

Charter for Equitable, Inclusive and Sustainable Universal Health Coverage

YALE CENTER *for the* STUDY OF GLOBALIZATION

Contents

4	Foreword
5	Acknowledgments
6	Introduction
11	Precept 1: Genuine Universality
15	Precept 2: Effective and Equitable Universal Insurance
21	Precept 3: Primacy of Public Financing for UHC
28	Precept 4: Efficient Delivery of Quality Health Services
34	Precept 5: Progressive Realization of UHC

As initially purported, the Charter is essentially a distillation – and no more – of what we consider the key lessons stemming from best experiences and analysis. No claim of originality should be associated to this text. But we of course are responsible for the interpretation we have given to the available evidence with a view to produce the five precepts of the Charter and their respective rationale. None of the numerous experts consulted in person or through their writings, who are listed in the acknowledgements and the bibliography, should be assumed to endorse this document. Yet our gratitude to them is immense.

Ernesto Zedillo

December 2022

Acknowledgments

Universal health coverage should be a serious goal in every country for all people. Yet, despite an embracement of this aspiration by practically all governments, not least as part of the Sustainable Development Goals, its materialization, except for a few countries, seems very distant if not practically impossible under present trends. It is for this reason that the Yale Center for the Study of Globalization—encouraged by The Elders, an independent group advocating peace, justice and human rights worldwide and of which Ernesto Zedillo is a member—endeavored to distill the available best knowledge and practical experiences in the pursuit of Universal Health Coverage (UHC) into a document titled: *Charter for Equitable, Inclusive and Sustainable Universal Health Coverage*.

Lacking in-house expertise on this complex subject, it was decided to consult extensively with professionals of well-recognized capacity on the subject, first to test the concept of a Charter, and next to obtain guidance as we progressed into its drafting. The biggest encouragement and support have been generously provided by Cheryl Cashin, who has helped us from the inception of the project to the provision of essential ideas and their expression in the Charter document here presented. Her expertise and thoughtful observations are reflected throughout the document and her guidance and candid responses to the various iterations have played a truly invaluable role.

Early in the process we were fortunate to communicate and receive useful guidance from a group of scholars and practitioners with significant work on UHC. This group consisted of Eduardo Banzon, Timothy Evans, David de Ferranti, Julio Frenk, Ravi Kanbur, Joseph Kutzin, Santiago Levy, Ariel Pablos-Mendez, Mark Pearson, Jennifer Ruger, Jaime Sepulveda, and Peter Smith. Some of these individuals, through their intellectual input and candid responses to our inquiries,

ended up being a true steering committee for the project. Our consultations with the group led to the commissioning of expert papers on the various critical subjects. We benefitted from expert papers written by Peter Berman, Cheryl Cashin, Nigel Edwards, Amanda Glassman, Adriana Kugler, Santiago Levy, Ariel Pablos-Mendez, Jonty Roland, and William Savedoff, as well as Hilary Brown Tabish and Kyle Karen.

The availability of those papers allowed us to organize a conference on UHC at Yale in the fall of 2018 where we benefited from the active participation of Daniel Cotlear, Midori de Habich, Tamas Evetovits, Soonman Kwon, Ann Kurth, Latha Swamy, and Sten Vermund.

In addition to Cheryl Cashin we want to underline the support of Joseph Kutzin for his inspiration, warm stimulation and help for the duration of the project, as well as Santiago Levy, who not only produced an expert paper on the critical question of labor market impacts but concisely showed how some essential prescriptions of the Charter could be applied to the case of Mexico's complex health system.

The Associate Director of the Center, Haynie Wheeler, contributed to the planning, organization and drafting of the Charter with the dedication and efficacy that have characterized her work at our Center from its inception.

None of this would have been possible without the generous support of the Rockefeller Foundation, Citi and the Vidanta Foundation. We extend our sincere appreciation to them for providing the resources that allowed us to pursue and achieve our objective of producing the *Charter for Equitable, Inclusive and Sustainable Universal Health Coverage*.

Ernesto Zedillo, YCSG Director

Introduction

The Constitution of the World Health Organization adopted in 1946 aptly stated that:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

This tenet has evolved over time to have as its practical expression the goal of universal health coverage (UHC) – all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

An international consensus on the meaning of UHC, although developing gradually, has had landmark events like the 1978 Alma-Ata Declaration, the WHO’s 2010 World Health Report and the 2015 “Agenda for Sustainable Development,” which included a target to achieve universal health coverage for all by 2030.

The commitment to achieve UHC by 2030 was strongly reaffirmed in a high-level political resolution adopted by the UN General Assembly in the fall of 2019, which improbably happened just a few weeks before the first outbreak of COVID-19.

If before the pandemic ensuring non-discriminatory access to essential health services should have been of paramount importance for all countries, the case for

taking seriously the pursuit of UHC, both as a right and as a collective moral obligation, has been made even more patent by the pandemic.

It is not idle to wonder how many lives would have been saved, how much human suffering would have been avoided, and what economic and social losses would have been prevented, if countries had been more advanced towards UHC and also towards complying with their international obligations to coordinate and cooperate to prevent and respond to pandemics, not least to abide by the International Health Regulations, which unquestionably was not the case.

If anything, the painful experience of COVID-19, far from diminishing it, has augmented enormously the value of achieving UHC.

The importance of UHC to people and communities goes beyond safeguarding people’s health. It is also an essential element of a prosperous society, as well as a driver of social justice, human rights and inclusive economic growth.

In addition, UHC may well be one of the essential components of a substantive and consequential social contract between the people and the government of a nation that conceivably could be needed to give feasibility and legitimacy to a broader transformative reform. A social contract that includes effective access, without financial hardship, to the health services that people need – along with other key social safety nets and the rule of law’s effectual protection, will make citizens more willing to contribute adequately and fairly to the financing of the State, including the provision of all the necessary public goods.

Yet the question remains whether most countries – notwithstanding the purported willingness of their societies and governments – were, are, or will be on the right course to attain UHC. The conventional answer to this question seems to be that as long as countries keep extending health services and diminishing financial hardship for users of those services, particularly of the most vulnerable and poorest ones, progress towards UHC would be happening irrespective of the specific approaches followed for such purpose.

This was, as one example, how the statement that “all roads lead to universal health coverage” expressed early in his tenure by the current WHO Director-General was, in some instances, misinterpreted.

In fact, the 2019 UN Declaration on UHC seemed to follow that unwarranted interpretation, by placing at its core simply the commitment to scale up health policy efforts, without setting priorities to stay focused on UHC and the reforms needed to accomplish it.

