National health insurance in Asia and Africa

Advancing equitable Social Health Protection to achieve universal health coverage

PROGRAMME DIVISION
May 2012

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Funded by THE ROCKEFELLER FOUNDATION

Forward

UNICEF is committed to strengthening health systems to ensure access for all to appropriate and equitable health services. Achieving Universal Health Coverage (UHC) necessitates addressing various barriers to access including financial obstacles, gender and other social inequalities, as well as institutional and political factors that can contribute to social and economic exclusion. Social health protection policies, such as health insurance, help expand affordable access to health care for vulnerable groups. This advocacy paper voices the findings drawn from a two-phase landscape analysis of national health insurance in developing economies conducted by UNICEF with funding from The Rockefeller Foundation.

UNICEF regards the achievement of UHC and removal of barriers - particularly financial and socio-political ones - as a core strategy to promote equitable health outcomes. The findings of this survey have informed development of a Social Protection Framework for UNICEF, and UNICEF is incorporating them into its equity-focused approach to strengthening national and sub-national health system management and performance. In general, they will affect how the organization works in partnership with governments to diagnose and overcome barriers in health and social systems that impede realization of UHC.

Key Terms

Universal Health Coverage (UHC): The World Health Organization (WHO) defines UHC as providing "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access."

Social Protection (SP): The inclusive system of public and private policies and programs "aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation" (Devereux and Sabates-Wheeler 2004).

Social Health Protection (SHP): The sub-system of public and private policies and programs aimed at reducing and eliminating the economic and social vulnerabilities of children, women and families, in order to ensure their right to Universal Health Coverage.

Publically-financed National Health Insurance (PNHI): A government-sponsored health care financing mechanism that is based on pooling health risks of those enrolled, but publically financed through regressive general tax funds; generally includes automatic coverage of all citizens.

Social Health Insurance (SHI): Another government-sponsored health care financing mechanism that is driven by social solidarity values and based on pooling health risks of those enrolled. It is funded through income-based contributions by those enrolled, with a portion paid by enterprises (for employees) and government (for civil servants). SHI typically requires mandatory enrolment of the entire population.

SHI-type mechanisms: These instruments possess a target of compulsory universal enrolment, an initial emphasis on income-based contributions, and a core benefits package available without discrimination to all participants. They typically require tax-based revenues to ensure enrollment of the poor, informal workers, and others unable to pay contributions.

National Hybrid Health Insurance (NHHI): Any government-managed insurance plan seeking to enroll the entire population into some financial and risk-pooling insurance mechanism, or set of mechanisms, with the aim of removing the financial barriers to attaining UHC.

Acknowledgements

This study and the accompanying landscape analysis report were made possible by a grant from The Rockefeller Foundation. The author thanks Dr A. Mushtaque R. Chowdhury, Dr Ariel Pablos-Méndez, Dr Jeanette Vega and Mr Robert Marten of the Rockefeller Foundation for their generous support and guidance. Sincere thanks go also to Ms Carolyn Weidemann and Ms Cynthia Joerger of the U. S. Fund for UNICEF. This report benefited from extensive comments from UNICEF colleagues in the Division of Social Protection and the Programme Division of UNICEF, with staff contributing from HQ, the four Regional Offices, and seventy-one Country offices. Their generous support and feedback made it possible to complete the extensive survey carried out in phase one, and the case studies of phase two.

Principal investigators were Caroline Knepper (UNICEF consultant), Danielle Charlet (UNICEF consultant), Nishant Jain (UNICEF consultant) and Thomas O'Connell (UNICEF), with O'Connell also authoring this summary report. The author wishes to give special thanks to the following UNICEF colleagues for their extensive comments and invaluable suggestions: Dr Julia Kim, Ms Rachel Yates, Ms Jennifer Yablonski, Ms Rebecca Nichols, Dr Alyssa Sharkey, Mr Ian Pett, Ms Ivana Chapcakova, Ms Natalia Elena Winder-Rossi, Ms Cecilia Sanchez, and Mr Jim Protos.

Disclaimer

The intention of this report is to stimulate discussion and reflection on the findings of the National Health Insurance survey conducted by UNICEF with financial support from the Rockefeller Foundation. The views and opinions expressed are solely those of the author, and the report's publication does not constitute an endorsement by, nor necessarily reflect the views of, UNICEF, the Rockefeller Foundation, those interviewed or those having reviewed or contributed to this paper. Any errors or omissions are the responsibility of the author. Comments are appreciated and encouraged, and should go directly to the author[i].

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Executive Summary

There is widespread consensus that providing universal, sustainable, affordable and quality health services underpins efforts to achieve equitable health outcomes. UNICEF in 2010-2011 conducted a two-phase landscape analysis, funded by the Rockefeller Foundation, to investigate how health insurance and other social health protection mechanisms contribute to achieving universal health coverage (UHC). The work built on previous research examining the protection from impoverishment that health insurance provides to vulnerable groups, the potential for increasing and expanding insurance coverage, and the options for and constraints limiting the use of insurance to attain UHC.

The first phase of the landscape analysis (LA) sought to establish a baseline of information on health protection schemes for mothers, children and other vulnerable groups, with a specific emphasis on assessing how national health insurance plans in Africa and Asia were contributing to achievement of UHC. In this phase the principal investigators issued a questionnaire to 72 UNICEF country offices, conducted an extensive global literature review, and carried out interviews with national and international experts. The second phase was comprised of nine case studies supplemented by additional literature reviews to identify how countries were using insurance to reduce financial barriers and provide protection against the consequences of ill health. UNICEF is applying the findings of the LA to inform other areas of work, such as its new Social Protection Framework to guide country programming; its efforts to strengthen sub-national capacity to recognise and remove access-barriers; and its support for the global strategic equity agenda.

Findings

Findings from the questionnaires, case studies and literature reviews carried out in phases 1 and 2 suggest that significant diversity exists in the form and scope of insurance and other social health protection (SHP) schemes. Despite numerous challenges, the survey finds uneven but encouraging success in using insurance to support the achievement of UHC in Africa and Asia.

I. Most countries have adopted UHC

Analysis of phase 1 findings shows that most low- and middle-income countries have adopted a formal UHC policy of some type. The review of literature and questionnaire responses both strongly support the notion that the adoption and application of UHC is an indispensable policy driver for realizing more equitable health outcomes. A national policy to achieve UHC can also act to reinforce and sustain high-level political will, and promote greater awareness of the importance of applying an equity-focused agenda for health and health-contributing social services.

II. Mixed and ad hoc Social Health Protection mechanisms are the norm

Most low- and middle-income countries are pursuing UHC through a diverse mix of social protection schemes, including health insurance. However, vulnerability within the context of health-related spending remains pervasive. The literature review reveals that most countries have an excessive reliance on private financing for health spending, primarily through out-of-pocket (OOP) payments. Moreover, subsidies for lost wages almost never go to persons facing prolonged illness, particularly those working in the informal sector. Together, these two factors can impoverish families, restrict the amount of services they receive, or even lead them to avoid seeking needed healthcare altogether.

III. All national health insurance plans are hybrids

Analysis of data from both phases leads to the conclusion that, in reality, no African or Asian country has a 'pure' form of health insurance model; all national insurance plans are mixed, or 'hybrid' schemes combining elements of Social Health and Publically-financed National Health Insurance. This report introduces the term *national hybrid health insurance* (NHHI) to describe such plans that share an aim of removing financial barriers to UHC. In Africa and Asia, financing of NHHIs is typically through a

combination of income-based contributions designed to promote social solidarity principles, and general tax revenues.

IV. The need for a practical way to identify NHHI system weaknesses

The LA indicates that the ability of NHHIs to contribute to UHC depends on their success in removing financial obstacles to accessing appropriate and high-quality health services. The LA idenitifes three major categories of barriers that constrain NHHI schemes, which the principle investigators believe *a priori* can apply to the analysis of virtually all Social Health Protection mechanisms:

- *Inability to enrol in schemes*: NHHI eligibility criteria create potential barriers to enrolment, and can arise from a lack of birth registration systems, overly restrictive citizenship requirements, outdated and inaccurate poverty-level indices, or insufficient funding of administrative mechanisms to provide equitable enrolment opportunities.
- *Inability to use the scheme when enrolled*: Frequently, health plan participants cannot access benefits they are entitled to, revealing a public sector inability to deliver coverage to all eligible persons. Barriers include non-portability of schemes and insufficient coverage of out-of-pocket (OOP) costs, such as transportation, co-payments, and unofficial or informal fees. Another barrier is inadequate protection against wages lost to illness, care-seeking or other 'opportunity costs' of accessing healthcare.
- *Inability to obtain appropriate and quality services*: Plan participants who succeed in overcoming barriers to enrolment and use of NHHI schemes may still not receive adequate protection. Care must be appropriate to the needs of each person, especially those in high-vulnerability groups such as children, women, or families facing other forms of discrimination. Country experiences show that vulnerable populations routinely receive a lower standard of care, which may be insufficient to reduce the incidence of death and dying.

The findings of the LA add weight to the conviction that UHC is realizable in most countries. They also indicate that health insurance plays can be an important part of a SHP framework. However, reaching UHC requires a comprehensive SHP system include policies to remove financial, socio-political and other barriers that prevent individuals from accessing the health care services they are entitled to receive.

An important finding is that attaining UHC will require a more granular equity analysis and categorization of mixed SHP strategies, including NHHI schemes. Clarification of the forms such strategies can take can assist policy makers to design complementary sets of solutions for resolving barriers to insurance enrolment and utilization, and for providing every person with equitable benefits for delivery of appropriate care of good quality. Using the above 3-step categorization of barriers as a starting point, policy makers can systematically review weaknesses and gaps in current SHP systems that continue to expose various groups and individuals to vulnerabilities that hinder national efforts to achieve UHC.

