Universal Health Coverage:
Perceptions, Policy Drivers and the Way Forward

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(DRAFT ONLY)

Table of Contents

Introduction ......................................................................................................................... 3

Methods............................................................................................................................... 4
  Country Selection ............................................................................................................ 4
  Interviews ....................................................................................................................... 4
  Analysis ........................................................................................................................... 5

Results ................................................................................................................................... 6
  Bangladesh ...................................................................................................................... 11
  Chile ............................................................................................................................... 14
  Ghana ............................................................................................................................ 17
  Pakistan ......................................................................................................................... 19
  Tanzania ....................................................................................................................... 21
  Thailand ....................................................................................................................... 23
  Turkey ........................................................................................................................... 25
  Viet Nam ...................................................................................................................... 27
  Limitations .................................................................................................................... 29

Conclusion ....................................................................................................................... 30

Appendix 1 ....................................................................................................................... 32

Appendix 2 ....................................................................................................................... 34
Introduction

As Universal Health Coverage (UHC) becomes the growing focus of global health and sustainable development, it is important to look at how this broad goal is understood. Coverage of population groups, benefits packages, and financial protection have been the staples of UHC in global dialogue. This project, however, seeks to go beyond the financing components of UHC to address a broader array of social inequities. In order for these three components to be addressed in a sustainable manner, national ownership is required to tailor services and strategies for the particular contexts in which they are being implemented. UHC is achieved through strengthening health systems to provide affordable, safe and high quality care that includes prevention, promotion, treatment, rehabilitation and palliative care. Seven essential principles to achieving UHC should be addressed and measured in tracking progress in UHC. These include acceptability, accessibility, affordability, availability, adaptability, quality, coverage and equity. This project seeks to understand whether different stakeholders across eight countries have the same understand of the UHC goal and to what extent components beyond financing mechanisms are referred to and addressed in efforts and dialogue surrounding UHC. As several stakeholders interviewed pointed out, the UHC goal suffers from being quite broad and if stakeholders within one country do not have a harmonized vision of what achieving UHC means, then efforts working towards it become disparate and ineffective as a whole. Through interviews with stakeholders, this project presents examples of how UHC is perceived by different stakeholders across countries in order to better understand differences in approaches to achieving UHC. Furthermore, it presents a range of drivers that have pushed the UHC agenda forward, challenges and areas of consideration for future research and policy focus.
Methods

Country Selection

This project focuses on stakeholder perceptions of universal health coverage and is meant to complement work done by the department of Health Systems Financing in financial risk protection under the direction of Dr. David Evans and the department of Health Statistics and Informatics (HSI) in the development of indicators under the direction of Dr. Ties Boerma. To complement work done by HSI, countries were selected from the same 13 countries which have been commissioned to produce case studies on measurement and tracking methods in UHC. These include: China, India, Vietnam, Bangladesh, Singapore, Thailand, Rwanda, Ghana, Tanzania, Chile, Brazil, Estonia, and Tunisia. From these, the eight countries selected were chosen based on geographic and socioeconomic diversity in order to have a representative sample with the addition of Pakistan to include an EMRO perspective. These include: Bangladesh, Chile, Ghana, Pakistan, Tanzania, Thailand, Turkey, and Viet Nam.

Interviews

To capture different views, 6 stakeholders from each country were interviewed: 3 policy or decision makers, 2 civil society representatives, and 1 representative from a funding body that supports health systems development and strengthening. As a first round of stakeholder selection, opportunity sampling was used to contact participants of the Second Global Symposium on Health Systems Research and partners of the Alliance for Health Policy and Systems Research. These participants, often researchers, were asked to assist in the identification of interviewees in their respective countries given their familiarity with leaders across sectors. Information was provided to them with regards to the type of stakeholders being sought. The selection criteria for policy or decision makers was to have leaders at the ministry of health (or similar ministry), including directors of department, previous members of the ministry, leaders of national health insurance initiatives as well as district-level decision makers in charge of specific programs and
initiatives. The criteria for civil society representatives included NGO directors or employees and consumer advocates. Funding body representatives were defined as people working for a funding body (national or international) that provides grants and funds for health systems strengthening initiatives and has an in-country office. Once the initial group of stakeholders was identified, emails were sent out explaining the objective of the study and asking for their participation. Stakeholders provided the date and time for the interviews. Interviews were conducted by phone or by Skype and notes were taken during the interview. An interview guide of eight questions was used for every interview with probes based on individual responses (see Appendix 1). Interview notes were put into the following nine categories: perception of UHC, the country’s path towards UHC, decision making mechanism behind selection of benefits, use of evidence, human rights considerations, measurement and tracking of UHC, and the way forward. The categories for these write-ups were selected based on pilot interviews; that is, interview questions were re-categorized into these categories based on how interviewees were answering the original questions (see Appendix 2). For example, in speaking about the country’s path towards UHC, many interviewees mentioned future direction and reiterated future direction and challenges in the next question on drivers and challenges as well; therefore, these comments were directly packaged into one category on “Way Forward.” These write-ups were sent back to the stakeholders who were asked to provide edits should they feel that their answers were not expressed exactly as they wanted. The edited write-ups were then analyzed using the WHO health systems building blocks and the human rights framework based. Interviewees were also asked to refer the interviewer to any relevant policy documents as they saw fit. They were also asked to identify other potential interviewees.