The Declaration is right to endorse a focus on service accessibility; equitable distribution of essential medicines and technologies; increases in overall health funding; protection from financial burden; the rights of vulnerable groups; growth of the health workforce; and strong health system governance. Yet, if anything, these actions are necessary but not sufficient to be on the right track to equitable, inclusive and sustainable UHC. A host of constraints and other complex challenges must be overcome to advance towards UHC, as proved by the good and bad experiences of many countries as well as the thinking and analyses of experts seriously engaged in the topic.

True, there is not only one way to UHC but it is equally true that not all roads lead to it. Each country’s history; capacities, present and future; and political willingness of its leaders, will influence decisively the particular design and construction for an equitable, inclusive and sustainable way to UHC. Actually, some designs and implementation processes work against UHC.

The commitment to UHC involves a series of intricate policy decisions – some politically very challenging even with significant income redistribution consequences – about how the system will be organized, the sources of financing, how resources will be used and governed, and the attributes of the health service delivery system and its workforce that are needed to deliver on the commitments. Although there are many options within each of these sets of decisions, all of which entail trade-offs, only some of the options will support a path toward achieving the goals of equity, inclusiveness and sustainability inherent to UHC.

Further, experience has shown that some of the competing choices have long-term consequences and, once taken, health policy actions are difficult to reverse. It is also important to consider that the policy decisions made to advance UHC may impact other aspects of the economy, including GDP and productivity growth and the structure and functioning of the labor market.

In sum, these decisions demand careful consideration of the long-term trajectory on which the country wishes to embark or shift toward, and policies must be developed in the context of broader economic, social and political principles and impacts.

Fortunately, there is now a wealth of evidence and knowledge about the key features that, while being congruent and supportive of other crucial development objectives, will take countries closer to a system that provides truly universal, equitable health coverage that protects individuals and families from financial hardship, as well as about choices and policies that pull systems in the opposite direction. Consequently, there is a substantial opportunity to take stock and distill the global experience and practical knowledge gained over the past several decades of working toward UHC, and with a broader human development, economic, and political perspective.

With this in mind, the Yale Center for the Study of Globalization (YCSG) endeavored to synthesize that experience and knowledge into a set of concise criteria, principles or precepts indispensable for developing strategies and policies to advance countries unequivocally towards UHC. That set of precepts are written and explained in the UHC Charter here presented.

PRECEPT 1 Genuine Universality

The commitment to Universal Health Coverage must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of economic and social exclusion or discrimination.

PRECEPT 2 Effective and Equitable Universal Insurance¹

UHC requires effective and equitable universal social insurance. Provided the pertinent governance is effectively put in place, social insurance is best organized through a nationally consolidated institution that insures into a single pool all individuals and purchases on their behalf the needed health services.

PRECEPT 3 Primacy of Public Financing for UHC

A system of public and prepaid financing from general taxation is best to achieve and sustain UHC. Furthermore, with this form of financing, UHC will contribute to fostering economic development with more and better paid jobs, not informal and precarious ones.

PRECEPT 4 Efficient Delivery of Quality Health Services

UHC requires a well-organized, adequately regulated, seriously supervised and fully accountable system of providers of the needed — people-centered and high-quality — services. Ultimately, the system should consist of a multiplicity of both public and private providers, all subject to precise and homogeneous standards of quality and accreditation. Competition among providers — with transparent and fair rules — to supply the services demanded by the single insurer/purchaser on behalf of the beneficiaries of UHC, should be a key feature of the system in order to foster efficiency, quality and innovation. Governments must have the pertinent policies to train, recruit, retain and retrain regularly the competent, committed and motivated health professionals required by the UHC system.

PRECEPT 5 Progressive Realization of UHC

In practice, because of resource constraints no country can achieve UHC immediately but a path to achieve it progressively should be determined and pursued from the outset. Achievement of UHC, even if done progressively, is dependent on creating the conditions for accomplishing dynamic economic growth along with inclusive, equitable and sustainable development, as well as effective rule of law.

¹ The term “insurance” is used here in its broader meaning (a means of guaranteeing protection or safety) not its narrower standard commercial meaning.

PRECEPT 1

Genuine Universality

The commitment to Universal Health Coverage must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of economic and social exclusion or discrimination.

Effective universality, as precisely expressed in the WHO Constitution, requires adhering unambiguously to the principle that access to health care is a fundamental right. This means that exclusion of any individual, whether explicit or implicit, is unacceptable.

Consequently, universality means that the necessary health care services are afforded to all persons, unequivocally and without favoritism.

The principle was operationalized by the WHO into the concept of universal health coverage as the system that provides all people with access to needed health services of sufficient quality to be effective – including prevention, promotion, treatment and rehabilitation – and ensures that the use of these services does not expose the user to financial hardship.

This definition has three crucial elements that are deeply consequential. One, that UHC must be for all people – entitlement to the benefits of UHC must be unconditional and automatic. Two, that UHC consists of the needed health services of sufficient quality. Three, that UHC entails insurance for all – constituted either formally or not formally as an insurance plan – that guarantees access to those services without any risk of financial distress. The term “insurance” is used here in its broadest meaning – the means of guaranteeing protection and safety – not the narrow commercial one – a contract where one party extends coverage and the other commits to pay a premium. Thus, the concept used in this Charter also encompasses systems that are not denominated or constituted formally as a standard insurance plan but, by virtue of protecting individuals from having to bear the financial costs of the risky event of disease, do provide insurance. The UK’s and Sweden’s are examples of such an arrangement of implicit insurance for the provision of UHC. In other countries, like Japan, the financial

protection from risky health conditions is provided by financial entities that look like insurers in the common understanding of the term. Regardless of whether the insurance arrangement is implicit or explicit, the important thing for UHC is to remove financial barriers and assure that everyone is protected from financial distress.

The principle of equality under UHC, as interpreted from the WHO Constitution and its 2010 report, is profoundly weighty. Strict adherence to the principle should make entitlement to UHC unconditional and therefore preclude exclusions frequently encountered that are either explicit or implicit in health and other policies as well as in cultural barriers, discriminatory practices, and societal prejudices.

Yet it is the case that health policies may often explicitly exclude some groups for practical, fiscal or political reasons. For example, the principles of equity and inclusivity under UHC are violated when, for any reason including budgetary ones, health insurance schemes permanently exclude, or cover only partially, the self-employed and the informal workers – usually large and vulnerable groups. For this not to happen, the self-employed and the informal workers must have the same right to financial protection and access to health services as formal, well-organized workers. Fiscal and other constraints should be dealt with, not by beginning with formal workers and then gradually incorporating others, but with a pro-UHC pathway that ensures coverage for the poor and harmonizes benefits with existing formal sector beneficiaries, and then incorporates more of the “middle” under the progressive realization approach explained in Precept Five.

