OF TOTAL HOUSEHOLD EXPENDITURE ON HEALTHCARE



Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel, 2017
Data: The Central Bureau of Statistics (Israel), 2015 Household Expenditure Survey

FIGURE 4. REGIONAL AND SOCIOECONOMIC DISPARITIES – WAITING TIMES AND GENERAL BEDS BY REGION (AS PERCENT OF NATIONAL AVERAGE)



Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel

Declining State Commitment

The commitment to universal health coverage in the state of Israel—mainly by the Ministry of Finance or the Treasury—has been uncertain from the outset. As a result, the negative attitude of the Treasury has prevailed, as evidenced by the 8.5% decline in the share of public health system funding out of total national health expenditure from 1996 to 2016, contrary to relevant international experience (Figure 2). Simultaneously, the share of private finance has increased, mainly in the form of voluntary supplemental and commercial insurance (Figure 3).

An outdated allocation mechanism

The Israeli managed competition model, recommended by the Netanyahu Commission, was to be implemented on a regional basis; the national sickness funds should operate as regional cost centers, assuring that funds intended for a regional population stay with those populations, even if treatment is rendered outside the region of residence (Chernichovsky & Chinitz, 1995). The goal was to ensure equitable regional resource allocation, to prevent public funds from "gravitating toward the center" at the expense of the more remote periphery. However, this recommendation was never legislated, let alone implemented. The risk-adjusted allocation was revised in 2011 to allocate extra funds to the "social periphery," but this change has done little to equalize care across Israel.

Additionally, the risk-adjusted allocation mechanism, based solely on age and gender with an adjustment for the social periphery, leaves excessive room for risk selection against those with chronic conditions. With a fast-growing and aging population, the prevalence of chronic conditions in Israel is rising quickly, highlighting the need for a reformed formula.

Poorly regulated public/private mix

Quasi-public supplemental insurance is regulated to be used only in "private" facilities that do not provide "public" entitled care. This rule also applies for commercial insurance.

However, these "private" facilities are often operated by physicians who also work in "public" facilities. These physicians then refer their patients from the public system to private facilities to augment their own incomes. This referral mechanism also shortens waiting times and increases physician choice for those with supplemental and commercial insurance coverage.

Hence, access to medical care, both in terms of quantity and quality (wait times and physician choice), depends increasingly on private spending, resulting in a growing burden on household budgets.

Persistent Disparities

Increasing system dependence on private funding, a poorly regulated public/private mix, and an outdated allocation mechanism

contribute to persistent and even growing regional disparities in medical infrastructure and access to care in Israel (Figure 4). These also reflect socioeconomic disparities that the NHIL aimed to minimize.

Conclusion

While Israel has equitable and efficient universal health coverage that contributes to the country's positive health indicators at a low cost, disparities in health outcomes and care access prevail. The increasing dependence of access-to-care on private and supplemental insurance in recent years has contributed to growing disparities.

Biographies

Dov Chernichovsky, PhD, is a Professor Emeritus of health economics and policy at Ben-Gurion University of the Negev in Israel. He is also a state-appointed chair of the Israeli National Nutrition Security Council, and leads the Health Policy Program at the Taub Center for Social Policy Studies in Israel. Dov also advises the Israeli parliament on health system issues, and is a consultant for the World Bank.

Marni Goldstein is a Master of Public Health and Healthcare Management candidate at the Icahn School of Medicine at Mount Sinai in New York City. She previously worked in communications and public relations for various healthcare companies, including the Mount Sinai Health System. Marni's interests include health policy reform, digital medicine and population health.

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Chile's two-tiered health system: Past and present policy challenges

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ABSTRACT: Chile relies on social health insurance (SHI) to provide universal health coverage (UHC) to its 17 million people. Its two-tiered SHI system was designed under General Pinochet in 1981. Since the return of democracy in 1989, it has been criticized by many for having two segregated subsystems: a large public insurer (Fonasa), covering mostly public health services for the low- and middle-income population (80 percent of the country), and several for-profit private insurers (Isapres) covering private care for the better-off (20 percent).
This paper reviews health reform initiatives implemented over the past 12 years in Chile. Chile's case is relevant to developing countries with SHI and which are debating the merits of alternative policies to achieve UHC. There are two competing views : SHI with a single insurer, which also acts as a single purchaser of health services; and SHI with a choice of multiple insurers for consumers, each purchasing health services for its insured population.

Health outcomes and health behaviors of Chileans

Chile exhibits relatively good health indicators. In 2015, life expectancy at birth was 81.74 years for women and 76.71 years for men. These figures were better than the average of the 20 countries immediately richer than Chile, according to per capita gross domestic product (GDP) adjusted by purchasing power parity (PPP). As expected, these figures were also much higher than the average for the 20 countries preceding Chile in PPP-adjusted GDP (Figure 1). Likewise, Chile's mortality and infant mortality rates were much lower than those of the 20 richer countries, and considerably less than those of the 20 countries with lower income.

These good health indicators coexist with poor health habits (Figure 1). Chileans feature higher rates of tobacco and alcohol consumption and a greater prevalence of overweight men and women than the 20 poorer and 20 richer countries. If left untackled, these poor habits may progressively erode Chile's good health outcomes.

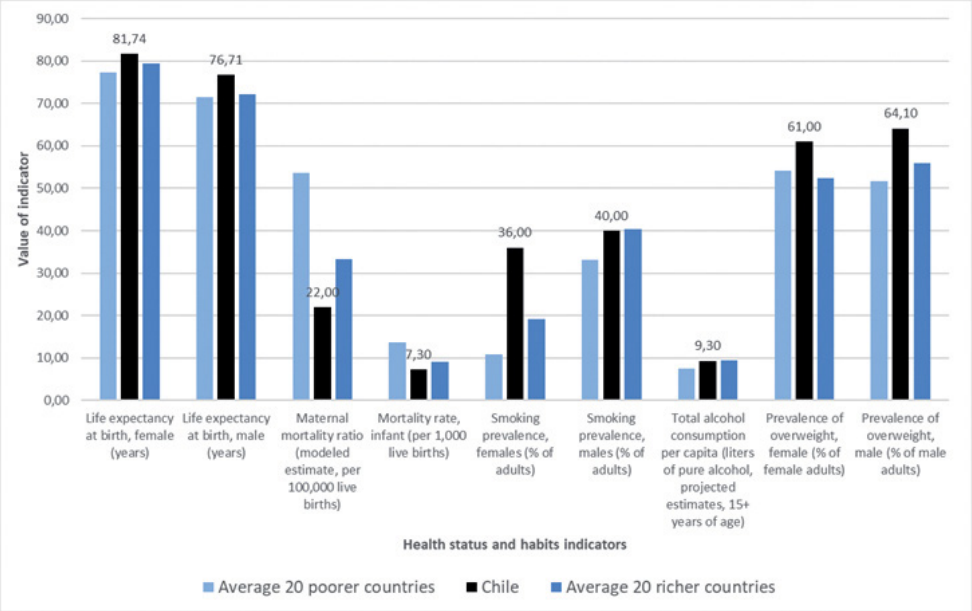
Chile's health system

Chile relies on SHI to provide UHC to its 17 million people. It has a two-tiered SHI system composed of two separate subsystems: one public and the other private. In the public subsystem, a large public insurer called the National Health Fund (Fonasa), covers over three-fourths of the population, including the indigent, most of the retired, low- and middle-income citizens. In the private subsystem, several for-profit private insurers, called Isapres, operate in competition and cover about one-sixth of the better-off population. Fonasa provides health services mostly through public providers whereas Isapres do so exclusively in the private sector.

By law, all dependent workers and all independent workers with a retirement fund must enroll with Fonasa or with an Isapre by making a monthly contribution amounting to 7 percent of their income, up to a monthly income ceiling of about US$2,700.[1,2] In theory each worker can select the insurer of his/her choice, although in practice it is the individual's income that largely determines whether he/she will select Fonasa or an Isapre. The legally certified indigent can enroll with Fonasa at no direct cost and can obtain health care from public health providers without any direct payments. Most workers in the second, third, and fourth lower income quintiles enroll with Fonasa because they cannot purchase a good enough health plan from an Isapre with their 7 percent. Workers in the 5th (highest) income quintile usually prefer to enroll with an Isapre, to have access to private health care. Most of them also make an additional voluntary payment to the Isapre, in addition to the mandatory 7 percent, to obtain better coverage. In contrast, Fonasa beneficiaries cannot supplement their legal 7 percent.

1 The maximum legal monthly contribution to Fonasa or an Isapre is therefore US$140.
2 Starting in 2011, a new law exempted legally retired workers receiving a pension from contributing 7 percent of their pension to health. The retired can now enroll with Fonasa (but not with an Isapre) without paying any premium.

