Summary Report

Stagnation in UHC Implementation:

What Effective Strategies to Remove Bottlenecks?

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The report contents were elicited from the consultation meeting organized by the National Health Security Office of Thailand from March 20-22, 2018, in Bellagio, Italy. The Rockefeller Foundation supported the venue and accommodations at the Bellagio Centre. The Rockefeller Foundation, the Japan International Cooperation Agency, Save the Children, and the Ministry of Foreign Affairs and the Ministry of Public Health of the Kingdom of Thailand supported travel costs. The Japan International Cooperation Agency supported the publication of the report.

First publication: November 2018

Graphic design: Work Design Co., Ltd.

Citation: Stagnation in UHC Implementation: What Effective Strategies to Remove Bottlenecks? Bangkok: National Health Security Office, 2018

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Statement

We know the facts. Half the world's population still lacks access to essential health services. The proportion of people paying more than 10% of their household budget for healthcare is not decreasing. Almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses.

Universal health coverage (UHC) by 2030 is a laudable goal. Yet alarmingly it is off track for many countries. Worse, there are relatively few signs of energy and actual dedicated attempts to implement policies towards reaching UHC in a meaningful way. The world has not found a way to get all countries to take the transformative steps that mean they will achieve UHC by 2030. In reality, some countries are making slow progress towards UHC; some are stagnating; some are even going backwards.

Globally, the scene is beautifully set with SDGs, UN Declarations, and country commitments. We have a better understanding of what to do and what not to do to make UHC happen, with decades of experience in countries at all levels of income, a plethora of technical recommendations, and loud advocate calls to action. Yet in all this global noise about UHC, to date, only a few countries have taken meaningful steps to transform their national situation in ways that will reach UHC by 2030.

Despite commitments and knowledge about implementation, most countries are not responding fast enough with the transformative policies and practice to take them to UHC. Limited access to health services was the main factor in the failure to achieve the Millennium Development Goals in low- and middle-income countries; this failure may be repeated again in achieving UHC and other health-related sustainable development goals by 2030.

In general, service delivery is improving slowly around the world, which is positive to a certain extent. However, financial protection is being driven downwards by the larger countries, which are failing their citizens. Even where countries are performing well on both service delivery and financial protection, progress appears to be too slow to achieve UHC by 2030.

Slow progress towards UHC is often due to the fact that - if at all - only small-scale projects are developed rather than comprehensive policy approaches and reforms. More generally, people, rights and values do not appear to be at the centre of health policies in all countries.

So what's holding us back? Why is so little of significance actually being done? How can we galvanise transformative action on UHC?

What actions can each of us take in our own unique role in the world? How can we breathe new life into the stagnation of UHC implementation?

It is clear that there are both technical and political constraints to UHC implementation. Yet we know from other countries' experiences that it is not impossible. A growing body of global knowledge and experience are built into existing well-evidenced technical recommendations for UHC. Putting them into practice requires strong and sustained political will and actions. It requires a 'whole of government' approach on coordinated legal and policy frameworks that focus on health policies and socio-economic policies to achieve equity and access.

Ensuring financial protection for people using health services also requires increased fiscal space and commitments to public financing for health. Political will to increase population and service coverage in countries is absolutely critical and requires actions from a range of stakeholders.

Governments need to step up their duty to ensure citizens do not have to scrabble around for health care and become poor or indebted as a result of getting the treatment they need. We need to find the right ways for governments to take their responsibilities seriously and do the following: set up and implement national legislation that provides access to adequate essential health care for all; collect and spend sufficient funds available to allow everybody everywhere to access quality care without financial hardship; and provide more and better paid jobs for health workers.

Leaders have both responsibility and opportunities to develop policies towards UHC for their country. The right to health embedded in national legislation, health as a public good that needs to be accessible for all, and health security should be of significant concern to those promoting real action on UHC.

Citizens should actively participate in available platforms to voice their needs around health services and need for financial protection. Channels should exist to hear the voices of patients and allow them to report their problems. UHC is fundamentally about the relationship between the citizens and the state and whether leaders are accountable and responsive to their citizens. Windows of opportunity are open at every general election campaign where UHC can be visibly high on a political manifesto, to be later declared and honoured by the elected government. We must build a sense of citizens' entitlement and right to health, and put mechanisms in place, including courts, to hold leaders to account.