Explicit exclusions may also be politically motivated, such as when policies permit entitlements only to citizens and legal immigrants, leaving others without those benefits. And yet, migrant populations keep reaching exceptionally high numbers with the addition of refugees, asylum seekers, internally displaced persons, and returnees. Undocumented migrants represent a uniquely vulnerable subgroup, experiencing particular barriers to health related to their background as well as insecure living and working conditions. UHC implies that health needs must be met regardless of migrant status.


Implicit exclusions occur when coverage does not match certain specific needs, or when physical or cultural barriers and discriminatory attitudes and practices are allowed to persist that effectively limit access to the care that is needed. Inequities and cultural practices related to stigma around disease, such as HIV/AIDS and mental health, are a source of implicit exclusion from the full benefits of UHC. Inequities and cultural practices related to gender are another source of implicit exclusion from the full benefits of UHC. Although women may not be explicitly excluded from coverage, they are implicitly excluded when the benefits package does not cover those conditions that are unique to women and often times are their most pressing health needs. Effective inclusion may also require the use of other social policy interventions, such as cash transfers to incentivize the use of health services and the implementation of outreach health services.

The principle is also violated when the elderly and disabled populations suffer from implicit exclusions. Even in well-performing health systems, people with disabilities do not have their needs properly recognized and face several obstacles, like financial

and cultural barriers, including misconceptions about disabilities as well as access to buildings and lack of transportation.

Admittedly, health inequity and exclusion cannot be solved within the health system alone. Better anti-discrimination and civil rights laws, with proper enforcement, are also a necessary, although not sufficient, step to achieve the equity and inclusiveness in UHC. More active citizen and civil society engagement against discrimination is also needed.

Many intrinsically related determinants of health and disease exist, including social and economic circumstances, education, employment, housing, and physical and environmental exposures. These factors interact to cumulatively affect the health and disease burden of individuals and populations, and to establish health inequities and disparities across and within countries. Realizing the right to health requires progress on health care as well as on the underlying determinants of health. This requires attention to the broad, community-wide focus on the essential social and economic conditions in which people live, not just to the immediate needs of any one individual. The design and implementation of UHC policies should be underpinned by intersectoral action and social participation.

A blue-tinted photograph of a newborn baby lying on a hospital bed. A hand is gently holding the baby's head. The baby has a medical band on its wrist. The background is blurred, showing hospital equipment.

Realizing the right to health requires progress on health care as well as on the underlying determinants of health. This requires attention to the broad, community-wide focus on the essential social and economic conditions in which people live, not just to the immediate needs of any one individual.

PRECEPT 2

Effective and Equitable Universal Insurance

UHC requires effective and equitable universal social insurance. Provided the pertinent governance is effectively put in place, social insurance is best organized through a nationally consolidated institution that insures into a single pool all individuals and purchases on their behalf the needed health services.

Authentic UHC seeks to ensure that the entire population has access to the needed health services without risking financial distress. With UHC every individual must have access to and insurance for needed health services, irrespective of that individual's particular health and economic situation. This means that UHC is first and foremost about providing insurance as defined above – unconditional and automatic – to every individual in the country. This universal insurance, which can be explicit or implicit – in other words, a formal or not formal insurance plan, is an indispensable element of a genuine UHC system.

The reality is that the health and economic situation of each person is unique; and yet rightly, all people must be considered equal under UHC. To achieve this equality, everybody must have insurance irrespective of their capacity to pay for it. But it is the case that not only does income typically vary a lot across individuals within a country but also that health care costs for every individual are highly uncertain. This uncertainty makes it necessary to pool risks across populations to insure individuals and families against the risk of financial hardship stemming from expenditures on the needed health services. Insurance against health risk, inherent to UHC, ultimately involves redistribution of funds based on ability to pay and according to need.

Without UHC and its indispensable collective insurance, the well-off would self-insure or buy insurance underwritten by a third party, whereas the economically worse off, unable to pay for it, either would be excluded from the needed health services, or at risk of severe financial hardship to pay for them. For UHC to exist, insurance – the guarantee of health protection with financial safety – must be for all; but this requires that the cost of this insurance, for those in society who cannot afford it, must be subsidized by the rest.

Not every modality of insurance will be consistent with the UHC objective. Voluntary insurance is an obvious case to be avoided. If being in or out of the health insurance system is left to every person, there will be many reasons – although essentially all of them financial – for some individuals, potentially a significant proportion of the population, who will not join the system.

Poor people would not take voluntary insurance simply because, other things being equal, they cannot afford to pay for it. A subsidy would be needed unequivocally to attract voluntarily persons who do not have the means to pay for the health insurance. Those within this group having significant health risks, provided they get the necessary subsidy, would then be even more prone to be insured voluntarily.

Others, however, better off in their health and finances, will tend to not join a voluntary system, precisely to avoid sharing the risks – health and financial – of the worse off in the population. The former will prefer to join an insurance scheme (pool) that excludes the latter. This kind of outcome is inherent to voluntary insurance. It is known as “adverse selection” and constitutes a key conundrum that must be resolved, or even avoided altogether, in the process of building a UHC system.

Adverse selection occurs when the relatively healthy people drop out, raising the average cost of covering the remaining people (since the relatively healthy are no longer in the pool). This raises contribution rates for those remaining in the pool, which causes more relatively healthier people to drop out, and so on until the system breaks down entirely.

Where insurance is voluntary, adverse selection will force the system to be one of many pools, each defined by distinct classes of risk and therefore of financial protection, with the practical consequence that many will be left out, or if insured thanks to subsidization only at a higher cost.

The most effective way to prevent adverse selection is to make it legally mandatory to have health insurance for all individuals, with the proviso of subsidizing the premium of those who cannot pay for it. Compulsory participation in the UHC pool is necessary to ensure a large and diverse risk pool and to avoid adverse selection, or the “death spiral” of insurance pools. Nearly all countries that have achieved population coverage of 90 percent or higher have legally mandated participation in health coverage.

Mandatory participation has numerous positive effects on the system, including the key ones of expanding coverage and reducing the average premium paid per person.

The principles of fairness and equity underlying the UHC goal of financial protection require that individuals contribute based on ability to pay and irrespective of this ability do have access to the needed health services. Clearly, compulsory participation would not be fair or feasible for the poor without subsidies to make participation affordable. Subsidization is therefore an essential element of UHC policies to ensure the full and equitable inclusion of the poor in the health system. In systems where the insurance is not formal but rather implicit, the subsidization would come through the tax burden of each individual—the poor, presumably paying low taxes, would be subsidized by those subject to higher taxation.