Though addressing demand and supply side factors inhibiting UHC policies is important, the LA also shows the need for strong political commitment spanning multiple ministries to coordinate strategies efficiently, address assorted vulnerabilities arising from lost wages and illness-based discrimination, and track progress towards UHC. A necessary step is to improve coordination across various SHP strategies present in a country to increase efficiency, close coverage gaps, and reverse the widening inequities in access to life-saving health services. A second step is to increase support for operational research on health-systems financing to identify strategies for reducing OOP payments to a level where they do not create a barrier to access. In the countries surveyed, a common need is to link results-based health planning coherently to results-based financing.

These findings suggest that eliminating impediments to attainment of UHC on the part of socially-vulnerable populations, especially of children, requires a broad and systematic approach to identify and resolve national and sub-national barriers, as described above. Leveraging its deep organizational commitment to an equity-focus for development, UNICEF will work with national, developmental and civil society partners to strengthen management and performance of health systems, especially at the levels closest to households and communities, to ensure that quality, effectiveness and appropriateness of care becomes the foundation of UHC.

A. Context

There is widespread consensus that providing universal, sustainable, affordable and quality health services underpins efforts to achieve equitable health outcomes. Improved health, in turn, is linked to accelerated national development (Commission on Macroeconomics and Health 2001; Commission on Social Determinants of Health 2008). The 2005 World Health Assembly resolution urges national governments to ensure that health-financing systems include prepayment, implement risk-sharing mechanisms to help households avoid catastrophic health care expenditure, and work towards Universal Health Coverage (UHC). The World Health Organization (WHO) defines UHC as providing "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access". Since the 2005 commitment, nations have almost universally embraced the principle of UHC, and are embarking on varied efforts to reduce the financial barriers that exclude poor and other vulnerable groups from accessing health care.

Equitable health outcomes - the aim of Universal Health Coverage

New data gleaned from the latest international surveys and national statistics show that an increased burden of ill health and death is progressively associated with exclusion from essential services, leading to worsening inequities and an alarming concentration of preventable disease within the poorest areas and amongst the world's most vulnerable population groups (UNICEF 2010).

Households in the wealthiest quintile, which capture a much higher share of rising national incomes than poorer households do, also enjoy greater access to health services and benefit from a reduced rate of all-cause mortality. WHO estimates that low-income groups lose 234 years of life compared to 55 lost by high-income groups, per 1000 persons; in other words, the poor die younger and at a greater rate than those better able to afford health coverage (Commission on Social Determinants of Health 2008). A special report in 2010 by UNICEF, "Narrowing the Gaps to Meet the Goals," shows that an equity-focused approach to child survival and development is a practical and cost-effective way to both meet the health-related Millennium Development Goals (MDGs), and to make much more rapid progress towards UHC. UNICEF embraces this equity-focused strategy as a way to optimize existing systems and accelerate development.

Building comprehensive Social Health Protection

A social protection framework

Broadly defined, social protection (SP) is the overall system of public and private policies and programs aimed at eliminating economic and social vulnerabilities of all persons in order to ensure their equitable right to a decent standard of living. As defined by UNICEF, SP comprises four core components that address the specific social and economic vulnerabilities of children and their caregivers to poverty and deprivation:

1. Social transfers to protect and prevent individuals and households from economic shocks while supporting the accumulation of human and financial assets
2. Programs to ensure access to services and overcome social barriers to access at the community, household and individual levels
3. Social support and case services to identify and respond to social vulnerability and deprivation at the child and household levels
4. Legislation and policy reform to remove inequalities in access and address issues of discrimination and exclusion

Principles of social health protection

UNICEF's work in this area rests on three basic principles that are required to remove vulnerabilities. The first is *Inclusive Social Protection*, combined with the second, *Progressive Realisation of Universal Coverage*. An

inclusive SP approach recognizes the diverse and overlapping vulnerabilities faced by children, particularly at-risk groups such as girls, indigenous peoples, and people with disabilities. Progressive realisation acknowledges that countries vary in current protection systems, coverage and gaps, and require a context-appropriate approach to achieve UHC. These two principles are embedded into the socio-legal and institutional framework of a country though promotion of the third precept, *National Ownership and Context Specificity*. All three are at the centre of UNICEF efforts to achieve UHC with equity.

The role of health insurance

A health insurance scheme is a financing mechanism to generate and pool funds to cover the cost of health care for members of that plan. The following sections provide a brief overview of the methods used in the LA to gather information on the place of health insurance in health-related SP strategies that contribute to UHC. First is a presentation of noteworthy findings on barriers to UHC and their causes, and highlighting examples of country efforts to remove such obstacles. These efforts give cause for optimism, demonstrating that countries have a growing portfolio of practical policies and strategies to overcome barriers to UHC. However, there are a lack of practical and systematic approaches to assist policy makers across multiple ministries to evaluate barriers to UHC. Accordingly, a next section offers a practical framework to assist countries in analysing barriers, and guidance on adapting potential solutions from other countries to countries' unique contextual needs. The final sections discuss how UNICEF is incorporating these and other related findings into its policy and technical support work to catalyse equity-focused national and sub-national health agendas, and strengthen the ability of district authorities to identify and resolve major types of access barriers.

B. Methods

Phase 1 of this landscape analysis combined questionnaires, interviews and a global literature review to examine national health insurance practices in 72 countries in Africa and Asia, with an emphasis on their importance to achieving UHC. A secondary aim was to explore the role of birth registration in enabling health insurance to contribute to UHC. Early findings from phase 1 established the scope and focus of the phase 2 review, in particular the nine case studies on country-specific approaches to health insurance and their contributions to achieving UHC.

Phase one

As a first step the Principle Investigators conducted a survey of the types of national health insurance available to mothers, children and other vulnerable groups in African and Asian countries. They drew on a baseline global literature review to design a questionnaire on national health insurance policies, practices and strategies for distribution to all 72 UNICEF country offices in Africa and Asia. UNICEF country office staff completed the questionnaire in consultation with their national health ministry counterparts and relevant partners, with the main thrust being to identify health insurance approaches, either planned or implemented, that aimed to remove financial constraints to UHC, particularly those using a Social Health Insurance model.

52 country offices responded to the questionnaire, with that information informing guidelines for a more in-depth literature review on strategies and challenges to the use of national health insurance to achieve UHC, and to identify global and regional experts able to assist in clarifying objectives and scope for the individual case studies in phase 2. The Principal Investigators interviewed experts from UNICEF, the International Labour Organization, Deutsche Gesellschaft für Internationale Zusammenarbeit, the World Health Organization, the United Nations Population Fund, and other leading global authorities to gather details on important country

experiences and practices, identify grey literature[ii], and to help conceptualize a new model for describing the characteristics of national health insurance schemes identified in Africa and Asia during phase 1.

Phase two

The second phase consisted of implementation of nine country case studies representative of the diversity of health insurance planning and implementation to further investigate lessons and good practices on the use of national insurance schemes to support UHC, especially for at-risk populations such as children, women and the very poor [iii]. Principal Investigators used the findings from phase 1 to develop content and methodological guidelines for the case studies. The goal was to identify and assess country experiences with various insurance schemes to either: reduce financial barriers to accessing health services; prevent household and individual impoverishment; or generate enough resources for the health sector to finance achievement of UHC. Some studies focused on only one aspect, while others were more comprehensive. All included a discussion of the role of birth registration.

Either a national consultant or a UNICEF HQ or Country Office staff led each case study. This country-specific methodology was able to reduce the bias that could arise if the principle investigators themselves had carried out interviews and synthesis of findings. However, a significant trade-off was the lack of a single, standardised methodology permitting comparison across various country contexts. Similarly, the lack of consistent disaggregation of data, and variance in terms and definitions across countries, limited possible comparisons on the effectiveness of various SHP approaches in increasing access to services by various vulnerable sub-populations. The value of the interviews was, as is difficult to avoid, coloured by concerns related to self-reporting, such as the difficulty in independently verifying facts and distinguishing them from opinions, selective memory issues, problems of attributions and pseudo-linearity (e.g. telescoping), and minimising or enhancing outcomes based upon personal beliefs. The Principal Investigators attempted to verify information obtained from interviews and case studies by requiring each national consultant or focal-point to carry out an additional country-specific literature review to broaden the information base. This they were able to reinforce with the second literature review of national health insurance schemes that they themselves conducted.

The following sections discuss noteworthy findings from both phases of the LA that highlight the uneven, but frequently encouraging, success of insurance plans in Africa and Asia to contribute to realization of UHC.

C. Findings

Three tiers of national health protection present in almost all countries work together to progress towards UHC: i) a base tier of protection delivered through free services for all citizens, such as childhood vaccinations; ii) a second protective tier composed of a diverse range of largely government-managed Social Health Protection systems, such as national health insurance; and iii) a third tier of private insurance and other risk protection plans that attempt to fill remaining gaps in coverage.

The first tier is typically composed of ‘basic health services’ provided free of direct user fees to everyone. Many of them, such as childhood immunizations, can be regarded goods of high public merit, defined by some economists as “goods to which people should have access, regardless of their ability or willingness to pay, because the goods display important externalities of public concern.” (WHO Commission on Macroeconomics and Health 2002).

[ii] Donor, development agency and civil society technical or statistical reports; memoranda; theses; conference proceedings; technical and commercial documents; and official government reports and documents were the broad categories of grey literature used in this LA Alberani, V., P. De Castro Pietrangeli, et al. (1990). "The use of grey literature in health sciences: a preliminary survey." Bulletin of the Medical Library Association **78**(4): 358-363..

[iii] The working papers describing the findings from both phase one and phase two, along with all the case studies, can be obtained from UNICEF by writing to the lead author at toconnell@unicef.org .

The second tier generally comprises government-led and centrally managed social health protection mechanisms, including national health insurance schemes. The completed phase 1 questionnaires indicate that 27 countries, such as China and Ghana, use NHHI plans as the basis of the second tier. In the absence of a NHHI, the second tier could offer direct abolition of user fees (as in Uganda), integrated community-based health insurance (as in Rwanda), or consist of numerous specialised plans not linked under a national SHP strategy (such as in India).