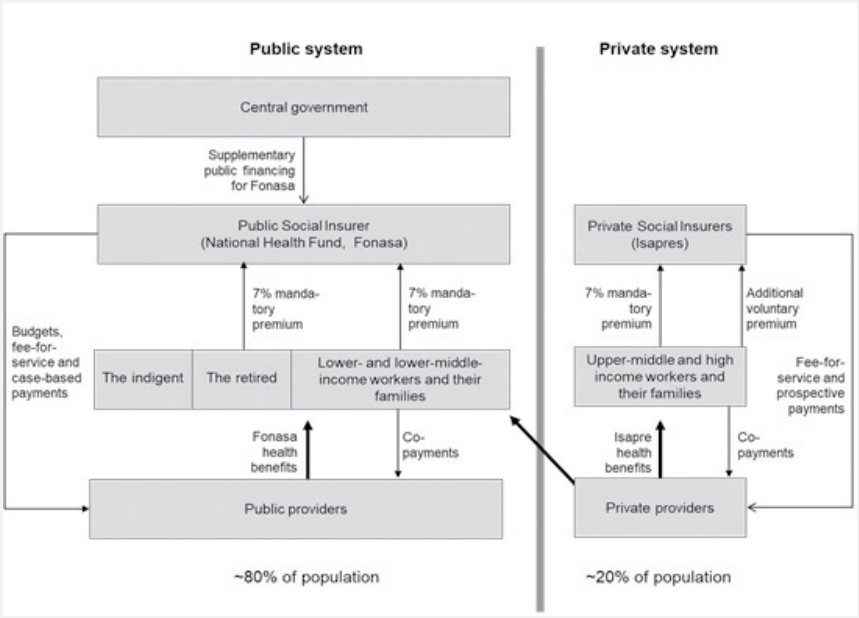
FIGURE 1 HEALTH STATUS AND HEALTH HABITS OF CHILEANS COMPARED WITH THOSE OF 20 POORER AND 20 RICHER COUNTRIES, 2015



Source: Author from World Bank Databank.

Figure 1 depicts Chile's health system in around 2004. As shown, a clear divide existed between the public and the private systems. The only public-private exchange of services in place was the ability of non-indigent Fonasa beneficiaries to purchase private health services through a voucher system, known as the Free-Choice Modality, by which the public insurer covered a portion of the bill, whereas the insured paid for the rest out-of-pocket.

FIGURE 2 CHILE'S TWO-TIERED HEALTH SYSTEM AS OF 2004



Source: Author.

Since the return of democracy in 1989, Chile's health system has been criticized by many for having two separate subsystems: a public one for the poor, lower and middle-income population, and a private one for the better-off. Some are in favor of eliminating Isapres as SHI insurers and expanding Fonasa to cover all Chileans. Others favor the multi-insurer model and recommend changes to overcome the problems of Isapres and those of the public system, while including both Fonasa and public providers.

Those preferring the single insurer/payer option argue that such an arrangement prevents insurers' discrimination against the old, the ill, and women of fertile age, that it saves on marketing and switching costs among insurers, and that its monopolistic power allows it to achieve economies in the purchase of health services. Those who promote a model with multiple insurers in competition posit that consumer choice reduces the cost and improves the quality of both insurance and health care, and avoids inefficiency problems that often affect monopolistic markets.

The health reforms of 2005

President Ricardo Lagos (2000-2006) made a significant and largely successful effort to improve equity in the health system. He proposed a reform with two related components, of which only one was approved in the parliament. The first component was the allocation to Fonasa of 3 of the 7 percentage points collected by the Isapres. His argument behind this initiative was that Isapres engaged in risk selection, retaining a group of insured citizens who were wealthier, healthier, younger, and with a lower proportion of women of fertile age. By transferring 3 of the 7 percentage points of Isapres' revenue to Fonasa, the private insurers would be compensating the public insurer for its larger actuarial risk. This reform component failed to receive endorsement in parliament.

The second reform component, known as GES (for its Spanish acronym of *Garantías Explícitas en Salud*, or Explicit Health Guarantees; Law No. 19.966), formulated an explicit benefits package for all Fonasa and Isapre beneficiaries.[3] The rationale behind this reform component was that while the system would remain segmented with its public and private subsystems a common and legally guaranteed health benefits package offered in both components would improve equity in access and financing.

The GES reform component was approved in parliament. The GES package initially covered 56 priority health problems and explicitly defined four legal guarantees for beneficiaries, including:

- Their right to health care for the priority problems
- The definition of treatment protocols and the explicit definition of the interventions to be guaranteed under the law for each health problem
- The adoption of maximum waiting times for health treatment
- The adoption of limits on out-of-pocket spending (OOPS) for health care.

The significance of this reform stems in part from its definition of explicit and legal health rights for Fonasa beneficiaries, including the poor and the non-poor, who up to that point did not have any explicit health rights. Its significance also stems from Isapres' legal obligation to adopt—at a minimum—the exact same legal guarantees as Fonasa. Although Isapres have had explicit and legally regulated health contracts with their beneficiaries, and a large share of beneficiaries obtained more coverage than GES requires, the advent of GES has served to define minimum benefits for these insurers. Thus, no Isapre beneficiary can get less coverage than what GES requires. GES constitutes a coverage floor, or standard, that all SHI insurers must abide by. For example, before 2005, Isapres had no legal obligation to cover antiretroviral therapy (ARVs) for their insured population suffering from HIV/AIDS, nor could Fonasa demand funding from the treasury to finance ARVs. Once in place, GES mandated ARV coverage by public and private insurers, and put in place financing mechanisms to pay for said benefit.

By mid-2007, 56 AUGE priority health problems with their respective guarantees were in place; they increased to 69 by 2010 and to 80 in 2013 (Table 1).

Contents of GES. The MOH and the Ministry of Finance (MOF) determine the contents of the GES benefits package, considering several criteria, including the burden of disease, the share of the population suffering from the disease, the expected cost per beneficiary, the supply capacity of the government health services network, and the effectiveness of interventions. Once a decision is made about any additions or subtractions from the GES package—the law requires that a costing study be carried out prior to making any changes to GES—the MOH issues a decree specifying the revised benefits package. The benefits package consists of the explicit prevention and treatment protocols associated with each priority health problem.

Financing of GES. In 2005, the Chilean congress approved a law whereby the main source of public financing for GES benefits in Fonasa would be a 1 percentage point increase in the value-added tax, which went up from 18 percent to 19 percent. Some studies have demonstrated that Chile's value-added tax is regressive in its incidence, and others have shown that it is progressive in the benefits it finances (Engel et al. 1997). While no specific studies are available, it is likely that this tax increase is progressive in the financing of GES benefits in Fonasa.

Providers. Fonasa mostly purchases GES benefits from public providers on all three levels of care. This is in accordance with an explicit policy adopted by Fonasa to minimize spending on GES by obtaining the highest possible share of services from the relatively least expensive public providers. However, in those situations where there is insufficient public supply, Fonasa may be forced to purchase GES services from a private provider at a much higher price. A policy adopted by Fonasa in 2011, known as the GES voucher, offered beneficiaries a nominal voucher to obtain GES services from private providers when such services were not available among local public providers. However, limited evidence showed that voucher use was modest because its value was too small to be attractive to private providers. The voucher policy was discontinued.

Compliance monitoring. The national health regulator, or Health Superintendence (*Superintendencia de Salud*) is responsible for monitoring Fonasa and Isapres compliance with

3 The GES reform was initially called AUGE, for its Spanish acronym *Acceso Universal con Garantías Explícitas*, Universal Access with Explicit Guarantees); it was later renamed GES.

TABLE 1 CURRENT 80 PRIORITY HEALTH PROBLEMS IN GES BENEFITS PACKAGE

Health problem	Health problem
1. End-stage chronic renal failure 2. Operable congenital heart disease (under 15 years of age) 3. Cancer of the uterus or cervix 4. Cancer pain relief and palliative care 5. Acute Myocardial Infarction 6. Diabetes Mellitus Type I 7. Diabetes Mellitus Type II 8. Breast cancer (15 years of age or more) 9. Spinal Dysraphia 10. Scoliosis surgery (under 25 years of age) 11. Cataract surgery 12. Total hip replacement in people with severe osteoarthritis of the hip (65 years of age or more) 13. Cleft palate 14. Cancer (under 15 years of age) 15. Schizophrenia 16. Testicular cancer (15 years of age or more) 17. Lymphoma (15 years of age or more) 18. HIV/AIDS 19. Ambulatory care lower ARI (under 5 years of age) 20. Ambulatory pneumonia (65 years of age or more) 21. Primary or essential arterial hypertension 22. Epilepsy (nonrefractory) (1 to 15 years of age) 23. Prevention and education for oral health (6 years old) 24. Prematurity–Retinopathy of prematurity–Deafness of prematurity 25. Conduction disturbance for those with pacemakers (15 years of age or more) 26. Bladder cancer preventive cholecystectomy 27. Gastric cancer 28. Prostate cancer 29. Adult leukemia 30. Strabismus (under 9 years of age) 31. Diabetic retinopathy 32. Retinal detachment 33. Hemophilia 34. Depression (15 years of age or more) 35. Benign prostatic hyperplasia 36. Acute stroke 37. Chronic obstructive pulmonary disease 38. Bronchial asthma 39. Newborn respiratory distress syndrome 40. Orthosis and aids (65 years of age or more)	41. Deafness (65 years of age or more) 42. Ametropia (65 years of age or more) 43. Eye trauma 44. Cystic fibrosis 45. Severe burns 46. Alcohol and drug dependency (10 to 19 years of age) 47. Pregnancy and delivery of integral care 48. Rheumatoid arthritis 49. Knee arthrosis (55 years of age or more) and hip arthrosis (60 years of age or more) 50. Intracranial aneurysm and venous malformation rupture 51. Central nervous system tumors 52. Herniated nucleus pulposus 53. Dental emergencies 54. Dental care (65 years of age or more) 55. Polytrauma 56. Traumatic brain injury 57. Retinopathy of prematurity 58. Bronchopulmonary dysplasia of prematurity 59. Bilateral sensorineural hearing loss of prematurity 60. Epilepsy in patients over 15 years of age 61. Bronchial asthma in patients over 15 years of age 62. Parkinson 63. Juvenile idiopathic arthritis 64. Secondary prevention of chronic renal failure 65. Hip dysplasia 66. Integral oral health in pregnant women 67. Multiple Sclerosis 68. Hepatitis B 69. Hepatitis C 70. Colorectal cancer in persons over 15 years of age 71. Epithelial ovarian cancer 72. Gall bladder cancer in persons over 15 years of age 73. Osteosarcoma in persons over 15 years of age 74. Surgical treatment of chronic injuries 75. Bipolar disorder in persons over 15 years of age 76. Hypothyroidism in persons over 15 years of age 77. Treatment of deafness in children under 2 years 78. Systemic lupus erythematosus 79. Surgical treatment of lesions in the mitral and tricuspid valves 80. Helicobacter pylori infection treatment

Source: Ministry of Health at www.minsal.cl. Translated by the author

GES guarantees and sanctioning those insurers that fail to meet one or more guarantees. It is also responsible for accrediting public and private health care providers engaged in the provision of GES services.