**Analysis**

Interview write-ups were coded based on two sets of analysis categories. One is the six building blocks of the health system as defined by the WHO: service delivery, health workforce, information systems, medicines and medical products, financing, and
leadership. Any areas where interviewees made reference to the building blocks as being addressed in the country or needing to be addressed as part of the move towards UHC, were coded. Components that did not fit into the health system building blocks were coded as cross-cutting components. A second analysis was based on a human rights framework developed by Bennett et al through the iCCM policy analysis project. These include freedom and entitlements, standards for healthcare and determinants of health, minimum core of immediate effects, nondiscrimination and equality, participation, accountability, progressive realization, and international law/development. Two spreadsheets were used to present these two analyses and trends across interviewees in highlighting more comprehensive components of UHC and the human rights implications were described.

Results

This section will first present results based on coded interviews both in terms of a human rights framework and a health system building blocks framework. This is followed by a compiled and summarized narrative of the interviews conducted with stakeholders in each country with the viewpoints of policy makers, civil society representatives, and funding representatives presented separately in terms of definitions, policy drivers and challenges. A summary box highlighting the drivers of success and areas where more work is needed can be found at the bottom of each country summary.
**WHO health system building blocks**

The 6 building blocks of a health system as defined by the WHO are as follows:

The interviews were coded according to mentions made of the building blocks. The goal of this was to understand whether a holistic view of the health system is being incorporated into discussions around UHC or whether stakeholders are focusing more on one building block: financing systems. Financing systems and leadership and governance were mentioned by almost all respondents (93%) while information systems were rarely mentioned (13%) with medical devices at 60% and health workforce at 63%. Service delivery followed financing and leadership with 67% of respondents mentioning components of service delivery when discussing UHC. The following highlights guidelines used to determine which building blocks respondents were addressing:

*Service Delivery*: mentions of mechanisms for improving accessibility and availability of services and improving efficiency

*Health workforce*: mentions of human resources in terms of capacity, training, numbers and other mentions of health workers.

*Information systems*: mentions of evaluation systems, data management, knowledge sharing or monitoring mechanisms.
Medical products: mentions of medicines, medical devices, vaccines, and other products; this includes aspects of cost effectiveness and resource allocation in terms of medical products.

Financing systems: mentions of financing schemes and mechanisms.

Leadership and governance: mentions of accountability mechanisms, political will, ownership, champions of UHC within government, effective leadership, and quality assurance through government mechanisms.

Cross cutting: mentions of cross sectoral collaboration or components of UHC not fitting under the 6 building blocks.

The following chart shows the percentage of respondents having mentioned various building blocks aggregated by country. Information systems were the least mentioned in most countries, with Turkey having the highest frequency. Interestingly, respondents from Turkey also highlighted improvements made to the information systems as contributing to Turkey's success on the path towards UHC with improved ways of monitoring systems and ensuring good quality services. Fifteen respondents focused on private sector collaboration, which is identified as important both in terms of supporting UHC if addressed appropriately and hindering UHC if communication, collaboration, trust and accountability are lacking. Moving discussions of quality assurance mechanisms, data management, access to medicines, health workforce capacity, training, supervision, workload, efficient service delivery systems, and accountability in governance structures more widely into the UHC dialogue can serve to round out discussions, leading to improved initiatives with increased likelihood of effectiveness and sustainability. Addressing the diversity and complexity of health system infrastructure is critical in the UHC dialogue and including these building blocks and interactions in the UHC definition can improve the approach towards this lofty yet achievable goal.
The human rights framework used was adopted from the iCCM policy analysis project run by Dr. Sara Bennett at the Johns Hopkins University Bloomberg School of Public Health. This framework is made up of 8 components:

1. Freedom and entitlements: involving a) the right to make one’s own decisions about one’s own health and b) the right to a systems of health protection (right to emergency medical services, right to underlying determinants of health). Generally, fewer respondents mentioned aspects of UHC related to the right to make decisions about one’s own health.

2. Standards for health care and determinants of health: availability, accessibility, acceptability, and quality. Quality was a hot topic of discussion for most respondents, primarily as a challenge faced on the path towards UHC. Quality is seen by most as
critical in achieving UHC and was voiced as a component of the UHC definition by several respondents. Accessibility was also mentioned by most respondents as access to health services by vulnerable populations and rural populations is a key challenge faced across countries. Availability of services and their acceptability were not key considerations in how UHC was perceived by most respondents.

3. Minimum core of immediate effect: includes primary health care/ national health plans, efforts addressing determinants of health, and prioritizing those with most basic needs/ most vulnerable.

Pakistan and Viet Nam had the lowest mentions of participation while Tanzania, Ghana and Thailand had the highest mentions, involving the public in UHC discussions and having mechanisms in place for complaints and decision making. Turkey and Ghana had the highest mentions of accountability with Chile and Tanzania having the lowest. With a small sample size, these mentions do not represent the general thinking of the countries, but they provide some insight into how various stakeholders might be prioritizing components of UHC.

The following are summaries of the 6 interviews per country (4 for each of Chile and Turkey). Perceptions, drivers and challenges of UHC across countries are described for groups of policy makers, civil society and funding bodies. Drivers of UHC success and areas to work on are laid out in boxes at the end of each summary.

