DELIVERING UNIVERSAL HEALTH COVERAGE
A GUIDE FOR POLICYMAKERS

Report of the WISH Universal Health Coverage Forum 2015

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FOREWORD

Universal Health Coverage (UHC) is an idea whose time has come. Over 1 billion people worldwide still lack access to basic healthcare. In response to this challenge, the United Nations General Assembly passed a resolution unanimously in December 2012. It called on all countries to plan or pursue the transition of their health systems toward universal coverage.[1] More recently, governments, the World Bank, the World Health Organization (WHO) and civil society organizations have been calling for UHC to be included in a post-2015 global sustainable development goal.[2]

UHC is a simple idea. WHO defines its goal as: "To ensure that all people obtain the health services they need without suffering financial hardship when paying for them."[3] According to the WHO Director-General, UHC is the single most powerful concept that public health has to offer.[4] The President of the World Bank has gone on record to say: "We must be the generation that delivers Universal Health Coverage".[5]

This consensus has arisen as a mounting body of evidence shows that UHC can deliver significant benefits: for individuals, in terms of access to health services and protection from financial ruin caused by ill health; for countries as a whole, in terms of population health and contribution to economic growth; and for the politicians who successfully lead its introduction.

However, designing and implementing an approach to achieving UHC is an extremely difficult endeavor. Policymakers must make complex trade-offs, overcome many practical challenges and secure strong, sustained political commitment from the very top of governments.

This paper aims to synthesize the research evidence on UHC and present policy recommendations in an accessible way to politicians and policymakers who might not have a technical background in health. In doing so, we hope to make our contribution to improving the condition of people across the world who still lack access to quality healthcare services.

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EXECUTIVE SUMMARY

This review summarizes the evidence around some of the critical policy choices and issues related to UHC and addresses:

- What to cover: The choices and trade-offs policymakers need to make between the dimensions of population coverage, service coverage and financial protection.
- How to pay for UHC: Raising the necessary resources, then allocating and managing these resources efficiently and equitably.
- How to implement UHC: The issues that need to be addressed to implement UHC reforms successfully.

In many instances, specific policy recommendations in these areas will be highly dependent on the context of the country concerned. In particular, the health needs of the population, the level of economic development and the country's political environment should be major factors shaping policy responses. Designing and implementing a UHC strategy should therefore not be seen as a one-size-fits-all process.

However, in reviewing the research evidence and drawing on the experiences of the WISH forum of experts who advised on this paper, we have identified some strategic issues where a consensus is emerging on approaches that are more likely to be effective. Our key policy recommendations include:

- Countries should give a high priority to achieving full population coverage of an affordable package of services, rather than covering selected population groups with more generous packages of services and leaving some people relatively uncovered.
- UHC can only be achieved through publicly governed, mandatory financing mechanisms (general taxation and social health insurance contributions) that compel wealthier and healthier members of society to subsidize the poor and the vulnerable. Financing systems dominated by private voluntary financing (user fees and private voluntary insurance) will never achieve UHC.
- The transition towards UHC, in redistributing health benefits and financial burdens, is a highly political process that is likely to face opposition from powerful interest groups. Sustained political commitment from the highest level of government, including the head of state, is therefore essential in implementing successful UHC reforms.

In recent months, a wide range of organizations has endorsed the evidence for these recommendations, including WHO, the World Bank, the Lancet Commission, the UN Sustainable Development Solutions Network, and the Royal Institute of International Affairs (Chatham House).

It is hoped that this concise paper, targeted at policymakers, will make an important contribution to the debate on UHC and whether this goal should be incorporated into a sustainable development goal for health in the post-2015 era.

INTRODUCTION

The case for Universal Health Coverage

Policymakers and political leaders face tough choices and trade-offs when considering where to allocate the limited resources at their disposal. Competing priorities make such decisions very hard, and political dynamics often have a bigger role in determining the answers than evidence-based evaluations of value for money. In this opening chapter we seek to make briefly the case for investment in UHC.

The benefits of investing in health are significant and not limited to improving the health of the population: there can be significant economic returns and social benefits. A recent report by the Lancet Commission on Investing in Health[6] lays out the channels by which health improvements have a direct impact on GDP: productivity (healthy people are more productive and less likely to take sick days); education (healthier children are more likely to go to school); investment (people are more likely to save when life expectancy is longer); access to natural resources (can be affected positively by a reduced risk from endemic diseases); demographics (temporary impact on ratio of working-age to dependent people). It showed that reductions in mortality accounted for about 11 percent of recent economic growth in low- and middle-income countries, or even 24 percent of growth if the value of added life years is used to calculate a country's 'full income'.

While the case for investment in health is clear, it is less straightforward to determine whether investments in health are more beneficial than those in areas such as education or infrastructure. Also, the strength of the case for investing in health varies among countries. The return on investment is likely to be highest for emerging economies: they can obtain significant improvements in health outcomes (eg life expectancy) through modest increases in health expenditure. However, higher-income countries might already be at a level of expenditure where the marginal return, in economic and health terms, for increased investment would be relatively small.[7]

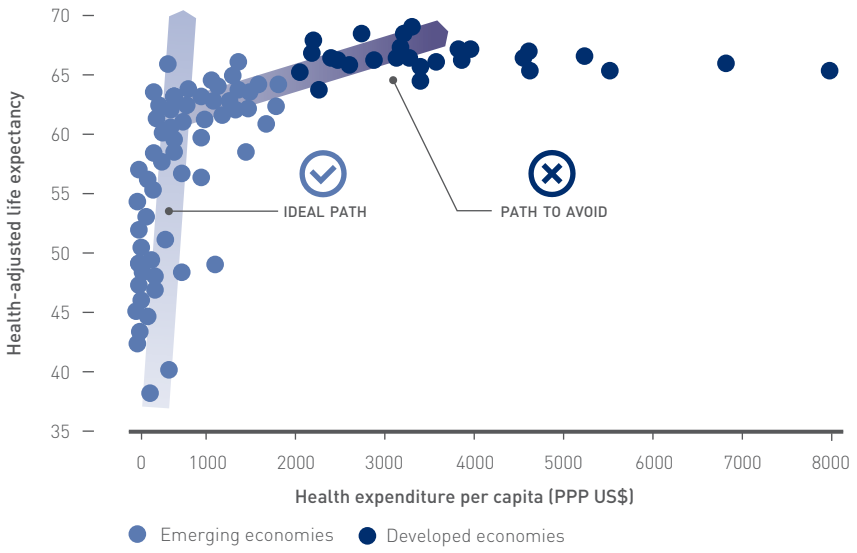
Where policymakers have decided to make transformative investments in health, there are further choices to be made, such as how to allocate resources between improving health services and addressing the social determinants of health. Improving water quality and sanitation, or funding girls' education, may be as effective at improving health outcomes as spending on health services. However, given that strengthening health systems is vital to improving health outcomes, UHC is a highly effective way for countries to deliver significant health, economic and political benefits:

- **Health:** There is now significant evidence that UHC brings health improvements to the population of countries that implement it. Researchers using data from 153 countries concluded in *The Lancet* that "broader health coverage generally leads to better access to necessary care and improved population health, with the largest gains accruing to poorer people".[8] A recent review study[9] found that

UHC reforms have been a powerful driver for improving women's health in a number of low- and middle-income countries including Afghanistan, Mexico, Rwanda and Thailand.

