

## Universal Health Coverage 2

### Political and economic aspects of the transition to universal health coverage

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Countries have reached universal health coverage by different paths and with varying health systems. Nonetheless, the trajectory toward universal health coverage regularly has three common features. The first is a political process driven by a variety of social forces to create public programmes or regulations that expand access to care, improve equity, and pool financial risks. The second is a growth in incomes and a concomitant rise in health spending, which buys more health services for more people. The third is an increase in the share of health spending that is pooled rather than paid out-of-pocket by households. This pooled share is sometimes mobilised as taxes and channelled through governments that provide or subsidise care—in other cases it is mobilised in the form of contributions to mandatory insurance schemes. The predominance of pooled spending is a necessary condition (but not sufficient) for achieving universal health coverage. This paper describes common patterns in countries that have successfully provided universal access to health care and considers how economic growth, demographics, technology, politics, and health spending have intersected to bring about this major development in public health.

#### Introduction

Countries have reached universal health coverage by different paths and with highly diverse health systems. Nonetheless, the trajectory towards universal health coverage almost always has three common features. The first is a political process driven by a range of social forces to generalise access to health care. Countries have responded to these social forces by creating public programmes or regulations that expand access to care, improve equity, and pool the financial risks of care across populations. The second feature is a growth in incomes and a concomitant rise in health spending. This increased spending enables the buying of more health services for more people and contributes to improved health. The third feature is an increase in the share of health spending that is pooled rather than paid out-of-pocket by individuals and families. This pooled share is sometimes mobilised as taxes and channelled through governments that provide or subsidise care, in other cases it is mobilised in the form of contributions to public insurance or mandatory private insurance.

The predominance of pooled spending is a necessary condition (but not sufficient) for achieving universal health coverage.

In this paper, we describe the historical, political, and economic trends associated with progress toward universal health coverage. We begin by reviewing different ideas of universal health coverage. We then relate lessons from historical research with regards to the political pressures for universal health coverage, the centrality of the public sector, and the contingent paths of reform. We then discuss the economic factors that lend

#### Search strategy and selection criteria

We used quantitative and qualitative data from academic studies and grey literature to review definitions and identify trends in achieving universal health coverage. We searched PubMed, JSTOR, and Google Scholar for relevant books and articles using the terms “universal health coverage”, “universal coverage”, “health reform”, and “social welfare reform”, combining each of these terms with the word “history”. We assessed and analysed material through a mix of historical, economic, and political science research methods. The findings in this review also rely heavily on literature reviews done by the authors for two working papers.<sup>32,44</sup>

#### Key messages

- Universal health coverage has been defined in terms of rights to health care, financial protection, and utilisation of health-care services
- Universal health coverage can be achieved through many different health financing systems, although the pooled share of health expenditures predominates in all successful cases
- The political processes leading towards universal health coverage differ between countries, but they are all ubiquitous, persistent, and contingent
- Political action to universalise health coverage is the major force behind the rising share of pooled financing of health expenditures
- Growth in health spending is driven primarily by rising national income and the expanding range of medical interventions, with population ageing playing a small part
- Countries that want to achieve universal health coverage need to adopt public policies that reduce reliance on out-of-pocket spending and improve the institutions that manage pooled funding to address the equity, efficiency, and sustainability of health expenditures

support to expanded coverage, finance access to a growing range of medical services, and restructure health financing through pooling mechanisms. In this way, we consider how economic growth, demographics, technology, politics, and health spending have intersected to bring about this major development in public health. Countries seeking to reach universal health coverage can learn from these trends by identifying the political sources of support for expanding coverage, designing policies to manage expected increases in spending, and facilitating the shift away from out-of-pocket spending.

### What is universal health coverage?

In its simplest form, universal health coverage is a system in which everyone in a society can get the health-care services they need without incurring financial hardship.<sup>1</sup> Whether or not a country has achieved universal health coverage therefore depends on three related factors: who is covered, for which services are they covered, and with what level of financial contribution?<sup>2</sup> Every society seeking to improve access to health care has debated who should be eligible and on what basis—whether all residents, citizens, or just working populations. They have debated what services should be guaranteed—whether inpatient or outpatient care, high-cost or low-cost treatments. They have also struggled over what share of health-care costs should be financed through public levies, private contributions, or payments at time of service.<sup>2</sup>

The most prominent approaches to the assessment of whether countries have achieved universal health coverage are framed in terms of rights, financial protection through enrolment in health insurance, and use of health care. The rights approach focuses on whether a country has established a social commitment to the generalising of access to health services and many countries have established guaranteed rights to health-care services by law. For example, 19 countries in Latin America have provisions in their constitutions that guarantee access to health care.<sup>3</sup> Use of a rights definition of universal health coverage distinguishes countries whose political systems have reached a consensus on aims but not necessarily on implementation. Many countries legally establish a right to health care without having policies or resources in place to guarantee that people who need care can obtain it without financial hardship.