**Bangladesh**

Bangladesh has what can be called the perfect storm of conditions necessary for UHC: political will, good governance, leadership, participation from civil society and a
reasonably strong health system infrastructure. However, Bangladesh has not moved very quickly on UHC with efforts being primarily project-based within maternal and child health and financing systems being limited to small community based insurance funds, which are important in making the transition to UHC but not sufficient.

Policy makers interviewed in Bangladesh defined UHC as having access to health services without financial barriers. The poor are focused on in the current schemes available in the country and a big challenge is getting the public to understand insurance schemes and prepayment in order to promote UHC through pooling mechanisms; this is a shift in known culture. Furthermore, challenges involving retention of health workers in rural areas are significant barriers to UHC. In fact, one policy maker highlighted access to services by rural populations as an important facet of the UHC definition. The programs being handled by the government are pro-poor, which shows the link between how policy makers define UHC as being access to services for vulnerable populations and how it is rolled out with a pro-poor focus. However, positive health outcomes in vulnerable populations remain low because of lack of sustainability of the programmes due to poor financial management and low quality. As part of the UHC definition, another policy maker included the adequacy of the health system as well as social security and no payment at time of service with effective resource mobilization and reduced wastage. In practice, however, health system capacity has not been a focus and therefore, individual programmes meant to address the UHC goal are not met with success. Policy makers see a move beyond programme-based attempts to UHC as critical in achieving sustainable reform through health systems capacity-building. With the 1972 Constitution recognizing the right to health as a basic right and national health policy of 2011 pushing for equity in health care for vulnerable groups, Bangladesh has the appropriate documents in place to push for UHC. In fact, the health care financing strategy of 2012 outlines a UHC goal by 2032 with pilot programs highlighted in certain areas- a focus which came as a result of global focus on UHC. In Bangladesh the move towards UHC is a collaborative process with the ministry of health, the health economics unit, funding organizations, population
council and research institutions involved in pushing the agenda forward. However, the private sector is acting separately and presents a challenge. Furthermore, advocacy is not as strong as it could be given the power of civil society in Bangladesh; the respondent attributed this to civil society not taking the UHC agenda into their mandates yet nor is the media discussing UHC. Mobilizing these groups and involving the public will be critical as Bangladesh moves forward.

One civil society representative defined UHC similarly to policy maker responses, focusing on the lack of barriers to access to health services while another equated it with a focus on primary health care. Pilot programs are being established by NGOs such as BRAC; however, the efforts are not concerted which makes large scale financing reform a challenge. Civil society has focused on creating demand, which is an important step in pushing the political agenda; however, with minimal media involvement, this hasn’t been very successful. Instead the international push for UHC has been a more effective political driver. Most NGOs are still focused on the MDGs; one respondent highlighted consideration of social determinants of health as an important precursor that still needs to be effectively addressed before UHC is achieved. These included factors affecting extreme poverty, promotion of education and addressing gender inequity, especially in training and literacy as well as an early age of marriage and poor maternal health capacities.

A funding organization representative defined UHC as access to quality services free of financial burden. This respondent also voiced the collaboration across government but lack of specific involvement of other sectors including NGOs. This is partly due to the other areas of focus and the lack of prominence of the UHC agenda currently. Furthermore, expertise in health reform and health financing is limited and individual leaders move across sectors frequently resulting in a lack of sustainability in establishing a focused mindset. Mapping exercises and summaries of the government’s plans were recommended as ways of involving civil society and spreading the dialogue.
Knowledge management is critical when trying to develop cohesive plans for development across a variety of stakeholders. Furthermore, efforts can be complementary if the primary health care aspects of UHC are brought into focus so that the work already done by civil society and government is additive and not duplicative.

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<tr>
<th>Drivers</th>
<th>Needs Improvement</th>
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<tbody>
<tr>
<td>• Constitutional right to health</td>
<td>• Retention of health workers in rural areas</td>
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<tr>
<td>• A focus on equity and vulnerable groups</td>
<td>• Social determinants of health, specifically with reference to female education</td>
</tr>
<tr>
<td>• Creating demand for UHC by the public</td>
<td>• Involvement of civil society and media in cross sectoral dialogue and public participation</td>
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<tr>
<td>• Collaborative environment across stakeholders to discuss plans and options to determine a cohesive mindset in approaching UHC</td>
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Chile

In Chile, GES (Garantías Explícitas en Salud) is the UHC system and it involves a lot of public ownership. This plan, also referred to as Acceso Universal con Garantías Explicitas (AUGE) takes a rights-based approach using principles of access to and quality of services in addition to financial risk protection.

It is outcome-based, which means that results in terms of disability adjusted life years (DALYs) and disease burden are used to make adjustments in UHC programming. Furthermore, although the media is perhaps not as engaged as it could be in UHC practice, users can still access most information relevant to healthcare access in the ministry of health website. There are powerful rules in place for ensuring that the rights of patients in demanding care to providers are maintained. In contrast to some other countries making strides in UHC, the public is not deterred from using services due to the likelihood of low quality; this is because quality is considered a critical component in
Chile’s UHC plan. However, wait times remain a problem with significant lags between diagnosis and treatment.