- **Economic:** Apart from delivering the aforementioned economic benefits deriving from improved health, UHC can be an effective policy to reduce inequalities and poverty levels. The financial protection it provides can have further beneficial effects, for example helping reduce excessively high savings rates in families concerned about unpredictable healthcare costs – as has been the case in China.[10] UHC systems can help generate and support significant employment in the health and life sciences sectors.[11]
- **Political:** The debate around the Affordable Care Act in the United States shows that the politics of UHC can be highly controversial. However, introducing UHC in a country with limited healthcare coverage for the majority of the population can provide significant benefits for politicians. The most recent example of this has been President Joko Widodo (Jokowi) of Indonesia, whose focus on improving healthcare coverage has been an important driver in his political rise from city mayor, to Governor of Jakarta, to head of state.[12] Politicians have also recognized the power of UHC to maintain social order and reduce the scope for conflict. Reporting on the decision of the Chinese Government to launch massive public health reforms in 2009, the then Minister of Health Chen Zhu said that the government's primary motivation was to ensure "a harmonious society".[13]

Figure 1: Health systems in emerging economies need to avoid the path of health systems in developed economies (Illustrative)



Year: 2010.
Source: Adapted from *Health Systems Leapfrogging in Emerging Economies*, World Economic Forum, January 2014

Aims

This report is aimed primarily at policymakers in countries that would benefit most from UHC and that are either planning (for example India and South Africa) or implementing (for example Indonesia and Ghana) UHC reforms. However, the lessons can also have relevance for countries that have already achieved high levels of coverage, as well as those that are just beginning their journey. For the former, the report may be helpful in considering actions to ensure the long-term sustainability of their system in the face of demographic and economic pressures. For the latter, it provides a guide to building a solid foundation for UHC and planning a strategy for when the economic and social prerequisites for it are in place.

Pursuing UHC is a complex, costly and politically sensitive process, often driven by politicians at the head-of-state level, rather than solely by ministers of health. This report will therefore aim to be accessible for an audience of policymakers and stakeholders with a non-health background. Many publications have analyzed technical issues related to UHC.[14] We aim to synthesize the evidence into a coherent framework, providing a comprehensive but accessible summary.

The report will first address the design choices and trade-offs between coverage of population, coverage of services and quality. It will then discuss issues relating to health financing and paying for services, and finally it will explore the main challenges related to implementation of UHC reforms.

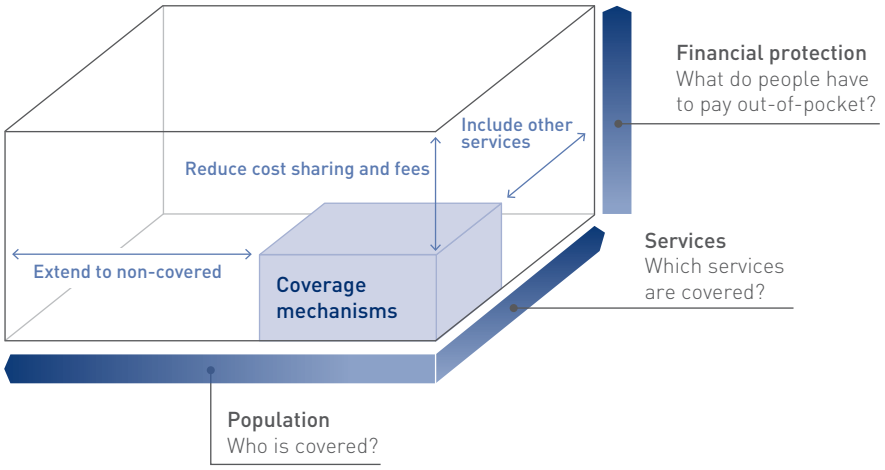
Methodology

No country has reached a perfect state of UHC where literally every person receives every health service they need, without suffering any financial hardship. Rather than trying to reach this utopian destination, countries should regard their health reforms as an ongoing journey in which they aim to make continuous progress towards universal coverage.

One of the most helpful ways to conceptualize the strategic choices facing governments as they undertake this journey is the policy box used by WHO in the World Health Report of 2010[15] (see Figure 2). This diagram proposes that governments plan their UHC strategies taking into account three key policy questions:

- Who in the population is covered?
- What services are they covered by – and at what level of quality?
- What level of financial protection do citizens have when accessing services?

Figure 2: Planning for UHC



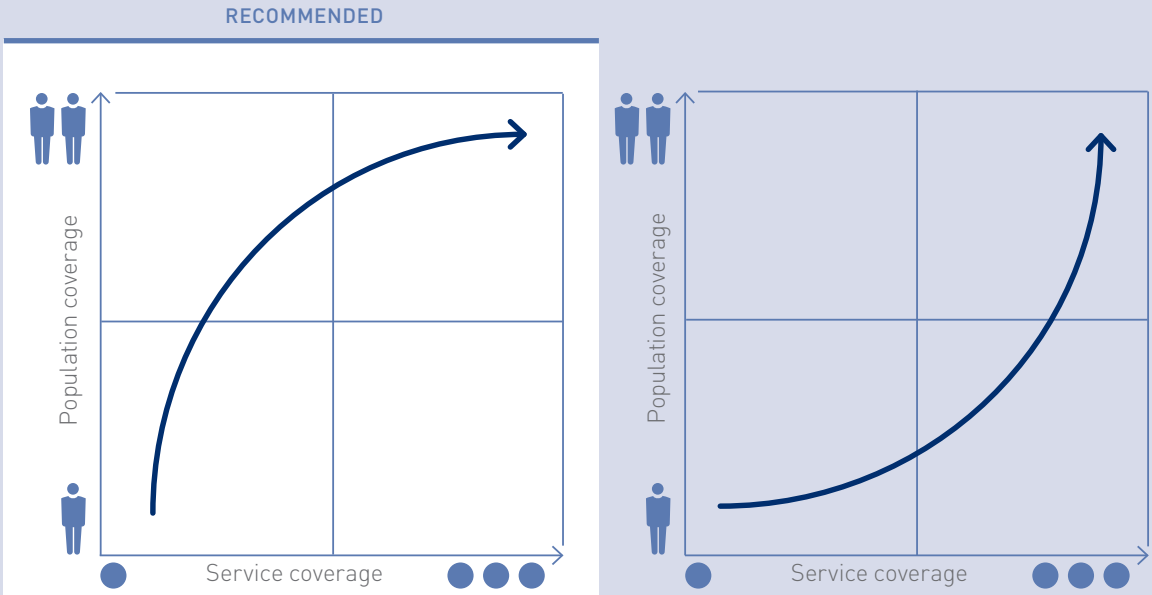
This approach helps policymakers realize that they need to make trade-offs across these dimensions and that progress along only one dimension might not be the best course of action. For example, promising free health services is an ineffective strategy if there is inequality in access or if services are of poor quality.

Initial design decisions should be made with three underpinning principles in mind: equity, resilience and sustainability.

- **Equity:** Make the path to UHC fair and equitable. This is a core objective of UHC reforms, supported by WHO.[16]
- **Resilience:** Ensure that the health system can survive potentially catastrophic crises and emergencies. This can be enhanced (or undermined) by the decisions made in terms of the levels of coverage and service packages. The recent Ebola outbreak in West Africa, which has decimated healthcare systems in Sierra Leone, Liberia and Guinea, illustrates the lack of resilience in these health systems, where coverage levels are some of the lowest in the world.[17]
- **Sustainability:** Design the system for long-term sustainability. Many middle- and high-income countries are currently grappling with the challenge of rapidly increasing healthcare costs while experiencing low or negative economic growth. A health system where costs are not managed with foresight is bound to arrive at a breaking point. The result, as recent examples in several member countries of the Organisation for Economic Co-operation and Development (OECD) have shown, can be deep cuts to healthcare budgets that have the potential to undermine benefits previously achieved through UHC.[18]

WHAT TO COVER: FULL POPULATION COVERAGE FOR A PRIORITY PACKAGE OF SERVICES

Figure 3: Choices on population and service coverage



	RECOMMENDED	
DESCRIPTION	Cover full population first with a priority service package	Target a limited group(s) and expand services for them first
BENEFITS	Delivered to and perceived by everybody Improved equity and efficiency	People that need healthcare and financial protection the most might get it sooner
CHALLENGES	Ensuring depth of quality and financial protection	Fragmentation is inefficient and can create barriers to covering more population groups
NOTABLE EXAMPLES	Brazil, Sri Lanka, Thailand	Vietnam, Philippines, Nigeria, Ghana

Issue

- In allocating financial resources, policymakers need to make choices on population and service coverage, and make trade-offs between these two dimensions.
- Deciding how to start on the journey towards UHC is critical. Countries usually pursue one of two broad strategies (see Figure 3):
  - Extend coverage to the whole population for a priority package of services.
  - Prioritize specific population groups (for example, people in formal employment or the poorest in society), offering them a broader range of services.

