Reaching universal health coverage: a political economy review of trends across 49 countries

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Key messages

- The paper quantifies the relative importance of different enablers, strategies and constraints that 49 countries faced on their move towards universal health coverage (UHC).

- Most countries move towards UHC as a result of disruption to the status quo, notably shifts towards democracy or recovery from episodes of state fragility. The barrier for disruption is lower when neighbours and peers have already achieved UHC.

- Most governments do not aim to achieve UHC when they start investing in health. Rather, iterative reform leads to UHC and, when it does, UHC is very stable.

- Strategies for extending UHC to left-behind groups commonly include targeted inclusion or eligibility, expanding health units focused on primary healthcare (PHC) across underserved areas, providing health cards to targeted groups and the creation of a parallel insurance scheme for those not covered. Government systems appear to perform better than privately financed initiatives at reaching left-behind groups.

- The literature is much better at capturing demand-based health strategies for UHC provision; this emphasis suggests that governments may seek to maximise system utilisation while working to acquire the political momentum and technical capacity to expand coverage through more capital-intensive supply-based mechanisms.

- Many countries cite limited resources as a constraint to achieving UHC but wealth is not a major determining factor. Instead decisions are driven by a willingness to make trade-offs; recent economic growth makes these trade-offs easier and UHC more likely.

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Acronyms

GDP	gross domestic product
HAQ	Healthcare Access and Quality
HIC	high-income country
IHME	Institute of Health Metrics and Evaluation
LIC	low-income country
LMIC	lower middle-income country
MIC	middle-income country
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
PHC	primary healthcare
PPP	public–private partnership
SDG	Sustainable Development Goal
UHC	universal health coverage
UNDP	United Nations Development Programme
WHO	World Health Organization

1   Introduction

Our aim is to understand why and how countries provide health coverage, particularly to left-behind groups (Box 1).[1] To address these questions, we identified 49 geographically, economically and culturally diverse countries that have either achieved universal health coverage (UHC) or have made good progress towards it (Box 2). Examining the literature for each country, we sought to identify the enablers, strategies and constraints each faced in trying to expand healthcare.

Box 1   The leave no one behind agenda

Underpinning the Sustainable Development Goals (SDGs) is the fundamental aspiration to 'leave no one behind'. This has two key aspects: to 'see the Goals and targets met for all … segments of society'; and to 'reach the furthest behind first' (UNGA, 2015), an approach known as 'progressive universalism'.

Five key factors have been proposed as key to understanding who is 'left behind' and why: discrimination, place of residence, socioeconomic status, governance and vulnerability to shocks (UNDP, 2018). While the SDG outcomes document provides an illustrative list of the groups who are left behind consistently, it stresses the need for countries to identify and illuminate the circumstances of disadvantaged or marginalised groups in each national context. Our interest in this paper is to illustrate general tendencies across nearly 50 countries, and so we adopt a broad definition of who is left behind: we consider left-behind groups as those who have less access to or benefits from health services because of where they live or aspects of who they are.

Box 2   Defining universal health coverage

Universal health coverage aims 'to ensure that all people obtain the health services they need without suffering financial hardship when paying for them'. Key elements include: an effective health system geared toward priority health needs; the affordability of care; access to essential medicines and technologies, and well-trained and motivated health workers (WHO, 2014).

The principle of UHC derives from the 1948 World Health Organization (WHO) constitution, which declared health a fundamental right (WHO, 1948), and from the Health for All agenda set out in the 1978 Alma-Alta Declaration (WHO, 2014). Explicit judgements of whether a country has achieved UHC depend on the precise definition of UHC that is adopted, such as which healthcare packages are deemed essential. Our inclusion criteria deem countries to have UHC if they provide 'healthcare and financial protection to more than 90% of [their] citizens' (Stephane Tajick Consulting, 2018).

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1   Our focus is primarily on UHC – and what can be learnt about left-behind groups from this perspective – as the evidence base is much stronger than that relating to the 'leave no one behind' agenda.

By researching and connecting many countries, and bridging the political and technical issues associated with rolling out healthcare, we have created a unique resource that provides a rich comparative perspective on pathways towards achieving UHC.[2] We find that there is no single path towards UHC; rather, each country takes forward its own approach and faces its own challenges. But common themes emerge: countries normally move to provide health coverage during the reconstruction that follows fragility, for example following a war, coup or economic crisis. Wealth appears to be far less important than government capacity in providing coverage (though poorer countries are more likely to struggle with capacity). Government-run health systems appear to perform better than privately financed alternatives (e.g. insurance models). Before UHC is achieved, health reforms are often subject to contestation but once countries move towards universal coverage, this becomes stable and is unlikely to be reversed.

This paper synthesises the existing literature, which allows covering a broader range of countries than would be otherwise possible, and enables us to identify global and regional trends underlying progress. We review 49 countries, which are selected based on an index that measures the quality and coverage of their healthcare systems. This paper expands an understanding of the different strategies governments adopt to expand health coverage by looking at the stage where UHC is embraced and at earlier government interventions, which were instrumental for achieving universality at a later phase. It also seeks to identify what these countries' experiences reveal about constraints to achieving UHC. In a companion paper (McDonnell and Samman, forthcoming), we review the literature on constraints that left-behind groups face to accessing quality healthcare and on interventions targeted toward disadvantaged and marginalised groups that can precede and accompany broad structural reforms aimed at UHC.

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2   See https://www.odi.org/resources/reaching-universal-health-coverage-political-economy-review-trends-across-49-countries for the country level database.

2   Literature review

Most of the academic literature on access to healthcare is based on individual countries and often seeks to understand a single reform or programme. This paper aims to build upon this large body of research by creating an overview of health provision across the world in countries that provide examples of progress.

Several papers examine how countries have achieved UHC. In *Universal Health Coverage for Inclusive and Sustainable Development*, the World Bank undertook qualitative analysis of how 11 countries moved towards UHC, looking at the political and technical challenges they faced. The authors find that strong political leadership, investment in prevention and a resilient primary care system are essential for effective and sustainable UHC. They also argue that resources and the health workforce need to be carefully managed, particularly when coverage is expanded (Maeda et al., 2014). The Organisation for Economic Co-operation and Development's (OECD) *Health Coverage and Health Outcomes*, uses a quantitative approach to assess UHC, combined with eight case studies. It focuses on the lessons low-income countries (LICs) and middle-income countries (MICs) can learn from considering OECD countries' moves towards UHC. In terms of policy, it suggests that financial sustainability needs to be built into a health system from the start by providing well-defined benefits and focusing on primary care (Person et al., 2016). More recently, World Bank's *Business as Usual*, quantitatively analyses progress towards UHC in those LICs and MICs with adequate data, arguing that currently it is not quick enough to meet SDG target 3.8 of achieving UHC by 2030 (World Bank, 2018a).[3]

Publications that examine how to reach left-behind groups within UHC are less common. The World Bank's *Going Universal*, examines how 24 different countries provide healthcare to marginalised groups and provides a detailed outline of different strategies countries can use. This paper again emphasises how money is spent rather than how much is spent. It finds that accountability is crucial at both a national and a local level to ensure that policy-makers and health providers are using funds efficiently and meeting their objectives. They also suggest that countries carefully consider what to include and when to expand health packages, as unaffordable but generous packages tend to lead to poor allocation and people being left behind. When countries include illnesses that are costly in their packages (e.g. cancer care) and cannot afford to provide these universally, it is typically urban populations and those with better connections who get preferential access, exacerbating inequalities in health. They propose that countries often make initial steps towards health for left-behind groups that are incompatible with UHC, such as a two-tiered structure, but these instead act as 'stepping stones' for a future expansion into UHC.

Other papers look more specifically at the enablers of or constraints to UHC roll-out. Stuckler et al. (2010) explores barriers to UHC, in particular the need for political support – which they argue is the main driver of universality, rather than resources. Their study explores how barriers to UHC such as low taxation, inequality or low heterogeneity can be overcome, and particularly the important role of both legal commitments and public sector funding. Savedoff et al. (2012) similarly

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3   SDG 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

focus on global or quantitative data to look at trends in health coverage. They suggest four main factors are needed to deliver UHC: political support, an increase in pooled health expenditure, a growth in income or government fiscal space, and a move towards risk-sharing and away from out-of-pocket expenditure. Finally, Gupta et al. (2015) interviewed policy-makers and civil society members from six MICs that have recently achieved UHC. The most important explanatory variable they identify is social solidarity – the sense of community within a country. They also found that economic growth (not absolute wealth) made it easier for countries to roll out UHC because it limited the objection that it could not be afforded; however, growth on its own was insufficient. They believe it is easier to achieve UHC in countries where there is legislative decorum, the 'relative ease of ensuring that the political agenda of an incumbent party or regime becomes law' (ibid.). Unsurprisingly, high dissatisfaction with the old health system and new political leadership also made UHC more likely.

We believe this paper is the first to bridge the political economy literature on factors enabling the roll out of UHC with the technical literature on how the roll-out was accomplished, while adopting a leave no one behind focus. We identify political drivers similar to those found in the political economy literature on UHC, such as political windows of opportunity, left-labour coalitions (Stuckler et al., 2010) or transformative leadership (Gupta et al., 2015). Beyond these shared findings, our research builds a more comprehensive perspective on the political economy process by complementing these social and political factors with enabling variables, such as the influence of similar states and state fragility. Overall, by analysing the political impetus for government interventions across different stages of the development of health coverage, we seek to shed light on the genesis of demand for UHC as well as to quantify the enablers, strategies and constraints among a range of different countries trying to achieve UHC.