Practically all countries also report a third tier comprising diverse private and specialised insurance schemes to cover those seeking more depth or breadth of coverage. This tier includes occupational and accident insurance, specialised coverage for the military and private sector plans.

This three-tiered approach to health protection exists as the predominant model for a comprehensive approach to UHC. In terms of development, the literature reviews and interviews show that countries typically start from the basic tier of free services, later providing access to a second tier of progressively more comprehensive benefits using a mix of SHP approaches, including health insurance. The third tier primarily responds to market demand generated by wealthier households working in the formal and civil sectors (Eme Ichoku, Fonta et al. 2012). With respect to the composition of and linkages among the three tiers, no dominant paradigm emerged from the survey. Each country's mix reflected a unique combination of offerings designed to address health-related financial vulnerabilities faced by its population. What they hold in common is the foundation of a government-led move toward achieving UHC.

Since the first tier tends to be government-sponsored and free to all citizens, and the third tier is accessible primarily to the wealthy, this paper focuses mainly on barriers to effective second tier schemes of social health protection, using the specific example of national health insurance plans.

I. Universal Health Coverage has been adopted as policy in most countries

Data emerging from the questionnaires and literature reviews support the view that all countries in Asia and Africa have some formal legislative or executive commitment to the ideal of UHC. The reviews of country experiences and pertinent literature suggest that actual execution of UHC policies is a vital driver for realizing the goal of more equitable health outcomes. This is not only limited to middle income countries such as China, India and South Africa. Poorer economies such as Rwanda and Ghana have shown that national implementation of a UHC policy has been followed by efforts to expand social protection through the use of insurance, user fee waivers, cash transfers, and other SHPs. The data suggest that policy adoption combined with programme implementation of UHC signals recognition at the highest political levels that healthy populations are more productive, enjoy higher rates of income growth, and tend to possess greater equity in related social measures, such as education and child welfare (Commission on Social Determinants of Health 2008).

A national policy to achieve UHC can reinforce and sustain high-level political will and promote greater awareness of the importance of applying an equity-focused agenda for health and other social services. Assessing the barriers to achieving UHC may catalyse a deeper analysis of patterns of deprivation, bring to light the causes of inequity, and help guide national efforts to remove barriers to life-saving and health promoting services (UNICEF 2010).

However, while policies promoting UHC were found in nearly all countries surveyed, full realisation of UHC is extremely rare. Our literature review and case studies indicate that only China, Ghana, Rwanda and Vietnam have approached near universal access to a formally defined set of essential healthcare interventions[iv].

[iv] The literature review also notes the Philippines and Thailand have come close to attaining UHC, but these two countries did not return questionnaires or conduct a case study, and so have been not been included in this summary of findings.

II. Mixed, and ad hoc, social protection plans are the norm

Responses to the Phase 1 survey indicate a wide variety of mechanisms to remove financial barriers to UHC in African and Asian countries. Community-based financial risk pooling, narrowly targeted cash transfers, and abolition of user fees for various primary health care services, are often the only means widely available to help vulnerable groups reduce their OOP payments. Of the 52 African and Asian countries that completed the Phase 1 questionnaire, only 27 reported implementing any form of a national health insurance scheme. Even fewer have managed to cover the majority of the population with health insurance, with only three making notable progress (China, Rwanda and Vietnam) and two others making smaller, but progressive steps towards full population coverage (Ghana and India).

The majority of countries surveyed acknowledge that their mix of SHP approaches ideally would embed in a broader SP frame that ensures protection from impoverishment and other vulnerabilities throughout an individual's life. This includes mechanisms to protect workers from job-related illness and accidents, safeguard the health of the unemployed and the retired, and replace lost income related to personal or family illness. Other health determinants, such as being underweight and suffering from poor nutrition, are equally important to address. For example, the *State of the World's Children 2011* report notes that in the East Asia and Pacific regions, 11 per cent of children are underweight and 22 per cent are stunted, and in Africa, 24 per cent are underweight and 40 per cent are stunted (UNICEF 2011). Survey findings suggest that policies and systems to ensure food security to families already at-risk from impoverishing health care costs is virtually non-existent in Africa and Asia.

A main culprit constraining progress towards UHC is inadequate coordination among the various SHP schemes in a given country. Even in China, with three national health insurance plans that cover almost the entire population, reviews of the literature suggest the presence of an ad hoc set of systems with inadequate data management capacity to ascertain enrolment or utilization of benefits (Estacio, Charlet et al. 2012). While Rwanda and Vietnam have managed to make real progress in coordinating their varied schemes under a single and strong national insurance strategy, most countries do not coordinate benefits across insurance and other SHP plans, leaving many groups with inadequate protection from health related impoverishment. Another common constraint is a lack of administrative and operational coherence between community and national insurance schemes, as is the case in Uganda.

Earlier, this paper described three tiers of social health protection: i) a base package of protection delivered through free services for all citizens; ii) a second tier composed of a diverse range of largely government-managed Social Health Protection systems; and iii) a third tier of private insurance and other risk protection.

Achieving UHC requires coordination of benefits primarily between the first and second tiers, which together form the foundation of an equitable social health protection strategy. The narrow scope of the first tier limits PHC services, rarely covers the full continuum of care needed by a person over the lifespan, and provides scant protection for the majority of vulnerabilities faced by different sub-populations. . Achieving comprehensive UHC requires access to a much greater range of interventions, which are provided by insurance and other SHPs found in the second tier. Benefits falling within the third tier are available mainly to a very small percentage of formally-employed persons or those with otherwise able to afford private plans, and are beyond the scope of this survey.

The findings of the LA suggest that the achievement of UHC requires sustained coordination among all three tiers, particularly the first and second, which provide the foundation of a pro-poor, equitable social health protection agenda. A well-coordinated SHP system readily employs first- and second-tier mechanisms to protect those citizens who are least able to access services.

Country Example: Uganda

In Uganda, despite user fees being waived for primary health care (PHC) services, indirect costs (such as payments for transportation to clinics), informal fees (such as illegal payments demanded by providers for 'free' services) and unofficial fees (such as requiring patients to purchase medicines that are no longer in stock), all create major barriers that prevent the poor and most vulnerable persons from accessing health care. For this reason, Uganda is planning to implement a comprehensive and harmonized NHHI plan, innovatively linking community health, Social Health, and private (risk-based) insurance models with the aim of eliminating all financial barriers preventing UHC (Basaza 2011).

III. National health insurance plans are hybrids

National Hybrid Health Insurance

About half of the countries surveyed have initiated, or plan to initiate, health insurance schemes to reduce health expense-related impoverishment, increase care-seeking behaviour, eliminate disparities in access, and fulfil national commitments to UHC. The initial aim of the LA was to identify the importance of a Social Health Insurance (SHI) model, as one of several presumed models countries were using to provide the second tier of protection. However, the study uncovered that all national insurance systems, even in developed countries, are in reality combinations of different insurance models. For this reason, in the second phase of the LA Principal Investigators developed a new definition of national health insurance schemes in Africa and Asia, recognising that virtually all national schemes develop as mixtures, or hybrids, of diverse types of insurance and other social health protection models. The definition of "hybrid" insurance plans reflects a core finding of this study.

This is an important outcome: low- and middle-income countries that use, or plan to use, national health insurance choose a mixed approach to financing and eligibility, combining elements taken largely from Bismarck and Beveridge insurance models[v]. The Bismarck, or Social Health Insurance (SHI), insurance plan rest entirely on contributions from employees and employers, based upon cross-subsidisation of the poor by the rich using income-based premiums. As enrolment is compulsory, with no possibility of opting out, the system is fiscally viable as long as contributions cover costs. However, this requires the state to be able to enforce mandatory enrolment as well as to impose and collect premiums. The Beveridge system, in contrast, largely uses general tax revenues to finance insurance coverage for the entire population, all of whom are automatically enrolled. This reliance on general taxation can make the Beveridge approach a more regressive financing system, for example if the main source of revenues is a sales or value-added tax not exempting purchases for food, school books, clothing and other essential goods.

As detailed below, the analysis suggests that policy-makers have found the Beveridge model to be persuasive in representing an approach for sustainable financing of national health insurance plans, while the Bismarck model has greatly influenced ideas of equity in terms of enrolment and contribution criteria. To describe health insurance plans in Africa and Asia, the author coined the term *national hybrid health insurance* (NHHI). This refers to any government-managed insurance plan, or set of plans, seeking to enrol the entire population, financed by any mix of general tax revenues plus contributions, and having the aim of removing the financial barriers to UHC.

Common traits of NHHI plans

Health insurance is a financing mechanism that generates and pool funds to cover health care costs for members of the plan. In virtually all countries with NHHIs, governments have had notable success in enrolling and

[v] The Beveridge system is a government-run National Health Service (as in the United Kingdom) which provides universal access financed through regressive financing, primarily from general tax revenues. The Bismarck model, a government-run insurance-based system requiring mandatory enrolment of the entire population, is financed primarily through progressive contributions based solely upon income.

collecting premiums from formal sector and civil sector employees. However, enrolment and provision of benefits to informal sector workers, subsistence farmers, the indigent, and others is often quite low. While employers often supplement employee contributions, and government pays a share of the insurance premiums for civil servants, these two groups typically make up only a small percentage of the total population. In developing countries the bulk of working age adults is comprised of the unemployed, subsidence farmers, and those working in the informal sector (Valodia and Devey 2010). The ILO estimates this group to comprise around 60% of workers in low and emerging economies (Bacchetta and Bustamante 2009).

This presents three obstacles to using a contribution-based approach to financing health insurance in Africa and Asia. The first is that few states have real capacity to enforce mandatory contributions (or tax collection of any sort) from informal workers and their employers. Second, even if workers were willing to contribute, many have little access to cash, especially subsistence farmers and others with only periodic incomes. Third, countries lack data systems capable of recording contributions and delivering to providers an accurate list of persons eligible for insurance coverage.