Key policy messages

- The whole population should be covered from the start with a priority package of services. This approach has been endorsed by most of the leading organizations and publications in the field of global health.[19, 20, 21]
- Decisions on the package of services to cover first are more contextual and there is less evidence in support of a specific course of action. However, primary and community care services, as well as some general hospital services, represent good value for money.
- Policymakers should ensure that the services covered are of appropriate quality and in line with the expectations of the population: otherwise, they won't be used, limiting the positive impact of UHC.

The case for full population coverage

UHC reforms stalling in countries covering selected groups

Several countries have tried to implement UHC by prioritizing specific segments of the population. However, in these cases achieving the ultimate goal of full population coverage has proven very challenging.

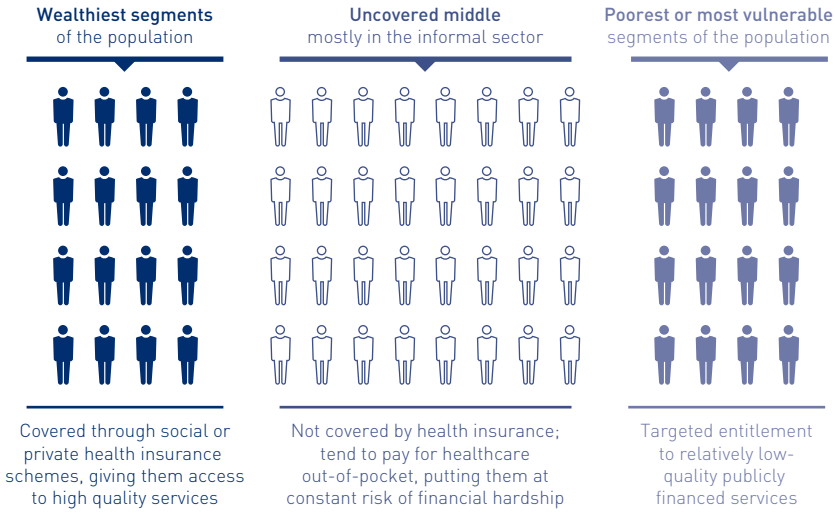
For example, in Zambia in 2006, the Government made a decision to only provide free public services to people living in rural areas[22] and continued to charge user fees in urban health facilities. In other countries, reflecting the Millennium Development Goals' priority population groups, governments have targeted coverage for pregnant women, children under five and people with, or vulnerable to, certain infectious diseases.[23]

Another common way to prioritize the population for coverage has been by economic and employment status. Specifically, since early in the twentieth century there has been a tendency in many countries to cover wage earners in the formal sector first, by introducing social health insurance schemes.[24] This was seen as a way to ensure a healthy industrial and military (mostly male) workforce. Civil servants and government workers have also been singled out as a priority group to receive preferential health coverage.

At the other end of the economic spectrum, charitable organizations and, increasingly, governments, have made attempts to selectively cover the destitute and the poor – recognizing that they often have no resources to access healthcare. In recent years some developing countries have established special health insurance schemes for the poor using tax revenues, sometimes augmented by overseas aid financing. India's RSBY insurance schemes (with 110 million people enrolled[25]) and Cambodia's Health Equity Funds are good examples of such arrangements.[26] However, there is a growing perception that these special schemes for the poor provide inferior and often inadequate coverage, so that 'services for the poor become poor services'.[27]

The experience of countries that have chosen to restrict coverage to selected population groups is that a polarization has often occurred. Healthcare coverage is maximized for the wealthiest groups in society, who are covered by publicly subsidized health insurance schemes, private health insurance or are able to pay out-of-pocket fees. Meanwhile, some attempt is made to cover the poorest members of society with a publicly financed, but often less generous, package of services.

Figure 4: The missing middle



This approach tends to create what has been referred to as a 'missing middle',[28] which in many developing countries represents the majority of the population – mostly people living in households in the informal sector. UHC reforms that remain at this stage are therefore:

- Ineffective: A large proportion of the population is uncovered.
- Inefficient: Fragmented systems have higher administration costs.
- Inequitable: The richest households benefit disproportionately.

Changing this situation is extremely difficult because the groups that are already covered do not have an incentive to support the extension to other segments of the population. Some countries trying to employ this incremental approach are making very slow progress towards UHC. In Indonesia, Vietnam and the Philippines, coverage rates are stuck at around 60–70 percent.[29] Progress has been even slower in Sub-Saharan African countries, with Ghana reporting 35 percent coverage[30] and Nigeria only five percent.[31] Others have been able to progress quicker only after large injections of public financing, amounting to a move away from a gradual strategy to a full population strategy. Rwanda rapidly increased coverage to over 90 percent once it made insurance membership mandatory and heavily subsidized household premiums.[32] Similarly China achieved coverage rates of around 92 percent once the Government spent an additional $125 billion in tax financing to subsidize the entire population.[33]

The main misconception in the approach that initially excludes the 'non-poor' informal sector is an implicit assumption that people who do not qualify for publicly financed safety-net schemes will join organized insurance schemes. These schemes may be private voluntary schemes or supposedly compulsory social health insurance schemes, which usually have low levels of enforcement. In either case this would require households to make regular health insurance contributions. However, there

is mounting evidence from across the world that this assumption is not valid: households in the informal sector do not tend to buy health insurance – unless it is heavily subsidized using public funding.[34] Therefore these approaches further feed the development of the 'missing middle'.

Faster progress in countries prioritizing full population coverage

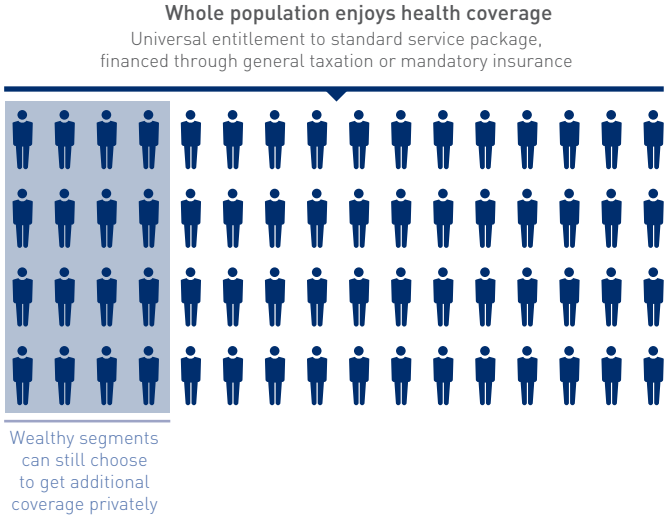
There are a number of positive examples of emerging countries moving rapidly and successfully to higher levels of effective coverage, using the strategic approach of prioritizing full population coverage. Countries such as Chile, Brazil, Mexico, Turkey, Thailand and China have used compulsory public financing mechanisms to close coverage gaps in the population.[35] These countries are often heralded as UHC success stories, because they improved health outcomes, lowered inequality and raised levels of financial protection compared to their peers.

Many countries have largely abandoned trying to differentiate between the poor and the non-poor in the informal sector and instead have been providing a universal entitlement to publicly financed services. This was the major change initiated by Prime Minister Thaksin in Thailand in 2002 when he launched the Universal Coverage Scheme.[36]

As well as rapidly increasing coverage, one of the major advantages of this approach is that it eliminates the need to undertake costly means-testing exercises among the population. It also avoids the problem of adverse selection associated with voluntary insurance schemes where people with lower perceived health needs do not tend to join.

Whereas some organizations and commentators have worried that the benefits of a universal entitlement will leak to richer income groups, there is good evidence that these systems tend to be more equitable. This has been shown to be the case in Sri Lanka, which has universal free health services and shows a pro-poor distribution in many publicly-financed services.[37] Countries like Thailand, Sri Lanka, Malaysia and Brazil[38] show that with a universal entitlement system, higher-income households still choose to pay voluntarily for services in the private sector. This is especially the case with ambulatory care, resulting in the poor capturing disproportionally more government subsidies for primary care and basic curative care.

