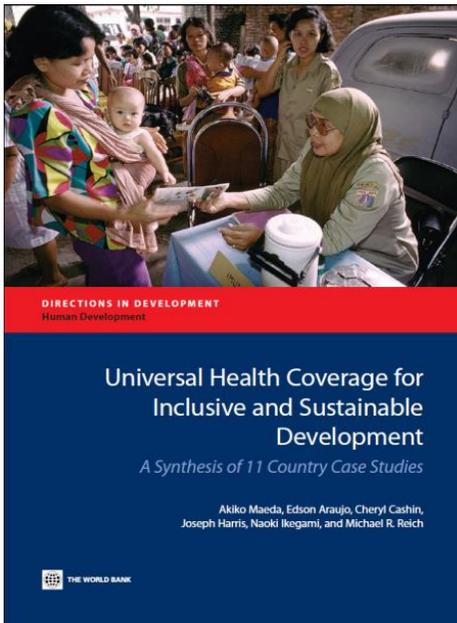


Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies



“Political Economy of UHC Policies”

Presented by: Prof. Michael R. Reich, Harvard University
Book Launch Event, UN University, Tokyo, Japan
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Introduction to “Lessons from a Political Economy Perspective”

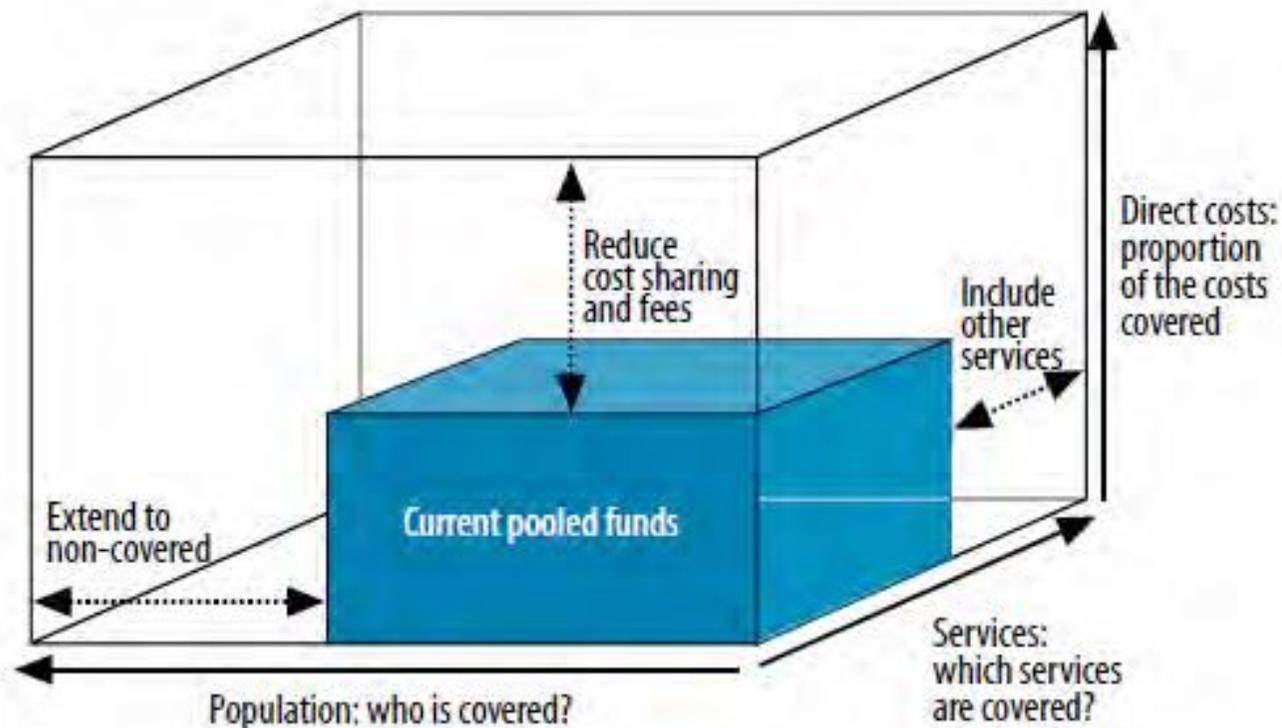
- ❖ Complex comparative study of UHC in 11 countries.
- ❖ Studies conducted by researchers in the World Bank, in Japan, and in the 11 country teams. In particular, thank the core group (A. Maeda, E. Araujo, C. Cashin, J. Harris, H. Barroy, N. Ikegami, and Y. Tsugawa).
- ❖ Key point: ***UHC changes ‘who gets what’; this involves redistribution of resources in society; UHC is not just a technical process, involves social values and requires political process.***
- ❖ Six lessons on political economy of UHC