Copayments for GES. The reform permits the adoption of copayments by Fonasa and Isapres for GES services. However, in order to prevent impoverishment and large financing shocks caused by health events, it establishes a limit on the size of these copayments. Under Fonasa, the indigent and low-income beneficiaries are exempt from copayments. In contrast, beneficiaries in higher-income groups must make maximum copayments of 10 and 20 percent, based on Fonasa's price list. In addition, the sum of all copayments over any given 12-month period cannot exceed two monthly salaries, if the family has a GES health problem, or three monthly salaries, if the family is affected by two or more GES health problems. Once this deductible is reached, Fonasa or the Isapres exempt their beneficiaries from any additional copayments until the annual period is complete.

Figure 2 depicts Chile's health system after the reforms of 2005. It shows the part of the reform that was approved -the GES benefits package- and the part that was rejected -the three percent cross subsidy from the Isapres to Fonasa.

Subsequent health reform initiatives

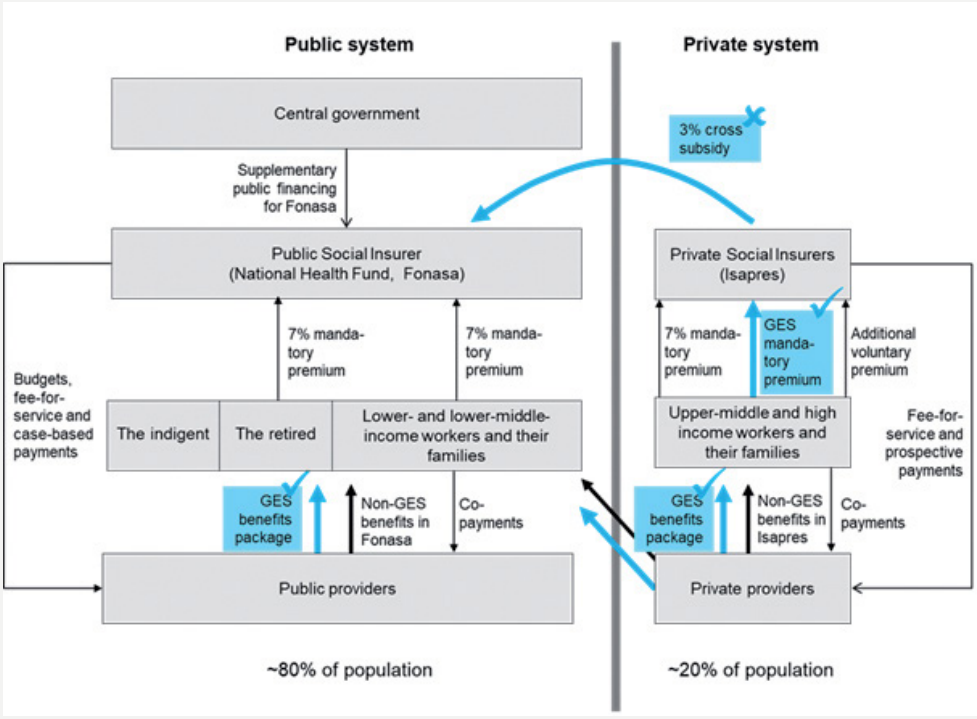
In 2011 President Sebastián Piñera passed a law eliminating the 7 percent mandatory health contribution for the retired. The rationale behind this reform was that the majority of Chileans who had retired were receiving a monthly pension payment that was smaller than their last salary before retirement. The requirement to contribute 7 percent of their pension further reduced their already modest income.

In 2014 President Michelle Bachelet was elected for a second term. She set out to reform the Isapre system on the grounds that it had multiple problems. A prime problem was that Isapre beneficiaries suffering from chronic health problems and/or who were above 65 years of age could not easily switch Isapre if they wanted to do so. This happened because Isapres can legally reject applicants on any grounds without having to justify their decision, and they can also exclude pre-existing conditions from coverage. The health regulator estimated that in 2009 up to 47 percent of all Isapre beneficiaries were potentially captives of their Isapre, that is, they were unable to switch Isapre either because they would not be accepted by another Isapre or because other Isapres would not cover their pre-existing conditions (Superintendencia de Salud 2009).

Another problem of Isapres was that annual increases in premiums were successfully being challenged by beneficiaries in the legal system. Consequently, Isapres had to freeze the premiums of those who legally challenged them and further increase the premium of those who did not to compensate for their revenue shortfall, in an environment of cost escalation.

A third criticism of Isapres was that they marketed numerous

FIGURE 3 CHILE'S TWO-TIERED HEALTH SYSTEM IN 2005



Source: Author.
✓: Reform approved.
×: Reform rejected.

health plans because they were legally entitled to charge a premium that was set in accordance with the actuarial risk of each individual or family. Critics of Isapres viewed this as a lack of solidarity which went against the basic principles of SHI.

Ms. Bachelet thus set up a Presidential Health Reform Commission with the mandate to correct these and other problems in the Isapre system. The Commission was composed of 17 members appointed by President Bachelet, 14 of which were explicit detractors of Isapres. In the first few sessions of the Commission it became clear that the presidential mandate was not to reform Isapres but instead to abolish them altogether, giving rise to an SHI system where Fonasa would become the single insurer and the single purchaser of health services.

Those favoring a single public insurer solution claimed that the 7 percent mandatory health contribution was not the private property of the contributor but was instead the collective property of all Chileans covered by SHI. Those opposing the end of Isapres argued that the 7 percent was the contributor's and that the Constitution gave them the right to decide where to direct that contribution: to Fonasa or to an Isapre.

The Presidential Commission's report contained two parts, one with the proposal of the majority of its members, and another with the proposal of the minority. The majority proposal was to eliminate Isapres, to make Fonasa the only insurer that could collect and manage the 7 percent health tax, and to turn Fonasa into a single purchaser. Individuals wishing to have additional coverage beyond that granted by Fonasa could voluntarily purchase private health insurance with regulated commercial insurers.

The position of the minority was to perfect the Isapre system through several measures. First, they proposed the creation and operation, within the Isapre system, of a risk-adjustment fund that would enable Isapre beneficiaries to switch Isapre freely. Two alternative risk compensation models were envisioned. With the first, all Isapres would contribute a monthly flat premium per beneficiary to the fund, and the fund would use its proceeds to compensate Isapres following an annual open enrolment period, based on their ex-post risk. With the second model, the Isapre losing a beneficiary would compensate the Isapre receiving it, with the compensation amount being determined according to the beneficiary's age, sex, and health status.

The Commission's minority group also recommended that this mobility mechanism would allow free movement of beneficiaries and hence make the system fully competitive. Thus it would not be necessary to regulate the premiums of Isapres, and the beneficiaries could no longer legally challenge premium increases.

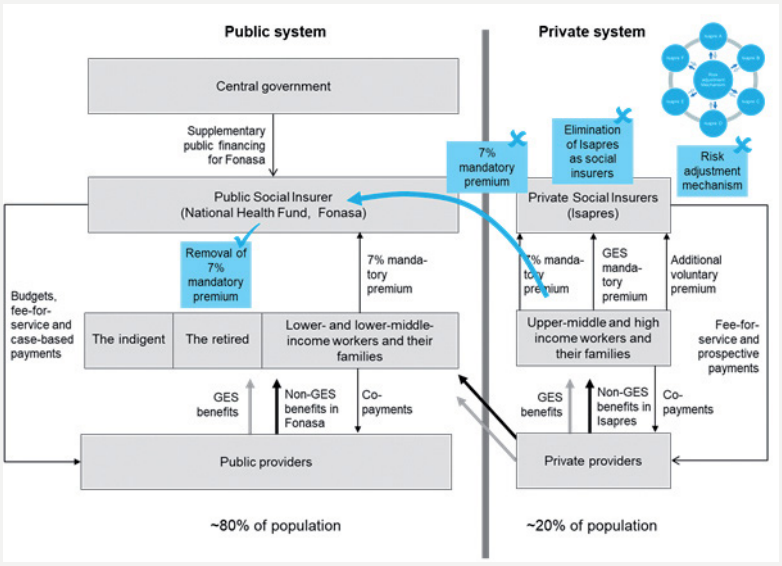
The Commission's mandate to reform the Isapres meant that during its several months of operation, its members did not raise or address any of the problems facing Fonasa and the government health care delivery system (more on this below).

The extreme views of the Presidential Commission gave rise to a heated debated in society and in the parliament. This debate ensued for the entire four years of President Bachelet's mandate, and no final decision was reached. In 2017, towards the end of Ms. Bachelet's term, her Minister of Health conceded that it had not been possible to reform the health system and that doing so should be the responsibility of the next government.

Today, Chile's health system remains unchanged and the failed reform initiatives of President Bachelet's government are depicted in Figure 3. Isapres remain in existence, their problems are yet to be tackled, legal challenges to their premium increases are on the rise, and between one-third and one-half (depending on the source of the estimate) of the beneficiaries are captives of their Isapre.