Thus it is unsurprising that low to middle income countries have been unable to use an insurance model relying exclusively on contributions. All 27 countries surveyed having, or planning, a national health insurance system, combine: (i) contribution-based financing elements from SHI models to enrol civil sector and formal sector workers, and (ii) tax-revenue financing elements from general revenue-funded insurance models to cover, or at least partially subsidize, informal workers, the poor and non-wage earners (such as subsistence farmers). More generally, to finance UHC in Africa and Asia, all countries surveyed indicated that an expansion of tax-revenue financing likely will be the only way to enrol persons who are not working in the formal and civil sectors.

While financing of most NHHIs adopts a mix of Bismarck and Beveridge approaches, NHHIs tend to have an equity focus based on principles of social solidarity associated with the Bismarck Social Health Insurance model. All 27 countries have legislative or executive acts that base health insurance on a platform of universal health coverage, with higher income households subsidising enrolment of poorer ones. For instance, contributions from formal sector employees and civil servants (and their respective employer and government co-contributions) are indexed to income, even though the package of benefits tend to be the same regardless of the level of contribution paid. In the few cases where marginalized groups also receive coverage under an NHHI, benefits tend to be the same, and their contributions largely, or fully, subsidized. With the emphasis on mandatory enrolment of the whole population, cross-subsidization of risk, such as from younger to older workers, is another equity-based aim NHHIs typically possess.

These social solidarity precepts have influenced NHHI evolution, though disparities in effective coverage persist. One example is China's three medical insurance schemes covering virtually the entire population. Within each scheme (Urban Employees, Urban Residents, and Rural Residents), contributions are based on income, but the package of benefits is the same for all persons enrolled from any one community. However, the three insurance schemes do differ greatly from each other in terms of fees and benefits: urban workers enjoy higher overall enrolment rates and, while they pay higher contributions, they gain substantially more depth and breadth in coverage compared to the plans covering urban residents or rural inhabitants (Estacio, Charlet et al. 2012).

IV. Policy-makers lack a practical way to identify barriers

Importantly, the LA suggests that for most countries, these second tier SHP strategies such as NHHIs typically reach only a small proportion of at-risk persons, with many persons either not enrolled, unable to use benefits, or not receiving appropriate or effective services. The feedback form interviews and reviews of the literature point to the absence of a widely-accepted, or at least widely-used, method for policy planners to assess barriers to designing and implementing an effective NHHI (O'Connell 2011). There is need for a systematic approach to assessing the effectiveness of insurance schemes in addressing the range of vulnerabilities various groups face. By examining where and how existing insurance schemes are lacking, policy-makers could expand the depth, breadth and height of insurance, as well as improve alignment with other social safety nets, to close gaps in protection.

The overall findings of the LA suggest that three main categories of barriers constrain how well NHHIs contribute to UHC:

- ***Inability to enrol in schemes***: This concerns various eligibility and exclusion criteria and their role as barriers to enrolment. Obstacles to enrolment include weak birth registration systems, lack of clarity on citizenship requirements, outdated or inaccurate poverty level indexes, or insufficient funding of administrative mechanisms to ensure equitable enrolment opportunities.
- ***Inability to use the scheme when enrolled***: Once enrolled, can participants access the benefits to which they are entitled? In essence, this category assesses the public sector's capacity to deliver the defined benefits package to all eligible persons, and enforce provider compliance. Two important barriers many countries struggle to resolve are non-portability of schemes (e.g. insurance does not cover persons working away from home), and inadequate reduction of OOP health-related spending, such as transportation, co-payments, and unofficial or informal fees. No country surveyed had mechanisms for ensuring enrolled persons would receive protection against income lost to illness, or similar 'opportunity costs' of obtaining healthcare. Concerns about impoverishment often contribute to a significant level of health care avoidance (ILO 2008). A third barrier is the lack of linkages amongst various insurance plans for coordination within a broader "Social Protection Floor" (ILO 2008). A fourth potential obstacle is the exclusion of pre-existing illnesses from coverage, although there is not enough country-based data to quantify how extensive this problem is.
- ***Barriers to receiving appropriate and quality care****:* If a person is enrolled and succeeds in overcoming any barriers to receiving insurance benefits, the final question is whether that person truly receives adequate protection. In other words, is the care appropriate to the needs of each person, especially high vulnerability groups such as children and women, or families who may face health-related stigma or other forms of discrimination? Here the analysis first aims to see if the available benefit packages address the full range of health needs of each vulnerable population. A second element, equally important, is the quality of healthcare received. Even if care is appropriate, country experiences show that vulnerable populations routinely receive a lower standard of care, one that may be insufficient to reduce the incidence of death and dying.

While this paper focuses on analysing NHHI schemes, the approach to examining barriers presented here could be applicable to analysing the effectiveness of Social Health Protection mechanisms in general. The following sections explore these three barriers in more detail.

D. Challenges to removing barriers

An approach to analysing barriers

UNICEF and related research reveals that SHP strategies, such as NHHI schemes, can only reduce inequities in financial access and contribute to UHC if they are part of an inclusive and comprehensive SP framework that covers the entire population. In countries surveyed, the second tier of SHP had evolved in response to specific gaps in the existing first tier of free services, but rarely did so in a comprehensive or evidence-based manner.

In analysing the effectiveness of various approaches to achieve UHC, the World Health Report 2008 provides a useful way of thinking about progress towards universal coverage along three dimensions (World Health Organization 2008):

- **Breadth of coverage** – the proportion of the population that enjoys social health protection
- **Depth of coverage** – the essential health services necessary to address people's health needs effectively that are covered through benefits
- **Height of coverage** – the portion of health-care costs covered through pooling and pre-payment mechanisms

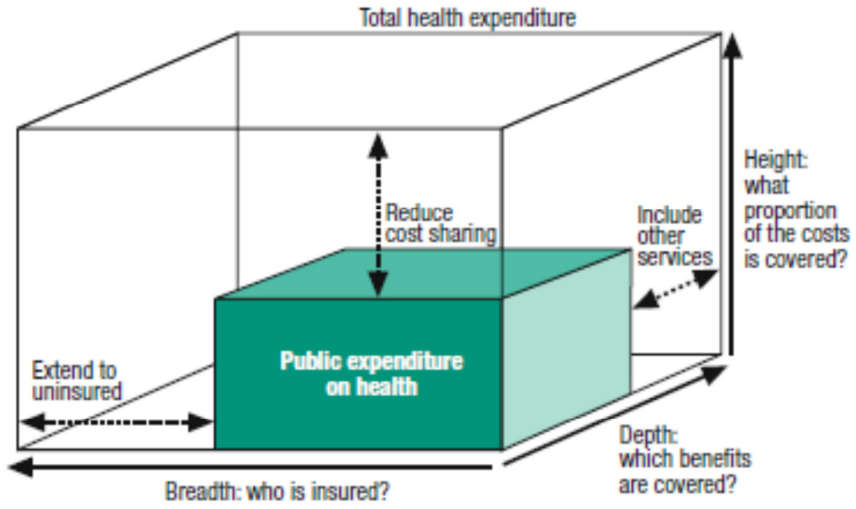

Figure 1: Progress towards UHC, from World Health Report 2008

Using this framework, it is seen that UHC is achieved not only by ensuring a comprehensive social protection system reaches 100 per cent Breadth; i.e. covering every person. Equally important is making certain that the Height (proportion of costs covered) is sufficient to eliminate financial barriers to access, and that the Depth (scope of provided benefits) is both appropriate to reduce financial vulnerability, and of sufficient quality to optimise each person's equitable opportunity to access needed services. From the policy-making point of view, there is need for a method that can identify barriers to enlarging the cube. At a minimum, it should identify weaknesses in the current set of insurance and other SHP schemes by assessing: i) inclusiveness of protection for the poor and other vulnerable groups; ii) reductions in financial and other barriers; and iii) the capacity to provide appropriate and quality care.

UNICEF research suggests this is best accomplished by taking an equity focus to diagnosing vulnerabilities and gaps in protection (UNICEF 2010). This approach begins with an analysis of the national context that leads to current patterns of inequity across various regions and population groups. Assessing disparities and understanding their underlying causes can form the basis of a coordinated approach to abolish barriers to UHC.

The analysis of findings suggests that an equity-focused diagnostic provides a practical way of assessing weaknesses in the current national insurance systems. The following section applies this approach to evaluate the three barriers outlined above: 1) barriers to enrolment; 2) barriers to use; and 3) barriers resulting from inappropriate and sub-quality health care. This provides a systematic way for government decision-makers to understand where existing NHHIs have fallen short.

1) Barriers preventing enrolment

Restrictions to enrolment stem from numerous sources, including inconsistent or incomplete policies regarding eligibility, inadequate information management systems to ensure access, and enrolment costs.

Lack of citizenship

Non-recognition as a citizen, i.e., having 'stateless' status, bars illegal immigrants, refugees, and others lacking formal proof of citizenship from accessing any social protection scheme, including health insurance. Such disenfranchised individuals and families can only access health care services for which they can pay out of pocket. A report by the *United Nations High Commissioner for Refugees* notes that only "46 per cent of new-borns in 103 refugee camps … were issued birth certificates" (UNHCR 2010). Another source notes that Vietnamese women married to foreign husbands who renounce their citizenship when moving abroad, become stateless once they return to Vietnam following a failed marriage. These women lose access to Vietnamese social

protection as well as the legal right to work, even if their foreign husband abandons them (McKinsey 2007). A similar issue influences pastoralist or nomadic populations who routinely cross national borders. Kenyan Somalis are one example, as they routinely face refusal in attempts to obtain citizenship papers. Lacking these proofs of citizenship, they are excluded from health insurance and other social safety nets, denied preventative and promotive health care, and face significantly greater risk of illness, death and health-related impoverishment (Carrin 2007; Kenya National Commission on Human Rights 2007).