A policy maker interviewed defined UHC access, equity and coverage of disease burden as intermediate attributes while focusing on the importance of considering outcome measures. Despite equity being a goal highlighted by policy makers in Chile, geographic inaccessibility and inequity in access to health professionals presents significant barriers to Chile’s UHC. However, Chile remains a frontrunner in dealing with inequity. For example, an element included in Chile’s UHC law that is less discussed in other countries is access to services by foreign bodies, including illegal immigrants. In Chile, unregistered individuals still have rights to emergency services as part of the nations human rights laws, taken into account in the design of the UHC plan. An important next step for Chile as highlighted by a policy maker is addressing the lack of human resources in remote areas both through training more professionals and through innovative approaches such as telemedicine to provide expert guidance to existing professionals in remote villages.

In defining UHC, one civil society representative focused on ability to pay while the other highlighted the use of public dialogue and opinion in making healthcare decisions and in identifying needs.

Chile’s universal healthcare law includes 4 guarantees:

1) access
2) opportunity
3) financial protection
4) quality

Access includes geographical access, which has been a significant challenge. Opportunity is an effort to address the problems with wait times by regulating the amount of time between diagnosis and treatment. Financial protection includes rules to define what percentage of income the public should be spending on health. And quality
ensures accreditation of health facilities by the government. This 4-wheeled approach has served Chile in its UHC success and in assuring accountability by the government.

Despite its success, the law was not without opposition. Pharmaceutical companies and the medical associations were not on board, with the media being mostly in support of pharmaceutical companies. However, with champions being those in power under a socialist government, UHC was pushed forward and concerns of the medical association were heard but the law was not impeded. In fact, the government was a big driver in ensuring that people knew of their rights and had an effective complaints mechanism. Medical associations’ concerns involved the decreasing autonomy and control of providers, but this issue has been diminishing as more and more doctors accept new standards.

A funding representative stated the relationship between the academic community and policy makers as an important driver in creating political will and in improving implementation of the GES. Evidence and opinion from the scientific society is used by government with many policy makers having training from strong institutions in Chile and the UK. Therefore, there is UK influence and a focus on building strong academic institutions such as the school of public health.

Good training and standardization of appropriate treatment and timing across the public and private sectors have also been key ingredients in the success of Chile’s UHC scheme.

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<th>Drivers</th>
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<tr>
<td>• Rights-based approach</td>
<td>• Sustainability of the scheme: appropriate funding channels</td>
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<tr>
<td>• User-focused: effective communication mechanism to hear the people’s demands</td>
<td>• Long wait times between diagnosis and treatment</td>
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<tr>
<td>• Use of evidence through an effective link with the scientific community</td>
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<tr>
<td>• Collaboration across sectors</td>
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Ghana

Ghana has taken a rights-based approach to health and has effectively used civil society and media to promote universal health coverage through a social health insurance scheme. They use multiple financing schemes including premiums from the informal sector, social security payments from the formal sector and tax-based VAT pools. Media has been used to relay information on how to register for insurance and how to access care, but primarily focuses on pitfalls in the new system. Geographical accessibility was raised by policy makers as a key challenge in expanding coverage, specifically in terms of transportation costs. Another challenge highlighted was the inconsistency between different levels of the health system since health facilities are not operating at a similar standard of services and it is challenging for providers to ensure that the scheme is achieving the same quantity and quality of services across the country. Ghana Health Services (GHS) was recognized as an important champion since the political environment was very favourable to reform. The public was frustrated with the cash and carry system and wanted change, which made health reform an important election issue in 2008, leading to ownership of the issue by government. Participation is an important factor in the success of Ghana’s national insurance scheme. That is, including several stakeholders in the design process including providers and beneficiaries. Providers are also seen by policy makers as important champions on Ghana’s path towards UHC. Experiences from other countries such as Chile and Thailand have been looked at by policy makers in Ghana and these have been adapted for the local context. To widen coverage and extend services, especially with an overloaded health workforce, inclusion of the private sector in service delivery has been seen as contributing to UHC. Next steps in Ghana’s path include addressing the problems of accessibility and variable quality of services across facilities. Ghana is purposively targeting geographic inaccessibility as a second component of its UHC plan, where affordability of services and subsidies for vulnerable groups were the first component. Furthermore, although many stakeholders have been involved in
consultations, there remain unhappy constituents as the system is not entirely tax-based and still requires dips into employees’ social security and requires premium payment from those in the informal sector, which serves as a barrier despite subsidies for vulnerable groups.

Civil society members furthered the two pronged approach highlighted by policy makers by adding sociocultural barriers to access that need to be addressed as part of the definition of UHC. One respondent stressed access to emergency services as well as disease prevention services using social determinants of health. They agreed that government is the primary driver of reform but criticized some of the financial management being conducted especially in terms of allocation of resources. For example, one respondent mentioned that too much is allocated to salaries as compared to the necessary infrastructural changes. The focus on gender has been important in the human rights approach that Ghana has taken on, primarily due to the election of a human rights advocate as the minister of health- a factor that stresses the importance of champions in driving UHC reform. In addition to ensuring equitable access to health services from a gender perspective, other social determinants of health such as education and poverty are also on the agenda.

The funding organization representative primarily defined UHC as an insurance system and stressed Ghana’s favourable political environment and participation by civil society as critical factors in its leadership role in Africa in terms of national insurance. Accessibility was highlighted as a challenge with innovative methods such as mhealth technologies to reach those in remote areas mentioned as strategies that are being explored in improving access. Programs that open communication channels between the public and the health sector such as TV and radio channels that provide maternal and child health information for example were also highlighted as helpful ingredients in the UHC path. However, Ghana continues to face a challenge of disconnect between policy and implementation due to several factors, one of which is the turnover of policy makers.
Bridging communication between those working on implementation of UHC initiatives and those designing policies is critical and can be improved using better systems of collecting meaningful evidence that can be considered in policy decisions and applied in practice.