A strong civil society and active citizens with high expectations can ensure local health services are accountable and include mechanisms such as checklists, health committees, reporting of absenteeism and bribes. CSOs should have more support for capacity building to allow them to take a stronger role in advocacy for UHC. A national focal point should advocate, oversee the situation and produce annual public report on UHC progresses and challenges. Experts and academia should contribute to developing, analysing and communicating data to policymakers and civil society. CSOs and academia can play a strong role to keep UHC visible at country level. Committees should exist at all levels in which members are composed of government experts and civil society.

Domestic resources are key to UHC, collected through fair pooling mechanisms such as tax or mandatory health insurance. Many governments could organize their national resources to spend closer to recommended levels needed for UHC such as government health expenditure of at least 5% of GDP. Increased government spending is crucial to end the injustice of out-of-pocket cash payments at the time of service use.

Donors have a role to play and must support UHC in countries where increased domestic resources would still be inadequate. Countries should insist that donors align their vertical programme funding streams with country UHC directions. They should foster political and social commitment, create broad-based UHC ownership and leadership by all, and create and strengthen accountability and responsiveness mechanisms for all partners.

Above all, we need champions for UHC in all of these groups of actors: citizens, civil servants, health professionals, NGOs, experts, health workers, local government officials and national political leaders. Existing champions need to be supported and celebrated, and new champions nurtured.

Political will, sustained commitments and concrete actions from everyone are absolutely critical for countries to achieve UHC. We must rise to this challenge.

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Contents

Executive summary

Universal health coverage (UHC) by 2030 might be off track for most countries unless serious actions are taken. Even worse, there are very few signs of energy and actual dedicated attempts to implement UHC in a meaningful way. The world has not found a way to get all countries to take the transformative steps that mean they will achieve UHC by 2030.

This is the key message from a meeting of policy makers, academics and civil society from Thailand, Japan, the Philippines, South Africa, Switzerland and the UK held at the Rockefeller Foundation Bellagio Centre in March 2018. The group discussed how to make progress on UHC implementation and confront the real challenges we face in countries. They immediately grasped the seriousness of the situation.

Globally, the scene is beautifully set with SDGs, UN Declarations, and country statements of commitments. We understand what to do and what not to do to achieve UHC with decades of experience in countries at all levels of wealth, a plethora of technical recommendations and loud advocate calls to action.

So what's the problem? Why is so little actually being done? How can we galvanise transformative action on UHC?

The world already knows and acknowledges that the following actions are needed to achieve UHC:

- Strengthening the health system is required;
- Sustainable financing structures are imperative;
- Public funding needs to replace out-of-pocket payments (OOP) by patients;
- Pooling of funds spreads the financial risks of illness across a population;
- Larger fiscal space for health is an important foundation; and
- Political commitments and implementation capacities are equally important for realizing UHC [1]

The global policy context is in favour of UHC. There are two landmark United Nations General Assembly (UNGA) resolutions. Among others, UNGA Resolution A/RES/72/L.28 calls for a UNGA high-level meeting on UHC in 2019; and UNGA Resolution A/RES/72/L.27 established the 12th of December as International UHC day.

Despite commitments and knowledge about implementation, most countries are not responding fast enough with policies and practice to take them to UHC by 2030. Some countries are making slow progress. Some are stagnating. Some are even going backwards.

Strengthening service delivery which ensures geographical access to quality health services is improving slowly around the world, which is positive to a certain extent. However, financial protection is being driven downward by the larger countries, the governments of which are failing their citizens by not investing enough in the health of the population. Even where countries are performing well on both service delivery and financial protection, progress is still too slow to achieve UHC by 2030.

In all this global noise about UHC, to date, no country has come forward to declare it will actually reach UHC by 2030.

Can we really afford to take such a leisurely approach to UHC?

The painful facts:

- 38% of the world's population does not have legal health coverage;
- Half the world's population still lacks access to essential health services;
- Some 800 million people spend more than 10 per cent of their household budget on health care;
- Almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses; and
- On average, about 32% of each country's health expenditure comes from out-of-pocket payments.[2]

Given these painful facts, countries need to build capacity to implement UHC.