Furthermore, for reasons of equity—inherent to UHC, as well as of efficiency, it is best to have all people insured in the same group or risk pool. The system is equitable when it collects funding from individuals based on their ability to pay and then directs resources to those with the highest need. A national pool with all risk shared and the burden distributed across the entire population provides the highest degree of predictability, risk-sharing, and equity.

A single national pool in principle allows for the most effective risk pooling, better redistributive capacity and consequently enhanced equity, as well as increased administrative efficiency. Obviously, the materialization of these benefits is not automatic, but the single pool makes them attainable. A national pool, with its many advantages, can be implemented in a UHC system where several insurance funds are retained, provided these are properly pooled too into the national risk pool.

Very importantly, a single national insurance makes possible the strategic benefit of constituting a single purchaser, on behalf of all the insured, of the health services comprised under the UHC system.

Although not without downsides that must be carefully mitigated and managed, there are numerous benefits from having a single entity that provides universal insurance, receives the pre-payments and all the other funds to comply with the insurance obligations, and contracts the health services of the UHC package to be received by the insured.

A single entity to pool risks and purchase services in principle would be better able to make sure that indeed all individuals have access to the same benefits comprised in the uhc system, something which

is hardly possible in a scheme of many insurers or pools. With one insurer, it is easier to regulate and enforce the equal protection included by the UHC system at any given time. It would also ease the implementation of the enhancements of the benefits package as this evolves over time, as well as the capacity to effectively supervise that the services delivered by each provider comply in quantity and quality with the UHC standards.

Having and executing this capacity is not a secondary feature of a UHC system. It is a first order and powerful instrument to fix a “market failure” practically immanent to the demand and supply of health services. The failure is the one of “asymmetric information”: that is, information held, on the one hand, by patients and, on the other, by the providers of the health services. In health care, due to asymmetry of information, patients do not have the knowledge to be an effective purchaser. This is why it is indispensable to charge an entity with the explicit responsibility for purchasing the needed health services. This entity should be given the legal and institutional authority to make evidence-based decisions on what services to purchase, which providers to purchase from and how to purchase to be cost-effective.

Without well designed interventions to fix the asymmetry—with instruments such as licensing, accreditation, regulation and enforcement, as well as smart purchasing ideally by a public entity—patients would not be assured that they are treated according to the UHC promise.

A single insurer/purchaser not only offers a better capacity to guarantee the quality of the product (the needed health services) but, very importantly, it provides market power to acquire it at a cost lower

than would be the case in a system with multiple insurance pools.

Advocating a single entity for insurance and purchase of health services would seem to contradict the conventional criteria applicable to most other markets of goods and services, where multiplicity of, and competition among, agents both on the demand and supply sides usually lead to an optimal allocation of resources with good economic and social outcomes. However, because of the market failures of adverse selection and asymmetric information, health goods and services are different from most other goods and services produced and traded in markets. Indispensably the health care market must be regulated, both on its supply and demand sides, to make sure that it achieves its health objectives, certainly its UHC aspirations.

Complying with the function of regulation will be facilitated if there is just one entity both specifying the particular goods and services comprised in the UHC benefits package, as well as verifying that they are effectively delivered by the providers—the two tasks certainly according to the standards determined by the health authorities. This governance arrangement will make it more feasible to prevent abuse and fraud by health care providers. Obviously, a single buyer of the UHC package will have maximum capacity to do strategic purchasing and bargaining power vis-à-vis the licensed providers. As long as the proper rules, strategies and governance are put in place to avoid misusing the monopsonic power entrusted to the single purchaser, the latter would be able to optimize the use of the resources collected and pooled into it.

A single entity, properly financed and governed, should be able to stimulate a competitive and cost-effective provision of the UHC benefits that can be financially sustained and enhanced over time.


Inconveniently, in many countries, existing health systems were created and have evolved with a multiplicity of risk pools, a circumstance that runs against the objectives of universality and equity necessary for UHC. Fragmentation limits the benefits of pooling funds for UHC and weakens the insurance function and purchasing power in the system. Drivers of fragmentation include: incremental population enrollment through multiple coverage schemes; fiscal decentralization for collecting revenue and setting priorities for expenditure without a strong equity-based mechanism for redistribution; and fragmented sources of revenue to finance the cost of insurance.

Once multiple pools have been established, it becomes politically difficult to merge or integrate them, as this will require dealing with some interest groups losing, or perceiving to lose, their privileged situation. It is often also administratively difficult to merge pools, as different pooling agencies typically use different operating systems, such as information systems, systems for contracting with providers, and many other different administrative systems that can be challenging to harmonize.

Notwithstanding these and other complexities, to firmly pursue UHC it is crucial to plan and execute a clear strategy to merge or consolidate the multiple pools of the existing health system, with a clear view to arrive into a single national pool as quickly as possible.

Countries that are close to – or practically have achieved – UHC with multiple insurers may assess whether further consolidation into fewer and even a single pool can provide meaningful gains in efficiency in service delivery and cost of UHC.

Achievement of a single pool would not preclude the acquisition of supplementary insurance by individuals willing to opt for services outside the UHC system.



Very importantly, a single national insurance makes possible the strategic benefit of constituting a single purchaser, on behalf of all the insured, of the health services comprised under the UHC system.

PRECEPT 3

Primacy of Public Financing for UHC

A system of public and prepaid financing from general taxation is best to achieve and sustain UHC. Furthermore, with this form of financing, UHC will contribute to fostering economic development with more and better paid jobs, not informal and precarious ones.

Even countries that purport to pursue UHC are found to finance health expenditures with multiple public and private sources, including out-of-pocket payments at the time of service, private voluntary health insurance premiums, mandatory or voluntary social health insurance contributions, and government revenues from different types of taxes. From the arguments explained in previous precepts, it should be clear that not every source of financing of health services is consistent with the goal of UHC.

If mandatory participation and subsidization are indispensable to achieve true UHC, then any voluntary contribution or even payment, certainly out-of-pocket payments at the time of service, should be discarded as coherent and legitimate sources of financing. The case for eliminating out-of-pocket payments for health services at the time of delivery is overwhelming. This form of health financing discriminates, first and foremost, against the poor, who will either forego necessary treatment for lack of means to pay for the service or suffer a catastrophic impact by paying a large share of their modest income to get the needed services, with the possible consequence of being pushed deeper into poverty.

Relying on voluntary prepayment into health insurance is also inconsistent with UHC. Because of adverse selection and the fragmentation to which this gives rise, the system will be limited in its ability to receive sufficient revenue to cover the health expenses of an entire population.