<table>
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<th>Drivers</th>
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<tbody>
<tr>
<td>• Rights-based approach</td>
<td>• Geographic accessibility: use of mhealth</td>
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<tr>
<td>• Participation by the people:</td>
<td>• Turnover of policy makers</td>
</tr>
<tr>
<td>communication channels with the public</td>
<td>• Disconnect between policy and implementation</td>
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<td>• Involving providers in the discussion</td>
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**Pakistan**

In recent years, Pakistan has started the dialogue on UHC with programs addressing certain components of the goal growing rampant. Policy makers define UHC with a focus on decreasing catastrophic expenditure in an equitable manner. One policy maker defined UHC as managing how government spends money for health.

Of particular relevance to Pakistan, decentralization, a large and diverse geography, and lack of national coordination have made progress in UHC challenging. The social sector is prioritized differently across states and stakeholders have diverging opinions and perceptions of UHC, with many focusing on disease outcomes. Pakistan is using small-scale initiatives to move forward with UHC, with many of them working at a disease-specific level through donor funding. Health insurance schemes are being piloted with the help of donors such as GIZ to support rural families using evidence from the poverty survey as well as evidence from studies looking at health from a human rights perspective showing gaps. One policy maker respondent focused on extension of services to the rural poor using a needs-based approach.

Policy makers pinpointed the lack of quality assurance mechanisms at the national level as well as the unregulated private sector as barriers in the path towards
UHC. However, progress is being made in this area as well with one province looking at legislation to involve the private sector using quality assurance mechanisms. Furthermore, existing civil society organizations working on programs that capture the spirit of UHC should also be mobilized and regulated to better address a common goal. This respondent also stressed the importance of maintaining context-specificity across provinces with varying disease burdens, resources and baseline health outcomes.

Civil society representatives defined UHC as equitable access to affordable and good quality healthcare; one in particular defined it as a commitment by government in terms of components of delivery and provision of services, and finally provision of financial services. Decentralization and power struggles between the government and civil society were listed among primary struggles on the path towards UHC. One civil society respondent felt that the government needs to have a long-term vision before things can move forward with tax based or insurance models. UHC is not well branded in Pakistan. That is, although most reforms have elements of UHC when designing basic health units, they are not considered under the umbrella of UHC and therefore are not building on top of each towards one coherent goal. One respondent also pointed out that the state government could have an effective role in making donor funding allocation decisions based on the health care service needs of the varied states.

Although not explicitly designed for improvements in health, gender equity has been a rising issue in Pakistan with the focus being on female literacy. According to civil society leaders, this will have a positive impact both in terms of improving accessibility and availability of human resources for health. Civil society representatives also resonated the comments made by policy makers that state policymaking roles should be strengthened to be capable of regulating the private sector.

A funding organization respondent defined UHC in terms of access to services for the worse off in a society. A disconnect between policymaking, implementation and funding are deterring progress. The changing face of media could contribute to
improving communication by highlighting issues of corruption and accountability, especially in terms of the tendency of the medical community to want to hold all power, leading to the concerns of providers taking precedence over quality and access to services. Another example of power balances impeding access to services throughout the country is the preference of hard and fast interventions by policy makers over soft ones. These are often unsustainable but more likely to enhance political power due to media coverage and apparent impact. More case studies such as those conducted by the world bank can serve to provide enough evidence to ensure more effective interventions rather than purely political decisions.

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<th>Drivers</th>
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<tr>
<td>• Primary health care focus</td>
<td>• National coordination (provincial and national communication)</td>
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<td>• Wide network of lady health workers</td>
<td>• Quality assurance</td>
</tr>
<tr>
<td>• National coordination (provincial and national communication)</td>
<td>• Unregulated private sector</td>
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<tr>
<td>• Quality assurance</td>
<td>• Gender equity</td>
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**Tanzania**

Policy makers responded to defining UHC in terms of accessibility and affordability of health services. One respondent also highlighted quality of services as part of the definition and emphasized its importance in the design, implementation and evaluation of UHC reform. This respondent felt that even in areas where people have access to health services, the poor quality- either attributable to lack of human resources, training or equipment- prevents good health outcomes and should therefore not be considered as addressing the right to good health. Another respondent included in the definition the responsiveness of the system as well as special consideration to women, people living with disabilities and those in rural areas. Gender equity was highlighted as a prerequisite of UHC as a cross cutting issue. Drivers in improving the responsiveness of the system include civil society organizations; they conduct situational analyses to inform media and therefore the public of the strengths and weaknesses of the health system and how to access services. Furthermore, they create and enabling platform for the public to
voice concerns and to demand better care thereby ensuring that government is working towards achieving more equitable distribution of quality services. Tanzania’s particular wins in terms of moving towards UHC are structured around the government’s commitment to improving access to health services. The government believes that if you invest in human beings, a healthy community can support socioeconomic development of the country. Additionally, the private and public sector work together fluidly and the media connects the public by informing and engaging people in dialogue around health topics. The media was seen as a strong advocate by all policy makers, especially in making the public aware of their rights.