Figure 5: The whole population approach



These countries were also able to create a system that is more likely to provide protection from healthcare costs. It is important to recognize that this in itself is one of the main objectives of effective universal coverage – an issue reflected in the title of the UK's blueprint for its National Health Service (NHS), which was called *In Place of Fear*.[39] Providing this protection has often proved very popular with electorates in these countries and delivered considerable political benefits to the politicians who led these reforms.

The whole population approach is necessary but not sufficient on its own: in some countries that have pursued this approach, major questions remain about the depth of financial protection and the quality of services available. For example, in China there are concerns that while 92 percent of the population has formal coverage, out-of-pocket payments are growing because doctors are over-supplying services and medicines which are only partially subsidized by the country's medical insurance schemes.[40] Also, while Uganda was heralded for providing universal free health services in 2001, inadequate levels of public health financing have resulted in chronic stock-outs of essential medicines.[41] These examples show that universal entitlement has to be coupled with significant investment to ensure access to medicines and services in a broader sense (eg in rural areas).

Achieving full population coverage may also generate political pressure to address problems associated with inadequate benefit packages and financial protection. Thailand has been an interesting example of this phenomenon, where political pressure from people in the universal coverage program resulted in services (for example renal dialysis and hemophilia treatment) being added to the benefit package over time and the removal of co-payments.

Case study 1: Achieving full population coverage in Thailand[42, 43, 44, 45]

Background

- Before 2002, 18.5 million people in Thailand (roughly 30 percent of the total population) were uninsured. The rest were covered by four different schemes, mostly focused on the formal sector.

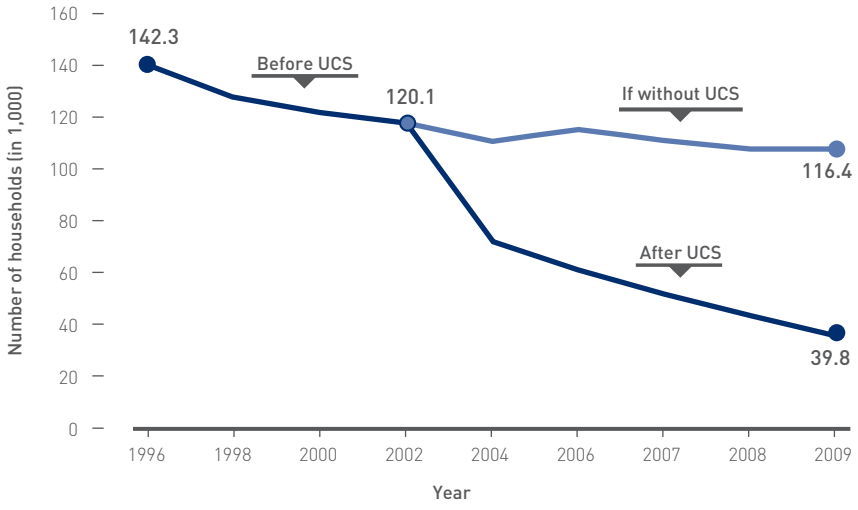
Reforms

- Thaksin Shinawatra won the 2001 elections, featuring the promise of UHC prominently in his campaign.
- In 2002, a new scheme to cover the uninsured was introduced. It required a payment of only 30 baht (less than $1) for each visit or admission.
- Some high-cost services were excluded from coverage at the outset, but added later (for example, anti-retroviral treatment in 2003 and renal replacement therapy in 2006).
- In 2006, the 30-baht payment was abolished.

Outcomes

- All health Millennium Development Goals achieved by the early 2000s.
- Biggest average annual reduction in child mortality between 1990 and 2006 (8.5 percent) among 80 countries.
- Household direct health payments went from 35 percent of health expenditure before UHC to less than 15 percent in 2010.
- Number of households impoverished by health expenditure fell from 120,050 in 2002 to 39,750 in 2009.

Figure 6: Number of households falling below the poverty line due to health costs, before and after the introduction of the Universal Coverage Scheme (UCS) in Thailand[46]



What services should be covered first and at what quality level?

The evidence strongly supports the strategy of extending coverage to the whole population for a priority package of services. What services should then be included in this initial package? What level of quality should be ensured in their delivery? The overall objective ought to be to include services that have the maximum impact on population health outcomes, reduce financial hardship for households and limit inequalities. The preferences of the population should also be taken into account: their evaluation might be less technical, but their opinions are crucial to ensure buy-in to support the UHC strategy.

This section provides an introduction to three critical considerations in this debate: value for money, quality and user acceptability, and access to medicines.

Value for money

WHO proposes three criteria to consider in evaluating services to cover: cost-effectiveness, priority to the worse off, and financial risk protection.[47] The evidence available shows that policymakers should prioritize primary healthcare interventions (especially preventive services)[48] and some hospital services (for example, facility-based deliveries) over specialized tertiary hospital services, providing coverage for the latter only when households are being impoverished by paying for these services out-of-pocket.

There have been many excellent examples of countries investing in district and community level health services, often delivering impressive results. China's famous barefoot doctors program, introduced in the 1960s, focused on simple primary care interventions and enabled China to achieve good population health indicators at relatively low cost.[49] More recently, Ethiopia has achieved impressive reductions in child mortality that have largely been attributed to its community health worker scheme.[50]

There are also many examples of countries overinvesting in urban specialist services, due to political pressure from wealthy urban populations, powerful healthcare providers and professional groups. A recent controversial high-profile project to build a state-of-the-art tertiary hospital in the capital of Lesotho, which appeared to reduce funding for rural health budgets, is a good example of this phenomenon.[51]

Quality and user acceptability

Merely ensuring that a package of affordable services is offered to the population is not enough to achieve the goals of UHC. Services need to be of good quality, so that they can be effective in delivering improved health outcomes. For example, people requiring curative services should receive accurate diagnoses and appropriate treatments and medicines. However, in many countries this is not the case, as has been shown for both public and private health service providers in India. A study in the state of Madhya Pradesh[52] found that 67 percent of healthcare providers had no medical training, correct diagnoses were rare and incorrect treatments were prescribed widely.

In addition, the population needs to make use of and value the services. They should therefore be readily accessible, provided in a timely manner and take into account the preferences and aspirations of individual service users and the cultures of their communities. Importantly, in a publicly financed system richer members of society should feel confident to use the services they are funding, so they have a stake in sustaining and improving the system.

Governments therefore need to adopt a systematic approach to improving quality, addressing issues of effectiveness and patient safety. England's NHS provided a good example of how a national health system can formulate such a strategy in 2008, with the publication of *High Quality Care for All*.[53] However, it is not sufficient to produce a quality improvement strategy; governments need to have effective institutions to implement the necessary reforms, as we will discuss (see 'How to implement UHC').

Access to medicines

Medicines deserve particular attention when defining a priority service package, as their availability is a key driver of healthcare-seeking behavior for people across the world. This has recently been demonstrated in South Africa, a country on the verge of implementing major UHC reforms, where a study showed that people prioritize medicine availability above many other service attributes, including human resources and the state of healthcare facilities: "Communities are prepared to tolerate public sector health service characteristics such as a long waiting time, poor staff attitudes and lack of direct access to doctors if they receive the medicine they need, a thorough examination and a clear explanation of the diagnosis and prescribed treatment from health professionals."[54]

Inadequate access to medicines can generate widespread dissatisfaction in the population and prompt major political campaigns, such as those related to the unaffordability of anti-retroviral medicines for people with HIV in the developing world – especially in Sub-Saharan Africa. A recent documentary film, *Fire in the Blood*, charts the success of the global campaign to reduce the prices of these life-saving medicines to make them more accessible to people living in developing countries.[55]

In India, politicians and health planners are recognizing that tackling access to medicines is a popular and efficient way to launch UHC reforms in a country often referred to as the 'Pharmacy of the World'. For example, following intense pressure from civil society organizations, the state of Rajasthan introduced a program to provide 324 free generic medicines throughout the entire public system. In six months the use of public facilities had increased by almost 50 percent.[56] Despite initial opposition to this strategy, the new Indian Government of Prime Minister Modi has announced that it intends to roll out a similar program to provide free generic medicines to the entire population of India.[57]

Examples such as these demonstrate that decisions about what services to cover, and to what level of quality, are highly driven by local factors and political pressure. This chapter has sought to make the case that policymakers should give a high priority to achieving universal coverage for the whole population, for a priority package of services that are right for their local context.