Breathing life back into UHC

At the Bellagio meeting, participants discussed the causes of the lacklustre approach to UHC implementation along the dimensions of the UHC cube – population coverage, service coverage and levels of financial protection – and additionally the two significant areas of governance and monitoring and evaluation.

They used this UHC model to explore existing causes for stagnation and the bottlenecks or challenges that stakeholders face at implementation level. The theme of political will and action by leaders and champions was present in all discussions, as a core foundation for UHC implementation. Using their collective experience and knowledge of implementing

UHC in different countries, they identified some key policy recommendations and suggestions that countries might find useful going forward.

The meeting, and the subsequent outputs including the policy matrix on "Strategies to Revive UHC Implementation", is an endeavor to breathe life back into real implementation for UHC, so that we move beyond an empty rhetoric of 'health for all.'

Political and policy actions of UHC

During discussions about the causes of the sluggish progress, stagnation or regression of UHC around the world, it was clear that there are both technical and political constraints to implementation. A wealth of global knowledge and experience are built into existing well-evidenced technical recommendations for UHC. Yet putting them into practice requires political will and action. The deliberations covered both of these political and technical aspects on the causes of UHC stagnation and potential remedial actions.

Summary points for policy actions

Below are some health policy actions discussed during the meeting. However, health policies alone will not be able to achieve UHC. A 'whole of government' approach is required on coordinated legal and policy frameworks that focus on health policies and socio-economic policies to achieve equity and access.

Further details for each action can be found in the policy action matrix on Strategies to Revive UHC Implementation. It is hoped that countries may find the recommendations useful and apply actions appropriate to their country context.

Crosscutting actions

- Increase fiscal space and fiscal space for health;
- Foster national political commitment;
- Establish broad-based UHC ownership and leadership;
- Empower and strengthen accountability across partners; and
- Reinvigorate the functions of national accountability mechanisms.

Actions to extend population coverage

- Adopt right to health approaches, universalism and citizen entitlement; and
- Extend coverage of prepayment systems to different population groups until full population coverage.

Actions to extend service coverage

- Generate evidence for policy decisions to increase service coverage;
- Strengthen network of primary health care which supports universal access to comprehensive health services; and
- Improve the number and distribution of competent, socially accountable and committed health workers.

Actions to extend financial risk protection

- Provide a comprehensive set of benefit packages with minimum level of copayments, which prevents catastrophic health spending and medical impoverishment; and
- Regulate prices of medical commodities.

Actions to strengthen monitoring and evaluation

- Establish transparent national M&E systems and improve capacities; and
- Disseminate M&E evidence.

Political will and action

Political will to increase population and service coverage in countries is absolutely critical, and requires actions from a range of stakeholders. At the meeting, participants agreed that everyone has a role to play in UHC. They want everyone to own UHC, but how? Here are some overall reflections from the discussions that took place.

Citizens

Citizens should actively participate in available platforms to voice their needs around health services and UHC. Channels should exist to hear the voices of patients and allow them to report their problems. UHC is about the relationship between the citizens and the state and how leaders feel they should behave in relation to their citizens' expectations. We must build a sense of citizens' entitlement and right to health, and put mechanisms in place, including courts, to hold leaders to account.

Civil society

A strong civil society with high expectations can ensure local accountability mechanisms such as community scorecards, health committees, reporting of absenteeism and bribes. CSOs should have more support for capacity building to allow them to take a stronger role in advocacy for UHC. CSOs can play a strong role to keep UHC visible at country level and hold the government accountable.

Experts

Experts and academia should contribute to developing, analysing, and communicating data to policymakers, civil society and the conventional media and increased role of social media.

Governments

Some governments are neglecting their duty to citizens who have to scrabble around for health care, and become poor as a result or fail to get the treatment they need entirely. We need to find the right ways to take their responsibilities seriously. Leaders have both responsibility and opportunities to lead UHC for their country. Committees should exist at all levels in which the members are composed of government experts and civil society.

Donors

Donors must support UHC and synchronize their support in countries. Countries should request donors to align their vertical programme funding streams in order to allow countries to develop UHC. They should:

- Foster political and social commitment;
- Create broad-based UHC ownership and leadership by all; and
- Create and strengthen accountability and responsiveness mechanism for all partners.

Champions

Above all, we need champions for UHC in all of these groups. The country needs a critical mass of champion citizens, civil servants, health professionals, NGOs, experts, health workers, local government officials and national leaders.