The share of the population with financial protection through enrolment in health insurance schemes is another common measure for universal health coverage. It is a useful indicator in health systems that manage access by explicitly enrolling individuals or groups with institutions that pay for or directly provide health-care services. However, enrolment rates will overstate coverage in countries where health-care supply is restricted or geographically concentrated, and where required copayments are a substantial share of household income.<sup>4</sup> Insurance enrolment also cannot be used to measure coverage in countries that offer all citizens access through

publicly provided or publicly subsidised services. In these cases, the public sector is still providing an insurance function, even if it is not formally constituted as an insurance plan.<sup>5</sup> A related indicator is the share of households who are impoverished by health expenditures, but this is also problematic because it does not count people who forego necessary care when they are unable to pay for it.

Rights establish legal entitlements and insurance enrolment establishes a contractual promise, but neither one indicates whether people are effectively using the health-care services that they need. Therefore, a third approach is to use health-care utilisation as a measure of progress towards universal health coverage. Utilisation is a better measure than either rights or enrolment because it is directly related to the aim of providing real access to health services, but it is a measure that also comes with limitations. It overestimates coverage when it counts unnecessary services along with necessary ones. It underestimates coverage in places where people get ill less often because of better environmental conditions or preventive programmes. As a measure of universal health coverage, utilisation indirectly addresses financial protection because it is sensitive to the costs individuals face when seeking care.<sup>6–8</sup> However, utilisation does not fully address concerns about financial protection because people who utilise care might still be impoverished as a consequence.<sup>9</sup>

Beyond rights, enrolment, and utilisation, progress toward universal health coverage can also be assessed less precisely but more comprehensively with reference to the characteristics of countries that are commonly recognised as achieving it. The term universal health coverage emerged in a specific context, describing countries like the UK, France, Germany, and Sweden in the 20th century when they generalised access to a set of basic health-care services. Access to care for all citizens was recognised as a right with a key role for the government in raising funds through taxes or mandating contributions to health-care schemes. Public programmes were implemented to assure that individuals would receive necessary care irrespective of their economic circumstances. These public policies coincided with a generalisation of health-care services that contributed to unprecedented levels of longevity and reduced morbidity and mortality. Although the term universal health coverage emerged in the context of western European countries, its aims of generalising access to health-care services and providing financial protection are now manifested by countries throughout the world.<sup>2</sup>

Universal health coverage can be achieved in many different ways. There is no single recipe, and advocacy on the issue in the past decade has explicitly recognised this fact.<sup>1,2,4,10</sup> Universal health coverage has been attained in countries with very different eligibility rules, sources of funding, payer–provider relations, and forms of ownership. For example, Swedish and Malaysian citizens rely on tax

revenues to finance their public health care, whereas Japanese and Chilean citizens rely on payroll deductions and insurance premiums. Despite these differences, all of these countries can be said to have achieved universal health coverage because they have established rights to care that are substantially fulfilled in practice and with substantial protections from financial hardship.

Institutionally, all of these systems share one important thing in common: they depend on substantial shares of pooled financing. In health systems, pooled financing is money raised through taxes or premiums that individuals must pay whether or not they need care. The criteria for contribution of funds (such as occupation or residence) are different than the criterion for the receiving of benefits, namely the need for health care. In this way, pooled financing reallocates funds from healthy to sick individuals. Dependent on its structure, pooled financing can also subsidise health care provided to poorer individuals with funds contributed by wealthier individuals. Pooled financing can substantially improve utilisation, equity, productivity, and effectiveness compared with systems in which patients are individually responsible for their own health costs at the time of service.<sup>21</sup> No country has achieved universal health coverage so long as the health system relies predominantly on out-of-pocket payments for costly medical treatments or basic preventive care.