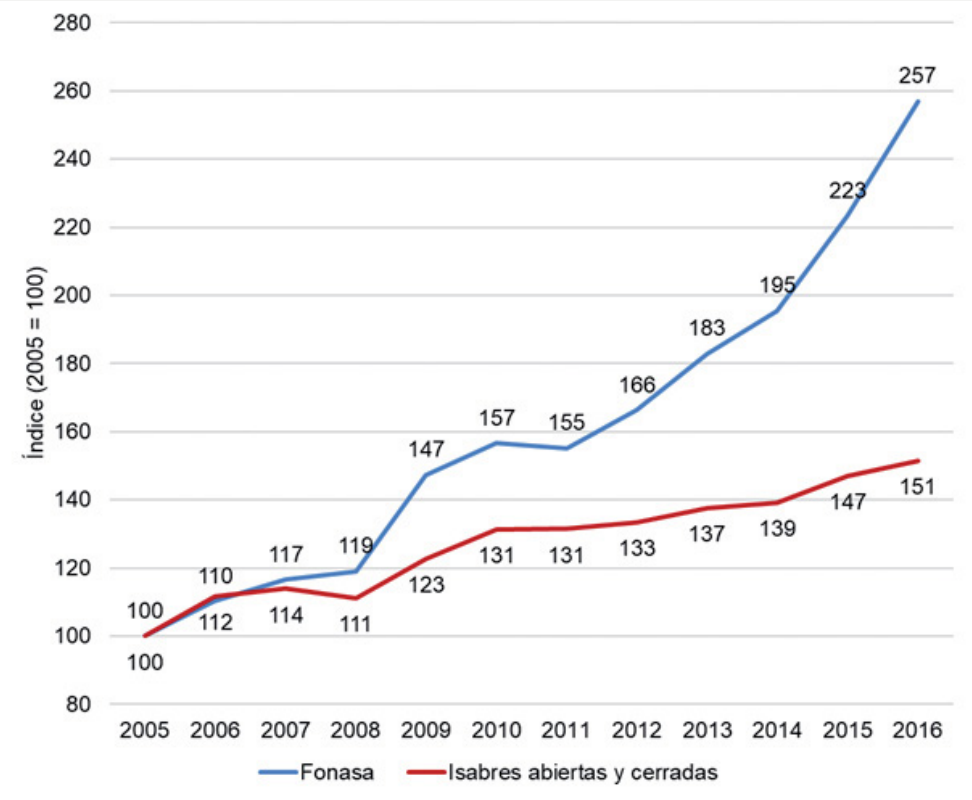
There is evidence that the GES reform has been successful in increasing equity in access and in financing within the health system (Bitran, Escobar et al. 2010, Bitran 2013). It is surprising, however, that such a complex and costly reform has not been

FIGURE 4 CHILE'S TWO-TIERED HEALTH SYSTEM TODAY



Source: Author.
✓: Reform approved.
✗: Reform rejected.

FIGURE 5 CUMULATIVE REAL INCREASE IN PER CAPITA HEALTH SPENDING IN FONASA AND THE ISAPRES, 2005-2016 (2005 = 100)



Source: Author with data from Health Superintendence at (http://www.supersalud.gob.cl/portal/w3-channel.html) and from Fonasa's Balance Presupuestario at www.fonasa.cl.

the subject of large, formal evaluations.

There is also evidence that GES has place considerable strain on public finances. Indeed, while Isapres are criticized each time they raise their annual premiums, on average their premium increases are well below the increase in expenditure by Fonasa.

In the last decade alone, Fonasa's real (inflation-adjusted) spending per beneficiary grew by 157 percent (Figure 5). In the same period, the real expenditure per beneficiary in Isapres grew by a much lower 51 percent. In Fonasa, real annual spending growth per beneficiary was, on average, 9.0 percent, while in the Isapres it was 3.8 percent. Thus, Fonasa had to undergo a much larger expansion of its budget than the Isapres, in order to be able to meet the growing financial demands of the GES reform. The 7 percent mandatory contribution of Fonasa beneficiaries has not increased nearly as fast as Fonasa's expenditure. Hence, the public insurer has grown increasingly dependent on supplementary public funding from the treasury to make ends meet. In 2005, Fonasa revenue from the 7 percent contribution accounted for 43 percent of Fonasa revenue; by 2016 it had fallen to 28 percent.

Despite this large expansion in Fonasa's revenue, the public insurer is striving to meet demand for health services by its beneficiaries. As of June 2015, Fonasa reported a waiting list of 1.6 million beneficiaries waiting to be seen by a medical specialist. Three-fourths of them had been waiting for three months or longer. Additionally, 240,000 beneficiaries were in line to receive surgery, with 56 percent of them waiting for one year or longer. Furthermore, there were thousands of Fonasa beneficiaries waiting to receive GES services. Failure to meet the GES time periods is a violation of the law and yet Fonasa has not been fined by the Health Superintendence. It is estimated that in 2017 as many as 25 thousand Fonasa beneficiaries die while on a waiting list for services.

Final thoughts

When pondering reform options to strengthen Chile's SHI system, it is important to have a clear vision of the current system's strengths and weaknesses. Isapres have multiple problems and correcting them is a policy priority. There are feasible remedies that can be adopted. For example, setting up a risk-compensation fund -a mechanism that many countries have implemented- would help promote mobility and competition among Isapres. However, Fonasa also has problems, including long and growing waiting lists for GES and non-GES medical problems, despite a steep increase in spending and growing reliance on public financing beyond the 7 percent health contribution.

It is doubtful that putting an end to the Isapre system is

the best policy prescription. Multiple opinion polls show that Isapre beneficiaries are happier with their insurer that Fonasa's. Furthermore, in Isapres there are no waiting lists, as any beneficiary asked to wait for service gives rise to immediate punitive action by the Health Superintendence. In contrast, Fonasa's waiting lines for GES are tolerated by the Health Superintendence, clear evidence of asymmetric regulation.

Per capita spending by Isapres has grown at a much slower pace than Fonasa's, to the point that in 2017 for the first time, per capita spending by Fonasa on health services became equal to that in Isapres. Yet, at the same time, waiting lines for GES and non-GES services have continued to grow in Fonasa. Also, government hospitals are accumulating a growing debt with providers, a clear sign of management inefficiency.

Biography

Mr. Bitran is a senior health economist from Chile with over 35 years of experience as a policy advisor, researcher, and professor in Chile, the US, and over 40 developing countries. He holds an M.S. in Industrial Engineering from the University of Chile and an MBA in Finance and a Ph.D. in Health Economics from Boston University. He specializes in the development and evaluation of health sector financing reforms. He is the founding partner of Bitran y Asociados (B&A), an international consulting firm based in Santiago, specializing in health policy.

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Exchanges Can Survive End of Individual Mandate

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ABSTRACT: This note argues that generous premium subsidies, claimed by the great majority of buyers on individual insurance exchanges in the United States, greatly mitigate the problem of adverse selection, because the after-subsidy premium is low compared to expected benefits, even for most low risks. One implication is that removal of the modest penalty imposed by the individual mandate should not seriously destabilize this market for subsidized purchasers. At worst it will affect the small minority of non-poor low risks who may exit the Exchange pool for group insurance or uninsured status.

The main accomplishment of the Republican-ruled government to fulfill the promise of changing Obamacare is to abolish the individual mandate to buy insurance, effective as of 2019. This mandate imposes a penalty of $695 per person, or 2.5% of income per family, for people who fail to obtain qualified health insurance. It isn't much of a penalty, because about half of the uninsured can get exemptions, and penalties are small compared to premiums. Whether to pay a fine of $695 or a premium of $5,000 for a policy with high deductibles will force the higher income uninsured minority to choose between paying a little something for nothing or a lot for a little something. While the penalty will tip some of them into buying, it is no sledgehammer.

However, the puny nature of the penalty has not stopped a paroxysm of handwringing about how there might be an exodus of low risk individuals from exchanges. Since the substantial excess of premiums over low risk average claims is needed to cross subsidize lower premiums for high risks, their departure could lead average premiums to rise, thus leading to the dreaded "death spiral."

That is what insurance economists predict would happen on an unsubsidized market, where premiums are "community rated" and averaged across all risks. However, it won't happen to exchanges—because the generous subsidies to premiums received by 90% of exchange buyers mean that what those buyers pay now and would pay if premiums rose, is not tied to premiums. Instead, their payment obligation is linked to a share of their income (up to 9.5%), and is not affected when premiums spike—so even for low risks, the subsidies make insurance such a good deal that there is no additional reason for them to walk away. The premium might jump to $7,000, but the person's premium would stay put at a few hundred dollars a month.

The worst-case scenario for exchanges is thus limited to the 10% without subsidies—for them there might be a death spiral as the premiums they have to pay without help increase (and make the mandate penalty even less effective). However, nearly all of the users of exchanges still have as much reason to stay in as they ever did. The market may shrink for some of the 10% (though many of them are high risks who will hang in there), but if nothing else changes, exchanges can continue to function in their usual clunky way. In effect, exchanges could become a government-run health insurance program for lower income people, more like an extension of Medicaid. A more serious threat is that insurers, in anticipation of being pilloried for high and rising premiums, abandon this sliver of the private insurance market (almost everyone who gets private insurance gets it through their job), and leave the exchanges bereft of options. However, even a single insurer can offer many different plans, so the slightly shrunken outposts of Obamacare can continue to survive this threat, and wait for the greater threat of across the board repeal-and-replace.