Introduction

On 20-22 March 2018, participants met at the Rockefeller Foundation Bellagio Centre to discuss how to inject new energy into the UHC implementation, which is currently too slow for the world to achieve UHC by 2030. Participants represented policy makers, civil society, diplomats, academia and communications from Thailand, Japan, the Philippines, South Africa, Switzerland and the UK.

"We are all active and global citizens on UHC. We recognize the need to galvanize transformative action for UHC at the country level."

The meeting sought better understanding of the causes of bottlenecks and potential solutions for key global events on three dimensions of UHC cube - population coverage, service coverage and levels of financial protection - and additionally the governance design of insurance agencies and monitoring and evaluation platforms.

Key messages from thematic areas

During discussions about the causes of the sluggish progress, stagnation or regression of UHC around the world, it was clear that there are both technical and political constraints to implementation. A growing body of global knowledge and experience are built into existing well-evidenced technical recommendations for UHC. Yet putting them into practice requires political will and action. The deliberations covered both of these political and technical aspects on the causes of UHC stagnation and potential remedial actions.

Theme 1

Policies and strategies to extend population coverage by prepayment schemes

What strategies do countries use at different stages of development to target different population groups? What are the schemes and sources of finance for different population groups? What are the causes of the stagnation of coverage?

The world is divided with clear distinctions in coverage between countries and regions. 99.7% of the population in Western Europe is covered by social health insurance, public health care systems or private insurance. In Asia and the Pacific, 56.8% of the population is covered, Africa has 26.1% coverage, and sub-Saharan Africa just 18%. In countries with the highest levels of health expenditure that are not mainly financed by out-of-pocket payments, coverage rates are nearly 100%, pointing to the crucial role of public funding in achieving UHC.

Coverage is also highest in regions with well-established legislation. But health policies alone will not be able to achieve UHC. A 'whole of government' approach is required on coordinated legal and policy frameworks that synchronize health and socio-economic policies.

Challenges include confronting a lack of knowledge and understanding of what UHC is and means to increase population coverage among broader public and decision makers at policy levels. Ensuring coverage of populations is impeded by a lack of political commitment, lack of fiscal space, supply side constraints, in particular the health workforce, discrimination against certain population groups, lack of concern, and structural inequity.

Poor governance and non-accountable government are root causes of these stagnations. This in turn reflects the lack of 'real democracy' and that political systems and politicians are not accountable to the citizens.

Political will matters. In Rwanda - a low-income African country with Gross National Income of US$ 720 per capita in 2017 - where political decisions were made and political will was strong, the country made hard and fast progress towards UHC. It is the responsibility of government to ensure they are building UHC in their country, that they use resources effectively, that they build technical capacity to deliver, and that they strengthen primary health care.

Recommendations

- Adopt right to health approaches, universalism and citizen entitlement; and
- Extend coverage of prepayment systems to different population groups until full population coverage.

Theme 2

Policies and strategies to ensure availability and quality of services

The linkage between financing and service delivery: how to expand benefits and improve the supply and quality of health services.

The challenges to increase service coverage include shortages of critical inputs such as the health workforce, medicines, and laboratory capacity. The motivation of the health workforce is often low. There are insufficient prepaid and pooled funds. For over 3 billion people, public investments in health are below US$ 30 per person per year (one third of the average cost of providing the most essential health services).

There is an over-reliance on out-of-pocket spending with an average of US$ 85 per capita per year in low-income countries. Poor people cannot afford to purchase health services and commodities, so good quality services are not available to them. There are also inefficiencies in the use of available resources with 20-40% wasted.

Politically, what are the circumstances that lead to some governments expanding service coverage and some not? All politicians promise health care to their people in some way. The question becomes not the promise, but the actual commitment to deliver it and the ability of citizens to hold their government to account. Some possible solutions are the following.

In health financing, it is to raise resources, increase prepaid and pooled funds, reduce OOPs, and purchase appropriately from prepaid and pooled funds. It is also possible to bring resources to the front line to the health workforce, including task shifting, training the right cadres, and reserving regional tertiary centres for specialties, rare conditions and referral back up from primary and secondary care.

Other actions are to reduce demand-side barriers such as transport costs and time costs, pay attention to quality assurance at frontline, referral systems and gatekeeping, and increase capacities to purchase, including separating functions of purchasing from service provision.