### How have countries achieved universal health coverage?

When examined in a historical context, almost every country shows a consistent drive towards the provision of universal health coverage. The trajectory is not smooth or free of conflict, but the general pattern of political action to mobilise funds, mandate participation in health financing schemes, and expand access to care is widespread. Countries have financed this expansion of care by increasing the share of national income devoted to health and have increased the equity of access by expanding the pooled share of health spending. This section describes the political and economic trends that have characterised progress toward universal health coverage.

The histories of countries that have achieved universal health coverage have four common patterns. First, domestic pressures for the provision of universal health care are widespread, varied, and persistent. Second, universal health coverage is everywhere accompanied by a large role for government, although that role takes many forms. Third, the path to universal health coverage is contingent, emerging from negotiation rather than design. Finally, the provision of universal health coverage takes time.<sup>12,13</sup>

The widespread shift towards pooled health-care financing is evidence of diverse and persistent domestic pressures to collectively address the costs of health care. Many individuals are involved for varied reasons, such as health professionals with a commitment to public

health, employers seeking government support to maintain a healthy workforce, unions addressing health care within a platform of workers' rights, imperialist regimes with an interest in healthy conscripts, political parties pursuing their political aims or co-opting the positions of political opponents, elites seeking to bolster citizens' allegiance to the state, local communities seeking relief from the burden of caring for the aged, and citizen's groups demanding equity. In Sweden, the temperance movement played an early and unique part in advocating for the expansion of health insurance coverage.<sup>14</sup> In the early 19th century in Japan, villages created collective associations for health-care funding called *jyorei*.<sup>15</sup> Although all individuals mentioned above have also resisted public health reforms at different times, the overall trend toward universal health coverage has been favourable.

Second, all countries that have achieved universal health coverage have done so with extensive government involvement in the financing, regulation, and sometimes direct provision of health-care services. The prominence of public policy in the achievement of universal health coverage is grounded both theoretically and empirically. Theoretical work has shown how difficult it is for competitive markets to provide socially efficient levels of health insurance.<sup>16,17</sup> Empirical studies of health-care systems have shown how public action can address health insurance market failures, protect consumers, and promote a better quality of care.<sup>18–22</sup> Although the development and execution of public policies are problematic, they are the only strategy by which countries have achieved universal health coverage in practice. Public approaches to health care are not without their problems. Public management of health-care financing and provision can be inefficient but so can private provision. Whether public or private approaches are more efficient in a particular context is essentially an empirical question.<sup>23–25</sup> Importantly, however, the only countries in the world to achieve universal health coverage have done so through strategies based on a prominent and active public role.

A key aspect of this active public role is to oversee a shift from out-of-pocket spending to pooled funding. The institutional forms societies have created to promote the pooling of finances are the result of collective action by groups of people organised by various forms of affiliation, such as place of residence or occupation. Over time, governments have had increasingly larger roles in the organisation of health-sector financing and are now the dominant forces in expanding the pooled share of health spending by allocating taxes or establishing mandates to enrol in insurance schemes.<sup>12,14,26–28</sup> Voluntary private health insurance has had an inconsequential role in the shift toward finance pooling and accounts for only a small share of health spending around the world.<sup>29</sup>

Third, the institutions created to provide universal health coverage are negotiated rather than designed. They

are the outcomes of politics and contestation. For example, some of the most celebrated health reforms of the past are presented as if they were implemented according to a coherent design when they actually emerged from pragmatic compromises and sharp struggles. In 19th century Germany, Chancellor Otto von Bismarck pushed for a central government role in social security but he compromised with the political opposition, settling for a compulsory health insurance system financed solely by employers and employees and administered by pre-existing sickness funds.<sup>14</sup> The UK's National Health Service was originally planned to be financed with payroll taxes but demand grew quickly and governments chose to rely increasingly on general revenues, giving the system its current tax-based structure.<sup>30–32</sup> More recent reforms, such as those in Chile and Thailand, show a similar tendency for political process to alter health system designs in unpredictable ways.<sup>33,34</sup>

Sometimes health care is the focus of debate, other times health policies change as a consequence of initiatives to reform pension systems or decentralise political power. Negotiations over health-care reforms are also affected by political institutions that filter and channel interests, by public discourses that frame debates, and by contests over social legitimacy. Such factors are why, despite the broad trend toward universal health coverage, the breadth of health-care coverage and its efficiency varies so much across countries.<sup>2,14,20</sup>

Finally, universal health coverage has been achieved incrementally and over long periods of time, although recent experiences suggest that rapid progress is possible. In systems that rely on social insurance mechanisms, different population subgroups have been incorporated gradually, often beginning with employees of large firms and small firms, followed by rural workers, the self-employed, and eventually the unemployed and indigent (table 1). In systems characterised by direct public provision, such an approach might be evident in the expansion of health-care facilities beyond urban centres to reach rural communities, or increased capacity of facilities to serve more people. The range of health-care services that are provided also tends to grow incrementally. Initial attention to public health measures and hospital care might expand to include outpatient services and preventive care. The achievement of universal health coverage is rarely a single event or a quick undertaking (panel 1) although many countries are achieving it more quickly now than in the past, as will be discussed below.