HOW TO PAY FOR UHC: USE MANDATORY FINANCING MECHANISMS

Figure 7: Choice of financing mechanism

Options		Description	Benefits	Challenges	Notable examples
Voluntary mechanisms	**Out-of-pocket payments**	Direct payments by the user, made at the time of delivery of services	Can provide funds at the facility level when public funding is compromised	Reduces uptake of health services, especially by the poor, and causes financial hardship	India, Pakistan, Myanmar
	Voluntary insurance	Personal non-mandatory contributions to commercial or community based health insurance schemes	Pre-payment and pooling can benefit members relative to out-of-pocket funding	Ineffective at reaching full population coverage; inefficient and inequitable	United States, South Africa
Mandatory mechanisms	**Taxation**	Indirect contributions to healthcare budget through general taxation revenues	Effective, efficient and equitable way to create a large risk pool	Requires strong performance in collecting taxes and leaves funds vulnerable to political allocations	United Kingdom, Sweden, Brazil, Sri Lanka
	Mandatory insurance	Mandatory income-related contributions to a social health insurance fund	Transparent levels of contributions from members	Difficult to collect contributions from the non-waged population	Germany, Japan, Taiwan
Other	**External sources**	Mostly refers to aid from international donors	Can help fill public financing gaps in developing countries	Can create distortions in the system and displace domestic financing	GAVI, Global Fund for HIV/AIDS, TB and Malaria

RECOMMENDED

Issue

- To truly reach UHC, coverage of the whole population for the services they require needs to be achieved while minimizing out-of-pocket expenditure by individuals.
- Policymakers must decide how to raise the money needed for UHC. A key policy choice is whether to use voluntary or mandatory financing mechanisms (see Figure 7).
- In spending UHC funds, value for money needs to be maximized. Countries should pay particular attention to fund pooling and provider payments.

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Key policy messages

- UHC can only be achieved through predominantly compulsory financing mechanisms. WHO, the World Bank and the Lancet Commission have endorsed this position.
- Evidence points to the importance of publicly governed systems and of minimizing fragmentation in funding pools.
- The choice of provider payment mechanism is highly contextual and should be driven by the incentives that policymakers wish to introduce in the system. The robustness of the health governance systems and institutions is likely to be a key determinant of the effectiveness of the chosen payment mechanism.

Financing UHC

Providing the entire population of a country with a broad package of health services is an expensive endeavor. Estimating exactly how much money is needed is difficult, primarily because it depends on which services are covered and on the quality of services being provided. However, a recent Chatham House report, building on the work of a previous multi-agency task force,[58] estimated that the minimum public expenditure to provide a priority package of services for the whole population would be $86 per person per annum.[59] In 2012 this minimum requirement for public financing was not achieved in 61 countries. This analysis shows the magnitude of the challenge of funding a global move to UHC: The question is then how to raise the money for it.

The topic of how developing countries should finance their health systems has been one of the most contentious issues in global development. In the late 1980s, donors encouraged countries to shift from publicly financing their health systems to relying more on private finance. The prevailing policy advice from the World Bank[60] in the following years was that countries should increasingly rely on charging patients user fees. However, while a few researchers argued that this policy helped improve the quality of services,[61] over the next two decades evidence amassed that user fees dramatically reduced uptake of essential health services – especially by the poor.[62] Recognizing that user charges were becoming a significant access barrier for poor people, agencies such as UNICEF and WHO tried to mitigate their impact through the Bamako Initiative, which introduced community management systems with the intention of exempting the poor.[63] However, these systems proved ineffective and in West Africa the number of people using outpatient services fell to as low as one visit per person every five years at the turn of the millennium.[64]

As concern grew about the impact of point-of-service fees, frequent attempts were made in developing countries to introduce voluntary community-based insurance schemes. However, evaluations over the last 20 years have shown that these initiatives have not been successful in scaling up coverage. In particular, most community insurance schemes have been ineffective (only reaching low coverage rates), inefficient (they have high administration costs) and inequitable (the poorest households are usually excluded).[65, 66, 67]

In recent years, a strong consensus has emerged that mandatory financing mechanisms (from general taxation and compulsory insurance schemes) are the best way to fund UHC. Organizations such as WHO[68] and Chatham House[69] have dismissed the viability of voluntary funding mechanisms. More strikingly, the World Bank has now become one of the leading agencies campaigning for publicly financed UHC.[70] The current World Bank President has described health care user fees as "unjust and unnecessary".[71] The 2013 Lancet Commission on Investing in Health made perhaps the strongest case in favor of compulsory, publicly-governed health financing in its report *Global Health 2035: A World Converging Within A Generation*.[72] Figure 8 synthesizes the main findings.

Even before this policy consensus was reached, several governments, in countries with differing income levels, switched to predominantly publicly financing their health

systems. These changes may have been driven as much by political considerations as by the realization of the failure of alternative schemes:

- In Africa, Uganda abolished all healthcare user fees in public facilities in the run-up to elections in 2001. Following this, many African countries did the same, at least for key population groups such as pregnant women and children.[73]
- In Southeast Asia, Thailand introduced its tax-financed, Universal Coverage Scheme for the entire informal sector in 2002 (see Case study 1).
- In South America, Brazil initiated an extensive program of health reforms in 1988, to increase the coverage of services for poor and vulnerable people. Following significant increases in public financing, the government was able to provide free health services to the entire population. Health indicators improved markedly: From 1990 to 2008, infant mortality in Brazil fell from 46 per 1,000 live births to 18, and life expectancy for both sexes increased by six years.[74]
- In Central America, Costa Rica has achieved full population coverage in the 1970s through the Costa Rican Social Security Fund.[75]
- In the Gulf Cooperation Council, Qatar is moving from a voluntary approach, with multiple funding pools and prospective reimbursement, to a mandatory one that has a single payer (the National Health Insurance Company) and retrospective/performance-based reimbursement. Implementation began in 2013, and full population coverage, including non-national migrant workers, for a broad package of services is expected to be achieved by 2016.[76]

Pooling funds

A key factor in improving the performance of health financing is the extent to which funds are pooled. The main arguments in favor of pooling relate to equity and to efficiency.

- Pooling funds improves equity because it facilitates cross-subsidization for poorer people and people with higher care needs. WHO strongly supports this approach and states: "Through reforms that reduce fragmentation in pooling, countries can increase the potential to provide financial protection and equity of access from a given level of prepaid funds." [77]
- There are also significant economies of scale to derive from pooled resources. Fragmentation creates inefficiency in a health system due to higher administration costs and weaker purchasing power. Larger pools achieve greater economies of scale and can use their market power to secure lower prices from providers.[78]

Chile, where the funding pool has been split between public and private insurance schemes, is a powerful example of the adverse effect of even limited fragmentation and the difficulty of integrating different risk pools (see Figure 8).

Pooling funds is, by itself, not a guarantee of capturing economies of scale: it is critical that in the implementation process a robust, efficient purchasing function is set up (see 'How to implement UHC').

Figure 8: Pathways to universal coverage[79]

PREFERRED

	Initial pathway through UHC cube			Efficiency in producing	
	% of population covered by publicly financed interventions	Initial fraction of interventions covered by public financing	Co-payments or premiums	Health	Financial risk protection
Progressive universalism (initially targets poor people by choice of intervention)	100%	◆	No	●●	●●●
Progressive universalism (initially targets poor people by exempting them from insurance premiums or co-payments)	100%	◆◆	Yes Only poor people are exempt	●●●	●●
Balanced pathway to universal health coverage insurance (with some public finance)	Depends on size and use of public finance	◆◆	Yes	●●	●
Private voluntary insurance (with some public finance)	Depends on size and use of public finance	◆	Yes	●	●
Public finance of catastrophic coverage	Depends on size and use of public finance	◆	Depends on design	●	●●

◆ Low fraction ◆◆ Large fraction

● Low efficiency ●● Medium efficiency ●●● High efficiency

Source: *Global health 2035: a world converging within a generation*,The Lancet

Giving providers the right incentives

Raising sufficient levels of public financing is a necessary condition to achieve UHC, but only represents half of the financing story. To turn these resources into a health system capable of achieving UHC, these funds must be allocated and managed efficiently and fairly. There are many health systems in the world that spend a lot more than $86 per person per annum in public financing, but which are a long way from achieving UHC because of inefficiency and inequality in their health systems.