3 Methodology

3.1 How countries are chosen

We sought to understand how and why different countries have provided healthcare to their citizens. Our focus is on the experiences of a geographically and economically diverse set of countries that have performed well in extending health coverage. We identified 49 countries for inclusion. Firstly, we divided countries into those that have achieved UHC using a 2018 index put together by Stephane Tajick Consulting (STC), which concludes that 105 countries have UHC and 77 have not (Stephane Tajick Consulting, 2018). Countries are deemed to have UHC if they provide 'healthcare and financial protection to more than 90% of [their] citizens'. While there are many indices on the quality of healthcare, this is the only index we are aware of that explicitly categorises countries as having achieved or not yet achieved UHC. The STC approach was not used in any of the subsequent analysis.

A secondary benefit to the STC approach as an inclusion criterion was its strong emphasis on financial protection as a metric for judging health systems. This renders it superior to other health indices in identifying countries that perform well in providing coverage despite resource constraints. Wealth was, however, still the largest driver of whether a country was classified as having UHC. Because we are predominantly interested in LICs and MICs, we removed all high-income countries (HICs) except for the first six to reach UHC and the six countries in the world deemed to have the best healthcare coverage according to the Institute of Health Metrics and Evaluation (IHME) Healthcare Access and Quality (HAQ) Index, of which Norway was in both groups. Only one LIC, Rwanda, was classed by STC as having achieved UHC. Because this is the group we are most interested in, we also added ten LICs with the best healthcare systems according to the HAQ index. Because of data constraints, we removed countries with a population of less than 2 million people. Finally, the progress of countries that were part of Yugoslavia or the Union of Soviet Socialist Republics (USSR) prior to the early 1990s followed identical pathways towards UHC. A large number of each group ended up within our inclusion criteria, so we only included the most populous half of these countries. This left us with 49 countries (see Appendix, which also describes the reasons for each country's inclusion, and the strategy they pursued).

3.2 Country-level data

We aimed to build a dataset giving an overview of each country's health system and progress. In particular, we collected detailed information on each country's general health coverage trends, the years they implemented new programmes that resulted in UHC (or for all LICs but Rwanda, expanded healthcare access), how long it took, factors enabling implementation, how the programme was financed, their strategy for achieving UHC (or progress in this direction) and the constraints they faced.

To collect this data, we searched for relevant academic and grey literature in PubMed, JStor and Google Scholar by combining the terms 'universal health coverage', 'health' 'reform', 'system', 'history', 'welfare state'. In Francophone and Hispanophone countries, searches were conducted in French and Spanish respectively, as well as in English. Data gaps were filled in by searching government websites or by looking at political and social events from the Freedom House report, *Freedom in the World* or the *CIA World Factbook*, during the years corresponding to decisive steps towards UHC. In a small number of cases, local newspaper reports were also used.

This research provided complex, idiosyncratic stories of how and why UHC was rolled out. To analyse them, we identified common patterns to create categories of strategies, health system structures, constraints to implementation, political impetus and enablers. We then assigned each country's experience to the relevant categories, thereby standardising 49 stories as to identify overall trends. In addition, we flagged whether each strategy was aimed at reaching left-behind groups, which groups were first reached and which groups were left-behind.

3.3 Quantitative data

We included approximately 400 sources of data in our country-level analysis (available on request). While this generated a lot of information, often comparing two different countries or different sources for the same country was quite a subjective exercise. Since we relied on diverse accounts of health system expansion, it is possible that two very similar processes could be described differently or, conversely, that different processes end up in the same category. We tried to limit this potential bias by having two people compare the literature and categorisations separately. We also introduced publicly available cross-national statistics from global institutions and, in some cases, academic literature to test the relationships we discovered in our qualitative exercise. This dataset allowed us to go beyond the 49 countries we analysed to examine if similar relationships existed elsewhere and to test constraints that were discussed in general literature but appeared to be missing from country-specific studies. Finally, we used this quantitative data to test the quality of healthcare provision emerging from different strategies and approaches to attaining UHC (or registering progress, in the case of all LICs but Rwanda).

Explicit judgement of whether a country has achieved UHC is challenging because it depends on the definition of UHC, in particular which healthcare packages are deemed essential. In the quantitative analysis, we used two indicators. Firstly, we used a UHC index that was created to monitor progress on SDG 3.8, which seeks to achieve UHC. The index, created by WHO and the World Bank, tracks whether and how far away countries are from UHC, and the quality of care people can access (Hogan et al., 2018).

Secondly, we used the HAQ, which was created by IHME to help the predict the future global disease burden. They calculate this index by taking 32 diseases that are treatable; they standardise the risk causes (such as smoking rate) and look at mortality and morbidity rates by country, giving each country a score between 0 and 100. The index has been calculated every five years between 1990 and 2015 (Barber et al., 2017). This metric is excellent at capturing the aggregate quality of and access to health.[4] However, it does not account for subnational inequalities in health outcomes. A country that has great health for the majority but leaves many groups behind is likely to have a similar score to a country with good (but not great) UHC, which does a good job of not leaving anyone behind. This limits the HAQ's value as a measure of the leave no one behind agenda.

We conducted various quantitative analyses, but standard controls included the IHME's socio-demographic index, which is a composite average of incomes per capita, average educational attainment and fertility rates (IHME, 2016); and data on inequality as measured by the Gini coefficient, homogeneity, democracy and the percentage of people who live in urban areas (see data sources in Appendix).

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4   The HAQ index measures overall health access not UHC, which is the reason for using the STC index as part of our inclusion criteria for the qualitative research.

4 Why countries move to universal health coverage

Two factors appear to enable countries to roll out UHC: disruption and peer trends. Applying a broad lens to disruption, we include movement towards democracy or recovery from episodes of state fragility. By peer trends, we mean that countries are heavily influenced by the action of their neighbours and global tendencies. In most countries, both factors seem to be at play: the vast majority of moves towards UHC are influenced by fragility and what other countries have done. In particular, we think peer trends might lower the bar needed to disrupt inertia, but they rarely remove the need altogether.

4.1 Breaking inertia

Most major moves towards UHC seem to be inspired by an event or change in circumstances that breaks the country's usual pattern and upends the inertia that has prevented healthcare reform. State fragility seems to have been a triggering factor in motivating governments. Democratisation, too, can be accompanied by UHC as governments in new democracies seek to win support by improving health services, which once again breaks the inertia that impedes health progress.

Seventy-one per cent of late stage or major steps towards UHC in our analysis take place shortly after instances of fragility.[5] Alongside this, more than half of countries' early moves into healthcare were influenced by a context of state fragility – mainly, the recent experience of a war that extended the active role of the state from a warfare to a welfare state. Of the countries in our analysis, 88% were influenced by state fragility in at least some stage during their move towards UHC.

Sources of state fragility include vulnerability to conflict (e.g. Uzbekistan), sequels to previous conflict (e.g. Rwanda's genocide, the Arab Spring, Nepal's civil war), social unrest (e.g. post-war Germany, Peru, Mexico, Colombia, Thailand), overall political crisis that threatens government legitimacy (e.g. Turkey, Paraguay) and post-war reconstruction (e.g. Belgium, Norway, Japan, United Kingdom). In practical regards, these were difficult times to roll out UHC, as money was usually limited and often subject to competing claims. But fragility appears to be a very powerful motivation because the disruption weakens some of the powerbases that might oppose UHC and because governments often seem to use healthcare provision as a way of building unity or legitimacy after conflict. This also suggests that governments see UHC as a way of creating stability. If countries undergoing the difficult task of post fragility reconstruction can find the necessary resources to create stable health systems, it suggests that the main barriers to UHC roll-out are political. However, while such reconstruction aids the creation of UHC, health systems are strongest when countries are stable.

4.2 Democratisation

Underlying state fragility, we found recurrent political instability leading to democratisation. Within this, UHC seems a powerful instrument to establish unity, legitimise rule and/or buy support. We found that political instability
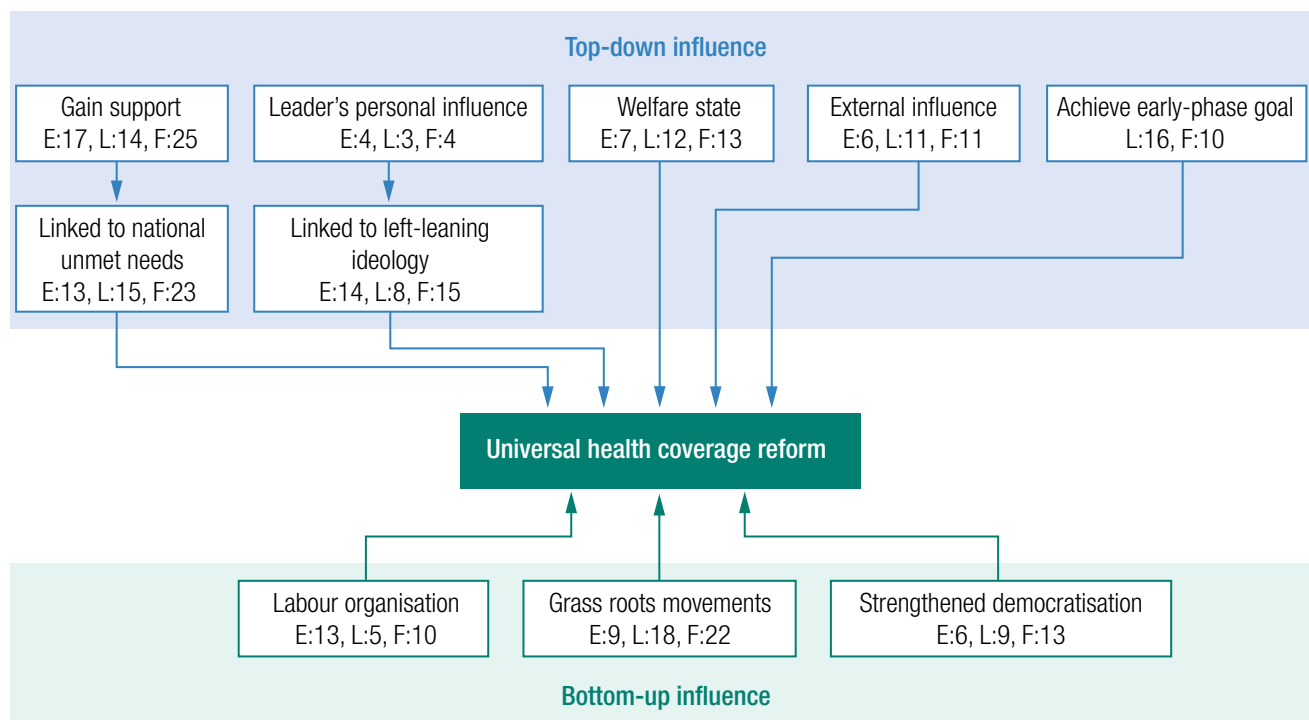
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5   We categorised a country as experiencing state fragility in cases of violence, political instability, social unrest, or poor economic foundations (e.g. countries with relatively high extreme poverty).

was linked to a country's move towards democratisation in around a quarter of countries.[6] We identify the transition to democracy as a key moment in the path towards UHC globally since it creates a window of opportunity. For instance, the government responsible for taking the decisive step towards universality was elected either under the first democratically competitive elections in Mexico, the first elections run by a new independent electoral commission in Kenya and the first elections held after expanding the franchise in Sri Lanka.