Countries achieve universal health coverage in response to widespread and persistent social pressures. A large government role is always an essential element in the expansion of access to care and provision of financial protection. However, the process of negotiation and compromise over health reforms leads governments to assume different roles and leads health systems institutions to take on different forms. Even in countries that have effectively universalised access to

most health care, the process of debate and contestation does not end. Instead, debates continue in response to changes in economics, politics, and medical technology, as well as inequities in access that persist even in the most effective systems.<sup>18,35</sup>

### Health spending and universal health coverage

Although political trends drive the key reforms necessary to achieve universal health coverage, economic trends also play a substantial part. In particular, economic growth generates both resources and demand for expanded health-care provision. As a result, countries dedicate increasing shares of national income to health-care services, more services are provided, and this contributes to better health. The way countries reform

	Expansion phase	Number of years
Belgium	1851 to 1969	118
Germany	1854 to 1988	127
Austria	1888 to 1967	79
Luxembourg	1901 to 1973	72
Israel	1911 to 1995	84
Japan	1922 to 1958	36
Costa Rica	1941 to 1961	20
South Korea	1963 to 1989	26

Information from reference 13. The source document<sup>13</sup> notes that effective implementation of the legislation occurred later in Costa Rica and Japan than indicated by the year of enactment of universal coverage.

**Table 1: Legislative timeline for reaching universal coverage, selected social health insurance systems**

#### Panel 1: The USA—the exception that proves the rule?

The USA is an outlier among high-income countries for its lack of universal health coverage yet its history still shows persistent progress in generalising access to health care. The largest expansion of public health coverage in the USA occurred in the 1960s when the government overcame opposition from many groups including the American Medical Association and created Medicare for the elderly and Medicaid for the poor. Demands for health reform continued in the face of political opposition, rising costs, economic stagnation, and ideological shifts. Serious plans for universalising health coverage were put forward by Presidents Nixon, Carter, and Clinton. Even without comprehensive reform, partial initiatives (eg, the State Children's Health Insurance Program) expanded public coverage enough that the USA performs well relative to its peers in terms of equitable access to many forms of health care.<sup>35</sup> About half of all US health spending is publicly financed and private insurance is publicly subsidised. Mandatory health coverage was ultimately enacted under the Obama administration in 2010, and, after surviving challenges in the courts, has now established the principle of universal health coverage in US law.

### Panel 2: Changes in health financing to support universal health coverage

Countries that expand access to health care tend to increase the share of health expenditures that are pooled. This can be shown by reference to the USA and Japan, two countries with adequate historical data on health spending (figure). Pooled health expenditures in the USA rose from 53% of total health spending in 1960 to 88% in 2008. Almost half of the additional pooled expenditures were funded through publicly subsidised private insurance premiums and the rest through general revenues. Japanese health spending has a similar pattern, although available data begin after the major universal health coverage reforms of the 1950s. The pooled share of total health spending in Japan increased from 60% in 1960, to slightly more than 80% in 2008.