Biography

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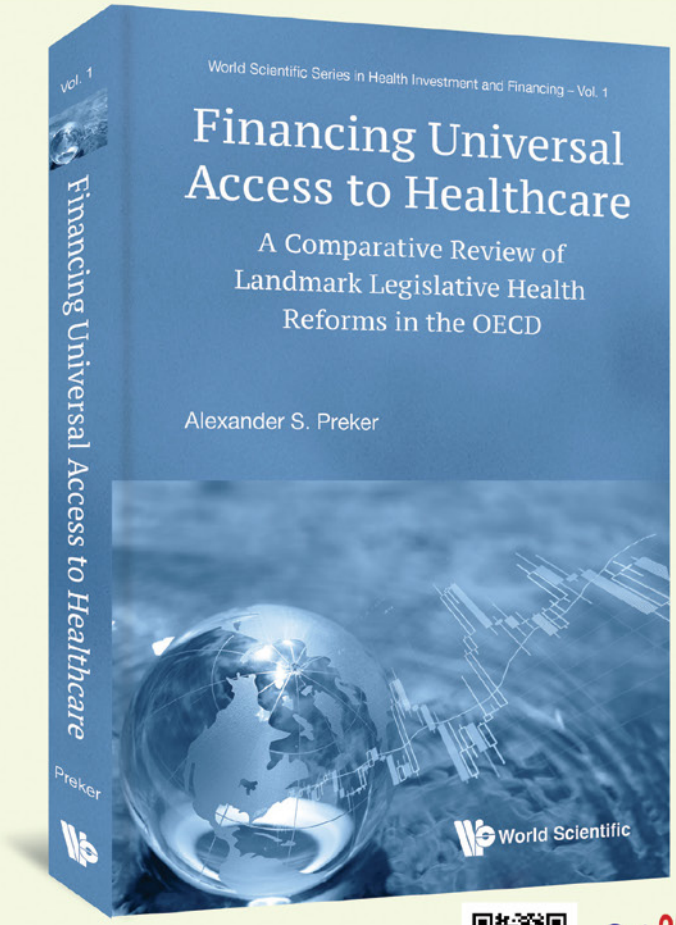
The International Hospital Federation (IHF) is committed to advancing the UHC agenda throughout the world, giving billions of people better access to critical hospital care and basic health services when needed, no matter their income or geographic location in the world. Since its establishment in 1929, the IHF recognizes the essential role of hospitals and health care organizations in providing health care, supporting health services and offering education to health care providers as a critical partner in during the drive for UHC throughout the world.

This volume is a tribute to the renewed effort in achieving "Health for All"

Eric de Roodenbeke, Executive Director
International Hospital Federation Geneva 2018



This book provides a comparative review of financing universal access to healthcare in the Organisation for Economic Co-operation and Development (OECD) countries.

The recent expansion of health insurance coverage in the USA under the Affordable Health Care Act, and current threats to reverse the benefits of this reform, have once again focused the world's attention on the difficult challenges faced by other countries trying to provide better access to healthcare to their population at an affordable cost.

Amidst this universal challenge, this book is a pioneer in providing a comprehensive synthesis for policy makers on the experiences of countries that have successfully introduced such reforms.

This book is designed as a learning tool for students and user guide for policymakers, including case material and an instructors' manual as well as sample exam questions. The data analysis of the cost of universal healthcare presented in the book is unique and has not been published before.

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Résumés en Français

Analyse des réformes progressives de la couverture maladie universelle dans les pays à faible revenu et à revenu intermédiaire

Avec le nouveau programme de développement élaboré en 2015, les Nations Unies ont établi que la «couverture sanitaire universelle d'ici 2030» était un engagement mondial au titre des objectifs de développement durable. Cet article explique comment cet engagement est mis en œuvre.

Ce document vise à décrire les politiques mises en œuvre par les pays en développement pour l'avancement progressif de la CSU. Basé sur une comparaison entre quarante pays à revenu faible et intermédiaire, il identifie l'existence de domaines de convergence des politiques, à savoir les domaines de politique dans lesquels les pays ont opté pour des mesures de réforme similaires. Il identifie également les domaines de divergence politique, où les choix diffèrent de manière significative. Cet article se termine par un résumé des principales conclusions et par une discussion sur les risques et les mesures d'atténuation que les pays qui cherchent à faire progresser l'universalisme progressif peuvent prendre.

Comment l'ont-ils fait ? Efforts en faveur de la CSU en faveur des personnes pauvres dans des contextes à faibles et moyens revenus

Ce document synthétise les conclusions de six pays faisant partie de l'UNICO qui ont fait des progrès considérables pour une couverture sanitaire universelle en faveur des personnes pauvres, malgré des ressources financières limitées. Ces pays comprennent le Kenya et l'Éthiopie qui font partie de la première série d'études de l'UNICO publiées en 2013, ainsi que le Cambodge, le Laos, le Malawi et la Tanzanie visés par la deuxième série d'études de cas publiée en 2018.

Ces programmes ont débuté dans un contexte de système de santé très difficile et visaient à répondre simultanément à de multiples contraintes. Face à ces défis, les programmes en faveur des personnes pauvres ont été en mesure de contribuer de manière significative à la performance globale du système de santé. Il y a un impact émergent sur les résultats en matière de santé et d'accès ainsi que de protection financière pour les pauvres - mais il y a aussi une feuille de route importante en suspens, incluant la qualité des services, les défis continus d'équité, le financement inadéquat et les faibles capacités. Cependant, ils ont montré avec succès des innovations concernant les achats, les systèmes d'information et leur forte focalisation sur les personnes pauvres, une leçon pour les autres pays à faible-moyen revenu.

Plus vite, plus haut, moins lourde, mais pas autrement : L'expansion de la couverture santé universelle (CSU) au Sri Lanka et en Malaisie au moyen d'un système de santé intégré

Ce document se concentre sur les caractéristiques des services de santé nationaux intégrés (SSN), comme en témoignent le Sri Lanka et la Malaisie, concernant les progrès en termes de couverture santé universelle (CSU) notamment dans le domaine de la santé maternelle et infantile (SMI). Les deux pays ont atteint des résultats élevés et équitables en matière de santé maternelle et infantile, avec une protection financière solide, plus rapidement et à un niveau plus élevé que les comparateurs économiques. Cependant, les défis auxquels sont confrontés les deux pays avec les maladies non transmissibles (MNT) montrent les limites des SSN intégrés non réformés et le caractère impératif des réformes. Étant donné que la Malaisie a un revenu national brut par habitant trois fois plus élevé que celui du Sri Lanka et qu'elle est actuellement confrontée à une stagnation des résultats en ce qui concerne la santé maternelle et infantile et des défis importants avec les maladies non transmissibles, nous émettons l'hypothèse que ces réformes devraient passer du statut de revenu faible-intermédiaire à moyen-aisé, ce qui équivaut approximativement à un revenu national brut par habitant de 4000 dollars américains.

UNIQUE : Stratégies de la demande pour la couverture santé universelle (CSU)

Cet article vise à mieux comprendre l'élaboration et la mise en œuvre des programmes axés sur la demande dans les pays à revenu intermédiaire documentés par la Banque mondiale par l'intermédiaire de l'UNICO, en mettant l'accent sur les progrès réalisés dans l'identification des populations bénéficiaires.

L'article se conclut en parlant des objectifs des programmes axés sur la demande et des réformes mises en œuvre dans les pays en vue de les atteindre. Il aborde également les défis rencontrés par les pays dans le cadre du développement de ces réformes, visant à augmenter la couverture sanitaire.

Résoudre les défis de la couverture santé universelle par l'apprentissage mixte

Alors que la couverture sanitaire universelle (CSU) prend de l'ampleur dans un plus grand nombre de pays, le besoin d'informations pratiques sur la manière de renforcer les systèmes de santé et d'élargir la couverture est apparu comme une priorité mondiale vitale. Le Réseau d'apprentissage mixte pour la couverture sanitaire universelle (RAM) réunit des praticiens et des décideurs politiques virtuellement et en personne pour des échanges d'apprentissage intensifs sur les obstacles techniques communs à la CSU. Au cours du processus, les membres co-produisent des outils pratiques sur la façon de concevoir et de mettre en œuvre des systèmes de santé efficaces, équitables et durables. Cet article explore comment le Ghana et les Philippines, deux pays membres de ce réseau, ont tiré parti de l'apprentissage entre praticiens pour faire face aux défis communs dans leur quête de la CSU.

Le système de santé en Angleterre : Avancées, défis et perspectives à l'approche de son 70ème anniversaire

L'article analyse l'histoire, les avancées, les défis et les perspectives du système de santé national en Angleterre, début 2018. L'ar-

ticle commence par examiner les résultats en matière de santé, en distinguant les résultats absolus des comparatifs. Il analyse ensuite l'impact du ralentissement économique mondial et du Brexit, de la dotation en personnel, des pressions opérationnelles et financières sur le système de santé anglais. L'article résume et commente ensuite le rapport du comité spécial 2017 de la Chambre des Lords sur la viabilité à long terme du système de santé angllais et des services d'aide sociale pour adultes. L'article conclut que le système de santé national en Angleterre n'est viable que si les ministres ont le courage d'adopter les conditions préalables fiscales et redistributives nécessaires. L'article se termine en posant une question sous-jacente plus vaste : dans quelle mesure les gouvernements britanniques actuels ou successifs, dans leur ensemble, acquièrent-ils les compétences et le rythme nécessaires pour s'adapter à «l'ère des accélérations».