While all countries' moves toward UHC had a top-down impetus (i.e. decided and implemented by central government) we found that in around a fifth of the countries, central government's decision was driven from below – that is, directly influenced by grassroots movements, organised labour or local governments – (Figure 1).[7]

In other cases, such bottom-up influence was present but did not appear as a catalyst for UHC. Figure 1 shows the breadth of influencers of UHC reform. When initiatives towards UHC were rooted in grassroots movements, societal demands for the right to health as a human right within a call for democracy were integrated into the constitution, as in Brazil and in Nepal. In the latter, the 2006 Democracy Movement took advantage of the window of opportunity created by political turmoil to push not only for democracy but also for the establishment of health as a right; this materialised in the first-ever government commitment to universal health as written into the Interim Constitution of 2007 (Jones, 2012; Sato and Gilson, 2015). In other cases, social movements might have been initially repressed by the state, yet social unrest eventually triggered political instability and a democratisation process that brought about

Figure 1   Political enablers underlying moves toward universal health coverage in 49 countries

Note: 'E' and 'L' are the number of countries to have been influenced by each political motivation in their early and late phase respectively. Because one country might have been motivated by more than one reason, numbers do not always add up. 'F' indicates whether the countries motivated by each strategy where also experiencing state fragility in either their early or late phase.
Source: Authors' own calculations and elaboration.

6   Brazil, Burkina Faso, Ecuador, Indonesia, Kenya, Liberia, Mexico, Nepal, Paraguay, Sri Lanka, Tanzania, United Kingdom.

7   Belgium, Brazil, Colombia, Indonesia, Malaysia, New Zealand, Sri Lanka, Tunisia, United Kingdom.

UHC (e.g. Colombia, Mexico, Tunisia). Against this backdrop, UHC emerged from a context of newly-gained independence, the end of an authoritarian rule, the first democratically held elections, etc. Overall, these experiences point to the complementary role of government and civil society in maintaining the impetus for UHC.

Combining our qualitative data with the available quantitative data, we found a lagged correlation between democratisation and health interventions. This suggests the possibility that democratisation puts pressures on government to expand health coverage; however, the link is not statistically significant.

Democratisation, rather than democracy, seems to push governments towards UHC, as they seek to build support from citizens in order to stay in office. However, equally, the multiple stakeholders needed to generate change in some democracies can impede progress on UHC. Moreover, there is evidence that governments institute healthcare programmes to gain legitimacy when elections are not truly democratic (e.g. as in Rwanda or in Gabon).

4.3 Peer trends

Three main peer trends appear to enable UHC: time, location and peer influence, which are all strongly interlinked. Initially, the late 19th and early 20th century witnessed a large move towards government involvement in healthcare in Europe. Over the past four decades, major expansions have taken place in Asia and the Americas, and numerous African countries are now making impressive progress towards UHC and committing themselves towards ambitious targets (see Box 3). It is clear in the literature and the various strategies used for UHC that both policy-makers and the public are influenced by healthcare provision in other countries, particularly neighbours. When countries in a region move towards UHC, others tend to follow.

Peer trends have evolved over time. In particular, the emphasis on health appears to have changed substantially in the last half century. Early moves into health expansion formed part of a broader welfare package, often implemented by left-leaning governments in higher-income settings. For example, the 1910

People's Budget in the UK set up the first unemployment benefit system and created health insurance for those in employment at the same time. Similarly, the Attlee Labour government created the UK National Health Service in 1946 as part of a plethora of reforms that became known as the welfare state. Germany's move towards healthcare was part of a wider *Sozialgesetzgebung* (social legislation) movement in the 1880s. This pattern is consistent with most moves into healthcare until the 1960s.

In the latter decades of the 20th century, this emphasis seems to switch. As governments withdrew from healthcare provision amid a wave of privatisation, rising out-of-pocket payments excluded an increasing share of people from access to health. Social discontent and claims of the right to health fuelled the efforts of grassroots movements to become key influencers in setting health as a government priority. Grassroots campaigns began to champion greater healthcare on its own merit across LICs and MICs, rather than wider social reforms that included healthcare. This was the case of Brazil's Sanitarista movement in the 1980s, the People's Health Movement working in around 70 countries since 2000, or the Action Committee for Social Security Reform (Komite Aksi Jaminan Sosial, KAJS) civil society organisation in Indonesia in the early 2000s (Ravenscroft and Marcos, 2012). Peer trends recur, as in Latin America where civil society movements shared the same aspiration of promoting equity in health by expanding coverage beyond formal workers, in Brazil in the late 1980s and in Colombia and Mexico in the 1990s. But even when governments roll out health coverage alongside wider social reforms, there is a greater emphasis on healthcare as a discrete component. The change in this rhetoric is evident in how it is presented across contexts – for example as a 'gift' from the President in Mali and Burkina Faso, or as a 'human right' in Ecuador and Brazil (Olivier de Sardan and Ridde, 2012; Malo-Corral and Malo-Corral, 2014).

More research is needed to understand this shift towards separating health from other welfare programmes, such as social welfare, pensions and free education. It might be linked to reduced social spending in Latin

Countries moved toward UHC in Africa in three waves. The first signs of government intentions to provide UHC appeared in the aftermath of countries' independence in the early 1960s, including in Algeria, Gabon, Kenya, Mauritius, Tanzania and Zambia. Motivations included socialist ideology (in Algeria and Zambia) and a will to strengthen the newly independent states' legitimacy. Among the countries in our sample, Algeria, Kenya, Mauritius and Tanzania took forward this intention by providing free healthcare, mainly through user fee removal in the 1960s and early 1970s.

A second wave of country moves towards UHC (including in Gabon, Ghana, Liberia and Malawi), dating from the early 2000s, aimed to address unmet needs and gain political support, against a background of increased poverty and inequality. This stood in contrast to the tendency in the last decades of the 20th century to privatise healthcare and introduce user fees (e.g. in Ghana, Mali, Malawi, Kenya). The rationale behind fees was to fight moral hazard in health and improve economic efficiency but there is wide evidence that they hindered access and worsened inequalities in health (Ferguson, 1994; Messac, 2014). As Alma Ata recommendations (see section 5.4; Table A.3) gained currency in the late 20th century, this prompted new collective thinking from international agencies who started pushing for removing barriers to healthcare and prioritising access for vulnerable groups. User fee exemptions for targeted groups started in the 1990s in Tanzania (which had reintroduced user fees) and Zambia. Then in the early 2000s, Ghana, Liberia, Mali and Kenya progressively removed user fees in public facilities or for selected treatments, a decisive step towards UHC. In Malawi and Liberia, a strong government commitment to UHC emerged as countries recognised that better health can raise productivity and thus address poverty (Chansa and Pattnaik, 2018; Svoronos, 2015).

Finally, in this last decade, a third wave of countries has moved towards UHC after instances of state fragility, for example with the 2015 peace agreement in Mali, the end of the Arab Spring in Tunisia and the expulsion of Burkina Faso's authoritarian government by a popular uprising in 2014.

America and Africa, particularly following the structural adjustment polices of the 1980s and 1990s. As governments had to make trade-offs, healthcare reforms may have gained momentum and become disentangled from other welfare policies. Alternatively, the shift might be linked to the rising price of healthcare. As medicine has improved, the cost of offering what is contemporarily considered good quality health coverage has risen. This is evident in G7 countries, most of which had achieved UHC by 1960. In 1960, G7 countries spent between 2% and 5.5% of their gross domestic product (GDP) on health, shares that increased to between 5% and 11% by 1987 (Schieber, 1990) and between 9% and 17% in 2015 (World Development Indicators, 2018). While we do not expect LICs and MICs to devote similar shares of GDP to health, this nonetheless illustrates how the costs of providing treatments have increased, which might limit countries' ability to provide UHC alongside other reforms.

Peer trends follow each other in what we will call direct 'peer influence', which was visible in around one-fifth of the countries in our sample.[8] Among early moves towards UHC in the early 20th century, left-leaning ideology and rising welfare states spread the goal of providing healthcare globally (e.g. from across Europe to poorer regions). By the end of the 20th century, international development agencies appear to influence strongly peer adoption of UHC. For example, multilateral development banks shifted their focus from

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8   Argentina, Australia, Finland, Haiti, Malaysia, Mexico, Nepal, Norway, Sri Lanka, Tanzania, Uzbekistan.