“We need a critical mass of committed health workers, UHC champions and role models.”

Health workers champions for UHC

Champions for UHC exist everywhere at all levels, but focusing on providing support to health worker champions is vital. What can we do?

- Identify champions at the country level who have high social and intellectual capital. They are credible and people trust them;
- Convince and solicit long-term commitment from these dedicated champions (not from politicians who move around all the time
- Once we know who these people are, we need to support them and motivate them, and these people will find solutions.

Recommendations

- Generate evidence for policy decisions to increase service coverage;
- Strengthen network of functioning primary health care, which supports universal access to comprehensive health services; and
- Improve the number and distribution of competent, socially accountable and committed health workers.

Theme 3

Policies and strategies to ensure financial risk protection

The root causes of gaps in financial protection, good practices in design of strategic purchasing, and solutions towards poor responsiveness by public health facilities.

Globally, countries are moving in the opposite direction on financial protection to their populations. The UHC Monitoring Report 2017 shows that at 10% (or 25%), the household spending on health as the proportion of household consumption expenditure had increased. This catastrophic expenditure leads to impoverishment or worse. It is a gloomy outlook. National resources for health stagnated over the MDG era and continued to the SDG era. Where Development Assistance for Health exists, it displaces domestic resources, reflecting poor government commitment to the health of the population.

While it is known that domestic resources are the best source of sustained financing for UHC, the latest World Financing report showed that government domestic spending on health figures have significantly deteriorated from before. This is an indication of a serious resource challenge hampering progress towards UHC.

While this might be challenging for some countries, CSOs strongly argue that governments should spend 5% of GDP on health. It is not sufficient to simply increase the share of GDP spent on health, but an absolute figure of 5% of GDP is needed. Health spending channeled through private voluntary insurance provides little financial protection. It is necessary to increase the share of total health expenditure that is prepaid, whether through taxes or mandatory contributions.

Achieving UHC is not a case of a country's wealth. There is no correlation between the wealth of a country and whether it achieves UHC. Rwanda achieved near-UHC with low-income status; Thailand achieved UHC with lower-middle income status; while the USA, a high-income country, has yet to achieve UHC. Ultimately achieving UHC is about political will, policy decisions and how a country organizes itself.

Recommendations

- Prevent catastrophic health spending and medical impoverishment by full subsidies to a comprehensive set of benefit packages through pre-payment systems and strongly regulated copayment practice; and
- Regulate prices of medical commodities both in and outside the benefit package.

Theme 4

Monitoring and evaluation framework to ensure steady progress towards UHC

M&E framework under the SDG 3.8 requirement and the availability and quality of national database essential to the M&E of SDG 3.8.

There are two SDG Indicators for UHC: 3.8.1 concerns the coverage of essential health services; 3.8.2 concerns financial protection. Existing M&E frameworks under SDG 3.8 are dependent on the availability and quality of national databases. Member states are encouraged to conduct regular and country-driven reviews of progress with inclusive engagement by all stakeholders including different departments and ministries, UHC champions, healthcare providers, media and citizens. The World Bank and WHO have also developed a monitoring framework to support countries to track progress to UHC.

Some of the challenges facing establishing good monitoring and evaluation systems relate to the consultation processes on indicators and the accuracy of indicators. Data on disaggregated socio-economic groups is hard to find. Another challenge is about who does the monitoring and how the information gets back to the country level. Finally, how can data be translated into concrete corrective actions for the Ministry of Health and other actors? It is hard for governments to invest in M&E systems, over and above medical products and

commodities. Yet supporting mechanisms for accountability for UHC are crucial.

Recommendations

- Establish transparent national M&E systems and improve capacities, review the existing M&E platforms, identify gaps and introduce corrective measures; and
- Disseminate M&E evidence to hold relevant actors accountable.

Theme 5

Policies and strategies to ensure good governance holding all actors accountable

The design of the governance of health insurance agencies and health providers; identify root causes of poor governance; identify best mechanisms to hold partner agencies, country governments, civil society accountable, thereby accelerating country's progress towards UHC.

We are facing stagnation in UHC progress despite series of repeated global and country commitments. Improving governance plays a key role in revving these commitments. A clear challenge is that unless there is true accountability throughout the system, including at the top level of head of state, it is impossible to effect change.