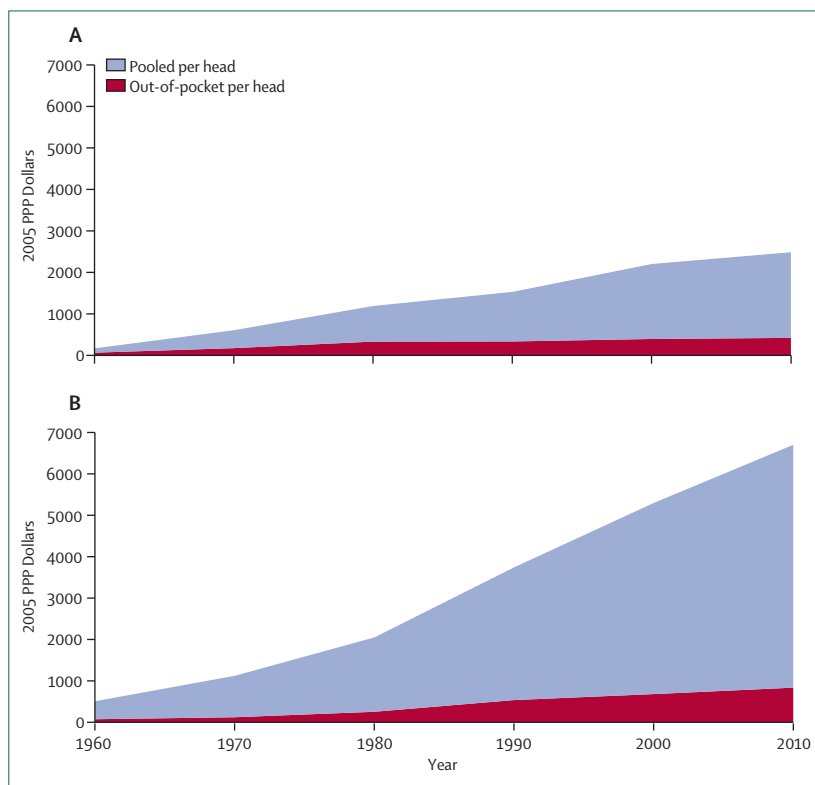


Figure: Rising health expenditures and pooled shares in the USA and Japan  
(A) USA.<sup>36</sup> (B) Japan.<sup>37</sup> PPP=purchasing power parity.

their systems also affects the composition of this growing health expenditure. Initially, most health care is paid for out-of-pocket, by individuals directly to health-care providers at the time of service. As countries grow economically and reform their health systems, prepaid pooling of health financing comes to predominate. In this sense, countries could be said to be moving through a health financing transition, from a situation in which health spending is low and predominantly out-of-pocket

to one characterised by much higher, mostly pooled spending on health (panel 2, figure, and table 2).<sup>38</sup>

Typically, health spending has grown faster than income. In OECD countries (excluding the USA) health spending per person grew by an average of 3.8% annually compared with 2.1% annual growth in GDP per head between 1970 and 2002.<sup>39</sup> In low-income countries, health spending per person grew by an average of 4.5% annually compared with 3.0% annual growth in GDP per head between 1995 and 2009 (these and subsequent figures are the authors' calculations from the National Health Accounts database<sup>40</sup> of WHO unless otherwise noted). The primary factors contributing to increased health spending are rising incomes and the expanding range of health services, with a small contribution from population ageing. Whether this increased spending contributes to wider access to necessary health care depends on political action to pool financing and establish mechanisms to spend efficiently and equitably.

### Income and health spending

Increases in national income affect health spending and the cost of universal health coverage in several ways. As households grow wealthier, they are able to purchase more health care and more health insurance. As countries grow wealthier, they can mandate larger contributions by employers and households or they can raise taxes from a larger economic base. At both the household and government level, increasing income raises the effective demand for health-care services. This increased demand is offset, to some extent, by the ways income contributes to improved health. With more income, households tend to purchase more food, better clothing, improved sanitation, and other goods and services that contribute to health. Governments in higher-income countries, too, can invest in improved environmental and public health services that improve health and reduce demand for health-care services.

Studies find that the net effect of income on health spending is positive and quite substantial. On average, a 1% increase in national income is associated with a 0.9% increase in health spending after controlling for other factors. Earlier studies estimated larger effects of income on health spending, but studies that used panel data from OECD countries<sup>41,42</sup> and data from a sample of 141 countries<sup>43,44</sup> have converged on this conclusion that the effect is smaller than 1%. Overall, income growth seems to account for between 10% and 25% of increases in health spending.<sup>45</sup>

### Changing medical practices and health spending

Changing medical practices seem to be the biggest contributing factor to growing health expenditures. Such practices make it possible to prevent or treat more illnesses even as they raise the costs of achieving universal health coverage. These changes are related to technological innovations that substitute for earlier

drugs, diagnostics, and procedures, or address disorders that were previously untreatable. They might also include the application of existing treatments more extensively and intensively. Studies have shown that the application of new medical technologies extensively and intensively accounts for between a third and two-thirds of the growth in health spending in the USA and France.<sup>45,46</sup>