In short, to comply with the conditions of universal inclusion and equity of UHC, an essential reform to achieve it must include the elimination of any out-of-pocket and voluntary contribution as a source of financing. If necessary at all – due to transitory fiscal constraints or to mitigate the risk of moral hazard of unwarranted consumption of health services –

any expedient such as copayments and deductibles should be kept small enough to avoid financial hardship.

Countries embarked on the journey to UHC should be aware that even mechanisms known as social health insurance, where mandatory contributions give individuals access to the insured health services, may be inconsistent with the achievement of UHC. These mechanisms have been put in place for particular sub-populations or segments of the labor market, typically for formal workers, and tend to preserve the fragmentation and inequities of the health system.

In order to maintain the UHC principles of fairness and equity, it is essential that all citizens' financial contributions to the system – either through taxation or combined with specific mandatory contributions for insurance – are unrelated to an individual's medical circumstances and risks, or employment status. Funding health from public resources is the only way to meet these criteria, and as such, public funding is the most equitable and efficient path toward the progressive realization of UHC.

Trends in low-, middle- and high-income countries alike confirm that general taxation has emerged as the cornerstone of revenue for successful UHC efforts – that is, those that raise funds equitably and sustainably, and are most likely to lead to universal or near universal population coverage, comprehensive access to high-quality services, and deep financial protection.

Given that public funding is essential to achieve equitable and sustainable UHC, governments acting responsibly must match political commitments to UHC with fiscal commitments. This requires prioritizing health within the budget and taking on

the political obstacles to freeing up fiscal space, and necessarily improving overall revenue collection to secure adequate funding for UHC and other government priorities.

To circumvent the annual process of setting budget ceilings and the uncertainty it creates for the health budget, some in the health sector advocate for a specific tax or a share of government revenue to be earmarked for health. In practice the results of earmarking in terms of equitable and efficient health revenue generation are highly context-specific and dependent on the political economy of priority-setting in the country's budget process. It may be a useful tool in some instances for countries to overcome failures in the budgeting process, but evidence suggests that the effectiveness of earmarks often diminish over time and the rigidity they introduce in budget allocations may become inefficient. Earmarking and other innovative financing “short cuts” do not take the place of effective and transparent government budget priority-setting and political commitment to UHC being accompanied by the indispensable budgetary commitment.

The obvious link between UHC and economic development consists of the benefits that countries derive when their populations have broad access to high quality health services. On one hand, healthier workers can more actively participate in the labor market, learn new abilities and contribute to increase productivity. On the other, healthier children are better poised to learn more and perform better while they are in school; and in turn be more productive when, as adults, they join the labor market.

However, there are other links that if ignored and left unattended may unduly limit the positive economic benefits from a healthier labor force. These

links are associated with the dependency of access to health insurance on employment status and the mechanisms used to finance UHC. These links are relevant to all countries but are particularly important in developing ones with large informal sectors.

Many countries have historically funded health insurance through earmarked payroll taxes, largely because of the historical connection between health protection and labor dating from the advent of public policy on health coverage in 19th century Europe, when the goal was different than UHC as understood today. Payroll tax-funded coverage, however, creates the dual problem of distortions in the labor market and often explicit exclusions of those not employed in the formal labor market—something that obviously goes against UHC.

Employer-based health insurance may generate “employment lock,” “job lock” or “entrepreneurial lock.” The first two occur when a person remains in a particular job, even if it does not meet their employment needs or match their skills, in order to maintain their health insurance. When a country moves away from employer-based health insurance, occupational mobility increases and, in some cases, it enables workers to move into better and higher paid jobs. Similarly, “entrepreneurial lock” refers to when a person will not exit their job to become self-employed or an independent business owner because he/she cannot afford to lose their health insurance. These phenomena have negative impacts on individuals and the economy in that they stymie upward labor mobility and entrepreneurship, and increase inefficiencies in the labor market significantly to the detriment of workers themselves.

In developing countries, employer-based health insurance financed from payroll taxes creates additional economic costs. Clearly, these taxes can only be collected from workers hired by firms that are registered with the tax authorities; that is, firms that are formal and offer their workers formal jobs. Formal firms withhold these taxes, which are almost always set as a proportion of workers' wages. Firms try to pass on or shift back to workers at least part of these taxes, in the form of lower wages, so that in the end workers' health insurance is jointly paid by firms and workers. To the extent that payroll taxes cannot be completely shifted back to workers, firms' labor costs will be higher, and will translate into lower formal employment.

Moreover, in some countries, payroll taxes are used to finance not only health services, but other components of social insurance, like retirement, disability and survival pensions (and in some cases other benefits like day care services for children or labor training programs). This means that formal firms and workers have to jointly pay for a bundle of present and future goods and services. However, it is often the case that the value that workers impute to this bundle is less than the payroll taxes paid. This may be because the quality of the health services is low, because workers discount heavily their future pension, or because they may not need some of the services in the bundle.

The difference between the payroll taxes paid and the value of the benefits is equivalent to an implicit tax on formal employment. In response to this implicit tax, firms will reduce their level of formal employment and may decide to evade payroll taxes altogether. The extent of evasion will depend on how countries enforce these taxes, and can take many forms, for example by under-declaring the number of workers in the firm or their wages. However, since it is usually easier for smaller firms

to evade, firms will tend to stay small. This behavior may make sense from the point of view of the firm, but is costly in terms of productivity and growth, as economies of scale and market opportunities are forgone. Moreover, if firms are engaged in illegal behavior, they will be less likely to access credit and, more generally, to engage in innovation, invest in training their workers and create high quality jobs.

But regardless of whether firms stay formal and reduce their level of employment in response to payroll taxes, or become informal and evade, the result will be lower employment in the formal sector (and fewer workers covered by employer-based health insurance). Lower formal employment will translate into a combination of more informal employment and higher unemployment, a mix that depends very much on country characteristics (although in general the mix will lean heavily towards more informal employment, as most developing countries have no unemployment insurance, and open unemployment is not high). The key point, however, is that reduced formal employment will hurt economic performance, since informal jobs are on average less productive and consequently worse paid than formal ones.

Furthermore, countries funding health services through payroll taxes will never achieve effective UHC, even if these taxes are perfectly enforced and there is no evasion, and even if firms are able to fully shift payroll taxes back to workers in the form of lower wages. This is because not all workers participate in the labor market as employees of firms. Many workers are self-employed; others exploit their own plot of land in rural areas; and yet others may be employed in small firms where all workers are relatives (a family firm) and no wages are paid, but members are remunerated through profit-sharing arrangements, or even do not receive any monetary remuneration but are paid in-kind.