A critical choice in the design of a UHC approach is how to pay providers. Such a decision can have a significant impact on the sustainability of the system, as financial incentives influence the behaviors of providers in ways that will affect quality, access and costs.

Recognizing the incentives created by each mechanism is crucial: just like all economic agents, healthcare providers respond to financial incentives and will have a tendency to maximize their income. For example, some payment systems might push them to over-supply services or use inputs that represent poor value for money (eg prescribing expensive branded medicines instead of cheaper generic equivalents). Others might incentivize them to under-supply services and cut costs inappropriately, compromising quality of care.

There is no consensus on a preferred payment mechanism. The suitability of any method is highly contextual and its impact is strongly influenced by the governance and institutional arrangements to regulate and enforce payment systems that exist in a country. Moreover, several countries have adopted different payment mechanisms for different levels of care, or use a mix of mechanisms within the same contract. For example, family doctors in the UK are mostly paid on a capitation basis but receive additional performance bonuses based on their activities.[80] The more broadly adopted payment mechanisms are:

- Fee-for-service, in which providers are paid for each service they provide. While this mechanism can maximize supply, it also runs the risk of creating incentives to over-supply and escalate costs. Ensuring that the purchaser, not the providers, sets the price for services, and imposing global budget constraints can mitigate some of the risks of this approach.
- Bundled payments, in which providers are paid a fixed fee for a bundle of units of activity (ie episodes of care). It can foster efficiency within a bundle, but it is complex and could still incentivize over-supply.
- Global budgets, in which providers are paid a fee to provide services for a certain amount of time. It can stimulate productivity improvements, but also incentivize providers to limit access to services and compromise on quality.
- Capitation, in which providers are paid a fixed amount per head of population. This approach can be effective in limiting costs, but again could incentivize access restrictions.

- Performance-based payments, in which providers are paid based on the outputs and outcomes they deliver. This could be a good option in some circumstances, but requires complex monitoring systems and may cause incentives to oversupply some services at the expense of other vital services.

One innovative approach at the system level is 'Accountable Care', where a group of providers are held jointly accountable for achieving a set of outcomes for a defined population over a period of time and for an agreed cost.[81]

Case study 2: Chile and the risk of fragmenting funding pools

Background

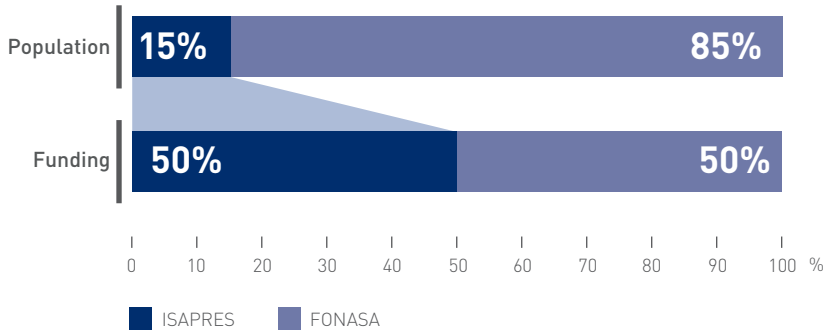
- In the 1950s, most of Chile's major health services were integrated into one entity, the Servicio Nacional de Salud – SNS (National Health Service).
- In the 1970s, under Augusto Pinochet's dictatorship, the system was broken up into a health fund (FONASA) and a service provision system (SNSS).
- In 1981, Chileans were allowed to opt out of the public system and transfer their payroll contribution from FONASA to the newly created Instituciones de Seguridad Previsional (or ISAPRES) to purchase individual private health insurance, with no cross-subsidies between the public and private funding pools and private provision of services.
- Changing the system requires a constitutional amendment.

Current challenge

- Since the 1980s, private insurers have systematically practiced the selective enrollment of young/healthy, and low-risk/high-income individuals, then devolving them to the public insurance when they get older, sick or can no longer afford the premium.
- The fragmentation has had adverse effects on the equity, cost, service quality, and appropriateness of the Chilean health system. While those opting-out of the public pool represent only 15% of the population, they take 50% of the funds out of the public pool, since contributions are proportional to income.

(Case study continued)

Figure 9: Split of population and funding between schemes

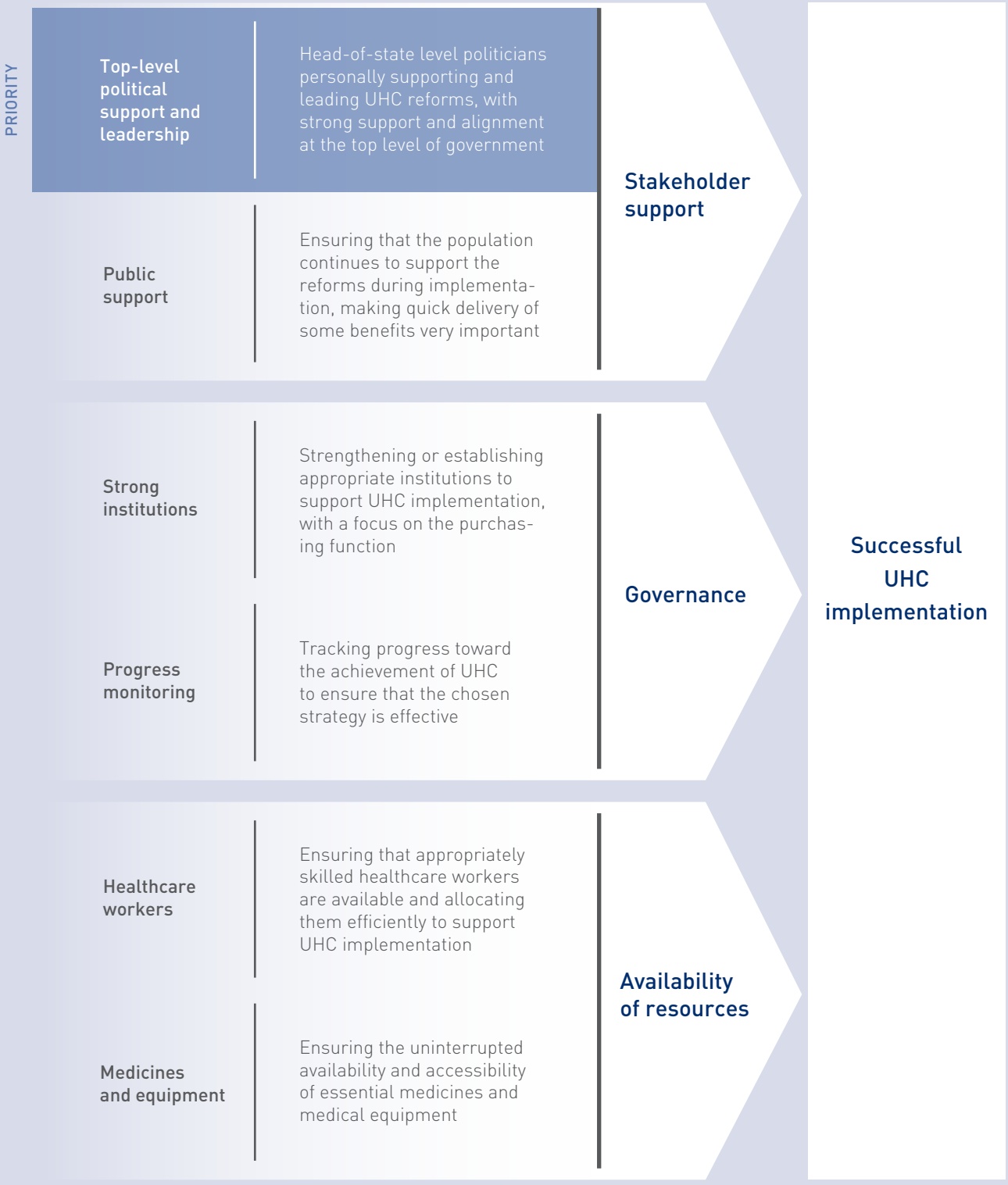


Attempts to change

- Since the 1990s, democratically elected governments have tried unsuccessfully to restructure the system.
- In 2014, a commission appointed by the newly elected president Michelle Bachelet proposed to move to a single public pool and payer system. The government is expected to propose a law based on the recommendations.
- However, the outcome of the process is unclear due to very strong resistance from the people enrolled in the private scheme, the owners of ISAPRES and lobbying groups for private industry. This has also resulted in a systematic media campaign against the reforms.