Structural Adjustment Programmes towards human-capital oriented policies, thereby motivating and facilitating governments' ability to achieve universality. This shift was partly influenced by the Alma-Ata Declaration of 1978, and was strengthened under the Millennium Development Goal and Sustainable Development Goal movements. The international development discourse primarily shaped national policies by highlighting the instrumental benefit of health as an accumulator of human capital, beyond its importance as a means of gaining political support.[9]

4.4   Countries settle on UHC

While all countries in our dataset have either achieved UHC or are aiming to achieve it, most governments did not roll out their initial health strategies with this end in mind. Just 13 countries in our dataset (27%) set out to achieve UHC with their initial strategy, and in these initial strategies it is an exception rather than the rule to see vulnerable groups being reached first. An instance of such exceptions are the first African government's interventions, which included fee exemptions targeting people in poverty, children, and women (e.g. Burkina Faso, Liberia).

With their later strategies, all countries in our dataset set themselves the goal of universality to leave no one behind, while 44 (89%) aimed at reaching the furthest left behind first. Even if UHC is not their final goal, or even a stated aim, once countries achieve limited health coverage, the tendency is toward expansion, at least judging by the countries in our dataset. Moreover, once countries achieve UHC, they tend not to overhaul their health system radically afterwards.

At a qualitative level, the literature suggests that dissatisfaction with care and the political pressure for radical change often remain strong until countries reach universality, at which point these pressures subside. Post universality, health has normally become one of the largest parts of government and remains politically sensitive, but the debates are more confined. Instead of discourse being driven by ideological questions of the state's role in health or of the best way to structure the health system, reforms and debates become much more dominated by questions around iterative reform.

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9   An alternative, the human development approach, championed by the United Nations Development Programme (UNDP), urged that countries advance health, education and other aspects of development as ends in themselves (see Stewart et al., 2018), but this approach has been less influential in shaping the policies of multilateral development banks.

5 Strategies for achieving universal health coverage and reaching the left behind

Countries follow different pathways in achieving UHC. Some countries use a health insurance-based approach, which is often heavily reliant on the private sector as the service-provider, while others focus on government provision. Governments also rarely build healthcare services from scratch, but often work to expand existing systems and manage them in such a way that more people can achieve access to a greater range of services.

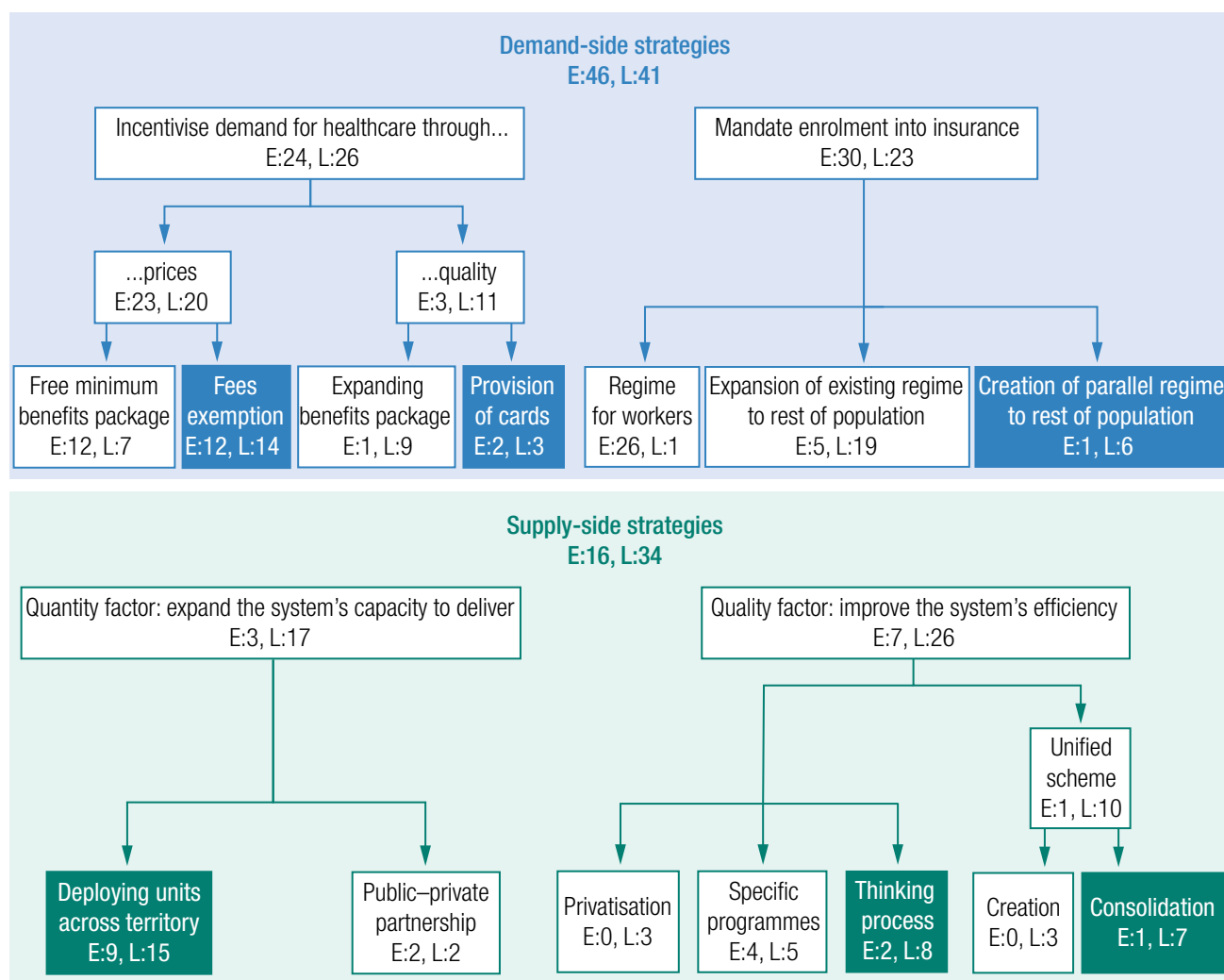## 5.1 The timing of coverage: early and later expansion

While no two countries' move to UHC was identical, we identified a common pattern. Most countries move into the healthcare space first by limiting eligibility in what we describe as their early phase, most commonly by making insurance compulsory for those in formal employment. This eventually leads to more ambitious goals and a move towards UHC in what we call the late phase. Sometimes, many decades elapse between these phases, and strategies for improving health can differ greatly between them. For example, the UK government introduced a system of mandatory health insurance for workers in 1911, which was expanded several times in the 1920s. Then, in 1946, the government passed the National Health Service Act, nationalising most of UK healthcare provision into one unified

service. The same pattern is evident in lower-income settings. In Thailand, the government initially moved into healthcare provision in 1975 to provide greater care for the rural poor. In the 1980s, it then set up systems to cover public sector workers and those in formal employment. After 2000, Thailand moved to UHC through providing a defined range of treatments, initially with limited user fees that were later removed.

We have divided each countries' approach to UHC into these two phases, the first focused on early strategies used when the government initially seeks to provide healthcare and the second, exploring their strategy for achieving UHC. Throughout this paper we refer to the first major government move into healthcare provision as countries' 'early phase' and their movement from basic provision towards UHC as 'later phase'.

Countries have passed through these two phases at very different times: some European countries started in the late 19th or early 20th century, while others did not enter what we classify as their early phase until the beginning of this century. Figure 2 outlines the different strategies we identified and the number of countries that adopted them at an early or later phase of their health system development. Most countries took more than one broad approach to achieving UHC, so adding these together, we end up with 76 early phase and 99 late phase strategies. An initial glance makes clear

Figure 2 Strategies underlying moves toward universal health coverage in 49 countries

Solid boxes indicate strategies aimed specifically at reaching left-behind groups

Source: Authors' own calculations.
'E' and 'L' are the number of countries to adopt each strategy in their early and late phase respectively. Because one country might implement two strategies in the same category, numbers do not always add up.

that no widely used strategy is unique to either the initial expansion of the healthcare system or the subsequent move to UHC. The figure also flags whenever a strategy was specifically aimed at reaching left-behind groups – for examples through the use of targeted inclusion/eligibility, the expansion of health units focused on primary healthcare (PHC) across underserved areas, the provision of health cards to targeted groups and/or the creation of a parallel insurance scheme for those not covered.

While only around a third of the early interventions aimed at covering vulnerable groups, almost all the later-phase strategies (89%) integrated the goal of reaching those left behind. We therefore examine coverage of left-behind groups as tightly linked to reaching universality in healthcare access through later stage strategies. Early interventions to provide healthcare mainly targeted workers in the formal economy and carried an urban bias, leaving most of the population uncovered.[10]

10 Those vulnerable to income shocks include marginalised, at risk, women, children, persons with disabilities, pensioners, students; but also, those too wealthy to qualify for existing government schemes but not well off enough to cover their own care.

Groups excluded from early phase interventions that were specifically targeted in later phases included rural dwellers (particularly those in remote areas), people vulnerable to income shocks, and indigenous and ethnic minorities. The main priority in later stages was on expanding coverage to people in poverty overall (evident in one-third of the countries in our sample), though sometimes governments targeted vulnerable groups or underserved areas more narrowly. For instance, rural dwellers received explicit attention in Algeria, Kenya, Liberia, Malawi, Tanzania and Zambia; while children, pregnant women and people with disabilities were the focus in Ghana. In other cases, lower-income groups were identified through a self-targeting mechanism as the state made public healthcare free but with lower quality than private alternatives (e.g. in Paraguay, Kenya, Malaysia and Jamaica).

We outline health strategies in more detail in the Appendix, section A.2.

5.2   Policy considerations: supply- and demand-boosting strategies

We further characterise each strategy as seeking to boost the supply of or demand for health. Demand-boosting strategies seek to reduce the cost of accessing the healthcare system or improve packages (e.g. the state benefit package). Supply-boosting reforms seek to improve the basic system and its ability to treat patients. Overall, while the majority of strategies have focused on demand both among early and late phases of adoption, we found an increase in approaches aiming to boost supply in later-stage interventions in the development of health coverage.