In all these cases, payroll taxes cannot be collected because either there is no firm involved, or even if there is a firm, there is no payroll. All these workers are informally employed in the sense of not working with a registered firm that withholds payroll taxes. These workers account for a large share of employment in developing countries, in many cases more than half. These workers will never be covered by employer-based health insurance. In addition, some workers in a firm where there is a payroll may also be informally employed because, as discussed, the firm breaks the law and evades payroll taxes.

At times informality and illegality are conflated, but from the point of view of UHC it is important to distinguish them sharply. The point is that even if the laws with regards to payroll taxes were fully enforced, many workers would be left out of a payroll-funded health system, for the simple reason that they do not receive a wage or a salary. Their earnings are more variable and sometimes the distinction between profits on capital and earnings on labor is unclear—as is the case of those working in a family firm, which in many developing countries is the most common form of business organization. Thus, UHC could not be reached through stricter enforcement of payroll taxes.

Informal workers pose difficult trade-offs for governments seeking UHC. Because these workers will never be covered if health services are funded only from payroll taxes, the choice for the government is to leave them without coverage, or to fund their health services from a source of revenues other than payroll taxes. Faced with this trade-off, many countries have created parallel systems of health service provision funded from general taxation. The result is a segmented health system, one for formal workers and another one for informal ones; one funded from payroll taxes (usually bundled with pensions)

and one from general taxation—sometimes complemented by out-of-pocket payments at the time of service.

Parallel and distinct mechanisms to provide health services to workers cause smaller and thus insufficient risk-pooling along with higher administration expenses, making the overall system costlier. More importantly, from a social point of view the solution is undesirable because the quality and scope of services is usually not the same; in general, services for formal workers are better than for informal ones, thus betraying the objective of equity inherent to genuine UHC articulated in Precept One.

Duality in health systems is also undesirable from the point of view of economic performance. The reason is that insofar as health services are paid, at least to some extent, from general government revenues, an incentive is created for informal employment even if health services for this sector are of lower quality than those employed in the formal activities. In such a dual system, workers get subsidized health care if they have an informal job (self-employed or in a family firm); however, if they get a formal job, they must pay for their health care as firms shift back at least part of the payroll taxes in the form of lower wages.

Firms hiring workers will also react to the provision of subsidized health services for informal workers. Evasion will be more tempting as now workers get benefits even if the firm fails to comply with its social health insurance obligations. And indeed, studies show that the introduction of free or partially subsidized health services for informal workers, combined with costly services for formal ones, has increased informal employment and promoted illegal behavior.

Thus, the unfortunate result of the combination of employer-based health services funded from payroll taxes for formal workers, and health services for informal workers funded from general government revenues, is to tax formal employment and incentivize informal employment, which is exactly the opposite of what is needed to increase productivity and accelerate growth with benefits shared fairly across the population. This is why the movement toward general taxation as the main funding source for UHC along with a diminishing role for payroll tax funding must be high on the agenda of UHC reform.


Discussions of UHC at times fail to pay sufficient attention to the impacts of various forms of financing on economic performance. It is as if the issue of where revenues come from is immaterial, as long as there are sufficient resources to properly fund services. However, the sustainability of UHC depends on it being funded from sources of revenue that contribute to a more productive and growing economy.

On the practical side, wage-linked contributions cannot generate a sufficient revenue base in high-income countries because of aging populations, and in lower-income countries because of low formal sector labor participation rates and weak tax collection systems.

The combination of population aging and the epidemiological transition will put increasing pressures on health systems everywhere in the world. Additionally, despite its central importance to social welfare, health competes with other priorities for resources.

Conflicts over funding are much more difficult to resolve when good jobs are scarce, productivity fails to grow, and tax revenues are stagnant. In contrast, when workers have jobs where wages increase over time because productivity is growing, and where tax revenues are increasing because the economy is expanding, UHC will be more sustainable.

In summary, UHC requires public funding to avoid out-of-pocket expenditures, ensure mandatory participation, prevent adverse selection, and make the pooling of risks through the largest possible population. For coverage to be truly universal, entitlement must be de-linked from employment, and from direct contributions more generally. Moreover, funding UHC from general tax revenues, rather than with payroll taxes, contributes to productivity and growth. This, in turn, generates the resources for the long-term sustainability of UHC, and creates conditions where workers can find better-paid jobs.



In order to maintain the UHC principles of fairness and equity, it is essential that all citizens' financial contributions to the system — either through taxation or combined with specific mandatory contributions for insurance — are unrelated to an individual's medical circumstances and risks, or employment status.

PRECEPT 4

Efficient Delivery of Quality Health Services

UHC requires a well-organized, adequately regulated, seriously supervised and fully accountable system of providers of the needed — people-centered and high-quality — services. Ultimately, the system should consist of a multiplicity of both public and private providers, all subject to precise and homogeneous standards of quality and accreditation. Competition among providers — with transparent and fair rules — to supply the services demanded by the single insurer/purchaser on behalf of the beneficiaries of UHC, should be a key feature of the system in order to foster efficiency, quality and innovation. Governments must have the pertinent policies to train, recruit, retain and retrain regularly the competent, committed and motivated health professionals required by the system.

Meeting the conditions explained in the previous precepts is necessary to take the road to UHC, but it is not sufficient. The means to provide high quality healthcare services must be put in place in order to complete the UHC apparatus. Attainment of a well-financed health coverage program for all individuals will not achieve its intended outcomes without a well-organized system to provide adequately the needed health services. UHC is only as good as the services it provides.

A well-organized system is one capable of providing integrated care to the population. As the WHO has stated, integrated service delivery requires “the organization and management of healthcare services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money.” Building an integrated service delivery system, as has been purported jointly by the WHO and the World Bank, requires “to move away from a system of ‘conventional care’ marked by a relationship limited to the moment of consultation and with a focus on illness, to a ‘people-centered’ model. This model is marked by an enduring personal relationship with a focus on health care needs, reflecting a mission of responsibility for health of all in the community along the life cycle, tackling determinants of ill health, and maintaining health.”

Obviously, a system of integrated care is the point of destination in a journey that starts with the existing arrangements and capacities, which currently imply that half of the world’s population lack access to essential health services and these, when available, may be of poor quality. In fact, more deaths are caused by poor quality care than lack of access in low and middle income countries. As countries embark seriously on reforms to achieve UHC, they will have to plan and create the conditions that build

a system that, notwithstanding the initial settings, incrementally but clearly moves towards an integrated approach to health care.