It is far from easy. It is challenging for those in power to engage and promote the meaningful interaction of all stakeholders in UHC including citizens, high-level government, regional and global bodies. A Ministry of Health might be strong, but unwilling to encourage genuine participation of its citizens, community representatives and civil society in decisions and accountability processes.

The right to health is concrete and enshrined in international law; it has a different status to the SDGs, which require voluntary reporting. There is strong evidence of accountability working to improve the right to health. When it is put into national law, and there is a strong judiciary, citizens are able to hold their government to account. The accountability of service providers is also critical; the stronger the government capacity, the stronger it is able to hold service providers to account. There should be clear anti-corruption mechanisms at all levels. The role of citizens is important in holding healthcare providers accountable, and in reducing absenteeism.

A lack of transparency is a critical issue, and public availability of information and benchmarking between countries are both powerful tools.

A strong civil society with high expectations can support all these processes. However, ensuring that civil society is not fragmented on UHC is a challenge. Many campaigning CSOs are about single issues such as HIV or maternal health. With UHC, the people who suffer the most are the poorest people with the fewest expectations. They are not empowered activists so it is important to bring together groups (such as women's rights groups and immunization advocates) and harness their energy in the UHC movement.

Other important processes are to use political parties and manifesto pledges during election campaigns to hold governments to account after election. Using both the independent media and regional bodies which can put strong pressure on governments are also powerful tactics.

Recommendations

Three distinct levels of governance and accountability:

- At the high level, how do governments prioritize and take hard decisions, in the context of competing budget across government sectors, about direction and funding of health, support for UHC and addressing corruption?;
- Now that there is money for health, how does the government decide what to spend it on? Evidence is important, and participatory budgeting has been used to explore what governments should spend money on; and
- How can citizens and communities lead demands for accountability? Everyone in the system needs to enforce accountability throughout.

Theme 6

Seizing opportunities: policy actions and strategies

Refine and discuss key messages, recommendations for policy action, and opportunities ahead.

Key messages

- We are not on track to achieve UHC by 2030. Even worse, there are very few signs of energy and actual dedicated attempts to implement UHC in a meaningful way. The world has not found a way to get all countries to take the ambitious transformative steps that mean they will achieve UHC by 2030;
- It is not that the goals are too ambitious; it is a great achievement for UHC to be included in the SDGs. We need to take it seriously and strive to achieve it by 2030;
- We need to stop preaching to the converted but reach those outside the health sector about UHC, particularly those concerned with the economy and look to work across

sectors and agencies;

- Many of us are still locked into vertical diseases specific programmes and processes instead of a UHC approach;
- There needs to be greater awareness and understanding about what UHC is among policy makers and politicians;
- Domestic resources are keys to reducing OOP and provide health care in a fair way.
- Keeping up political momentum is critical. The global movement for UHC is really important, and it can support country level work. They both need to happen in parallel; and
- Can we make the distinction between eliminating short-term bottlenecks and making fundamental changes? Let's be ambitious.

Strategies to revive UHC implementation

The situation of stagnating UHC is nuanced with countries experiencing different levels of progress, stagnation or regression in service delivery and financial protection. However, all the evidence points to the fact that if we carry on as usual, we are not going to achieve UHC by 2030. We need radical action. How can we motivate countries to implement UHC faster?

Participants agreed that "we are all active and global citizens on UHC, we all recognize the need to galvanize transformative action for UHC at the country level," and developed a matrix of recommended policy strategy and actions for use by countries according to their own particular context (page 18).

Key global events to take action

With contributions by UHC champion countries and actors, the World Health Assembly in May 2019 may adopt a Resolution through the 144th session of Executive Board (in January 2019) on UHC in connection with the need for well-prepared contents for the UN high-level meeting on UHC in September 2019.

The contents of the 2019 WHA resolution should highlight concerns over the stagnation and reiterate the need for active implementation of UHC worldwide. Problem streams will pinpoint concrete actions for WHO, development partners and Member States. It may cover how the WHO, Member States and international development partners could take advantage of the annual International UHC Day on December 12 to move UHC agenda. This could be to review UHC progress at country level on the three dimensions of population coverage, service and cost coverage, identifying bottlenecks and setting annual milestones for follow-up until the SDGs end in 2030.