This finding suggests that countries might have found it more feasible – technically and politically – to emphasise first creating an incentive for, or mandating that access to, healthcare reach those who were uncovered, using existing facilities and delivery capacity. Maximising the utilisation of the existing system need not mean investing in building new facilities or training. Similarly, it may be efficient to appeal to excluded groups' demand for healthcare, for example through means-tested fee

exemptions, to identify them to then build health units over their territory. It might be also more politically feasible given that the health benefits from reduced user fees accrue much more quickly than the health benefits from investing in infrastructure; it takes time for health facilities to be built and users do not experience the benefits until they are up and running. Then, once UHC becomes an explicit goal, investments that expand the system's delivery capacity and efficiency might appear more technically and politically feasible.

Our finding that demand-boosting approaches appear more frequently might also reflect the literature and possibly the search strategy. Our information derives from a literature review focused on UHC expansion and not on health systems overall. One consequence is that programmes undertaken to build health delivery capacity were less clearly visible as direct contributors to reaching UHC than user fee exemptions or health insurance mandates. This may be in part because countries can increase hospital capacity slowly, in a way that is not picked up by the literature, while changes to fee structures, insurance or other demand-led changes tend to be done on a large scale. Indeed, there was no link between changes in doctors per capita nor in the number of hospital beds in a country and the literature's flagging of hospital-building strategies. Moreover, it was not possible to disentangle the effect of programmes that build overall state capacity to identify those aimed at delivering health services.

Overall, this predominance of demand-boosting strategies suggests that countries might be opting to first maximise system utilisation by stoking demand for healthcare while in the meantime seeking to acquire the political momentum and technical capacity to expand coverage through more capital-intensive supply-side mechanisms.

5.2.1   Categorising interventions aiming to boost demand for health services

We further categorised demand-boosting interventions into those that affect price or quality and those that mandate adherence to contributory insurance schemes – for example,

by creating regimes segregated by employment or income status.

We identified two common price-based mechanisms. One is the introduction or expansion of user fees exemptions for targeted groups, which was particularly important among late movers and often targeted people in poverty through means tests. The other is the provision of a free – or at least highly subsidised – guaranteed minimum benefits package, often restricted to primary healthcare, which was a common feature in late and early European interventions as well as in some early phases of LICs and MICs (e.g. India, Indonesia, Malawi, Algeria).

Similarly, quality mechanisms were of two types. The first involved expanding a country's minimum package to more complex treatments, which was particularly evident in Europe. Such treatments included higher quality interventions, addressing diseases that require better trained doctors, more expensive drugs, etc. The second mechanism, adopted in LICs and MICs, involved providing cards aimed at improving the management of benefits from the intervention and facilitating access to health by communicating to people (particularly those that were previously uncovered) their entitlements, thereby raising awareness of the services available. Cards are considered a means to improve the quality of delivery and information, as opposed to how many people are targeted.

Finally, demand-boosting reforms can involve insurance-based systems, which divide further into systems focused on those in formal employment, parallel two-tiered systems where workers' insurance sit alongside social assistance, and mandatory insurance where healthcare is compulsory, and usually involves subsidies for poor groups. Among early interventions to provide healthcare when UHC was not yet a goal, insurance schemes for formal workers appear in half of the countries studied, particularly in European and Latin American countries. As these interventions expanded coverage to a high share of the population, they were instrumental in governments' achievement of universality at a later stage. Such insurance schemes are often voluntary and contributory; they firstly target formal workers given the importance of workers' unions and their

influence on government policy. Then, at later stages, governments expand insurance-based coverage, either by mandating the enrolment of the rest of the population – as in most European, Western Pacific and some Latin American countries (e.g. Uzbekistan, Peru, Japan) or by creating a parallel scheme targeting informal workers – with it being deployed in four out of the nine Latin American countries we looked at, including Mexico and Colombia, (although it was less common elsewhere, with only Tanzania, Mauritius, Mali and Thailand using it).

5.2.2   Categorising interventions aiming to boost supply of health services

We also break down supply-boosting interventions into two groups. The first group focuses on mechanisms aimed at expanding systems' capacity to deliver health services by building more health facilities. This is often to address regional inequalities, which is usually done directly but occasionally through public–private partnerships. The second group focuses on interventions aimed at improving system efficiency. This again can be broken down further into: the privatisation of services (as in Malaysia or in the Netherlands); processes of trial and error, where countries embark on pilot programmes or learning processes (e.g. Romania, Burkina Faso); or what we label 'specific programmes' including a number of efforts to improve efficiency such as cost containment in Germany, the creation of a pool fund in Liberia, or the building or enlargement of specialist facilities for more complex treatments in Algeria and in Turkey. A final approach to raise efficiency is what we called a 'unified scheme', which is where the state either creates a unique system to cover all citizens, as in Gabon or in Mali, or consolidates multiple programmes into one health system, as in Argentina and India.

5.3   Drivers of different regional strategies to attain universal health coverage

As seen in earlier sections, the path towards UHC was premised on political considerations, influenced by state fragility and external factors such as peer trends. We also find that global

and regional trends had a large impact on the strategies different countries take.

Globally, the first interventions in expanding access to healthcare appear to revolve around demand-boosting approaches, though with some regional variation. To lower the cost burden of healthcare, African countries often introduced user fee exemptions for vulnerable groups such as children, women and poorer people. While in ex-Soviet countries and some Asian countries (e.g. India and Indonesia), governments opted for a free benefits package, in practice access to quality healthcare was unequal. Kenya stands out in its aim to reach all those not covered through a self-targeting mechanism. By removing fees for maternity care and PHC in all public facilities, it maximises access for the poor while minimising delivery costs, since formal workers preferred to seek care through their own health insurance. Instead of boosting demand by lowering prices, many Latin American and European countries, along with HICs from the Western Pacific (e.g. Australia, Japan) tended first to mandate that formal workers receive health insurance (as discussed previously). Despite this worker – and urban – bias, these insurance schemes were often complemented by state provision of free care for people in poverty and other vulnerable groups (e.g. free PHC in Indonesia, family healthcare units in Paraguay or medical relief in the Netherlands). Asian countries mainly followed a supply-boosting strategy as a first-stage intervention, based on deploying health units focused on PHC, and targeting indigenous communities (as in Malaysia) or more broadly underserved areas (as in Sri Lanka and Thailand).

Once countries adopted a goal of UHC at a later stage, strategies became tailored to better reach excluded groups and to universalise access. In Africa, though the main strategy of the use of fee exemptions remained, around one-third of countries entered a process of consultation or of trial and error to work out how to achieve such goals, for example through consultations with civil society organisations in Tunisia, pilot programmes in Kenya or calls for external funding in Burkina Faso.

In Latin America, second-phase strategies faced the challenge of covering informal workers, other vulnerable groups and rural areas. Governments took three main approaches:

1. Creating a new branch of social insurance, non-contributory or partly subsidised, parallel to workers' insurance, with special focus on PHC for rural and indigenous communities, as occurred in Mexico and Colombia. This might have appealed to governments where politically organised workers had become a solid constituency and the most feasible reform was not to pool resources into a unified system but rather to create a parallel branch for informal workers.
2. Consolidating multiple pro-poor programmes into a unified health system for those uncovered, as in Brazil and Argentina.
3. Mandating compulsory enrolment into the existing system through gradual expansion, as in Costa Rica, Peru, and Ecuador. Ecuador's experience stands out regarding supply-boosting strategies as it ensured service delivery through public–private partnerships by establishing service-level agreements within an integrated public health network.

In Asia and Oceania, second-phase interventions were again shaped by early experiences. In India and Indonesia, where state-level governments led the provision of a pro-poor benefits package, the federal governments took the lead by consolidating multiple programmes into a unified scheme, broadening the target beneficiaries and expanding its service delivery networks. Countries that started reaching left-behind communities through health units' deployment continued to do so by strengthening their public PHC delivery network while letting the private sector grow for the non-poor (e.g. Malaysia, Sri Lanka and Thailand). Interestingly, this latter strategy led to situations where the mix of private and public sector delivery ended up being pro-poor because it is financed through progressive taxation and because of relatively high standards in efficiency levels despite comparatively low government spending (Rannan-Eliya et al., 2016).

HICs and UMICs from Europe, Asia and Oceania tend to have followed similar paths

to reach those uncovered in a second phase. The most common intervention was to mandate compulsory registration to a health insurance scheme, either directly to all citizens (e.g. as in Russia and Uzbekistan) or by gradually extending the target from all workers, to workers' dependents, self-employed, the unemployed, etc. thereby reaching all those that were uncovered (e.g. as in Belgium, Germany, the Netherlands, Norway and ex-Yugoslav countries). In several cases, explicit efforts were needed to reach left-behind communities by expanding health units focused on PHC across rural, underserved areas (e.g. Serbia, Finland, Norway, Belarus, Kazakhstan, Australia, Japan, New Zealand). In other countries, regional and socioeconomic inequalities persist such that reaching these communities is an ongoing process (e.g. Romania).

5.4   The influence of global policy on moves toward universal health coverage

Global policy forums have also influenced country strategies, notably the Alma-Ata Declaration, which is often seen as a seminal moment in the move towards UHC. The Alma-Ata conference united most of the world's major health stakeholders in 1978 under the slogan 'Health for All by 2000'. The resulting Declaration invited governments to align their public health efforts with a strategy based on PHC, prioritising reaching left-behind groups first and fostering community participation. It is often touted as one of the main milestones in the drive towards UHC (WHO, 1978; Lawn et al., 2008). To give one example, reforms in Liberia sought to incorporate community expectations and views on healthcare into policy-making, improve government accountability and boost coverage enrolment (Kruk et al., 2011). Moreover, as participation contributes to build trust and legitimise the process of change, it generates impetus and democratic pressure to sustain UHC despite changes in governments as in Sri Lanka and Ecuador (Jayasuriya, 2010; Chang Campos, 2018).