Le « modèle Bismarck »- le système d'assurance maladie allemand dans son contexte historique

Le système allemand d'assurance maladie obligatoire, communément appelé modèle Bismarck, s'est développé au cours de ses 135 années d'existence, en commençant avec un système d'assurance obligatoire des travailleurs en évoluant vers un système permettant une couverture universelle de la population, un généreux panier de prestations et un partage des coûts réduit. Cet article donne un bref aperçu de l'histoire de l'assurance-maladie allemande sur la voie de la couverture sanitaire universelle tout au long de son histoire et des événements politiques du pays, ainsi qu'un aperçu de son fonctionnement actuel.

Le système de santé français

Le système de santé français est un modèle d'assurance maladie nationale (AMN) qui fournit une couverture médicale à tous les résidents légaux. C'est un exemple de financement public de la sécurité sociale et des soins de santé privés, associé à un mix public-privé dans la prestation de services des soins de santé.

Le système de santé français reflète trois valeurs politiques sous-jacentes: le libéralisme, le pluralisme et la solidarité.

Cet article donne un bref aperçu de l'évolution de l'AMN française depuis la Seconde Guerre mondiale ; le financement de son système de soins et la couverture ; et surtout, sa performance globale.

Couverture universelle d'assurance maladie en Suisse - oui, mais ...

Cet article soutient que dans le cas de la Suisse, les subventions financières visant à l'adhésion à l'assurance maladie étaient si fortes qu'elles ont permis d'éviter le mandat imposé par une réforme en 1996. Cette réforme a introduit des subventions aux primes versées à ceux dont la prime d'assurance maladie dépassait un certain pourcentage (selon les cantons) du revenu imposable. Les subventions auraient permis d'exposer les assureurs santé à une concurrence totale, plutôt que de maintenir et même de renforcer la réglementation existante. Avec des primes suffisamment élevées obtenues à partir de risques élevés (abaissés par la subvention), les assureurs concurrents n'auraient aucune raison de les préférer à des primes favorables. Par conséquent, une réglementation visant à prévenir l'écrémage, en particulier un système d'ajustement des risques et une majoration des primes sur les options de bonus pourrait être évitée. En ce sens, la réforme « a raté le coche », c'est-à-dire une amélioration de l'efficacité de l'assurance maladie sociale.

Couverture sanitaire universelle en Israël : Aller au-delà du nombre couvert

Les indicateurs de santé d'Israël sont élevés, alors que les dépenses relatives aux soins de santé sont faibles. La promulgation de la Loi nationale sur l'assurance maladie (LNAM) en 1995 a permis à tous les résidents israéliens de bénéficier d'une couverture médicale gratuite ou presque gratuite grâce à l'accès à un «panier» de soins médicaux déterminé par la société. Cependant, la LNAM reconnaît que la couverture sanitaire universelle (CSU) va au-delà des «chiffres», à savoir les parts de couverture de la population. Selon cette loi, la CSU comporte également une série d'attributs qualitatifs.

Cet article met en évidence les attributs de la CSU obtenus dans le cadre du système de santé israélien, au-delà de la couverture de la population : couverture équitable, contributions progressives, accès dépendant uniquement des besoins médicaux, de la responsabilité et du libre choix. Il présente également des défis particuliers en matière de mise en œuvre et de continuité: le manque d'engagement ferme de l'État en faveur d'une CSU équitable, conduisant à des disparités persistantes à travers Israël.

Le système de santé à deux vitesses du Chili : Défis politiques passés et présents

Le Chili compte sur l'assurance-maladie sociale (ASS) pour fournir une couverture maladie universelle (CSU) à ses 17 millions d'habitants. Son système de sécurité sociale à deux niveaux a été mis en place sous le général Pinochet en 1981. Depuis le retour de la démocratie en 1989, beaucoup ont critiqué l'existence de deux sous-systèmes distincts : un grand assureur public (Fonasa), couvrant principalement les services de santé publique pour les populations à faible et moyen revenu (80 % du pays), et plusieurs compagnies d'assurance privées à but lucratif (Isapres) couvrant les soins privés pour les plus aisés (20 %).

Ce document passe en revue les initiatives de réforme de la santé mises en œuvre au cours des 12 dernières années au Chili. Le cas du Chili est pertinent pour les pays en développement avec l'AM et qui débattent des mérites de politiques alternatives pour garantir la CSU. Il y a deux points de vue opposés : Système de sécurité sociale avec un seul assureur, qui agit également comme acheteur unique de services de santé ; et un système de sécurité sociale avec un choix d'assureurs multiples pour les bénéficiaires, chacun achetant des services de santé pour sa population assurée.

Les échanges peuvent survivre à la fin du mandat individuel

Ce document soutient que les généreuses subventions aux primes, réclamées par la grande majorité des acheteurs de contrats d'assurance individuelles aux États-Unis, atténuent grandement le problème de sélection adverse, car la prime après subvention est faible par rapport aux bénéfices attendus, même pour les risques les plus faibles. Une conséquence est que la suppression de la pénalité modeste imposée par le mandat individuel ne devrait pas sérieusement déstabiliser ce marché pour les acheteurs subventionnés. Au pire, cela affectera la petite minorité des faibles risques représentés par les personnes non pauvres qui peuvent quitter le pool d'échange pour l'assurance collective ou le statut non assuré.

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Resumen en Español

Una descripción de las Reformas de Cobertura Sanitaria Progresiva Universal en Países de Ingresos Bajos y Medios

Mediante la nueva agenda de desarrollo establecida en 2015, las Naciones Unidas establecieron la «Cobertura Sanitaria Universal para 2030» como un compromiso mundial dentro de los Objetivos de Desarrollo Sostenibles. Este trabajo explica cómo se está implementando este compromiso.

El artículo tiene por objeto describir las políticas de desarrollo que los países están implementando para mejorar progresivamente la UHC. Basado en una comparación entre cuarenta países de ingresos bajos y medios, identifica la existencia de ámbitos de convergencia política, denominados ámbitos políticos donde los países han optado por utilizar medidas similares. También identifica aquellos ámbitos de divergencia política donde las decisiones varían de manera significativa. Este artículo concluye con un resumen de las principales conclusiones y con una discusión sobre los riesgos y las medidas paliativas que los países buscan para que la mejora progresiva universal se lleve a cabo.

¿Cómo lo han hecho? Iniciativas de UHC pro-pobres en contextos de ingresos bajos a medio- bajos

Este trabajo sintetiza los hallazgos de seis países en la serie UNICO que han realizado considerables progresos para lograr la cobertura sanitaria universal (UHC) pro-pobre, a pesar de los recursos financieros limitados. Estos países comprendieron Kenia y Etiopía en la primera fase de los estudios UNICO publicados en 2013, y Camboya, PDR Lao, Malawi y Tanzania en la segunda fase de casos de estudio, a publicar en 2018.

Estos programas comenzaron dentro de un contexto sanitario muy difícil e intentaron responder simultáneamente a las múltiples limitaciones. En medio de estos retos, los programas propobres han sido capaces de aportar significativas contribuciones al desempeño del sistema sanitario general. Hay un impacto emergente en los resultados sanitarios y en el acceso y la protección financiera para el pobre - pero existe también una voluminosa agenda pendiente, incluyendo la calidad del servicio, los problemas constantes de equidad, la financiación inadecuada y la escasa capacidad. En cualquier caso, han demostrado innovaciones eficaces en la compra y en los sistemas de información y una especial preocupación por las personas de menores recursos, una lección para otros LIC y LMIC semejantes.

Más rápida, más elevada, más sencilla pero no más adelantada La expansión en Sri Lanka y Malasia de la Cobertura Sanitaria Universal (UHC) empleando una NHS integrada

Este trabajo se focaliza en las características de los servicios sanitarios nacionales integrados (NHSes), como lo ejemplifican Sri Lanka y Malasia en lo que se refiere a la Cobertura Sanitaria Universal (UHC) para la salud materno infantil (MCH). Ambos países han alcanzado resultados MCH elevados y equitativos, con una importante protección financiera, más rápida y de un nivel más elevado que los comparadores económicos. En cualquier caso, los desafíos a los que se enfrentan ambos países con enfermedades no transmisibles (NCDs) indica las limitaciones de los NHSes integrados no reformados y la urgencia de las reformas. Dado que Malasia posee un PIB per cápita tres veces superior al de Sri Lanka, y actualmente está afrontando el estancamiento con los resultados de MCH y de cara a los grandes retos de las NCDs, postulamos que estas reformas deberían programarse en base a una graduación de ingresos bajos-medios a elevados-medios equiparando aproximadamente a un PIB per cápita de US$ 4.000.

UNICO: Estrategias basadas en la Demanda de Cobertura Sanitaria Universal (UHC)

Este artículo intenta facilitar una mejor comprensión del diseño y de la implementación de programas, desde el punto de vista de la demanda, desarrollados en países de ingresos medios y documentados por el Banco Mundial a través de UNICO. Se ha centrado en el progreso logrado en identificar poblaciones beneficiarias y en separar financiación de prestación.

El artículo concluye con los objetivos de los programas del punto de vista de la demanda y con las reformas implementadas en países con la intensión de alcanzar dichos objetivos. También se refiere a los desafíos encontrados por los países en desarrollar estas reformas con el objetivo de aumentar la cobertura sanitaria.

Solución de los Desafíos de la Cobertura Sanitaria Universal mediante el Aprendizaje Conjunto

Dado que la cobertura sanitaria universal (UHC) cobró impulso en muchos países, la necesidad de información práctica sobre cómo consolidar los sistemas sanitarios y expandir la cobertura surgió como una prioridad global vital. La Red de Aprendizaje Conjunto (JLN) sobre la Cobertura Sanitaria Universal convocó virtualmente y en persona a los profesionales médicos y a los legisladores para intercambios de aprendizaje intensivo relativos a las barreras técnicas de la UHC. Durante el proceso, los miembros produjeron los instrumentos prácticos sobre cómo diseñar e implementar sistemas sanitarios sostenibles, equitativos y eficientes. Este artículo investiga cómo en Gana y en Filipinas, dos países miembros de la JLN, han aprovechado el aprendizaje de profesional a profesional para orientar los desafíos comunes que permitan alcanzar la UHC.