The contents of the UN High-Level Meeting on UHC in 2019 may set an accountability framework holding all actors, in particular the government, accountable to UHC commitments.

STRATEGIES TO REVIVE UHC IMPLEMENTATION

Listed below are some key strategies and policy actions to promote and revive the implementation of UHC. While not all will be appropriate in every context, they all have relevance around the world. Countries and partners may apply recommendations in line with the country context.

Strategies	Strategic Actions
I. CROSS CUTTING	
1. Increase fiscal space and fiscal space for health	• Tax reform to achieve government revenue of 20% of GDP; • Legislate universal health coverage, or social health insurance or dedicated health tax or contributions that is appropriate to country context; • Mobilize innovative financing for UHC such as tax on health hazardous products; • Increase General Government Health Expenditure (GGHE) up to 15% of general government expenditure (GGE); • Negotiate the inclusion of these fiscal targets into the Political Declaration of the UN High Level Meeting on UHC (2019) and UNGA resolution (2019);

2. Foster national political commitment	• Establish and implement the targets and timeline for progressive realization of UHC by 2030
	  • Government revenue up to 20% of GDP;
	  • GGHE, 15% of GGE;
	  • Increase service coverage (SDG3.8.1);
	  • Reduce the size of out of pocket payment for health by households;
	  • Reduce the incidence of catastrophic health expenditure (SDG3.8.2);

3. Establish broad-based UHC ownership and leadership [include government, private sector, health professionals, healthcare providers, citizen, civil society organizations]	• Build and sustain network of UHC champions in countries to accelerate UHC implementation and monitoring; • Sustain momentums of UHC throughout the year, maximize use of International UHC Day as platform to foster commitments by all actors and monitor progresses at national level;

Strategies	Strategic Actions
4. Empower and strengthen accountability across partners	Government and political parties • Be accountable to their legal mandates, role, responsibility on UHC; • Convene annual monitoring of UHC implementation progress, engaging all actors, discuss and solve bottlenecks on International UHC Day; • Ensure fair distribution and efficient management of resources for health; International development partners • Propose UHC monitoring as a substantive standing agenda at the Governing Bodies of World Health Organization[3] to monitor global/regional progresses; • Adhere to the five principles of Paris Declaration: ownership, alignment, harmonization, managing for results and mutual accountability [4, 5]; Healthcare providers • Monitor adherence to Patient Right Charters where existed [6]; • Exert social pressure and disciplinary measures for improved accountability; Academia • Build, strengthen, sustain national capacities of health systems and policy research which generate evidence for policy decision; • Transform health professional education systems to train socially accountable and committed health workforces; Citizens • Create awareness of right to health and their obligations, awareness of government obligations to UHC; awareness of healthcare providers' obligations to the health of the people; • Take responsibility to lead a healthy life style and refrain from unhealthy food and diet, including use of tobacco and alcohol, practise safety behaviour and engage in physical activities to prevent NCDs Private sectors • Ensure contribution to social health insurance by employers and employees; Civil society organizations • Monitor progress of UHC implementation; • Empower citizens by increasing their awareness of their rights and obligations to UHC;

Strategies	Strategic Actions

5. Reinvigorate the functions of national accountability mechanisms	• Review and remove bottlenecks of the following accountability and responsiveness frameworks;
	  • Courts of justice and judiciary bodies;
	  • Parliamentary scrutiny and impeachment mechanisms;
	  • National health assemblies or equivalent bodies;
	  • Public hearing, active citizenship and civil society organization;
	  • Public media, public reporting and publicly available information;
	  • Public mechanisms such as call center, dispute settlement and conflicts resolution between patients and healthcare providers;

II. POPULATION COVERAGE EXTENSION	

1. Extend coverage of prepayment systems to different population groups until full population coverage	• Mobilize general tax and other mandatory contributions to increase population coverage;
	  • Identify the most vulnerable population who are at risks of certain illnesses, financial catastrophic and social exclusion, and prioritize them with tax financed system;
	  • Legislate the responsibility of the formal sector employers for the health of the employees;
	  • Introduce mandatory participation of informal sector in social contribution, either by premium or public subsidy when fiscal space allows;
	• Prevent inequity across different schemes through harmonizing benefit package, standardizing level of public subsidies and provider payment methods;