To explore its influence, we examined whether country strategies broadly matched those set out by Alma-Ata. Of the 26 countries that had launched their early healthcare strategies prior to Alma-Ata in 1978, just 7 (27%) followed strategies that mapped onto the conference's recommendations, whereas this was true of 10 (43%) of the 23 countries that launched their early strategies after Alma-Ata. For countries that launched their later strategies prior to Alma-Ata, 6 out of 10 (60%) followed Alma-Ata approaches, compared with 19 of the remaining 39 (49%). It is hard to make causal inferences with such a small sample size, but it seems likely that early-phase strategies may have been influenced by Alma-Ata. It is not surprising that Alma-Ata's later recommendations were matched by a large proportion of the countries that had already rolled out their finalised strategies by 1978, as the recommendations and report commissioned prior to the conference both drew heavily on best practice at the time (Djukanovic and Mach, 1975).

More broadly, among the countries studied, around 60% incorporated and strengthened PHC within their strategy to achieve UHC. That means that regardless of whether the strategy involved setting a free benefits package to all, reducing user fees for some or mandating health insurance for instance, the strategy had a PHC focus. While most of these countries did so only at a later stage in the process of rolling out coverage, around a third put PHC at the core of the strategy during both early and later phases, including India, Japan, Kazakhstan, Kenya, Liberia, Malaysia, Sri Lanka, Tunisia and Zambia.

5.5   Benefits to different approaches

Our final approach to understanding strategies different countries employed is to understand which appear to be associated with health quality. It is hard to establish causality because countries that choose healthcare strategies that correlate with better outcomes in our analysis might also implement them more successfully or take other decisions that improve health outcomes. However, it is nonetheless valuable to highlight the types of strategies that more successful countries have undertaken.

We used two models to measure success (see Appendix, section A.3). The first explored how the UHC index and the HAQ index vary depending on the strategy adopted, while the second explores which strategies are associated with the biggest improvements in HAQ between 1990 and 2015. In both models, we control for education, female fertility, wealth, urbanisation, democracy, homogeneity and inequality. The Appendix contains the full model specification including controls and data sources.

Table 1 synthesises the results for high-level strategies and the statistically significant findings (full results are in the Appendix). Our main takeaway is that private-sector approaches including the privatisation of government services and increasing healthcare through insurance-based models, particularly insurance mandates, are associated with a 1 point decline (out of 100) in the HAQ index, which is statistically significant at 1% in both models.[11] Improving a healthcare system by reducing prices is associated with improvements in health quality, as are making health facilities more efficient and unifying multiple health systems under one structure.

Table 1   Effect of demand- and supply-boosting strategies on health outcomes

	Dependent variable		
Model	UCI (1)	HAQ (1)	HAQ_15 (2)
Private sector	1.615 (1.992)	−0.936*** (−0.262)	−0.839*** (−0.299)
Demand price	−0.648 (−2.093)	0.686** (0.294)	0.608* (0.32)
Demand insurance	2.18 (2.049)	−0.911*** (−0.276)	−0.890*** (−0.301)
Demand quality	2.29 (2.41)	−0.036 (−0.363)	−0.03 (−0.375)
Supply unified	−1.831 (−2.335)	0.587* (0.339)	0.617* (0.352)
Supply efficiency	0.18 (2.403)	0.587* (0.347)	0.691* (0.359)
Supply capacity	−0.17 (−1.99)	−0.529* (−0.285)	−0.407 (−0.293)
Demand price	0.209	0.640**	0.721**
Fee exemptions	(2.199)	(0.305)	(0.334)
Demand	0.923	−0.949***	−0.867***
Insurance mandate	(2.058)	(−0.27)	(−0.285)
Supply efficiency	3.236	0.856*	1.126**
Specific programmes	(3.426)	(0.499)	(0.523)
Observations	49	49	47
R2	0.811	0.996	0.93
Adjusted R2	0.784	0.996	0.91

Note: R2 and Adjusted R2 are based on the mean of all of the regressions run *p<0.1; **p<0.05; ***p<0.01

11 *P* values of 0.0005 for HAQ and 0.0019 for HAQ_15.

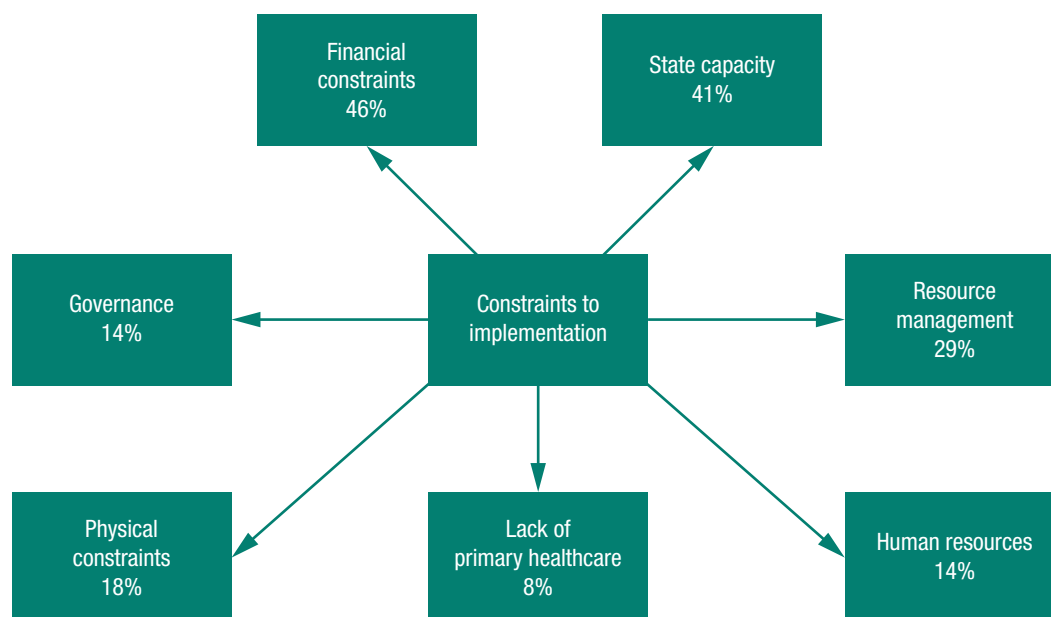# 6 Constraints to implementing universal health coverage

Having outlined key enablers and strategies employed among 49 countries that have obtained or advanced toward UHC, we now consider the main constraints they encountered. It is important to underline that while our literature review enabled us to identify a wide range of challenges and obstacles, it was difficult to separate genuine constraints from other reasons used to justify poor delivery. Moreover, the extent to which the same constraints were binding to different countries varied according to factors such as the country's level of development at different periods in the process of expanding coverage. These caveats notwithstanding, we identified seven categories of constraints (Figure 3), five of which correspond to Alma-Ata recommendations for investment (see Appendix). Most constraints relate to boosting the supply of healthcare, that is, the capacity of the health system to deliver efficient services. This may explain the predominance of demand-based interventions that we outlined earlier.

The main constraint to rolling out UHC that emerged in our analysis was a *lack of financial resources*, leading to an underfunded public sector and rising out-of-pocket payments, which are a particular barrier for poorer individuals. The literature reported finance as a binding constraint for almost half of the countries in our sample, across all regions. World Bank data suggests that countries where financial resources were not cited as a binding constraint had a 50% higher gross national income purchasing power parity per capita, on average, compared to the remainder. However for four HICs, resources were cited as a constraint, while for seven they

were not; and if we remove these countries from our sample, the average gross national income for a country where resources were not seen as a binding constraint was $12,833 compared to $11,309 in countries where it was a constraint – only a 13% difference. In both cases there is a wide variance, such that there is not a statistically significant correlation between the two variables with or without HICs.

There is also a link between the proportion of GDP that countries spend on healthcare and the likelihood of their facing a financial constraint: countries where resources are cited as a binding constraint spend an average of 7.5% of GDP on healthcare versus 6.4% in countries that do not. We group these resource-constrained countries into three groups. In countries such as Malawi and Burkina Faso, resources are so limited that the provision of even basic health coverage is a huge burden on the exchequer. A second group contains wealthier countries such as Thailand and Costa Rica, where healthcare is very good but resources genuinely seem to constrain the country's further health system development. Finally, a third group of countries, which includes Bulgaria, have modest health spending, are not hugely resource constrained and do not have great healthcare systems – yet the literature, and policy-makers in these countries cite resources as a binding constraint to their improving health. Judging which country is in which group is highly subjective, but probably more than half fall into this last category, where the real challenge is the lack of political will rather than resource based. These countries tend also to have less effective governments as measured

Figure 3   Constraints to advancing universal health coverage in 49 countries

Financial constraints 46%		State capacity 41%
Governance 14%	Constraints to implementation	Resource management 29%
Physical constraints 18%	Lack of primary healthcare 8%	Human resources 14%

Source: Authors' own calculations and elaboration.

by the World Bank, but this relationship is not statistically significant.

It is worth noting that a disproportionately large amount of official development assistance (ODA) is directed towards health compared to education or other government services. We wanted to test its impact quantitatively but it was not possible to compare health-specific ODA with health outcomes because the spending data only goes back to 2008. We did find a non-statistically significant correlation between countries that receive more total ODA and those government health spending. But even if this relationship was statistically significant, it would not be clear to us whether donors are simply more likely to fund governments seeking to increase health expenditure, or the fiscal space given to governments by greater ODA renders them more likely to invest in health. This would be a fruitful area for future research.