HOW TO IMPLEMENT UHC: SECURE AND SUSTAIN TOP-LEVEL POLITICAL LEADERSHIP

Figure 10: Key factors for implementation



Issue

- A perfect UHC design is likely to fail if it is not implemented effectively.
- Implementing UHC reforms is an extremely challenging process, further complicated by how politically sensitive the topic is.
- Countries require guidance on what issues to prioritize across three dimensions: support from key stakeholders, governance of the process and availability of resources.

Key policy messages

- Strong political commitment at the highest level (ie head-of-state) is the most important success factor for the introduction of UHC. In most successful cases, prime ministers or presidents lead UHC reforms personally and feature them in their electoral platforms.
- Other critical factors include sustained public support, strong institutions (particularly a robust purchasing function), a system to monitor progress, availability of appropriately skilled healthcare workers and access to needed medicines and equipment.
- More attention and research should be devoted to the practical issues of UHC implementation. The evidence currently available is not as extensive or clear as it is around the design of UHC systems.

A perfect design for a UHC system becomes worthless if it is followed by ineffective implementation. Interviewed by *The Lancet* in 2012, the President of the World Bank suggested that the "science of implementation and execution" in global health has been neglected, relative to the focus on discovery and development of new treatments.[82]

Extensive literature exists on the key determinants of successful public policy implementation,[83, 84] not only in healthcare. While the specifics vary, three broad themes are common across most of them:

- Support from key stakeholders.
- Robust planning and governance of the implementation process.
- Availability of appropriate resources.

This chapter explores the specific shape these themes take in the context of UHC. It does not attempt to provide an exhaustive list of all the relevant factors, focusing instead on the ones that are particularly important for the implementation of UHC.

Securing stakeholder support

While there are several other important stakeholders in the UHC implementation process (for example clinical personnel, intergovernmental organizations, healthcare industry players), politicians at the top level of government and the general population of the country stand out as the most significant.

Sustaining top-level political support and leadership

Looking back through history, the factor that overall appears most critical to successful implementation is genuine and sustained political leadership – often at the head-of-state level. This was one of the key findings of a recent synthesis report of eleven UHC case studies published by the World Bank.[85] Its first policy recommendation states that: "Strong national and local political leadership and long-term commitment are required to achieve and sustain UHC … capable of mobilizing and sustaining broad-based social support while managing a continuous process of political compromises among diverse interest groups without losing sight of the UHC goals."

When analyzing some of the most significant UHC reforms, top-level political leadership clearly emerges as a common trait (see Table 1).

For example, during the 2014 presidential campaign in Indonesia, Governor Jokowi of Jakarta announced that he would provide all uncovered households with a free insurance card if elected. Within two weeks of taking power in October 2014 he started implementation of this policy, using savings made from reducing fuel subsidies to pay for it.[86] If these reforms are implemented successfully they will create the biggest publicly financed, single-payer health system in the world.

There are several examples of planned health reforms being unsuccessful due to the failure to secure alignment and support at the top level of government. The Indian Planning Commission's High Level Expert Group report on Universal Health Coverage set out a strategy to achieve UHC in 20 years, requiring a doubling in public financing.[87] Despite being adopted in 2012 and incorporated into the country's five-year plan, the government did not substantially increase health budgets in two subsequent budget cycles. As a result, the main recommendations of the strategy were not implemented. Kenya is another country which produced a strategy in 2004 to reach full population coverage, but where differences within the cabinet resulted in these plans being shelved.[88] It appears from news reports that something similar might happen in South Africa to the Ministry of Health's plan to introduce a National Health Insurance program.[89]

Maintaining broad popular support

UHC reforms are often led by heads of state and featured as part of electoral platforms because they tend to be very popular among certain population segments. This is particularly true in situations where coverage is extended to large segments of the population that were previously left out. It reinforces once more the appeal of a strategy that aims for coverage of the whole population from the start: such an approach is more likely to obtain broad popular support.

Countries that have not yet introduced UHC often end up in a polarized situation, where the rich are covered by health insurance schemes and the poorest are targeted with free or subsidized government services (see 'What to cover'). This leaves out a 'missing middle', often including the majority of voters in a country. If properly engaged, these groups can be a key driver of the global expansion of UHC.

Policymakers should be aware of this and ensure that they effectively obtain the support of this important block of voters. They also need to maintain it: delays and failure in the implementation of UHC can alienate supporters and negatively affect the popularity of the reform as a whole. In the US, technical issues with the healthcare.gov website for insurance enrolment significantly affected public support for the whole healthcare reform: unfavorable ratings rose from 43 percent in September 2013 to 49 percent in November 2013.[90]

It is therefore crucial that plans for the implementation of UHC reforms are delivered promptly and effectively, and include the provision of tangible benefits in the short term to maintain momentum in public support.

Table 1: Political leadership in major UHC reforms[91]

Country	Year	UHC reform	Top-level support
Indonesia	2014	National health card and expansion of coverage (planned)	Core component of electoral platform of president Jokowi
USA	2012	Reform of insurance system to reduce uncovered people	Personally championed by president Obama
Georgia	2012	Health coverage to all citizens	Key component of the manifesto
Sierra Leone	2012	Free healthcare for pregnant women and children	Promoted by president Koroma, around 2012 elections
China	2009	Increase in public spending to improve service coverage and financial protection	Supported by Party Central Committee and State Council and supported by president Hu
Qatar	2008	Extensive health coverage to entire population (ongoing)	Key component of country's development strategy
Ghana	2008	National Health Insurance to all pregnant women	Launched by president Kufour before national elections
Nepal	2008	Universal free healthcare up to district hospital level	Flagship policy of newly-elected government
Burundi	2006	Free healthcare for pregnant women	Launched by president Nkurunziza
Zambia	2006/ 2009	Free healthcare for people in rural/urban areas	Introduced before 2006 elections by president Mwanawasa
Chile	2005	Legally enforced free benefit package	Personally championed by president Lagos
Thailand	2001	Coverage for informal sector	Signature electoral promise for president Shinawatra
South Africa	1994	Tax-financed services for pregnant women and children under 6	Announced by president Mandela during his first 100 days in office
Brazil	1990	Universal tax-financed health services	Priority of new democratically elected government (added right to health in the Constitution)
South Korea	1977	National health insurance scheme	Flagship social policy of president Park Jung Hee
Japan	1961	Nationwide universal coverage reforms	Post-war priority of National Government
United Kingdom	1948	Tax financed system with universal entitlement	Led mainly by Minister of Health Bevan, priority reform for Labour government

Governance of the implementation process

The previous chapters have analyzed in detail the key design choices needed while planning the introduction of UHC reforms. Once those decisions are made, leaders of health reforms should leverage a wide range of regulatory, planning, management and monitoring functions to implement their policy objectives effectively. Governments therefore need to strengthen the governance of the health system which, as well as being a technical challenge, is also a political process that requires balancing competing influences and demands. WHO[92] identifies the main objectives of strengthening governance in the health sector as:

- Maintaining the strategic direction of policy development and implementation.
- Detecting and correcting undesirable trends and distortions.
- Articulating the case for health in national development.
- Regulating the behavior of a wide range of actors – from healthcare financiers to healthcare providers.
- Establishing transparent and effective accountability mechanisms.