Weak birth registration systems

A fundamental challenge is the effectiveness of birth registration systems to enrol poor and vulnerable groups. Obstacles include high fees, inadequacy of administrative infrastructure, overly complicated registration processes, and gender-based discrimination. There is also a pervasive problem of insufficient awareness of the requirements and benefits of registration among the poor, the functionally illiterate, and other at-risk groups. At the same time, weak information systems and poor quality data limit the potential of administrators to measure the extent of under-registration. Complicating matters further is the fact that birth registration also requires coordination across multiple line ministries and programmes, so systemic improvements are difficult to design and implement (UNICEF 2010).

In China, incomplete birth registration, common in rural and poorer areas, limits the ability of authorities to quantify or identify the target population. China's complex system involves multiple administrative steps that prevent many parents from registering their children. This makes it impossible for them to enrol in a social protection scheme, including health insurance. China is not alone in facing the challenges of sub-par birth registration rates, as the literature indicates unrecognised citizenship is a barrier to UHC in many countries in Africa and Asia (The World Bank 2010; UNESCAP 2010).

Preferential enrolment of formal and civil sector workers

The typical sequence in countries implementing NHHI is to first cover the formal sector before extending coverage to the informal sector, the poor, and the unemployed, even if actual rollout plans call for enrolling the entire population. Evidence suggests that coverage gaps are due in large part to the limited public resources budgeted towards implementation. Complicating factors include incomplete and inaccurate demographic data to ascertain actual coverage levels for various groups, and insufficient coordination of different NHHI elements to cover specific vulnerable groups, such as street children (Vietnam), migrant workers (China), and rural populations (Pakistan).

Specific NHHI benefits intended to cover the particular needs of migrants, the indigent, pregnant women, mothers, and children are often lacking. Several countries have sought to build political will for expanded coverage by establishing a timeline for the provision of full coverage to initially excluded groups. Strong political support is required in such cases to ensure adherence to the timeline and that planned coverage of vulnerable groups is not perpetually deferred. China provides a good example of such strong political will; the latest data from the Chinese government report in March 2010 indicates that its three national insurance plans cover 0.93 billion people, amounting to over 90 per cent of the total population (Barber and Yao 2010). Other countries, such as Rwanda and Vietnam, have built upon strong community-based insurance schemes to increase rapidly the breadth of coverage.

Among the countries with some form of NHHI, the vast majority reported that civil servants and the formal sector were mandatorily covered, despite traditionally being the least vulnerable segments of the population. For more vulnerable groups studied, such as women, children, and the indigent, the information collected through the phase 1 questionnaire indicated that less than half the countries have managed to extend to them any mandatory coverage, either though NHHIs or other SHPs (see Table 1 and Annex 1). Motivation for countries having succeeded in expanding coverage beyond the formal sector and civil servants appears to be an equity agenda, driven by national commitments to achieving UHC.

Table 1: Mandatory coverage by group in countries with SHI schemes (Charlet, Chapcakova et al. 2012)

Groups mandatorily covered	No. of countries	Countries
Civil servants	24	All except Angola, Benin, Cambodia
Formally employed	21	All except Benin, Burundi, Cambodia, Cameroon, Maldives, Tanzania
Informal sector	4	Ghana, Mongolia, Rwanda, Thailand
Unemployed	4	Ghana, Mongolia, Rwanda, Thailand
Pregnant women	10	Burundi, Ghana, Madagascar, Mongolia, Nigeria, Rwanda, Tanzania, Thailand, Vietnam, Zimbabwe
Mothers	6	Mongolia, Nigeria, Rwanda, Thailand, Vietnam, Zimbabwe
New born children	9	Burundi, Ghana, Madagascar, Mongolia, Rwanda, Tanzania, Thailand, Vietnam, Zimbabwe
Children 0 to 17 years old	8	Burundi, Ghana[1], Madagascar[2], Mongolia, Rwanda, Thailand, Vietnam, Zimbabwe
Poor	10	Ghana, India, Indonesia, Maldives, Mongolia, Philippines, Rwanda, Tanzania, Thailand, Vietnam

Inability to identify and enrol vulnerable groups

The most common pattern for expanding the breadth of SHP plans is to commence with enrolment of the formal and civil sector workers. This presents a challenge to effective enrolment of at-risk groups. One contributory factor is a lack of clear data and reliable measures for identifying vulnerable persons and sub-populations (Morestin, Grant et al. 2009). In India, the survey found the BPL (Below-Poverty-Line) lists, which record who is eligible for various social health protection plans, are often outdated. There, as elsewhere, lack of information to accurately describe and quantify the eligible BPL population means that it is difficult to assess regional variations in insurance coverage rates, utilization, and the impact of enrolment strategies for BPL at the household level. As a result, it can be dauntingly hard to detect areas where targeted enrolment drives could be beneficial, and close to impossible to gauge the level of actual protection insurance could offer to the BPL population (Jain, O'Connell et al. 2011).

Especially common in the countries surveyed are large informal sectors, with a significant percentage living off subsistence farming or fishing. In such cases, the inability to identify or apply reliable and accurate inclusion and exclusion criteria seems to lead to under-enrolment in plans. Countries such as Burkina Faso, India and Vietnam report that it is difficult to define enforceable guidelines on who is entitled to join various insurances. Further, given the multi-component nature of NHHIs, at the implementation level there often are differing and inconsistently applied eligibility criteria for the constituent plans. In China, each region can set its own eligibility benchmarks for the poor, with correspondingly inconsistent subsidies for poor families' insurance premiums. The Chinese government has increasingly supported research on barriers to UHC, with the result that it has identified coverage for migrant workers, along with inadequate birth registration, as a central issue to resolve if UHC is to be achieved.

Issues can also arise when a country elects to expand the breadth of coverage rapidly, while being unable to predict the feasibility of enrolment goals or what constitutes a sustainable enrolment strategy. Mass enrolment days, i.e. inviting universal enrolment on a specific date, may not be practical in poorer countries given the technical, financial and human resources required. However, some countries have used targeted enrolment windows with some success, including India, which instituted a four-month annual enrolment period in each area, and Ghana, which hosts periodic enrolment camps.

One exciting development is the growing use of 'smart' (microchip embedded) national identity cards, as in India and China, to establish eligibility and facilitate universal enrolment into insurance and other social service plans. Uganda has a plan to eventually encode the unique patient ID number provided at the time of birth into a smart card, to ensure access to all entitled social services for various at-risk groups throughout the lifecycle.

2) Barriers to accessing benefits once enrolled

In many countries, a discrepancy exists between nominal, or recorded, and real, or effective, enrolment in insurance plans. Nominal enrolment reflects the number of persons administratively registered in a given scheme, while effective enrolment signifies the portion of all enrolled persons that truly are able to access all of benefits when needed. Although surveyed countries employ a range of policies to increase enrolment of vulnerable populations, they usually rest upon the flawed assumption that enrolment equates with access.

Barriers posed by inaccurate and incomplete data

The survey found pervasive data and information deficits in most countries, greatly hindering determination of the extent to which vulnerable populations can actually use the benefits for which they are nominally eligible. The experience in India illustrates the problems with assuming that enrolment automatically translates into the ability to take advantage of benefits. Indian insurance companies receive compensation based on how many families they enrol during the four-month annual enrolment period, which incentivizes the enrolment of as many people as possible, regardless of whether or not enrolees live close to a plan-eligible service provider. As a result, due to distance and transportation costs, many enrolees cannot reasonably access authorised health providers.

All countries examined describe a similar lack of accurate data on vulnerable populations. Interviews with health administrators in countries as dissimilar as Bangladesh, India, Kenya, Mali, Nigeria, Uganda and Zimbabwe indicated a common concern that many remote and rural populations are unable to use benefits to which they are entitled.

Barriers from under-investment

In addition to addressing issues related to geographic access, ensuring sufficient investment in supplies, staff and equipment for facilities is essential. Inadequate investments in supplying public health facilities with sufficient commodities, equipment and staff are common throughout Africa and Asia. If a health system is unable to provide consistently the fully-defined benefit package to the entire population, introducing or expanding NHHI will not be effective. Recognizing this fact, many countries have undertaken initiatives to increase health system capacity to deliver defined service packages. For example, in Ghana, the Community-based Health Planning and Services program has worked to expand clinics across the country, leading more people to be closer to a point of service, and more likely to see a professional when needed.

Lack of portability

Another barrier relates to the 'portability' of benefits; that is, the right to access benefits while away from a person's home. In both China and Vietnam, household registration systems effectively tie people to their place of residence. In both countries, migrant workers who enrol into the rural component of the national insurance schemes are not entitled to protection under urban insurance plans when working in metropolitan centres. Although migrant workers enrolled in their home districts can maintain coverage for their families, individual workers effectively have no protection at their distant place of employment. Their only option is to pay out-of-pocket (OOP) for needed healthcare, as returning home for healthcare is likely too costly and time consuming, and may endanger their employment.

The problem is significant; in China alone there are over 100 million migrant workers, with the majority lacking insurance coverage. Recent changes have loosened some restrictions to permit migrant workers to enrol outside of their home district, though this typically requires paying for dual coverage.[vi] However, Chinese migrants, like those in many other countries, are often 'undeclared' workers. It is common practice for employers not to register them as formal employees in order to avoid having to contribute the employer portion of insurance

[vi] The migrant worker could take an individual policy for coverage at the place of employment, while the family is covered under another plan purchased in the community where worker resides. However, a review of literature for the LA suggests that few migrants are willing or able to pay for dual coverage.

premiums, thereby leaving workers unprotected. China, as with several countries, have or are beginning to enact policies to increase portability by waiving regional limitations on accessing insurance benefits. Unfortunately, little data yet exists to assess the impact these revisions have had (Estacio, Charlet et al. 2012).

Financial barriers

Evidence collected during this LA suggests that a persistent barrier to UHC is an over-reliance on private financing of health interventions, primarily through OOP payments for services. OOP payments can impoverish families, reduce the amount of services they can receive, or even lead them to avoid seeking needed care altogether (Kruk, Goldmann et al. 2009; Gustafsson-Wright, Janssens et al. 2011; Minh and Ngyen 2011) The removal of financial and other barriers to access is requisite to achieving UHC, the health-related MDGs and other pro-poor social outcomes. Fortunately, most governments are responding to this challenge with a range of solutions, from health insurance to other approaches, all in an effort to remove financial barriers to UHC.