Civil society defined UHC as increasing coverage, pooling risk, and increasing access especially for the most vulnerable. One respondent defined it simply as access to essential health services through a scaling up method. Respondents identified civil society as having a watch dog role to increasing accountability by the government and to ensure that the public’s voice is heard. Like policy makers, civil society representatives also highlighted the importance of situational analyses to determine which building blocks of the health system are presenting barriers to UHC. Furthermore, Tanzania’s tendency towards private public partnerships through for example, accreditation drug dispensing outlets (ADDO) was outlined by civil society representatives as helpful in maintain sustainability in UHC reform as well as long as civil society continues serving as watchdogs to ensure good quality and regulation of standardized medical products and services.

From the funder’s perspective, UHC was defined as access by everyone to all essential health services without risk of financial problems. Tanzania started its path at UHC as more of a focus on availability of services with a disease focus as a result of an effort to meet MDG goals. However, slowly it became clear that accessibility and financial coverage were big barriers and with international rhetoric falling towards social insurance and UHC, Tanzania focused more on these aspects as well. Individuals within the ministry
of health pushed hard but due to a lack of more comprehensive stakeholder participation, there are still significant challenges especially in terms of budgetary allocations and accountability. These challenges have created donor problems with some donors withdrawing support due to disagreements in allocation decisions.

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<td>• Government commitment/ Political Will</td>
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<tr>
<td>• Linking health as a critical ingredient of socioeconomic development</td>
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<td>• Use of media to make the public aware of UHC dialogue</td>
<td>• Quality of services</td>
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<td>• Lack of human resource capacity</td>
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<td>• Rural Access</td>
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<td>• Resource allocation</td>
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<td>• Accountability</td>
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<td>• Better stakeholder participation</td>
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**Thailand**

In Thailand, policy makers, civil society and funders alike stressed the importance of collaboration in achieving Thailand’s success in UHC. Ministry of health leaders are seen as the champions, with physicians providing support, along with academia, and civil society. Policy makers included aspects of access as part of the UHC definition. One policy maker highlighted the WHO definition of UHC including promotive, rehabilitative, preventive, curative and palliative services at sufficient quality and levels of access. As part of the access issue, public hearings are run by policy makers in all regions in order to increase awareness of rights, to gain input on necessary improvements, and to promote advocacy. The media is also involved in advocacy with evidence being provided to them to relay to the public in order to push for improved quality of care, access and utilization. This serves to increase the responsiveness and accountability of the system. Currently, as Thailand continues to makes adjustments in its health system, long term care for the elderly is increasingly becoming an area of focus under the umbrella of UHC. Thailand is covered by 3 schemes including national insurance, social security through employment, and government employment schemes.
One respondent stressed the importance of having good labour management systems and continuously working on the economy as critical factors in improving UHC. Furthermore, public awareness of entitlements was another point raised so that ownership of UHC schemes by the public was increased and incentives for the government to ensure good quality using existing quality assurance mechanisms (accreditation systems etc).

Civil society representatives also spoke of Thailand’s tendency to bring in all stakeholders in decision-making and to work together to make strides in UHC and defined UHC using the coverage and financing components. The relationship between national and community levels is also described as being strong leading to experiences at the community level being used in decision making at the national level. One respondent mentioned greater cooperation being necessary for moving from 3 relatively disjointed schemes to one universal scheme, making management easier. A second civil society representative stressed the role of media and NGOs in serving as the voices of the public, creating platforms upon which the public could voice concerns and an effective complaints mechanism. Not only are these groups critical in ensuring accountability, but they also served a critical role in pushing UHC law forward using signatories to draw the government’s attention to the topic and using media stories to put pressure for action behind UHC laws. Civil society groups also provide hotlines not only to collect suggestions and complaints to communicate to providers and the government but also to provide the public information on their rights and eligibilities.

A funding representative highlighted equity in access, primary health care and emergency care in defining components of UHC. The respondent also identified the capacity of the research community as one of the drivers of reform since meaningful evidence was provided to decision makers in an effective and timely manner and was used due to good communication channels. Furthermore, the civil society advocates that
were involved in the process had connected well with government champions leading to good working relationships and successful reform.

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Needs Improvement</th>
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<tbody>
<tr>
<td>• Media involved in advocacy</td>
<td>• Streamlining the UHC system</td>
</tr>
<tr>
<td>• Political will</td>
<td>• Care for the elderly</td>
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<tr>
<td>• Collaboration among stakeholders</td>
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<td>• Collaboration through effective communication</td>
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<td>• Public participation through involvement</td>
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<td>• Civil society</td>
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<tr>
<td>• Capacity of research community in</td>
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<tr>
<td>• Generating evidence that was used in</td>
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<tr>
<td>• Decision making</td>
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**Turkey**