Two factors appear particularly important to achieve these objectives: establishing strong institutions to govern the health system, in particular with regards to the purchasing function, and carefully monitoring progress in implementation. In addition, countries should be aware that effective clinical leadership is also an important contributor to the success of UHC reforms.[93]

Establishing strong institutions

The successful implementation of UHC reforms depends on developing a broad range of effective institutions. Where institutions are weak or are potential impediments to progress (for example if they are corrupt) there may be a need to invest heavily in strengthening institutional capacity. It may be necessary to create totally new institutions to introduce arrangements that strengthen the purchasing function.

The Lancet Commission on Investing in Health highlights six institutional functions that must be satisfied to support the successful implementation of UHC.[94]

- Institutions for information.
- Institutions of deliberation.
- Institutions of finance.
- Institutions of stewardship.
- Normative institutions.
- Institutions of independent accountability.

Building a strong purchasing function

We have seen the impact that the institutional setup for provider payment can have on the success of various mechanisms (see 'How to pay for UHC'). The strength and approach of the purchasing function is another critical factor.

First, countries need to make a strategic choice on the best institutional arrangement to maximize efficiency: the purchasing function could remain within government structures, be managed by a semi-autonomous agency (usually on a not-for-profit basis) or even contracted out to a private for-profit organization such as an insurance company. While there is no consensus on which option is best, countries need to carefully evaluate the capacity of their institutions, including their ability to regulate non-state purchasers.

Thailand is an example of a country that has created a semi-autonomous agency to purchase health services for members of its tax-financed, Universal Coverage Scheme. This body, the National Health Security Office, is governed by a 29-member board from public and private sector organizations and has a high level of representation from civil society organizations[95]. The 10-year review of the Thai Universal Coverage Scheme has attributed a lot of the success of their reforms to the performance of this agency in driving down costs and maintaining quality standards.[96]

In India, a different approach has been followed, with management of the state level insurance schemes for the poor contracted out to private sector insurance companies. While there has not been a systematic review of these schemes, some research papers and articles in the Indian media are questioning the performance of these organizations in controlling costs and meeting the needs of members.[97, 98] Furthermore, extensive evidence from the US would indicate that competing private health insurance companies are not very effective at driving down costs.[99]

Monitoring progress towards the UHC goal

It is crucial that leaders and key stakeholders in UHC reforms are able to monitor the country's progress towards UHC. This enables health planners to determine whether the strategy is being implemented effectively and what corrective measures are needed to improve health systems, revise financial allocations or amend the overall strategy.

The World Bank and WHO, after an extensive consultation exercise, have recently produced a joint framework document on measuring progress towards UHC.[100] In this paper they recommend using indicators that measure the two key elements that make up the UHC definition, namely health service coverage and financial protection. Specifically, they propose indicators that measure the effective coverage of both preventive and curative health services, and financial protection measures that track catastrophic and impoverishing health expenditures. They recommend measuring both the aggregate level of these indicators and their equitable distribution, stratified by wealth quintile, place of residence and gender.

A recent Public Library of Science (PLOS) collection of papers applied this measuring framework in 13 country case studies from Bangladesh, Brazil, Chile, China, Estonia, Ethiopia, Ghana, India, Singapore, South Africa, Tanzania, Thailand, and Tunisia.[101]

Availability of resources

Money is perhaps the most critical resource needed for the successful implementation of UHC. While 'How to pay for UHC' discussed in depth the mechanisms needed to provide appropriate funding to expand coverage of health services, it should be noted that the implementation process requires a specific budget. Deciding that a certain service package should be covered and providing funding for it is only a first step. The health system needs to be capable of delivering these benefits to the population. Two resource-related factors are critical: the availability of properly skilled healthcare workers and the appropriate supply of, and access to, medicines and medical equipment.

Ensuring availability of a skilled healthcare workforce

The availability of appropriately skilled healthcare workers is a major issue in developing countries, particularly in rural areas. Several countries have therefore chosen to employ community health workers to work in these areas, given the challenges in finding and funding adequate numbers of qualified doctors and nurses. These workers are usually recruited from local communities and after a period of training they provide basic primary care services, often visiting households rather than being facility based. This strategy appears to have been very effective in Ethiopia, Rwanda, Nepal and Malawi in rapidly scaling up the coverage of cost-effective health services among high-need populations.[102]

Given that the supply of healthcare workers is still likely to be limited, countries should also focus on using human resources efficiently.[103] In this area, there are two priority topics that countries should consider carefully:

- Ensuring an optimal skill-mix of health workers in delivering services.
- Designing payment mechanisms that provide appropriate incentives to health professionals.

In both cases, amending existing arrangements (for example allowing nurses to undertake duties previously performed by doctors, or renegotiating employment contracts) can be met with strong opposition from powerful professional bodies.

Ensuring access to medicines and medical equipment

Ensuring uninterrupted availability and accessibility of essential medicines and equipment is a typical problem in developing countries. According to WHO, which has devoted significant attention to this topic, a reliable health supply system should:[104]

- Integrate supply management into health system development.
- Develop an efficient mix of public–private partnerships.
- Maintain medicines' quality in distribution channels.
- Ultimately increase access to essential drugs.

Countries should again be focused not only on the availability of medicines and equipment, but also on improving efficiency in this area. In looking at how governments can achieve 'more health for the money', the 2010 World Health Report highlighted 10 sources of inefficiency in health systems. Three of them were related to medicines: underuse of generics and higher than necessary prices for medicines; use of substandard and counterfeit medicines; and ineffective and inappropriate use.[105]

This chapter has aimed to highlight the significance of implementation in ensuring that the benefits of UHC are actually delivered and to illustrate the key determinants of successful implementation, especially the importance of top-level political support and leadership. However, the evidence available on the specifics of UHC implementation is less robust and structured than that related to the benefits and the main design choices. Going forward, there is a clear need to promote more research into implementation topics. We know the why and the what; we now need to better understand the how.

A CONCLUDING CASE STUDY

The purpose of this report has been to inform policymakers about the benefits and costs of universal health coverage and highlight the political, financial and health systems reforms that are required to achieve it. This agenda might appear daunting. We therefore conclude with a short case study, which illustrates that when all these aspects of UHC are addressed, the impact on the health and welfare of a country's population can be profound.

In 2005 a shocking report by Human Rights Watch showed how low healthcare coverage rates had fallen in the Central African country of Burundi.[106] Poor women who had undergone life-saving caesarean section operations were being imprisoned with their babies in the country's public hospitals because they were unable to pay their hospital bills. The public health system was therefore not only failing to protect this highly vulnerable population – it was violating their basic human rights.

> I had to come to the hospital because I needed a caesarean delivery. When I got the bill, the doctor said to me, "Since you have not paid, we will keep you here."
> Life here is difficult. I don't have permission to leave with my baby. We are often hungry here. I cannot stand this situation any longer.
> 18-year-old woman, held with her baby at Louis Rwagasore Clinic, Bujumbura

This damning report created political pressure for change that was felt at the highest level of government. Alerted by these findings, the President of Burundi visited some of the hospitals concerned and, horrified by what he found, announced that all women and children should be released from public hospitals across the country.

He also recognized that the problem had been caused by a systemic failure of the health system to protect women from the cost of their maternity care. He therefore went further and in August 2006 launched a new policy, which would enable all pregnant women and all children under six to access health services free of charge.[107] His government also realized that the success of this policy would require concurrent supply-side reforms in the health sector to replace lost user fees income with public financing, and that these resources would need to be used to strengthen service delivery. The government was supported in this process by international donors who provided assistance in improving the availability of essential medicines and by channeling more resources to front-line health services. This included increasing the pay of health workers to reflect their higher workloads.

These reforms may not have brought UHC to the entire population of Burundi, one of the poorest countries in the world. However, the impact of the policies on pregnant women and children has been extraordinary. In 2005, women feared being locked up in hospitals and only 22 percent of babies were born in health units. By 2011 the proportion of babies born in a hospital had risen to 75 percent.[108] The demographic and health surveys of 2005 and 2010 have also registered a 43 percent reduction in infant and child mortality in Burundi[109] – one of the fastest declines ever witnessed.

In June 2010, Pierre Nkurunziza was re-elected President of Burundi.

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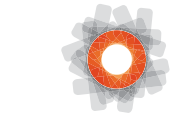

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