El Servicio Sanitario Nacional en Inglaterra: Logros, Desafíos y Expectativas que van a cumplir el 70° Aniversario

El artículo examina la historia, los logros, las expectativas y los desafíos del NHS (Servicio Nacional de Salud) en Inglaterra hasta principios de 2018. El artículo comienza examinando resultados

sanitarios, distinguiendo entre absolutos y comparativos. Luego considera el impacto de la Desaceleración Económica Mundial, el Brexit, el empleo de personal y las presiones operativas y financieras en el NHS. Posteriormente resume y comenta el Informe de 2017 del Comité Selecto de la Cámara de los Lores relativo a La Sostenibilidad a Largo Plazo del NHS y la Asistencia Social para Adultos. El artículo concluye que en Inglaterra el NHS es sostenible sólo si los ministerios tienen la voluntad política de promulgar los pre-requisitos fiscales y redistributivos necesarios. El artículo concluye formulando un problema de fondo más importante: hasta qué punto pueden las actuales Autoridades del Reino Unido, o sus sucesoras, en su conjunto, adquirir las competencias y el ritmo para adaptarse a «La Época de las Aceleraciones».

El "Modelo Bismarck" –sistema de seguro sanitario alemán en su contexto histórico

El sistema alemán de seguro sanitario estatutario, en general conocido como el modelo Bismarck, ha evolucionado durante estos 135 años de existencia de un seguro obligatorio para los trabajadores a un sistema que ofrece cobertura universal a la población, un abanico generoso de beneficios y acuerdos de participación a bajo costo. Este artículo ofrece una breve explicación de la trayectoria histórica del seguro sanitario alemán para ofrecer cobertura sanitaria universal a lo largo de los períodos políticos e históricos del país, así como una vista panorámica de su funcionamiento actual.

El sistema sanitario francés

El sistema sanitario francés es un modelo de seguro sanitario nacional (NHI) que ofrece cobertura médica a todos los residentes legales. Es un ejemplo de seguridad social pública y financiación sanitaria privada, combinadas en una mezcla de público y privado para ofrecer servicios sanitarios.

El sistema sanitario francés refleja tres valores políticos básicos: liberalismo, pluralismo y solidaridad.

Este artículo ofrece un breve resumen sobre cómo el NHI francés evolucionó desde la Segunda Guerra Mundial; su organización sanitaria financiera y su cobertura y, lo más importante, su desempeño global.

Cobertura del seguro médico universal en Suiza - sí, pero...

Este artículo argumenta que en el caso de Suiza, los incentivos financieros para suscribirse a un seguro médico social han sido muy fuertes para eludir el mandato impuesto por una reforma de 1996. Esta reforma introduce pagos subsidiarios de primas para aquellos cuyas primas de seguro médico superan un cierto porcentaje (dependiendo del cantón) de ingresos imponibles. El subsidio habría permitido exponer a las aseguradoras médicas a la plena competencia, en lugar de mantener y endurecer la normativa existente. Con primas suficientemente elevadas obtenidas de riesgos elevados (inferiores al subsidio) las aseguradoras competidoras no tendrían ningún incentivo para preferir éstas respecto a otras más favorables. Por lo tanto, la regulación entendida para evitar el 'cream-skimming', en particular un esquema de ajuste riesgoso y un recargo de las primas en las opciones bonus malus podían haber sido evitadas. En este sentido, la reforma 'perdió el tren', como por ejemplo una mejora de la eficiencia del seguro médico social.

Cobertura Sanitaria Universal en Israel: Superando el Número Previsto

Los indicadores de salud en Israel son elevados, mientras que el gasto en sanidad es relativamente bajo. La promulgación de la ley de Seguro Médico Nacional (NHIL) en 1995 legitimó a todos los residentes israelíes para recibir una cobertura sanitaria gratis o casi gratis mediante el acceso a un determinado «colectivo» social de asistencia médica. Sin embargo, el NHIL reconoce que la cobertura sanitaria universal (UHC) supera «los números» o los porcentajes de cobertura de la población. De acuerdo con esta ley, UHC también encarna una serie de atributos cualitativos.

Este trabajo destaca los aspectos de la UHC logrados por el sistema sanitario israelita, más allá de la cobertura de la población: cobertura equitativa, contribuciones progresivas, acceso dependiendo exclusivamente de las necesidades médicas, responsabilidad y libre elección. También demuestra una implementación particular y desafíos constantes: la falta de un firme compromiso estatal para una UHC equitativa, es el principal motivo de la disparidad persistente en todo Israel.

Sistema sanitario de dos niveles de Chile: Desafíos de la política pasada y presente

Chile depende de un seguro sanitario social (SHI) que proporciona cobertura sanitaria universal (UHC) a 17 millones de personas. Este sistema SHI de dos niveles fue diseñado bajo el gobierno del General Pinochet en 1981. Desde la vuelta de la democracia en 1989, ha sido criticado por muchos por contar con dos sub-sistemas segregados: una gran aseguradora pública (Fonasa), que cubre la mayoría de los servicios sanitarios públicos (el 80 por ciento del país) y numerosas aseguradoras privadas con fines de lucro (Isapres) que cubre la asistencia privada para los más pudientes (20 por ciento).

Este artículo revisa las iniciativas de la reforma sanitaria implementada en los últimos 12 años en Chile. El caso de Chile es relevante para los países en desarrollo con SHI y en los cuales se debaten los fundamentos de políticas alternativas para conseguir una UHC. Existen dos visiones encontradas: Un SHI con una aseguradora individual, que también funcione como un comprador individual de servicios médicos, o un SHI con la opción de múltiples aseguradoras para los usuarios, con cada servicio sanitario adquirido para su población asegurada.

Los Cambios Pueden Sobrevivir al Final del Mandato Individual

Este artículo argumenta que subsidios de primas generosas, pedidos por la gran mayoría de compradores de intercambios de seguros individuales en Estados Unidos, mitigan notablemente el problema de selección adversa, porque la prima después del subsidio es baja comparada con los beneficios esperados, incluso para la mayoría de riesgos bajos. Una implicación es que la eliminación de la modesta penalidad impuesta por el mandato individual puede no desestabilizar seriamente este mercado para los compradores de subsidios. En el peor de los casos afectará a la pequeña minoría de riesgos bajos no pobres quienes pueden abandonar el grupo de Intercambio por el seguro colectivo o pasar a no asegurado.

Canadian success stories on health and social care Volume 54 Number 1

中文摘要

中低收入国家/地区全民医疗覆盖渐进式改革剖析

到2015年确立新的发展议程之时，联合国已将“到2030年实现全民医疗覆盖”作为可持续发展目标下的一项全球承诺。本论文对该承诺的落实方式进行了阐释。

本论文旨在介绍发展中国家为逐渐推进全民医疗覆盖而实施的各项政策，并通过对四十个中低收入国家/地区进行对比，确定了政策趋同领域（亦即各国家/地区选择使用相似改革措施的政策领域）的存在。本文还指出了政策趋异领域，亦即在重要方面选择各异之领域。最后，本文对主要调查结果进行了总结，并探讨了各国为推进渐进式普世主义而可能采取的风险缓释措施。

中低收入背景下的全民医疗覆盖扶贫工作：硕果何来？

本文整合了六个国家在全民医疗覆盖系列项目中取得的成果。这六个国家利用有限的财政资源，在全民医疗覆盖扶贫工作方面取得了重大进展。这六个国家包括参与2013年发布的第一轮全民医疗覆盖项目研究的肯尼亚和埃塞俄比亚，以及参与2018年发布的第二轮案例研究的柬埔寨、老挝人民民主共和国、马拉维和坦桑尼亚。

这些项目在极为艰难的医疗制度环境下拉开序幕，旨在同时解决多项棘手问题。尽管困难重重，扶贫项目仍然成功地为医疗制度的整体效果作出了巨大贡献。在这样的助力下，贫困人口的医疗成果、享受到的医疗服务和财政保护均得到逐步改善，但任务仍然很艰巨：服务质量有限，公平问题持续存在，资金不足，接待能力薄弱。尽管如此，这些国家在采购、信息系统及其对扶贫的重点关注上成功展现了出色的创新能力，值得其他低收入和中低收入国家/地区学习借鉴。

更高、更快、更精简，但未进一步推进：斯里兰卡和马来西亚采用整合式国家医疗服务方式扩大全民医疗覆盖面

本文重点介绍斯里兰卡和马来西亚的整合式国家医疗服务(NHS)所展现出的各项特征，因为这与其成功扩大妇幼保健(MCH)全民医疗覆盖面息息相关。这两个国家均已取得公平优质的妇幼保健成果并实现了强有力的财政保护，并且与其他经济比较对象相比，速度更快，层次也更高。但是，两国面临的非传染性疾病挑战亦表明了未经改革的整合式国家医疗服务的局限性和改革的紧迫性。马来西亚的人均国民总收入是斯里兰卡的三倍，目前妇幼保健成果停滞不前，还面临着严峻的非传染性疾病挑战，因此我们推测，应当在中低收入提升到中高收入（亦即人均国民总收入大约为4000美元）时进行改革。

UNICO：全民医疗覆盖(UHC)的需求侧战略

本文旨在让人们更好地了解如何规划和落实中等收入国家/地区所制定的需求侧计划（均由世界银行通过全民医疗覆盖项目记录在案），并重点介绍了在确定受益人口和分离融资资金和准备金方面取得的进展。