UHC was defined by policy makers in Turkey as access to the health system without harm or catastrophic expenditure; policy makers interviewed tended to focus on the key component of range of people and services covered as part of the UHC definition as well as a consideration of equity between rural and urban populations. Key drivers according to policy makers was the joint push of prime minister and the minister of health as well as the prioritization of health in the government’s agenda. Information sharing and collaboration is part of the political culture in this area and the media facilitates these efforts. Good information systems have been critical in maintaining the quality of healthcare services and monitoring coverage. Challenges remain in establishing a sufficient health workforce to handle the load of universal coverage. Unequal distribution of human resources is a key challenge especially as UHC gains more momentum and demand for services increases. The unique characteristic of UHC’s success in Turkey has been governmental support and this was not achieved easily. The ministry of health prepared a long tem program focusing on two phases of structural changes and continuous improvements in health services. The public impact from the improved health outcomes showed satisfaction resulting in better public support of
government. The longer term perspective of the program and the stability within the ministry were important in the success leading to more support of health policies as a way of gaining public votes. The health sector eventually became a soft power in Turkey, used even to improve relationships with neighbouring countries. Economic growth in Turkey was also important in its UHC success in that it provided sufficient money for the health policies being implemented. At a fundamental level, health as a human right has been at the heart of the UHC dialogue and with collaboration among stakeholders both in public and private sector, efforts are being made towards realizing this right and providing the public with the right to make their own health decisions and to have access to quality services.

A civil society respondent also highlighted the importance of a functional information system in Turkey’s path towards UHC. The system runs across both private and public sectors, further connecting the two for improved patient centered care. Collaboration and public participation were also highlighted as key factors leading to success but this was not without its challenges since the prejudices of institutions and organizations and individual objectives were sometimes prohibitive; however, effective communications channels helped to overcome this barrier. The approach to UHC in Turkey is quality-based and citizen-oriented with focus on facilitating access to health services, evaluating and introducing new methods of treatment, drugs and technologies to the system, decreasing bureaucracy and, and monitoring expenditure. The constitutional obligation of viewing health as a human right has been key in pushing forward the UHC agenda. Furthermore, constant improvements are being made to this agenda specifically in terms of quality and equity with advancements being made in information technology and data management to better audit and monitor health services.

The funding perspective added another dimension in the question of what contributed to Turkey’s success in UHC. In addition to the longer-term collaborative
efforts, quick wins are also important in gaining public trust to have popular support. This respondent also defined UHC as access to quality services without risk of financial ruin and highlighted the importance of understanding what stakeholders mean by UHC. This respondent outlined further challenges in the efforts towards collaboration among stakeholders, specifically disdain for the plan by the medical association as well as the justice and development party. Evidence from Thailand had demonstrated that generating evidence prevents this kind of polarization among stakeholders and leads to faster reform. Once Turkey made it over this barrier, challenges included health system capacity especially in terms of the health workforce as well as evaluation of the health system. These are issues that are continuing to be worked on through training programs and improving information systems.

### Drivers

- Political will
- Push of prime minister and minister of health
- Information sharing through media
- Long term stability within ministry
- Citizen oriented
- Use of technology and improved data management

### Needs Improvement

- Human resource capacity
- Health system capacity to deal with increased demand
- Evaluation systems
- Insufficient information systems

### Viet Nam

Policy makers interviewed in Viet Nam highlighted the importance of refocusing on primary health care and addressing social determinants of health. They defined UHC as providing health care for everyone without risk of catastrophic health expenditure. Awareness of UHC across all sectors of government was articulated as critical to its movement; as it stands, the understanding of UHC and what it means is not widespread and while the MOH is leading the way, many vulnerable populations in the informal sector remain uninsured and the public push is not very strong. The effort however, to include the public is present through a media-facilitated complaints mechanism on
quality and access to health service, further supported by meetings with congress and voters. Since the PHC approach requires support at the grassroots level, improved investments at the grassroots level are important, especially when the push towards health promotion is coming from local health centers as drivers of reform. The pro-poor and vulnerable population focus of the MOH in ensuring coverage is also a key feature of the move towards UHC in Vietnam since equity is considered an important output of the system. The informal sector is seen as the biggest challenge but also the primary reason for the need of a UHC mechanism since 70-80% of the population is in the informal sector. The MOH is seen as the primary champion pushing for an increase in the government’s budget allocation for health. An approach to reaching the informal sector has been the expansion of primary healthcare networks and strengthening its capacity to reach all communities.

Civil society representatives were focused on the social determinants of health such as poverty alleviation and education. Their approach goes beyond the health sector and not only includes other sectors but also goes beyond public sector roles and seeks to include the private sector. In line with what policy makers expressed as their goals in UHC, equity is the main focus of civil society representatives as well. The approach however is different in that civil society was more focused on involving the private sector to allow increased resources for primary healthcare at the community level by the government and expanding the capacity of the health system in general. However, it was stated that regulating the private sector and assuring quality in this sector are challenges that need to be explored.

Interestingly, the media’s role is seen as much more influential by civil society than by policy makers with civil society highlighting media’s role in raising awareness of entitlements and mobilizing the public, while policy makers express that media highlights some problems with the system but is not contributing to moving the dialogue forward since most of the conversations are still within national committees. In line with policy
makers’ thinking however, civil society members also saw involvement of the private sector as important, but also further highlighted a focus on strengthening the capacity of health workers.

The funding representative was also focused on equity as a driver with a focus on financial equity as well as ensuring access for vulnerable groups, with specific reference to differences across wealth quintiles and genders.