A primary health care (PHC) system, capable of meeting a wide range of the population’s health needs in a proactive way, constitutes the indispensable foundation of a strong UHC complex. Investing in the organization, infrastructure and human resources required to provide PHC universally is an obvious choice not only to achieve better health outcomes for the general population sooner rather than later, but also to start integrating the system for meeting the conditions, purported in previous precepts, that make achieving effective UHC feasible in the long-term. As efficiency and equity in the delivery of PHC is being put in place, the proper governance, the national insurer/buyer, the required fiscal reforms and, very importantly, the formation of the needed human resources, should be implemented with a view to integrate a national health system that truly furnishes UHC.

Through progressive realization, as explained in Precept Five, an integrated delivery system would be one that has the attributes of equity – effective coverage and no disparities in access; quality – achieves the desired health outcomes; responsiveness – meets people’s expectations; efficiency – available inputs yield the highest possible level of health outcomes; and resilience – capacity to respond effectively to crises. A system with these characteristics would give the population access to a network of healthcare entities capable of providing health promotion, disease prevention, diagnosis, treatment, management, rehabilitation, and palliative care. In practice most, if not all, countries lack a truly integrated system with these attributes and capacities. Even those with explicit or implicit universal insurance, and even with a unified system of public health facilities, may

fail to meet the required standards because of insufficiencies in their respective delivery systems.

The failure stems, even in the presence of a single insurer/purchaser, from not leveraging to its full extent, on the one hand, strategic purchasing and, on the other, competition among properly regulated and supervised providers.

Countries claiming to have or be close to UHC and counting with an extensive network of health facilities may still fall short of the integration and coordination needed to meet the ideal UHC standards. Much more distant from it are those with disorganized, fragmented, disarticulated and uncoordinated health providers.

If a State is capable of advancing towards a robust framework of governance of the health sector—with the proper regulation and enforcement—as well as toward developing an institution to serve as national insurer/purchaser, then it should also aim to develop a strong capability of strategic purchasing. These three capacities should be articulated to foster the supply of health services required for UHC, which typically is not the one developed over time by traditional health policies. Historically, in most LMICs, the State builds, funds and operates its own health facilities, frequently grouped around different entities serving distinct sectors of the population. Those entities are practically unexposed to any competition and exempted from any serious accountability, particularly for delivery of outputs and outcomes. Each entity is just part of a fragmented system that, unless consolidated, will fail to deliver UHC. Consolidation of public entities will be useful if done to make the government health providers competitive yet wasteful if procured to create inefficient monopolies for the provision of health services.

As much sense as it makes—due to the market failures of both adverse selection and asymmetric information—to have a national pool for all insured and a well-governed buyer with strategic market power, it is questionable to give up the enormous potential offered by a multiplicity of health services providers competing among themselves to supply the needed services, obviously subject to well-crafted, transparent, fair and enforceable regulations that guarantee the desired quality of services. The single buyer should use its market power to select the most qualified and efficient providers of UHC in order to maximize population health and reduce financial risk.

Competition among different public providers, once they are mandated to serve a consolidated pool of insured, makes eminent sense but still falls short of what is desirable and possible for UHC. The latter's progressive realization can be speeded up if private entities are allowed to participate as providers of the precisely defined UHC services. As long as these are delivered at competitive prices in conformity with the approved standards, there is no reason why private suppliers should not become partners in the UHC undertaking. This can be leapfrogged if opened to the investment, innovation and management expertise brought by non-public entities.

The decision to open up the UHC endeavor to non-state entities can be inhibited by the belief that either it would not be cost-effective for the government or sufficiently attractive economically for the private sector to be engaged. In all likelihood this belief is wrong. Health systems that currently serve just a portion of the population, in multiple and heterogeneous segments and with limited or nil competition, carry inefficiencies and rents that if wiped out by competition and smart regulation,

would translate into better quality services at a much lower cost per person than currently prevails.

The extent of the potential market, provided there are clear and enforceable rules along with competitive pricing, will make it attractive for non-state participants, for profit and non-profit entities, to join the UHC system as suppliers.

The commitment to invest long-term into the health sector by the private sector can also be incentivized by the careful implementation of advanced long-term purchase agreements of health services, allocated by the single purchaser on the basis of competition (with price and quality) through well-crafted bidding processes.

Scrupulous mandatory accreditation is a key instrument to insure not only that the potential providers have the capacity to deliver the required health services according to the standards determined by the responsible authority, but also that they comply with those standards consistently or else risk losing the corresponding accreditation and license to be providers of UHC services.

Opening to the non-state participants will not be meaningful if these are left to play a purely residual role or in segments seen as undesirable, for budgetary or bureaucratic reasons, by public entities.

There must be a leveled playing field between public and non-state providers, through transparency and enforceability of the rules. These should include precise stipulations to prevent any form of discrimination or favoritism. Among many aspects, this implies that public and private providers should be subject to the same accreditation and compliance standards.

The method to pay providers is another key instrument to run the UHC system efficiently. Deciding on the method implies non-trivial decisions on critical aspects such as the unit and level of payment, and whether the latter is made prospectively or retrospectively. The decision must also deal with delicate trade-offs. For example, if in order to mitigate the uncertainty in costs inherent to health attention, too much of this risk is transferred to the provider, this would be more inclined to limit care and quality. Similarly, if for the sake of ensuring adequate service, the purchaser is budget lenient, the provider will be emboldened to incur over-provision.

Consequently, the purchaser should be mandated to avoid fee-for-service models and adopt as soon as possible payment methods that incentivize budget discipline, efficiency and quality on the part of the providers. Experience from many cases advise evolving towards prospective payment approaches – like capitation, case-based payment, or global budgets – combined with rules to limit expenditure growth.

Evidently, having a purchaser capable of stimulating adequate and competitive provision of the needed UHC services requires the development of an institution with the proper governance and strong management, empowered with the right tools to carry out its duties.

The opening to the private sector should not inhibit the State's investment in health infrastructure, particularly if directed to accelerate the provision of services to the poorest segments of the population, foster research in medicine and other health sciences, and develop and apply technologies to improve the management and delivery of the UHC services.

Furthermore, the State has a fundamental responsibility to address what may be an enormous obstacle to achieve UHC: the chronic and severe shortage of health professionals and competencies. Health workers are the brains, heart and hands of the health system, yet there is a global deficit of health professionals, which under current trends will keep growing in the foreseeable future. Governments seriously engaged in the pursuit of UHC must adopt a dynamic plan to have their education institutions – public and private – produce the personnel required by their respective health systems in order to close the existing deficit as well as to ensure that sufficient numbers of health workers, motivated into lifelong learning and service, are available and employed at the right places with the adequate compensation and social protection.

Attainment of a well-financed health coverage program for all individuals will not achieve its intended outcomes without a well-organized system to provide adequately the needed health services.