Lesson #1: Countries confront changing political economy challenges over time

1. Bangladesh Ethiopia	Adopting UHC goals: agenda-setting, piloting new programs and developing new systems within limited resource envelope, often in response to political changes
2. Ghana Indonesia Peru Vietnam	Expanding coverage: implementation of new policies, with ongoing re-evaluation of effects; facing challenges in extending coverage to the remaining uninsured and under-served population groups
3. Brazil Thailand Turkey	Reducing inequities: strong political leadership and citizens' demands contributed to UHC; reducing inequities requires explicit policies to redistribute resources
4. Japan France	Sustaining UHC: a never-ending process requiring adaptive leadership and continuous learning, to improve quality while containing costs

Lesson #2: Three aspects of WHO UHC Cube represent key political economy conflicts

Fig. 1.2. Three dimensions to consider when moving towards universal coverage



Lesson #2: Three aspects of WHO UHC Cube represent key political economy conflicts

- ❖ **The population covered:** Which population groups first receive coverage? Which groups receive priority in incremental expansion of coverage?
- ❖ **The services covered by pooled funds:** How are benefit packages decided? Which services are covered for which population groups?
- ❖ **The proportion of costs covered by pooled funds:** What are the premium or copayment levels for different population groups? To what extent do different population groups receive support from central tax revenues?
- ❖ *These decisions on 'who gets what' are deeply influenced by political economy processes and by social values.*

Lesson #3: Problems of fairness and equity persist as a country moves toward UHC

- ❖ The distribution of resources along the three UHC dimensions (population covered, services covered, and allocation of pooled resources) creates issues of fairness and equity in society.
- ❖ Economic growth and favorable macroeconomic conditions help with coverage expansion, but they are not a sufficient conditions for ensuring equitable distribution of coverage.
- ❖ Countries need policies that redistribute resources and target subsidies to reduce disparities as they move towards UHC.

Lesson #4: Political leadership and social movements can promote UHC

Strong political leadership combined with social movements helped to overcome economic constraints and competing policy priorities, thereby moving countries towards UHC. Two country examples:



Brazil's *sanitarista* (public health) movement advocated for more equitable health reforms and played a critical role in institutionalizing the principles of universalism in the 1988 Constitution, as part of democratization. This led to the 1990 Unified Health System Law.



Founding members of Thailand's *Rural Doctors' Society*, composed of health professionals who worked in rural areas, collaborated with civil society to put healthcare access on the agenda in the national elections in 2001, in conjunction with a new electoral system. This led to the implementation of the Universal Coverage program.

Lesson #5: Health insurance schemes tend to persist once created

- ❖ Countries often create specific health insurance schemes for different population groups, and those organizations then become difficult to merge.
- ❖ Countries with multiple programs face challenges in harmonizing contributions and benefits across groups, making it difficult to improve equity.
- ❖ Creating a unified or harmonized risk pool is not easy, because of political economy challenges.
- ❖ Institutions develop positive feedback loops to assure self-survival → **path dependence.**

Lesson #6: Creating the capacity to deliver services is critical to maintain legitimacy for UHC

❖ *The effective rollout of universal coverage is often supported by a strong focus on primary health care, which can improve equity by providing services outside urban areas. Three country examples:*



Brazil's Family Health Strategy gave priority to providing primary care services to families in underserved regions, and is the main vehicle for expanding health coverage.



Thailand's Universal Coverage Scheme promotes primary care services by requiring beneficiaries to register with the primary care contracting unit as its first line of contact.



Turkey's Family Medicine Program explicitly encourages family physicians and other family health workers to serve in rural populations, and this has been the primary means for expanding coverage.

Conclusions on the UHC process

From a political economy perspective

- ❖ Efforts by countries to move towards UHC require a continuous process of addressing fiscal pressures and making trade-offs, through adaptive political leadership.
- ❖ Political compromises can result in decisions that exclude coverage for some population groups, reduce benefits, increase cost-sharing, or increase total costs.
- ❖ Therefore, countries need to develop a combination of policy means, political strategies, and social values to guide progress toward UHC, assure a fair distribution of resources, and make adjustments over time.