A typology of user fees

User fees are a form of health system financing; they are charges levied for healthcare at the point of use that shift some of the costs of services to those receiving care. Proponents of user fees had hoped for improved quality and better service provision, though opponents cite mounting evidence of increased exclusion of the most vulnerable and most at-risk population groups in virtually every country instituting user fees. However, user fee abolition must be part of a coherent approach that replaces revenues lost by providers with tax-based financing, to ensure all appropriate services are delivered (Ridde 2011). It is therefore important to analyse types of user fees, as the choice of strategies to reduce financial barriers will depend on the kinds of fee faced by each vulnerable group. It is useful to think of three broad categories of user fees:

Formal fees: Official tariffs set by the government for specific services rendered, such as fees for caesarean sections and other in-patient services; fees for treatments, consultations and medicines provided in out-patient services; and fees for services rendered in communities, such as spraying the walls of family dwellings with insecticide to exterminate mosquitos that transmit malaria. Social protection mechanisms such as insurance, cash transfers, or fee waivers can address barriers to access imposed by formal fees. Additionally, there are ranges of fees that vary from unofficial, but legal, fees, to 'informal' and largely unsanctioned fees. While the two types often co-exist, they have different underlying causes; therefore, the removal of bottlenecks caused by their presence typically requires quite different strategies.

Unofficial fees: Fees users pay for supplies and commodities that are out of stock at the public health facility from which they seek care. For instance, in remote, rural areas in Burkina Faso, Uganda and Nepal, patients must purchase gloves, bandages and medicines from private sector providers in order to obtain treatment at 'free' public facilities. These end-user expenses fill the gap caused by insufficient government spending for supplies and equipment for public services. In theory, full funding of all needed supplies and commodities would end such out-of-pocket expenses by health service clients.

Informal fees: Additional fees charged at the point of service provision by health staff with the primary aim of supplementing their income. These fees are more difficult to manage, as they require a combination of improved governance (enforcement of user fee waivers, pro-poor subsidies and social protection schemes), plus improved motivation and incentives for public health care providers (e.g., higher wages, other non-wage incentives or some mix). Community-based oversight, for example clients using SMS texting to report instances where they are charged informal or unofficial fees, is another potential strategy that could help to reduce these fees.

However, financial barriers from a multitude of causes continue to curtail access to healthcare even in countries with NHHI schemes. Although insurance premiums are commonly indexed to income, these fees still pose a significant barrier to poorer households in several countries.

A related concern is the various forms of user fees (see box above) not covered by NHHIs or other SHP mechanisms. Co-payments at the time of service are common among schemes; in Rwanda, such payments were found to pose a significant barrier to service access (Dhillon, Bonds et al. 2011). Another factor is the height of coverage, typically much less than 100 per cent, indicating that significant barriers in the forms of additional necessary OOP spending, may persist even where NHHIs have been implemented (Jain, O'Connell et al. 2011).

A third issue is reimbursement schemes, which require upfront payment of healthcare costs with repayment occurring later, and often with a significant delay. In the instance of insurance coverage for rural residents in China, final OOP payments, *after* all reimbursements, were equal to over half of annual per capita income for 2009. The Chinese government has highlighted this as an area for action and has recently enacted reforms to eliminate most OOP spending by shifting reimbursement for costs of services from patients to service providers, limiting OOP spending to a small co-payment and expanding low-income waivers of co-payments to the near-poor. Important to the success of this initiative will be the degree to which medical officers in Chinese health facilities enforce the new regulations on payments. Although data is not yet available to quantify the impact of the reduced OOP fees, interviews conducted during the development of this project's case study on China indicates access for the poor is increasing (Meng 2011).

Fourth, temporary or permanent loss of income due to illness can be catastrophic and push families deep into poverty, in particular seasonal workers, small-plot farmers, and informal workers. NHHIs generally focus only on financial protection from the direct costs of illness. Although rife with difficulty, it is essential to explore coverage of lost wages as part of a comprehensive social protection approach to removing financial barriers to UHC. Survey evidence appears to indicate that no NHHI offers protection against lost income due to illness, either as a benefit or via a link to an anti-poverty cash transfer scheme. Several countries have social security plans, though these are uniformly limited to subsets of civil sector and formal sector workers. One example is Myanmar's social security scheme, which provides covered workers with cash benefits for employment injury, temporary and permanent disability, maternity leave, and for loss of income due to other reasons. No country reported a scheme for reimbursing lost wages from death or disability to informal workers or subsistence farmers themselves, or their families.

3) Barriers to appropriate and quality Universal Health Coverage

Lack of adequate data and analysis on patterns of inequities

A critical barrier in designing evidence-based benefit packages is the absence of data on the causes underlying why certain groups suffer disproportionately higher rates of illness and preventable illness. The need clearly exists for coverage of sufficient depth to prevent and eliminate dissimilar causes of illness and burden of death profiles between differing vulnerable groups. Countries with NHHIs rarely define their benefit packages on explicit equity criteria, or on an analysis of differences in vulnerabilities across various at-risk groups. Defining an ideal package of covered interventions for each endangered group remains challenging due to the limited nature of research on health outcomes related to the breadth and depth of insurance. Outside of China, Ghana and Rwanda, the survey identified few countries that had used local research to define benefit packages.

UNICEF promotes enhanced monitoring of barriers to equity at the country level, and supports efforts to assess systematically specific vulnerabilities of various at-risk groups. The organization has a long-term commitment to work with governments to put into place information and management systems that expose patterns of inequity and their causes, and which will inform national plans to reach UHC.

Lack of incentives for preventative and primary care

A number of existing benefit packages, such as those in Rwanda and Ghana, are extremely comprehensive and include emphasis on preventative care. However, many other countries limit insurance coverage to certain types of services or care. In India, for example, only inpatient care is covered under RSBY, although health authorities are exploring possibly increasing the depth of coverage to include outpatient services. Even the typically-

covered preventive interventions, such as antenatal care visits, only reduce direct fees, and fail to compensate patients for indirect costs.

Provider reimbursement arrangements also can distort healthcare choices. In China, the government regulates the prices of most health services, with payments for many preventative services set at a level that is below their cost, including general examinations and treatments, hospital bed and board, and out-patient surgical operations (Herd, Hu et al. 2010). By comparison, the reimbursement level for costly diagnostics, such as computed tomography (CT) scans, is higher than its cost, therefore making such procedures profitable. This system skews the delivery of services away from primary and preventative care in favour of more expensive, high-tech examinations and procedures. In order to maximize profits, hospitals attract investors to purchase high-tech equipment, and then incentivize staff to shift their service-delivery practices towards more profitable procedures and examinations.

Ultimately, this type of price structure leads to over-investment in building up service capacity of tertiary, rather than primary, health care services. Such "perverse incentives" decrease the cost-effectiveness of health care, as reimbursement rules incentivise providers to prescribe in-patient and curative treatments rather than low cost outpatient interventions, including promotive and preventative care.

Barriers to receiving care of sufficient quality

Ensuring universal access to appropriate health care is critical for reaching the goal of equitable health outcomes. While indispensable, access is not sufficient. Numerous researchers and public health experts over the years have noted that coverage of interventions has to be of sufficient quality to be effective, that is, to reduce substantively the rates of preventable illness and death. The "effective coverage" of an intervention is the specific type and quality of coverage associated with a measurable reduction of illness or death, validated by peer-reviewed research. [vii] The package of insurance benefits needs to have suitable breadth, depth and height to achieve quality coverage. Only this can lead to real improvements in equity as well as overall health outcomes (Pariyo 2008). In effect, the ability of the health systems to deliver quality coverage measures progress in health system performance at local, district and national levels to achieve UHC.

Weak national and sub-national governance

NHHI plans frequently lack adequate supervision and oversight of their implementation, particularly in regards to addressing barriers. An example is the absence in many countries of a Quality Assurance mechanism to investigate if appropriate care actually reaches the population. Few countries participating in the survey have functional regulatory bodies, or strong oversight mechanisms able to ensure attention to treatment guidelines and standards. Rwanda is one of few countries to have set up a "Health Insurance Council" to assure that the national health insurance plan achieves UHC of adequate quality to increase the level and equity of health outcomes for the entire population (Republic of Rwanda 2010).

Vietnam provides another example of a high-level political commitment to improving the inclusiveness of social health protection plans. Figure 2 below presents the successive policies having influenced enrolment in health insurance since 1992. Strong governmental support allowed the passing of the Vietnam Law on Health Insurance in 2009, under which all children under six years old and all near-poor people were compulsorily covered by health insurance. The law also provided for the enrolment of students and pupils from January 1, 2010; farmers and workers in the agriculture, forestry, fishery and salt production sectors as of January 1, 2012; and all remaining population groups as of January 1, 2014 (Ha 2011)[viii].

[vii] Evidence on impact is derived from various sources such as the CHERG *Lancet* series articles and other rigorously peer-reviewed research. CHERG (Child Health Epidemiology Reference Group) works under World Health Organization and UNICEF guidance to develop the methodologies and processes such that the total burden of childhood mortality and causes of death can be estimated and published annually.

[viii] Meritorious persons are those awarded by the government of Vietnam for notable contributions to national development and solidarity.