This overall increase would be even greater if innovation did not also replace expensive interventions with less costly ones. Detailed studies have shown decreasing costs in particular kinds of surgery and pharmaceuticals.<sup>47,48</sup> The rapid decreases in prices of antiretroviral drugs since the 1990s, achieved through political pressure as well as negotiation, is another demonstration of how drug prices can decrease substantially.<sup>49</sup>

Low-income and middle-income countries are also affected by changing medical practices. Demand for advanced medical technologies and new drugs has driven-up costs to public health programmes in many of these countries.<sup>50</sup> Adoption of these practices makes the addressing of many illnesses and injuries possible, but also increases the challenge of financing universal coverage. Where health care is restricted to small shares of the population, simply extending existing health services to more people is likely to be the bigger challenge.

### Ageing and health spending

Despite popular perceptions, population ageing contributes only slightly to health spending growth and is not a substantial impediment to the achievement of universal health coverage. In most countries, people are surviving longer, fertility rates are decreasing, and the share of older people is growing. Older people tend to need more health-care services than do younger people, which generates additional spending on health care. However, the reasons for increased longevity are intrinsically tied to improvements in health. Nowadays, elderly people are in better health than were elderly people in the past, with improvements seen in every successive generation.<sup>46,51,52</sup> This offsets the effect of ageing on the overall demand for health care. Furthermore, health-care spending is more closely associated with an individual's proximity to death than it is to their age.<sup>53-55</sup> As people live longer, these end-of-life expenditures are delayed, which reduces current aggregate health-care costs.

Thus, most studies have shown that population ageing has only a small effect on health spending. Getzen<sup>56</sup> used data for 20 countries from 1960 to 1988 and showed that the correlation between health spending and ageing tends to disappear once changes in income and other time trends are incorporated. Dormont and colleagues<sup>55</sup> describe this trend as a common pattern of healthy ageing and project that demographic changes will contribute only slightly to increased health spending in OECD countries during the next 50 years. The effects of ageing in non-OECD countries in the next few decades are likely to be even smaller wherever the demographic

	1995	2009
Brazil	61%	69%
Democratic Republic of the Congo	22%	42%
Gambia	61%	67%
India	34%	49%
Indonesia	54%	64%
Thailand	57%	84%

We calculated pooled health-care financing by subtracting out-of-pocket spending from all health expenditures financed from domestic resources (ie, excluding foreign aid) using data from WHO's Global Health Expenditure database.<sup>49</sup> The denominator for the share of pooled health-care financing is all health expenditures financed from domestic resources. Such financing is strongly associated with the public share of total health expenditures but the two measures differ by the amount of voluntary private health insurance spending, which is a small share of total health expenditures in most countries.<sup>49</sup>

**Table 2: Increasing share of pooled health-care financing, selected countries (%)**

transition is less advanced and age-specific morbidities are decreasing. The exceptions in this case are countries with a continuing high burden of infectious disease, especially those with high prevalence of HIV/AIDS.

### Pooled financing and health spending

The shift towards pooled health financing has two different effects on health spending. First, pooled financing contributes to higher health spending by increasing the effective demand for health-care services. Pooled financing enables poorer households to get services they would otherwise be unable to afford, and all households tend to use more health care because of the tendency to prescribe or use more of a service when the marginal cost is paid, in whole or in part, by someone else. Dependent on the context, this increased utilisation could be beneficial or unnecessary. But either way, health spending will rise. Second, pooling can lower health spending when health financing organisations manage care in ways that improve health at lower costs, through the encouragement of cost-effective prevention, better management of chronic disorders, or the addressing of environmental and social health risks. By pooling funds, the institutions that manage them can also negotiate fees and prices, set global budgets, restructure provider payments to encourage efficient care, and rationalise the use of new technologies.<sup>41,57</sup> A central goal of the shift towards pooled financing is to remove financial barriers that inhibit people from using necessary health-care services. The related questions are whether the institutions that manage pooled funds can discourage unnecessary care and improve the efficiency of provision.