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Needs Improvement</th>
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<tbody>
<tr>
<td>• Coherence across government sectors on the UHC goal</td>
<td>• Coverage for vulnerable populations</td>
</tr>
<tr>
<td>• Participation of the public through complaints mechanisms</td>
<td>• Unregulated private sector</td>
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<tr>
<td>• Primary health care focus-grassroots organization</td>
<td>• Capacity of health workers through training</td>
</tr>
<tr>
<td>• Political will</td>
<td>• Gender equity</td>
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**Limitations**
This study is limited in its scope as the sample size in each country is small and therefore respondents cannot be seen as representative of the entire country. The goal is to present a few different viewpoints of the situation in-country according to a range of stakeholders with a focus on perceptions of UHC since the broad UHC goal has been viewed so differentially across stakeholders and countries. Other limitations include bias introduced in the way that interviews were analysed according to building blocks and human rights components since the personal views of the reader of the interviews may have affected their intended meaning since they were not explicitly categorized into building blocks nor human rights components by the respondents themselves. Some limitations are also introduced by the selection process of respondents as opportunity sampling was a central methodology resulting in potentially similarly-minded individuals being interviewed. These limitations were addressed by randomizing selection as much as possible and extending the reach through an extended network.
Conclusion

Through dialogue with policy makers, civil society, and funder representatives, it became clear that most stakeholders define UHC similarly to the WHO definition with a focus on coverage, risk protection, and expanding a benefits package; simply put, UHC was defined by most as access to health services for all. Components of quality and a focus on equity for vulnerable populations were also added by approximately half the respondents within the definition. Other varieties of the UHC definition included a focus on gender equity, ensuring access to quality emergency services specifically, focusing on primary health care and accounting for social determinants of health. These however were not in the majority. In countries with higher levels of success towards achieving UHC relative to their region, such as Turkey, Chile, Ghana and Thailand, primary drivers of reform included first political will. This means that the government backed up the allocation of resources to healthcare and had on their political agenda (sometimes for election reasons) improvements in coverage. For example in Ghana, to regain the public’s trust, a move towards UHC had to be made. Other drivers include effective collaboration across government civil society and the public as well as longer term commitments by government and more stability in leaders across sectors. This includes the appropriate use of media to convey messages and to gain the public’s perspective and address complaints. Taking a rights-based approach has also helped governments and civil society in pushing the UHC agenda forward through legislation and international support, especially with global focus growing on UHC. This can be an opportunity that other countries moving towards UHC can take advantage of in their progress. Also important to UHC success is the presence of good information systems to monitor and evaluate health services to ensure quality- a key component of UHC as highlighted by nearly all respondents. Good working relationships between the scientific community and policy makers was also mentioned as a driver of reform since it creates a culture of evidence use and knowledge translation resulting in more effective and sustainable initiative and interventions that contribute to UHC. Areas that require more focus and research include
quality assurance and how to appropriately carry it out, dealing with an unregulated private sector and using the private sector to optimize services and increase access, increasing the capacity of the health system to address increased demand, specifically in terms of human resources for health, and finally, addressing social determinants of health instead of merely focusing on financing aspects. As more and more countries start to make the move towards UHC, looking at stories of success and the drivers that have helped them, as well as exploring the areas that are still presenting challenges, can serve to expedite the process and support more sustainable and effective interventions.
Appendix 1

1. What does UHC mean to you?

2. What has Country X been doing in terms of UHC?
   a. What important policies (programmes, reforms, laws, constitutions, meetings, etc) have taken place in X over the past 10 years in support of UHC?
   b. What initiated a move towards UHC?

3. What has helped drive the UHC agenda forward and what has been a challenge?
   a. Have there been champions or leaders that have been particularly prominent in pushing the UHC agenda forward?
   b. What, if any, has the role of media been in describing UHC or communicating the right of the public to a basic package of services?
   c. Has your country been influenced by UHC models in other countries or at a more international level?
   d. Are there particular groups of people or organizations that push for or against UHC?
   e. Where do you see future challenges on the path towards UHC?

4. How are decisions on benefits packages, selection of beneficiaries, or financing mechanisms being made? (Is there an evidence base?)

5. Would you say there is more focus on one component of UHC as compare to others? (eg. Increasing services versus expanding coverage to marginalized or reducing cost sharing)

6. Is the public involved in the dialogue around UHC?
   a. How is information regarding UHC policies and programmes relayed to the public?

7. What do you consider to be some of the strongest indicators for measuring the progress of UHC?
a. What quality assurance mechanisms are in place for services provided under UHC?

8. Are human rights discussions part of the UHC dialogue in your country?
   a. Do you think that constitutionalizing the right to health would improve progress in UHC?
### Appendix 2

<table>
<thead>
<tr>
<th>Write up Category</th>
<th>Questions that fit in this category</th>
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<tbody>
<tr>
<td>Perceptions</td>
<td>Question 1</td>
</tr>
<tr>
<td>Country’s path towards UHC</td>
<td>Question 2</td>
</tr>
<tr>
<td>Drivers</td>
<td>Question 3 &amp; 6</td>
</tr>
<tr>
<td>Challenges</td>
<td>Question 3</td>
</tr>
<tr>
<td>Decisions on services covered</td>
<td>Questions 4 &amp; 5</td>
</tr>
<tr>
<td>Use of Evidence</td>
<td>Questions 4 &amp; 6</td>
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<tr>
<td>Measurement</td>
<td>Question 7</td>
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<tr>
<td>Human Rights</td>
<td>Question 8</td>
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<tr>
<td>Way Forward</td>
<td>Question 2 &amp; 3</td>
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</tbody>
</table>