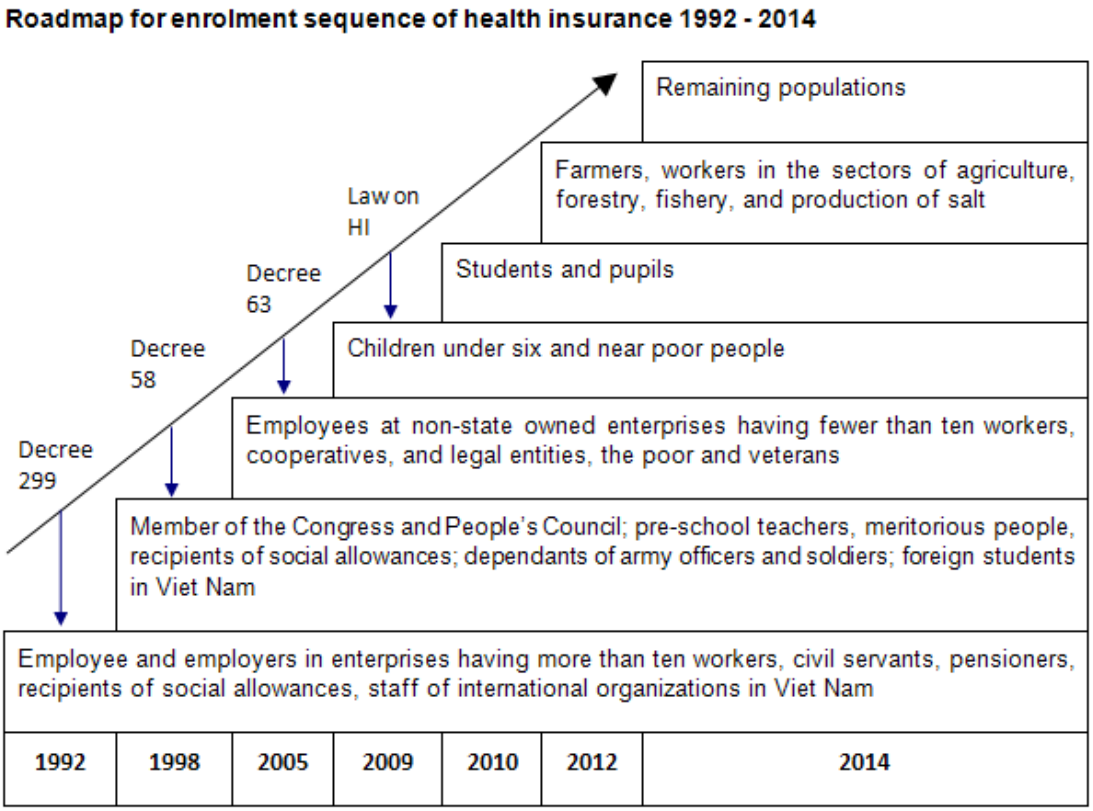

Figure 2: Progressive inclusiveness of Vietnam's Social Protection System

Adapted from Ha, D.A. *Social Health Insurance in Vietnam, Final Version* 2011, UNICEF Vietnam: New York.

E. Discussion

The goal of UHC is to provide equitable opportunity for people to fulfil their essential right to achieve the highest possible standard of health. Many countries consider health insurance to be a useful component of social protection policies designed to achieve UHC. However, there is need for caution against taking a too narrow focus on health insurance as the sole means for reducing financial risk, and as the lynchpin for achieving UHC. Ridde and Haddad (2009) note that protection against household impoverishment, catalysing more equitable distribution of social welfare benefits across society, and complementary effects to education and other welfare measures from health maintenance are all equally valuable outcomes. Noting that "protecting families against catastrophic health care costs and removing financial barriers to health care should be a health system priority", they warn that health insurance is not a panacea: its design must be suitable and effective according to national context (Ridde and Haddad 2009). As with other SHP mechanisms, insurance needs to link with other methods for reduce household and individual vulnerabilities to the costs of accessing healthcare.

The full Landscape Analysis[ix] hints that an increasing number of countries are looking at other causes of health vulnerability, such as gender, HIV status, ethnicity and other factors, and seeking to identify ways to build a social protection floor that removes all barriers to UHC and other social welfare targets. Many sources report governments in Africa and Asia increasingly see the need for a comprehensive social protection framework to complement and optimise the impact of insurance, such as ensuring some replacement of income lost due to disability, illness or death (Social Protection Working Group 2010; UNICEF 2010). Countries are increasingly

[ix] The complete reports form Phase 1 and Phase 2, as well as the nine country case studies, can be obtained from UNICEF by contacting toconnell@unicef.org .

looking for clear guidance and policy options for building systems comprehensive enough to reduce health-related impoverishment and inequities, but that are fiscally feasible. While most countries are addressing some barriers described in this report, almost none are doing it in a systematic way. The approach to analysing barriers, described above, offers a practical way for government, civil society and development partners to identify and resolve constraints to UHC.

Countries are also seeking practical models to assist them in improving coordination and harmonization of enrolment and eligibility criteria across all tiers. A challenge has been to expand access to the minimal first tier of free health services in a coordinated and rationale manner, especially for formerly under-served populations, and then to ensure that the entire population is enrolled in insurance and other second tier schemes. Adapting the WHO model presented earlier, Figure 3, below, represents the movement towards achieving UHC by expanding the second tier of social health protection. Where a well-functioning NHHI is the primary mechanism of the second tier (dark shaded box) then the portion of total UHC – breadth, depth, and height – that is attributable to NHHI will be high (Figure 3a). In countries still developing a NHHI, or where they limit enrolment to the formal and civil sectors, or use other SHPs, insurance will contribute a smaller proportion of UHC achieved (Figure 3b).

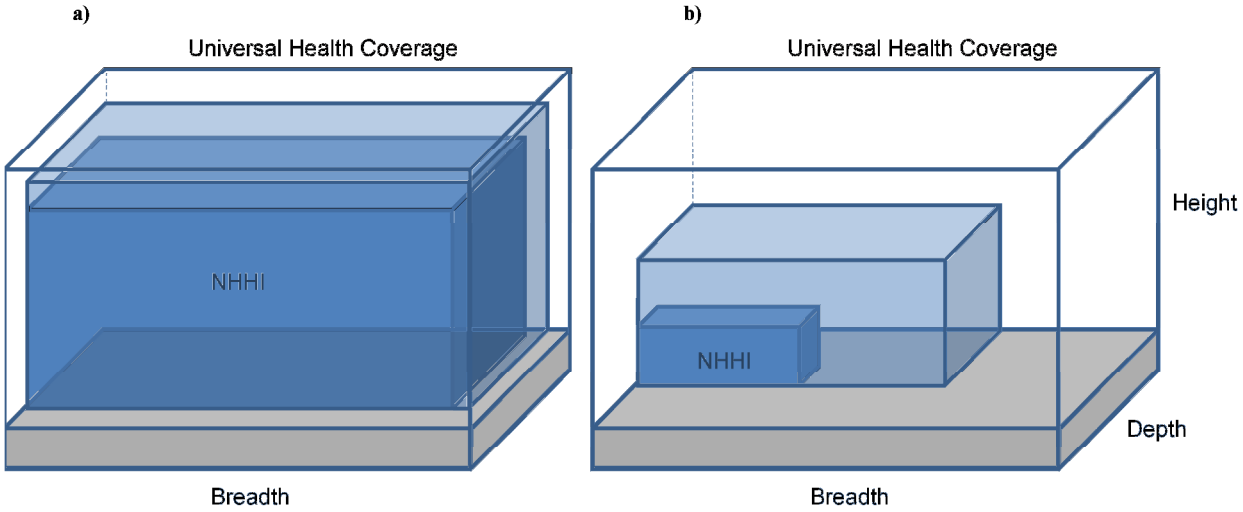

Figure 3: Contribution of NHHI to Universal HealthCare Coverage. Adapted from Danielle Charlet

In Uganda, the proposed National Health Insurance seeks to align a wide array of community, private and civil sector insurance schemes, to ensure universal insurance coverage as the foundation for UHC. In China, research continues to explore how to best integrate its three major schemes, which cover the entire population, into a single administrative framework. Vietnam, Rwanda and Ghana also aim to achieve UHC by rationalising eligibility criteria and integrating diverse health protection plans, including insurance, into a single policy framework.

In removing barriers to access, it will be important to exploit opportunities to integrate birth registration with other public services. In general, improved birth registration systems could form the basis of enhanced social protection schemes in which insurance and other financial safety nets are linked together to maximize efficiency and coverage for vulnerable populations, households, and individuals. Several countries, such as India, China and Pakistan, have successfully piloted simplifying registration requirements and procedures to overcome common barriers and increase birth registration rates. Other countries should explore linkages between birth registration and NHHI enrolment. For instance, Uganda is piloting a SMS (short message service) mobile phone initiative (mTrac) to assign a unique patient ID number to every person who coming into contact with the health system. Eventually, reporting and registering of all facility- and home-based births can use the same SMS system. This solution can increase birth registration rates as well as help capture trends in family healthcare behaviours, thus contributing to identification and removal of barriers to full benefits of insurance coverage.

Using the approach outlined here to assessing barriers will assist governments to identify upstream and downstream factors behind major barriers. For instance, while the design of birth registration enrolment strategies resides largely outside the health ministry in most countries, enforcement is primarily the responsibility of chief medical officers who manage facilities or other staff, such as skilled birth attendants, who actually register new-borns. Since health staff play a vital role in helping mothers to understand the necessity of birth registration as a prerequisite to insurance coverage and other social benefits, regulations governing and systems enforcing staff incentives need to be aligned so as to support UHC targets for insurance enrolment, use, and receipt of appropriate and quality care. This includes sensitizing and rewarding managers who overcome barriers faced by vulnerable groups. Another example is in Uganda, where UNICEF is working to link equity-focused management strengthening of districts with high disease burden, to the rollout of the National Health Insurance strategy. This will permit assessment of how well the prosed diagnostic can evaluate and catalyse action to overcome sub-national barriers to enrolment, use and access to quality healthcare.