The second most common barrier to implementing UHC that we identify is a *lack of state capacity*, evident in 40% of countries. We categorised this as a problem when the literature for a country indicated that it struggled to enact its health plans because of government capacity. This included countries that were considered to lack efficient administration, to struggle with the delivery and maintenance

of services and those where user fee exemptions or systems to protect vulnerable groups were poorly targeted or otherwise ineffective. This was identified for more than half of African and Latin America and Caribbean countries but it was also the case in other regions (though in only 2 out of 11 HICs). Excluded groups are particularly affected since they tend to be harder to reach. For instance, low state capacity in Turkey led to poor targeting, which prevented health improvements; and it led to the poor design of annual registration fees in Ghana, which impeded health access. Unsurprisingly, the World Bank judged that these countries had less effective governments. Unlike resource constraints, a lack of capacity is disproportionately and statistically significantly linked to poorer countries, though the correlation is imperfect. The main barrier to rolling out health coverage in resource-constrained environments might be a state's capacity to get a system off the ground and to maintain it. This suggests there may be a role for international agencies and countries with experience of rolling out UHC to support countries facing capacity challenges.

The other constraints we identified were much less consistent. Fourteen countries (29%) struggled to keep costs in check while rolling out UHC, suggesting that financial sustainability

should be at the heart of any new proposal. Nine (18%) of countries in our sample, faced geographical barriers such as mountains or poor infrastructure, which impeded efforts to cover more rural areas – all affected countries had low population density. While these geographical problems are real and make providing healthcare more difficult, we only found this to be a binding constraint when resources were limited. To give an example, the most sparsely populated country in our data is Australia, which has invested heavily in providing health coverage to hard-to-reach groups. This includes programmes specifically aimed at reaching Aboriginal groups and guaranteeing their right to health through community-controlled health services, which have provided comprehensive PHC since the early 1970s (Freeman et al., 2016). Telehealth has been another means of covering hard-to-reach groups in Australia. In Malawi, motorcycle ambulances were used to cheaply provide emergency care to rural patients (McDonnell and Samman, forthcoming).

Seven countries (14%) face a lack of trained human resources (including poor incentives to ensure that the workforce reaches left-behind areas) as well as geographical constraints such as a lack of supplies, infrastructure, transport or drugs. A constraint that appears to have only affected Eastern European countries is an imbalance between PHC and hospital ('secondary') care. For instance, ex-USSR countries inherited a system with excess hospital capacity along with an underutilisation of PHC and community care. Finally, political instability, legislative gridlock or corruption provoking inefficiency have prevented UHC roll-out in some countries: WHO estimates that between 20% and 40% of the global health expenditure is wasted through mismanagement, inefficiency and corruption (WHO, 2010).

Other studies exploring the political economy of UHC have found that countries with a diverse population are less likely to provide public healthcare It is argued that they tend to

have lower social solidarity, reducing people's willingness to contribute towards other's health needs (Savedoff et al., 2012; Gupta et al., 2015). However, this factor is rarely mentioned within the literature on individual countries. We therefore analysed it using global data on religious, ethnic and linguistic fractionalisation (Alesina and Ferrara, 2005).[12] Our results echoed those of other research. Controlling for democracy, social development, inequality, agriculture and urbanisation, fractionalisation has a major impact on health. Depending on the type of fractionalisation (religious, ethnic, linguistic), going from the 25th percentile to the 75th percentile in any metric, is associated with a 3.5 to 4.0 point decline in the UHC index (statistically significant at 0.1%). The relationship between the HAQ index is much smaller and not statistically significant at 5% for ethnic or linguistic fractionalisation. Moreover, health spending and a government's proportion of health expenditure does not seem to be associated with fractionalisation. There is a high correlation between these three types of fractionalisation but all three remain statistically significant when included in the same regression with the UHC index. Among the three, religious fractionalisation appears to have the strongest relationship to healthcare outcomes.

Comparing the fractionalisation index to our qualitative data showed that more diverse countries are less likely to focus on universality in the early phase of their strategy. We found a correlation between ethnic diversity and greater human resource constraints.[13] State capacity constraints are also worse in ethnically diverse states, even when using the same controls. The strongest correlation we found was the link between geographical constraints and ethnic diversity; however, this appears to be almost entirely driven by wealth. Diverse countries are poorer and poorer countries suffer the most from geographical constraints. However, these links between diversity and lower health outcomes are not universal. Indeed, countries like

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12 The variable fractionalisation is the probability that two randomly drawn individuals in a country would be part of different groups.

13 This relationship holds even when we control for education rates, wealth and female empowerment.

Rwanda have used health as a means of building solidarity between different groups, while many other countries like Zambia and Sri Lanka have high rates of diversity but very good health outcomes. These problems are therefore not insurmountable but should be considered when planning health expansions.

Around eight countries in our sample (15%) appear to have faced threats to their health system that stood to jeopardise UHC achievement or stable progress towards this goal. In all cases this is driven by local and severe shocks or wider political problems. Examples include armed conflict despite strong political will to provide UHC in Ukraine, financial unsustainability in Tajikistan, decreasing financial allocation to health in Haiti or state capacity hindered by state fragility in Tanzania. While tackling state fragility seems an obvious first step to galvanise efforts towards UHC, tapping into the political benefits of health improvements could be also instrumental in reinforcing state legitimacy, gaining support and thereby addressing state fragility. These countries all suffer from increasing levels of corruption as judged by the World Bank, while corruption rates have been falling in most countries in our dataset.

Though UHC is at risk in these countries, it is far from certain that the progress will be fully reversed in any of them. Indeed, in many countries such as Thailand, future governments found it politically too difficult to reverse even small parts of the reforms. In the case of Malawi, civil society has since independence resisted the introduction of user fees by leveraging political support to maintain free healthcare; the only time when user fees were introduced in the 1990s, these were quickly removed. Kenya and Jamaica, instead, introduced and removed fees several times since independence yet strong government efforts since the turn of the century made UHC a matter of social justice, which make efforts likely to be sustained. In Algeria, Law No. 18-11 guarantees free access to healthcare as an 'irreversible principle' (Algérie Presse Service, 2018). This leads us to believe that while UHC can be difficult to set up, it is highly robust. An important caveat is that while UHC can be declared on paper, there is in practice a mismatch between what the state is able to deliver and what the state should be delivering (e.g. as in Algeria, Ghana, Paraguay, Ecuador). In such cases, supply-boosting efforts, as recommended in the Alma-Ata Declaration, appear crucial to making UHC a reality.

7 Implications

To conclude, we sum up four main implications stemming from this research:

1. the primacy of political economy in explaining advances toward UHC
2. iterative reform as a stepping-stone towards universality
3. the robustness of UHC
4. the need for further research on effective strategies to reach left-behind groups.

The primacy of political economy
Political economy is paramount in explaining the push towards UHC; where there is political will, governments find a way to progress. Most initial movements toward UHC have occurred in the contexts of movement toward democracy or recovery from episodes of state fragility. Indeed four-fifths of the countries we looked at took major steps towards UHC while rebuilding in the aftermath of fragility. These tend to be periods of self-reflection during which countries decide what they want to be and where there is a need for unity, forces that combine to create the political appetite for UHC. These are also periods where countries were poorer than normal and face many important competing claims on resources. While many countries cite limited resources as a constraint, we find that wealth is not a major determinant of movement towards UHC. Instead decisions are driven by a willingness to make trade-offs; recent economic growth makes these trade-offs easier and UHC more likely. One implication is that other poorer countries could achieve UHC too, if they are willing to make the necessary trade-offs.

Iterative health reform as a stepping stone for universality
In the early phases of expansion, government interventions to provide healthcare tend to cover a limited share of the population, often politically organised groups such as workers in the formal sector, particularly those in urban areas. While some countries also started with very limited schemes aimed at the poorest, these were far from comprehensive. Countries then tend to expand eligibility in stages and thereby move towards universal coverage. Once governments embrace the goal of universality, left-behind groups more commonly become a focus.

UHC is usually stable
Once achieved, UHC is usually accepted across the political spectrum and thus highly robust. We identified very few examples of countries taking major and long-term steps backwards in their move towards UHC. While many African countries reintroduced user fees in the 1980s, this tended to result in social unrest and the decisions were later reversed. Regression also appeared imminent at some points in time among several countries in our sample that have attained UHC. However, few do so over a meaningful time period; rather, when countries achieve universality, social and political pressures appear to ensure that the system lasts.

Further research on strategies to reach the left behind
We hoped to have a stronger 'leave no one behind' focus in this paper than has been possible. In fact, only a small portion of the 400 papers used in our analysis focused primarily on groups that are often left out of healthcare systems. Nonetheless, we managed to identify strategies most commonly used to reach left-behind groups. These strategies included the use of targeted inclusion or eligibility criteria, the expansion of health units focused on PHC across underserved areas, the provision of health cards to targeted groups and the creation of a

parallel insurance scheme for those not covered. However, our review also highlighted a lack of evidence on the complex problems that marginalised groups face and how they might be overcome, as well as on the instrumental benefits to reaching left-behind groups and how these vary by the strategy employed. We hope further research will help to inform these gaps.

Appendix

A.1 Controls

For *democracy* we used an index created by the Variety in Democracy Institute based at the University of Gothenburg, Sweden, which aims to answer the question 'To what extent is the ideal of electoral democracy in its fullest sense achieved' (Coppedge et al., 2019).

For *urbanisation* we used World Development Indicators.

We measured *inequality* using the Gini index from World Development Indicators, where recent data existed, or otherwise PovcalNet. For New Zealand, we used an OECD estimate.

For *homogeneity* we aggregated the linguistic, ethnic and religious fractionalisation indices created by Alesina and Ferrara, which looks at the likelihood that two random people selected in a country will be from the same group (Alesina and Ferrara, 2005).