PRECEPT 5

Progressive Realization of UHC

In practice, because of resource constraints no country can achieve UHC immediately but a path to realize it progressively should be determined and pursued from the outset. Achievement of UHC, even if done progressively, is dependent on creating the conditions for accomplishing dynamic economic growth along with inclusive, equitable and sustainable development, as well as effective rule of law.

The universality principle of UHC is aspirational for many countries and may not be immediately feasible given constraints. These countries should prioritize their investments in UHC and make step-by-step progress over what may take a number of years – or progressive realization of UHC. Choices and trade-offs, within and across the dimensions of progress, will be faced. Yet, an explicit path towards universality, acknowledging the pertinent constraints, that is equitable, inclusive and sustainable needs to be mapped.

With progressive realization, a UHC framework is stated explicitly as an over-arching goal for universal population coverage, starting with a comprehensive essential service package provided in a way that does not present any risk of financial hardship for any user. Certain population groups or services should be included rapidly, but with a clear strategy to expand towards universality as fiscal and other resource constraints ease. Even if a country has started its UHC journey with a targeted scheme for the poor, a UHC policy framework charts steps for progressively expanding coverage, managing the transition, and unifying the system. It is crucial, though, to define at the outset the elements of the system that must be universal from the beginning, such as data systems comprising all patient activity, the planned trajectory of unified benefits and of core public health functions to be organized on a system-wide basis. Along the same lines, it is important to state as soon as possible the path for the progressive universalization of services for key communicable diseases and in general basic primary care.

Once a country has unequivocally taken the political decision to pursue and achieve UHC, robust planning for transiting from its available health system to the one that will deliver UHC must be undertaken.

The planning must start with a candid and rigorous assessment of the existing health system, with emphasis on the features that conceivably make it inconsistent with the UHC goal. This assessment in all likelihood will make clear that due to limitations – financial, infrastructure, governance, organization, and human resources – the goal of UHC cannot be attained immediately.

Transparent and accountable headway on that path will furnish progressive realization of UHC. Movement must occur along the stepping stones consistent with the objective of universality purported in other precepts.

It is important to stress, again, that simply advancing in the provision of health services and reducing the financial stress stemming from their use may not imply progressive realization of UHC. Just extending coverage for some and even reducing financial risk, if not done with a view, and clear strategy, to achieve universality (as defined in Precept One), may in fact deviate from its progressive realization.

Progressive realization of UHC recognizes that fiscal and other capacities are limited and prioritization is required. Unquestionably it is necessary to clearly target certain groups, like the poorest of the population, for the provision of health services, but it should be done without deepening the fragmentation of the health system because this would make even harder the eventual consolidation of the system as required by UHC. Prioritization should avoid fragmentation as well as stigmatization of the targeted groups. Separate administrative and financing structures for the priority target groups should be avoided because not only can they deepen segmentation, but they can also worsen social segregation and reaffirm a public perception of inequality.

Progressive realization demands explicit commitments from the government, with mechanisms to hold it accountable for progress. First, the government is obligated to develop, and constantly update, plans, policies, and processes to ensure the path is clear for maintaining progress toward UHC commitments. Second, the government must allocate more resources to UHC as the budget envelope increases, and make the most effective use of those resources. And very importantly, the government has the obligation to protect UHC progress even during times of crisis. In the face of fiscal problems, actions must be taken to prevent either explicit or implicit erosion of coverage and access to services or financial protection, most pertinently for vulnerable members of society.

Information about government decisions and actions for the progressive realization of UHC should be accessible – transparently and easily – ideally supported by modern freedom of information laws. Authorities should be required to justify their criteria and decisions when questioned. Remedies should be available when agreed-upon services are not available in practice, or when such decisions have been shown to be arbitrary or discriminatory. The public's role is to actively hold the health authorities accountable; and institutions, such as Ombuds offices, courts and other independent review mechanisms, are required to enforce health rights in practice.

Constant learning and adapting are essential to the process of realizing the aspiration of UHC. Given the importance of understanding the personal experiences of vulnerable people in accessing needed care, the information used for policy decisions should include qualitative measures. Participatory models are needed that involve representation for all citizens, particularly members of vulnerable popula-

tions, in policy development and decision-making processes at all levels. Their enactment should allow for redistribution of power and overcoming the implicit exclusions that undermine the realization of access to health care as a human right and UHC as a true expression of that right.

The progressive realization of UHC in any particular country will depend critically on whether progress is consistently pursued and achieved in other crucial aspects of its development. For one thing, it is unlikely that the economy could generate the fiscal resources needed to pay for UHC unless it is not only growing dynamically but also sharing that growth more equitably across its population. A stagnant or sluggish economy will make it much harder, or even impossible, for the State to obtain the resources needed to advance towards UHC through general taxation. It is easier to collect the needed resources if the economy grows. A dynamic economy not only makes the required fiscal revenues financially affordable for the population but also makes it politically more palatable to accept their collection by the government.

The willingness and capacity to comply with tax obligations will be reinforced in turn if it is clear to citizens that their contribution to the country's treasury will be put to good use in a fair and equitable way, which is the case for UHC.

The promise and, over time, delivery of a growing economy – with the jobs and other opportunities such growth entails, along with progressive realization toward UHC would make it more socially acceptable to undertake the reforms needed to enhance productivity and GDP growth. Those reforms – comprising liberalization of product and factor markets, not least to address the fragmentation of the labor market, along with the restructur-

ing of the tax and social security regimes, among others – are not of trivial political difficulty. The assurance of enhanced economic opportunities and a stronger social safety net with UHC at its core could well be the most powerful argument to gain acceptance of the indispensable reforms by a country's citizens.

Achieving UHC and the economic and social conditions it enables also need effective rule of law, including compliance first and foremost of the essential condition of equality – precisely – before the law. Fixing the weak rule of law prevailing in many developing and emerging countries also requires significant legal and institutional reforms that involve short-term economic and political difficulties. However, as history shows, the pay-off of building true rule of law is immense in terms of economic prosperity and human development.

Patently, all the reforms needed to enable a successful strategy to achieve UHC, and with it a prosperous and equitable economy, transit through the formation of solid and effective institutions. Such a course is, undoubtedly, a stupendous undertaking but, as experience proves, an indispensable one. Ultimately, as countries and their political leaders commit to seriously go after UHC they also do so to achieve an even greater good: sustained, sustainable and inclusive development. This and its essential component, UHC – Amartya Sen's affordable dream – will be the prize for embracing the undertaking.



Once a country has unequivocally taken the political decision to pursue and achieve UHC, robust planning for transiting from its available health system to the one that will deliver UHC must be undertaken.