Barriers to use have multiple aspects, and again require a well-coordinated inter-sectoral response. Very few countries have enrolled much of their population in a NHHI, as have China, Rwanda and Ghana. Others have removed most formal user fees for health services, including Sierra Leone and Uganda. In both cases, despite notable gains in initial access, the analysis of data from both LA phases finds indirect costs and hidden fees can still lead to high OOP spending to access health interventions. The consequence is that financial constraints remain a tenacious obstacle to extending UHC to the poor. Nevertheless, success stories are emerging from several countries, notably China, Rwanda, Thailand and Vietnam. Many countries are motivated by the ideals of Social Health Insurance as a means for achieving UHC. They have reduced higher out-of-pocket payments for services through a combination of insurance coverage, user fee waivers and cash transfers to cover indirect fees. All 27 countries with, or planning, national health insurance plans are linking contribution levels to income, with waivers of premiums for the poor and indigent. Despite challenges, these countries and others have made real strides towards using interconnected social protection approaches to achieve UHC. Especially impressive is the instance of China. Its progressive rollout of three insurance plans has achieved enrolment of almost 95 per cent of the registered population since 2008.

The match between care provided and the needs of the client, especially the quality of that care, lags far behind efforts to improve access to services. While there are reports of several examples of increased utilization of health services resulting from the introduction or expansion of NHHI schemes (Ministry of Health Ghana 2010; Ha 2011), questions remain about whether or not this increase represents a true improvement in access for poor or marginalized populations (Saksena 2010; Wagstaff 2010). Additionally, little robust data is available to evaluate efforts to address effective barriers to use, what barriers continue to limit use, and the extent to which they do so. Some encouraging examples exist; India in particular has introduced several measures through its RSBY[x] insurance scheme for the very poor to address barriers to full access to all covered benefits. Important elements include the use of smart cards to increase portability, the removal of co-payments, direct payment of transportation costs to the user upon discharge from accredited health facilities, and rapid scaling up of facility accreditation.

Experiences in Uganda, China, Rwanda, and Thailand also illustrate the critical importance of coordination across SHP programmes, and of placing health insurance rationally into a broader social protection framework. Enhanced coordination could not only speed up the pace to UHC, it could help reverse the widening gaps in health outcomes found in most countries (WHO Western Pacific Region 2009; UNICEF 2010; Gwatkin 2011). Solutions need to be pursued at all administrative levels. District health managers must ensure that facilities provide covered benefits without charging additional fees. On a national scale, there is need for substantial political will, better coordination across various types of social protection schemes, and technical support to design more comprehensive plans that address inequities in disease burden, if financial barriers are to be eliminated.

[x] Rashtriya Swasthya Bima Yojana (an Indian health insurance scheme for the very poor, called “Below Poverty Line" or BPL families).

One major challenge is the current paucity of good data on the full range of access barriers faced by different groups, as well as information on effective practices to address the varying vulnerabilities of each group. Barriers to insurance schemes seem pervasive, yet the principal investigators simply lack the data in most cases to quantify the extent of exclusion to enrolment in plans, access to full benefits even if successfully enrolled, or the appropriateness and quality of care obtained under such schemes. Estimates for China indicate that up to 12 million children in 2000 alone were excluded from birth registration and thus lose their right to access health insurance and virtually all other social safety nets, including subsidised support for schooling (Estacio, Charlet et al. 2012).

A pressing need is for operational research on financing options for health systems that succeed in eliminating OOP payments as a barrier to access. Increased access does not appear to lead consistently to an improvement in health outcomes (Ridde and Haddad 2009; Liu, Ye et al. 2010). One step is to examine how current efforts to promote an equity-focus for results-based national health planning links coherently to results-based health financing. Without overcoming the pervasive disconnect between planning and budgeting, there may be efficient expenditure of funds, but on the wrong priorities. A common example is overspending on curative care instead of preventative services (Russell 2004). Conversely, social protection policies that fail to account for ensuring sufficient revenue streams to providers have been shown to lead to minimal improvements in either access to services or reduction of OOP payments (Opwora, Kabare et al. 2010).

As removal of barriers to access and extension of social protection begin, there will be need for research to generate policy guidance on how to maintain quality and appropriateness of care. Also needed will be more downstream support for collecting and analysing accurate data on exclusion of all vulnerable groups, coupled with upstream actions to track resolution of barriers to UHC against changes in health outcomes for all at-risk groups. UNICEF, through its new Social Protection Framework, will support and catalyse operational research in removing exposure to vulnerabilities, especially those faced by children and their caregivers.

F. Advancing towards UHC

UHC is achievable, but requires a comprehensive system of social protection, including policies to remove financial, social and other barriers that prevent individuals from accessing health care services they are entitled to receive. Health insurance is an important element of Social Health Protection systems, and can play an important role in achieving UHC. In Africa and Asia, existing health insurance plans are 'hybrids', or mixes of various types of insurance models. To assess weaknesses in social health protection systems in decentralized settings, policymakers can use an approach to i) assess barriers to enrolling in SHP schemes, ii) consider the ability of participants to truly receive covered benefits, and iii) examine the appropriateness and quality of care they receive. These measures can greatly enhance efforts toward the goal of UHC with equity.

While addressing demand and supply side factors will be important (Jacobs, Ir et al. 2011), a social protection framework to facilitate coordination across multiple ministries is required. In addition to removing financial barriers, replacing a portion of lost wages, and ending illness-based discrimination are just some of the various enabling factors needed to achieve UHC. Beyond ensuring technical feasibility, countries successful in moving towards UHC have managed to create a political commitment to achieving equity in healthcare access and coverage. China, Ghana, Rwanda, Vietnam are all good examples of how political will drove greatly expanded social protection programmes.

The findings of the LA, and the proposed classification system, is informing other areas of policy work by UNICEF, such as the development of a Social Protection Framework and the advancement of an equity-focused agenda. UNICEF has joined with other partners to have an in-depth dialogue on issues of equity and the promotion of policies to reach the "lower quintiles" and the most vulnerable. This is in line with UNICEF's traditional concern for the poorest countries and all, but especially the most vulnerable, children in all countries. UNICEF is incorporating the findings in this study in its efforts to advocate for and support equity-based health policy implementation.

For instance, UNICEF is rolling out an organization-wide initiative to accelerate the development and enactment of a health system diagnostic to improve district-level delivery of effective coverage of maternal, neonatal, and child health interventions. One component of this approach is a four-step approach to strengthen sub-national performance and accountability for equitable results, termed District Health System Strengthening (DHSS). The aim is to identify sub-populations not being reached, and address the specific bottlenecks they face in accessing proven life-saving interventions. This enables sub-national managers to assess the root causes of bottlenecks, and to prioritize and implement feasible solutions through annual plans which all stakeholders then monitor in real-time to evaluate results obtained, especially for the poor and marginalized. The focus is on groups and areas consistently unreached by services, and thus exposed to much greater risk of impoverishment and inequitable health outcomes. The approach will use the findings of this LA to help sub-national managers more systematically assess demand-side barriers, analyse the effectiveness of insurance and other SHPs, and develop locally appropriate solutions that contribute to UHC.

Empowering communities to oversee and provide feedback on health services, using innovative mHealth technologies for persons to report on quality and access, is being investigated in Uganda and other countries to spark mutual accountability of Civil Society and government to attaining UHC. A comprehensive approach, which builds on existing social safety nets with the aim to getting to scale, is part of long-term UNICEF commitment to achieve UHC. Likewise, UNICEF is building alliances with several partners to strengthen efficiency and coordination of implementation through identification and removal of supply and demand side barriers to UHC.

Universal Healthcare Coverage with equity is necessary to meeting and surpassing the Millennium Development Goals. The work of UNICEF will champion efforts to reduce barriers that obstruct the ability of countries to achieve UHC. This study has made an essential contribution toward translating research knowledge and country experiences into political action to protect the health of all vulnerable persons, but most particularly women and children.

Annex 1: Phase 1 results – Policies targeting special groups in countries with NHHI schemes

Population group	Country	Scheme in place
Poor	-Ghana (indigents), Maldives, Mongolia, Rwanda, Vietnam -Cambodia, Laos -India (poor below poverty line) -Indonesia (poor and near poor) -Madagascar (extreme poor) -Philippines -Senegal, Tanzania -Thailand -Zimbabwe (very poor)	-SHI national scheme -Health Equity Funds -National RSBY scheme, State level schemes -JAMKESMAS scheme -FANOME – Equity Fund -SHI – PhilHealth "Sponsored Program" -Fee waivers and exemption scheme -SHI - Universal Coverage Scheme -SHI – Assisted Medical Health scheme
Women	-Caesarean section: Benin, Mali -All deliveries: Senegal -Pregnant women: Ghana, Tanzania -India, Kenya (pilots) -Nigeria -Tanzania	-Fee waivers -Fee waivers -Fee waivers (covered under NHIS) -Reproductive health vouchers, RSBY Scheme -Debt relief pilot project in 6 states (Gombe, Sokoto, Niger, Oyo, Baylesa, Imo) -Fee waivers
Children	Under 5 years of age: Ghana, Mali, Tanzania, Zimbabwe Nigeria India, Senegal	 -Fee waivers -Debt relief pilot project in 6 states -Fee waivers
TB patients	Madagascar Benin, Burundi, Cambodia, Cameroon, Côte d'Ivoire, India, Laos, Senegal, Tanzania, Vietnam, Zimbabwe	-Fee waivers (Global Fund) -Fee waivers
HIV/AIDS patients	-Madagascar -Benin, Burundi, Cambodia, Cameroon (only children), Côte d'Ivoire, India, Laos, Senegal, Tanzania, Vietnam, Zimbabwe	-Fee waivers (Global Fund) -Fee waivers
Others: Elderly Unemployed Special packages[xi] Malaria & diseases of public health interest	 -Tanzania, Madagascar (but reaches only 10% of target population), Mali -India -Philippines -Senegal	 -Fee waivers -Fee waivers -SHI – PhilHealth -Fee waivers

(Source: compiled by C. Knepper and D. Charlet, 2011 from phase 1 questionnaires and the literature reviews from phase 1 and 2)

[xi] Up to the 4th normal delivery, newborn care package, TB treatment through DOTS, SARS and Avian Influenza Package, Influenza A package, Cataract package and Voluntary Surgical Contraception Procedures.

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