本文还总结了这些需求侧计划的目标和各国家/地区为实现目标而采取的改革措施。最后，本文指出了各个国家/地区为提高医疗覆盖率而制定这些改革措施的过程中遇到的挑战。

通过共同学习解决全民医疗覆盖难题

随着全民医疗覆盖(UHC)在越来越多的国家/地区深入发展，对有关如何巩固医疗体系和扩大覆盖率等实用信息的需求已经成为全球关注的头等大事。全民医疗覆盖共同学习网络(JLN)号召从业者和决策者就大家共同面对的全民医疗覆盖技术壁垒展开广泛而深入的学习交流。在此期间，各成员针对规划和落实高效快捷、公平合理的可持续医疗体系共同创造具有指导意义的实用工具。本文探讨了共同学习网络的两个成员国 - 加纳和菲律宾如何利用从业者对等学习这一技术，积极应对其在实现全民医疗覆盖的过程中面临的普遍挑战。

英国国家医疗服务体系：于成立70周年之际，回顾成就和挑战并展望前景

本文回顾了英国的国家医疗服务史以及截至2018年开年所取得的成就、遭遇的挑战和未来前景。本文以检阅医疗成果为切入点，对绝对成果和相对成果进行了区分。然后，文章考量了全球经济衰退和英国脱欧的影响，以及国家医疗服务承受的人员配备、运营和财务压力。文章继而概括了英国上议院2017年专责委员会报告《国家医疗服务和成人社会医疗的长久可持续性》并作出评论。接着文章得出结论，只有各部长产生政治愿望去制定必要的财政和二次分配先决条件时，英国国家医疗服务才能实现可持续发展。最后，文章提出了一个更宏观的深层问题：作为一个整体，英国现任政府或继任政府可以在何等程度上习得各项技能并调整步伐，从而适应“加速时代”。

“俾斯麦模式”- 德国历史背景下的医疗保险制度

德国法定医疗保险制度（俗称“俾斯麦模式”）已经存续135年，从一项强制性的工人保险发展成为一个提供全民医疗覆盖的体系、一项慷慨的福利组合与低成本分摊协议。本文简要介绍了德国医疗保险如何在其历史与政治进程中走向全民医疗覆盖，并概括了德国医疗保险制度目前的运作情况。

法国医疗制度

法国医疗制度是国家医疗保险(NHI)的典范，该制度的医疗服务覆盖所有合法居民。法国医疗制度结合公共社会保障和私人医疗筹资，并在提供医疗服务时采用公私部门相融合的方式。

该医疗制度折射出三种深层次的政治价值观：自由主义、多元主义、团结互助。

本文简要介绍了法国国家医疗保险从二战后如何逐步发展、

其医疗融资机构和医疗覆盖面以及最为重要的一点，其整体效果。

瑞士全民医疗保险覆盖 - 确已覆盖，但……

本文指出，在瑞士，签订社会医疗保险的经济诱因非常强大，甚至让1996年改革实行的强制保险化于无形。该改革提出向医疗保险费用超出应税收入一定百分比（具体取决于各行政区）的人群支付保费补贴。在这一补贴的推动之下，各医疗保险公司均面临全面竞争，而不是维护甚至收紧现行规定。竞争激烈的保险公司从高风险人群（通过补贴降低）收取足够高的保费后，可能就不会任何激励他们选择优惠保险的动机。这样一来，便无需制定旨在防止吸脂效应的规定，尤其是风险调整方案和针对无索赔奖金选项收取的保费附加费。从这层意义来说，改革“错失良机”，换言之，改革反而提高了社会医疗保险的效率。

以色列全民医疗覆盖：更上一层楼

以色列的健康指标较高，但医疗保健相对支出较低。以色列于1995年颁布《国家医疗保险法》(NHIL)，规定所有以色列居民均有权通过使用由社会决定的医疗保健“篮子”，享受免费或近乎免费的医疗覆盖服务。尽管如此，《国家医疗保险法》也承认，全民医疗覆盖(UHC)率已经超出人口覆盖率的“数字”或份额。根据《国家医疗保险法》，全民医疗覆盖还包括一系列质化属性。

本论文重点介绍了以色列医疗保健体系在人口覆盖率之外实现的全民医疗覆盖属性：覆盖面公平合理，工作成果逐渐推进，权利完全取决于医疗需求，采用问责制，并且可以自由选择。本文还论述了具体的实施方式和持续的挑战：国家缺少对公平合理的全民医疗覆盖的稳定投入，导致以色列全国范围内始终存在差异。

智利双重医疗制度：过去和现在面临的政治挑战

智利通过社会医疗保险(SHI)为其1700万人民实现了全民医疗覆盖(UHC)。其双重社会医疗保险制度由皮诺切特将军于1981年制订。1989年智利重回民主制度，此后该社会医疗保险制度便因为拥有两个独立的子系统而一直受到诸多人士的口诛笔伐：一家大型的公立保险机构(Fonasa)为中低收入人群（人口数量占该国80%）提供大部分公共医疗服务，而多家营利性私立保险机构(Isapres)则为富裕人群（人口数量占该国20%）提供私人医疗服务。

本文回顾了智利过去12年来实行的各项医疗改革行动。对于已推行社会医疗保险制度但正在讨论是否需要采纳其他政策以实现全民医疗覆盖的发展中国家来说，智利的情况具有借鉴意义。目前存在两种对立的观点：一种倾向于社会医疗保险加上一家保险机构，该机构同时作为医疗服务的单一购买者；另一种则倾向于社会医疗保险加上多家可供消费者选择的保险机构，每家保险机构为其参保人群购买医疗服务。

个人强制保险走到尽头后保险交易所仍可存活

本文件指出，美国个人保险交易所绝大多数购买者所领取的丰厚保费补贴极大地缓和了逆向选择问题，因为与预期收益相比，算上补贴之后的保费相对较低（即使对大多数低风险人群而言）。这意味着，对于领取补贴的购买者而言，免除个人强制保险收取的适度罚金不会大幅动摇这一市场。在最坏的情况下，受到影响的将是少数非贫困低风险人群，他们可能会退出交易所资源，购买团体保险或不参保。

IHF events calendar

2018

IHF

42nd World Hospital Congress
October 10-12, Brisbane, Australia
http://event.icebergevents.com.au/whc2018
For more information, contact
2018congress@ihf-fih.org

2019

IHF

43rd World Hospital Congress
November 7-9, Muscat, Oman
For more information, contact
patricia.mencias@ihf-fih.org

2020

IHF

44th World Hospital Congress
November 2-5, Barcelona, Spain
For more information, contact
patricia.mencias@ihf-fih.org

2018

MEMBERS

BRAZIL
Hospital Summit ANAHP
National Association of Private Hospitals (ANAHP)
22-25 May, São Paulo (SP)
http://www.hospitalsummit.com.br/

6th Conahp (Brazilian Hospital Congress)
National Association of Private Hospitals (ANAHP)
7-9 November, São Paulo (SP)
http://www.conahp.org.br/2017/

CANADA
National Health Leadership Conference
HealthcareCAN
June 4-5, St. John's, Newfoundland and Labrador, Canada
http://www.healthcarecan.ca/whats-happening/events/national-health-leadership-conference/

COLOMBIA
VI Feria Internacional de la Salud, Meditech 2018
Asociación Colombiana de Hospitales y Clínicas y Corferias
July 3-6, Bogotá, Colombia
https://feriameditech.com/

XIII Congreso Internacional de Hospitales y Clínicas
Asociación Colombiana de Hospitales y Clínicas
July 4-5, Auditorio Corferias. Bogotá, Colombia
http://achc.org.co/congreso-internacional-de-hospitales-y-clinicas/

Entrega V Galardón Nacional Hospital Seguro
Asociación Colombiana de Hospitales y Clínicas
July 5, Bogotá, Colombia
http://achc.org.co/galardon-nacional-hospital-seguro/

FRANCE
Paris Healthcare Week 2018
French Hospital Federation
May 29 – 31, Paris Expo – Porte de Versailles, Paris
http://www.parishealthcareweek.com/

Congress MAP
UNICANCER
September 14-15, Marriott Rive Gauche Hotel and Conference Center, Paris, France
http://www.esmo.org/Conferences/MAP-2018-Molecular-Analysis-for-Personalised-Therapy

HONG KONG
Hospital Authority Convention 2018
The Hospital Authority, Hong Kong SAR
May 7-8, Hong Kong Convention and Exhibition Centre
www.ha.org.hk/haconvention/hac2018
www.ha.org.hk/haconvention/hac2017

INDONESIA
PERSI Annual West Regional Meeting
Indonesian Hospital Association
May 2-4, Grand City Convex, Surabaya, East Java

JAPAN
68th Congress of Japan Hospital Association
Japan Hospital Association
June 28-29, Ishikawa prefecture, Japan
http://www.hospital.or.jp/gakkai.html

PORTUGAL
7th International Hospitals Congress
Portuguese Association for Hospital Development (APDH)
November 21-23
http://www.apdh.pt/eventos/3

SOUTH KOREA
9th Korea Healthcare Congress
Korean Hospital Association
April 12-13, Seoul, Korea
https://www.koreahealthcarecongress.com/eng

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: info@ihf-fih.org or visit the IHF website: https://www.ihf-fih.org

2018 IHF BRISBANE
42nd World Hospital Congress
10–12 OCTOBER 2018 BRISBANE AUSTRALIA

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Preliminary program announced
March 2018

Earlybird registration closes
30 June 2018

World Hospital Congress
10-12 October 2018

www.hospitalcongress2018.com

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