III. SERVICE COVERAGE EXTENSION	
1. Generate evidence for policy decision to increase service coverage	• Assess, identify and prioritize gaps of service provision and develop policies to fill these gaps; • Monitor and redesign health system that is responsive to rapid urbanization, epidemiological and demographic transitions; • Monitor effective coverage of essential services [7, 8, 9] and inform policy for improvement;
2. Strengthen network of primary health care which supports universal access to comprehensive health services	• Strengthen network of PHC, ensure equitable geographical distribution, improve quality and trust, strengthen referral systems for continuity of care; • Establish, strengthen and sustain quality assurance mechanism, patient safety and accreditation; • Strengthen the capacity to regulate and appropriate use of private health providers;

Strategies	Strategic Actions
3. Improve the number and distribution of competent, socially accountable and committed health workers	• Identify gaps between national health workforce density and the benchmarks of 2.28 [10, 11] and 3.45 [12, 13] doctors, nurses and midwives per 1,000 population; commits to train and deploy adequate number and equitable distribution of socially accountable and committed health workers in line with WHO guidelines [14, 15]; • Improve in-country retention of health workforce through implementation of the WHO Global Code of Practice on International Recruitment of Health Personnel [16]; • Confer annual Prime Minister/President, WHO Global, WHO Regional Awards for "the committed health workforce" from different cadres. Invite these awardees to deliver key notes at prestigious national forums, Regional Committee and World Health Assembly; • Support networking of health workforce to foster full engagement in UHC implementation and monitoring;
IV. FINANCIAL RISK PROTECTION EXTENSION	

1. Prevent catastrophic health spending and medical impoverishment	• Reduce the number of households with expenditures on health more than 10% of their total household expenditure;
	• Design "strategic purchasing" which achieve low level of OOP and gain systems efficiency;
	  • Device a comprehensive benefit package guided by cost effectiveness evidence, budget impact and ethical/equity consideration;
	  • Device appropriate policy and regulation on copayment and in specific contexts, regulate or prohibit balanced billing;
	  • Contract primary health care providers network to enable access to use of health services with minimal travel cost;
	  • Introduce primary care gate keeping function and appropriate referral towards health systems efficiency;
	  • Exert monopsonistic purchasing power by commissioning body or insurance agency to achieve lowest possible price given assured quality;
	  • Introduce stringent health technology assessment for inclusion of new medicines and technologies into the national benefit package;
	  • Accelerate implementation of National Essential Drug List Policy and monitoring progresses;
	  • Apply closed end provider payment methods which send strong signal towards efficiency;

2. Regulate prices of medical commodities	• Regulate prices of medicines in retail sector; private medical services through contracting by the insurance agencies; • Apply reference price for procurement of medicines in public sector; • Regulate private health insurance premium and conditions for filing claims as complementary or supplementary coverage; • Make prices of actual purchases of medicines in pubic sector publicly available and consider this as the reference price;

Strategies	Strategic Actions
V. STRENGTHENING MONITORING AND EVALUATION	

1. Establish trans-parent national M&E systems and improve capacities	• Invest, establish or strengthen national household surveys and routine administrative dataset to monitor progresses of effective service coverage in SDG 3.8.1 and financial risk protection in 3.8.2; and stratify UHC achievement by e.g. wealth quintiles, rural/urban, ethnicity, disability status and geographical region;
	• Create a system for appropriate data sharing among interested partners;
	• Strengthen and sustain national health account and maximize use for monitoring, make NHA evidence publicly available;
	• Develop systems which monitor fungibility of domestic resources in the context of donor resources;
	• Produce Voluntary National Reviews [17], fast track review of UHC achievement;
	• Produce evidence on
	  • Benefit Incidence (which population groups—rich or poor benefit from public spending);
	  • Financial Incidence (the progressivity of different sources of financing);
	  • Unmet health care needs in the population [18];

2. Disseminate M&E evidence	• Invest and improve national capacities on data analysis, interpretation and translation of evidence to policy decisions at all levels; and • Make all M&E findings publicly available in various media and make UHC a publicly owned agenda.

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What effective strategies to remove bottlenecks?

Despite commitments and implementation knowledge,
most countries are not responding fast enough to take them to UHC.

What's holding us back?
Why is so little of significance actually being done?
How can we galvanise transformative action on UHC?

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