### Implications for reaching universal health coverage

Countries of all income levels are pursuing the goals of universal health coverage. Middle-income and high-income countries that have achieved universal health

	Health spending (% of gross domestic product)	Pooled health spending (% of total health spending)	Tax-based health spending (% of total public spending)	Gross domestic product per person (US\$)
<b>High-income countries with universal health coverage</b>				
Germany	11%	89%	52%	40 275
UK	9%	90%	100%	35 163
Sweden	10%	85%	100%	43 472
<b>Middle-income countries with universal health coverage</b>				
Chile	8%	66%	87%	9 487
South Korea	7%	65%	56%	17 110
Malaysia	5%	60%	99%	8 373
<b>Middle-income countries making rapid progress toward universal health coverage</b>				
Brazil	9%	69%	100%	8 251
Mexico	7%	52%	65%	7 852
Thailand	4%	84%	92%	4 608

Calculations made with data from WHO's Global Health Expenditure database.<sup>60</sup>

**Table 3: Health financing for selected countries by income and progress toward universal health care, 2009**

coverage are still reforming their systems to address remaining inequities, improve efficiency, and contain costs. Low-income and middle-income countries that have yet to attain universal health coverage are at various stages of policy reform and resource mobilisation.

Low-income and middle-income countries face a series of challenges that high-income countries did not confront when they began to develop universal health coverage systems. The demands on health-care systems were fewer in the early 20th century because the available medical technologies were also fewer. Epidemiological challenges facing low-income and middle-income countries might also be more serious because they generally have faster-growing populations, a higher prevalence of infectious diseases, and a growing burden of non-communicable illnesses compared with countries that attained universal health coverage earlier.

However, many of these countries have learned from previous successes and failures, allowing them to make faster progress with fewer resources than did high-income countries that have already achieved universal access. Countries like Malaysia and South Korea have reached universal health coverage in two to three decades and at lower income levels and with a smaller share of national income than the higher-income countries that preceded them (table 3). Most health spending in these middle-income countries is pooled but the mechanisms for pooling vary. For example, pooled funds in Malaysia are generated almost exclusively from general taxes whereas in South Korea they come mostly from mandatory payroll contributions.<sup>28,58</sup>

Low-income and middle-income countries are using a wide range of strategies to achieve universal health coverage.<sup>2,11,59,60</sup> Mexico is aiming to close coverage gaps by focusing on poor and marginalised groups. Its *Seguro*

*Popular* programme provides access to health services for people who are ineligible for employment-based insurance schemes because they are self-employed, unemployed, or out of the workforce (eg, students, children, and people who are retired).<sup>61</sup> National health insurance schemes are being implemented in countries as different as Ghana, Colombia, and Indonesia.<sup>59</sup> Brazil has expanded access to health care through its family health programme (Programa da Saude Familiar) and related reforms to its national Unified Health System.<sup>62</sup> Thailand has dedicated public revenues to a programme that finances care, largely through public health services, for people who are otherwise uninsured.<sup>33,63</sup> India is among those countries with the lowest share of pooled health spending, yet it is pursuing multiple initiatives to reach universal health coverage.<sup>64</sup> China, which initially turned health care over to private initiative during its early market reforms, has since recognised the limitations of private financing and is seeking to expand insurance coverage through public programmes.<sup>65</sup> These programmes have yielded varying degrees of success but the overall trend is favourable. They generally are pragmatic responses to a range of resilient popular pressures demanding better access to health care with greater financial protection.

This change will not, however, happen on its own. Although health spending is likely to rise in any country that has substantial economic growth and can access new medical technologies, universal health coverage will only be achieved if public policies ensure that a large share of this increased spending is pooled through a mechanism that promotes equitable and efficient utilisation of care. The exact mechanisms for pooling will depend on social processes and political action that establish the parameters for an acceptable public role in health care. In some cases, the result will be a government that primarily regulates the health-care sector, in other cases a government that finances or directly provides care.

## Conclusions

Universal health coverage costs money but it doesn't have to be expensive. Good health can be achieved at low cost whenever countries allocate resources towards more cost-effective care as shown in several low-income countries and regions.<sup>11,60</sup> Countries are likely to be more successful if they recognise that political action is needed to direct future growth in health spending through pooled financing mechanisms that enable the promotion of equitable and efficient health care. Countries are more likely to succeed if they identify and mobilise the groups and institutions that are most favourable to the provision of universal access, negotiate public roles that are compatible with their domestic political institutions, aim to extend health-care access to everyone, and take advantage of cost-effective approaches and cost-constraining strategies.

### Contributors

WDS was primarily responsible for writing the review and participated in all phases of the study. DdF contributed to the review's formulation and writing. ALS contributed to the review's formulation, writing, and literature review. VF contributed to the review's formulation, literature review, and data interpretation.

### Conflicts of interest

We declare that we have no conflicts of interest.

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