For *wealth*, *fertility* and *education* we used the Social Development Index, an aggregate measure created by IHME to use these three variables to control for how development impacts health (*Global Burden of Disease Study 2015*, S*ocio-Demographic Index 1980–2015, 2016*).

A.2 Methodology for assigning countries to different strategies

We identified 14 common strategies for expanding health coverage. Each strategy was defined as either supply based (aiding the supply of healthcare) or demand based (stimulating or reducing barriers to demand). These strategies were then divided into six types, such as those about expanding the quality, or the capacity of healthcare. Four of these are demand based and two are supply based. Each of these sub-groups contains two or three specific strategies.

These strategies are not mutually exclusive, with countries often employing two, occasionally three and in two instances four, in their move towards more extensive health coverage.

1. **Demand price minimum packages:** state guarantee of a minimum benefits package – which is universally available, but not necessarily extensive enough to count as UHC
2. **Demand price fee exemptions.** State introduction or expansion of user fee exemptions for targeted groups or for selective care
3. **Demand quality expand package:** State expansion or upgrading of their benefits package to include more complex treatments
4. **Demand quality provision cards:** State distribution of provision cards outlining entitlements, which aimed to improve access to health by raising awareness of existing entitlements
5. **Demand segregated insurance worker.** Creation of insurance schemes, often voluntary and contributory, firstly targeting workers
6. **Demand segregated insurance mandate:** Where countries made registering for insurance compulsory
7. **Demand segregated insurance parallel.** Creation of a new branch of social insurance or health assistance regime parallel to formal workers' insurance. These are normally either non-contributory or subsidised by the state.
8. **Demand unified consolidation.** Consolidation of multiple health programmes into one system
9. **Demand unified scratch.** Creation of unified health system from scratch rather than consolidation

10. **Supply capacity new health units.** Deployment of clinics, health units or programmes focused on PHC across territory, often integrated within service delivery networks
11. **Supply capacity PPP.** Use of public–private partnerships to expand the number of health clinics
12. **Supply efficiency privatisation.** State privatisation of health services aimed at making them more efficient
13. **Supply efficiency specific programmes.** Any substantial programmes used to improve the state's capacity to provide health coverage, including cost containment plans, creation of a pool fund, the enlargement of facilities to provide more complex treatments; and a reorganisation of healthcare system
14. **Supply efficiency trial and error.** Research and pilot projects designed to improve health efficiency

A.3 Methodology for quantitative analysis of strategies

There were several difficulties with analysing the different strategies, among which we highlight two. Firstly, our dataset consists of 49 countries only, rendering statistically significant outcomes less likely. Secondly, we only look at which strategies are associated with better health outcomes, rather than a causal relationship, because of omitted variable bias. Countries with better healthcare systems might choose to implement a particular strategy and have better results not because of the strategy but because of other unobserved qualities that we cannot control for. It is, however, still useful to look at the strategies adopted in those countries that have improved the most.

In model one, we conducted two ordinary least squared regressions, examining the relationship between the interventions, the UHC index and the HAQ index, controlling for the Gini, social development index, democratic index, urbanisation and fractionalisation. These variables capture 80% of the variation within UHC, and 97% of the variation within the HAQ index.

Where health is either HAQ or UHC index, Dem is democracy, and SDI is the social development index.

In model two, our dependent variable is the change in the HAQ index between 1990 and 2015. Where the '90' version of each variable is the country's total score in 1990 and the '15' version is the rate of change between 1990 and 2015. We did not have data on 1990 homogeneity for any country, and we were missing 1990 Gini coefficient for a large number of the countries in our dataset, so we only used the 2015 data here (conveniently, both of these variables change slowly over time).

Box 4 Models for quantitative analysis of strategies

$$\text{Health}_c = \beta_0 + \text{Strategy}_c\beta_1 + \text{SDI}_c\beta_2 + \text{Homogeneity}_c\beta_3 + \text{Dem}_c\beta_3 + \text{Urban}_c\beta_4 + \text{Gini}_c\beta_5 + \in \qquad (1)$$

$$\text{HAQ\_15}_c = \beta_0 + \text{Strategy}_c\beta_1 + \text{SDI\_15}_c\beta_2 + \text{SDI\_90}_c\beta_3 + \text{Homogeneity}_c\beta_4 + \text{Dem\_15}_c\beta_5 + \qquad (2)$$
$$\text{Dem\_90}_c\beta_6 + \text{Urban 15}_c\beta_7 + \text{Urban 90}_c\beta_8 + \text{Gini}_c\beta_9 + \text{Health\_90}_c\beta_{10} + \in$$

Table A.1 Full strategy regression

Model	Dependent variable		
	UCI (1)	HAQ (1)	HAQ_15 (2)
Multiple strategies	2.796 (2.215)	−0.16 (−0.335)	−0.034 (−0.35)
Alma-Ata focus	0.891 (1.994)	0.312 (0.286)	0.098 (0.312)
Private sector	**1.615 (1.992)**	**−0.936*** (−0.262)**	**−0.839*** (−0.299)**
Quality	0.992 (2.341)	0.382 (0.345)	0.369 (0.228)
Demand	6.113** (2.53)	−0.241 (−0.401)	−0.038 (−0.41)
Supply	0.523 (2.066)	0.298 (0.305)	0.27 (0.316)
Demand price	**−0.648 (−2.093)**	**0.686** (0.294)**	**0.608* (0.32)**
Demand insurance	**2.18 (2.049)**	**−0.911*** (−0.276)**	**−0.890*** (−0.301)**
Demand quality	2.29 (2.41)	−0.036 (−0.363)	−0.03 (−0.375)
Supply unified	**−1.831 (−2.335)**	**0.587* (0.339)**	**0.617* (0.352)**
Supply efficiency	**0.18 (2.403)**	**0.587* (0.347)**	**0.691* (0.359)**
Supply capacity	−0.17 (−1.99)	−0.529* (−0.285)	−0.407 (−0.293)
Demand price Fee exemptions	**0.209 (2.199)**	**0.640** (0.305)**	**0.721** (0.334)**
Demand quality Provision cards	4.731 (4.02)	0.229 (0.608)	0.094 (0.613)
Demand Insurance mandate	**0.923 (2.058)**	**−0.949*** (−0.27)**	**−0.867*** (−0.285)**
Supply unified Consolidation	0.655 (2.759)	0.575 (0.402)	0.551 (0.424)
Supply capacity New health units	−1.231 (−2.069)	−0.524* (−0.299)	−0.452 (−0.3)
Supply efficiency Privatisation	−1.506 (−4.08)	−0.241 (−0.608)	0.247 (0.673)
Supply efficiency trial And error	−0.95 (−2.863)	0.739* (0.412)	0.683 (0.462)
Demand price Min package	0.338 (2.855)	0.544 (0.417)	0.652 (0.505)
Demand quality Expand package	0.521 (2.556)	−0.158 (−0.38)	−0.134 (−0.395)
Demand Insurance worker	−0.028 (−6.934)	0.089 (1.033)	0.195 (1.084)
Demand Insurance parallel	2.002 (3.029)	−0.362 (−0.45)	−0.362 (−0.479)
Supply unified Scratch	−6.594* (−3.845)	0.486 (0.588)	0.562 (0.576)
Supply capacity PPP	5.63 (4.739)	−0.282 (−0.717)	0.115 (0.721)
Supply efficiency Specific programmes	**3.236 (3.426)**	**0.856* (0.499)**	**1.126** (0.523)**
Observations	49	49	47
R2	0.811	0.996	0.93
Adjusted R2	0.784	0.996	0.91

Table A.2   Countries assigned to strategies

Country	Early phase strategies	Late phase strategies	Reason for inclusion
Algeria	Free minimum benefits package. Specific programmes to improve efficiency	Provision of cards. Specific programmes to improve efficiency	LMIC with UHC
Argentina	Insurance for workers. Deploying units across territory	Creation parallel regime for rest of population. Consolidation of unified scheme	LMIC with UHC
Australia	Insurance for workers	Expansion of existing regime to rest of population. Deploying units across territory	HIC with a good HAQ index score
Belarus	Free minimum benefits package	Deploying units across territory	LMIC with UHC
Belgium	Insurance for workers	Expansion of existing regime to rest of population	Early mover to UHC
Brazil	Insurance for workers	Creation parallel regime for rest of population. Consolidation of unified scheme	LMIC with UHC
Bulgaria	Insurance for workers	Fees exemption	LMIC with UHC
Burkina Faso	Fees exemption. Deploying units across territory	Thinking process/trial and error	LIC with a good HAQ index score
Colombia	Insurance for workers	Expansion of existing regime to rest of workers. Creation parallel regime for rest of population. Deploying units across territory	LMIC with UHC
Costa Rica	Insurance for workers	Expansion of existing regime to rest of population	LMIC with UHC
Croatia	Insurance for workers	Fees exemption. Expansion of existing regime to rest of population	LMIC with UHC
Ecuador	Provision of cards. PPP	Expansion of existing regime to rest of population. PPP	LMIC with UHC
Finland	Insurance for workers	Expansion of existing regime to rest of population. Deploying units across territory	HIC with a good HAQ index score
Gabon	Thinking process/trial and error	Creation of unified scheme	LIC with a good HAQ index score
Germany	Insurance for workers	Expand benefits package. Expansion of existing regime to rest of population	Early mover to UHC
Ghana	Fees exemption for the vulnerable. Insurance for workers	Fees exemption	LIC with a good HAQ index score
Haiti	Expansion of existing regime to rest of workers. Deploying units across territory	Thinking process/trial and error or	LIC with a good HAQ index score
India	Free minimum benefits package. Expand benefits package efficiency. Insurance for workers	Fees exemption. Expand benefits package. Consolidation of unified scheme	LMIC with UHC
Indonesia	Free minimum benefits package. Insurance for workers	Fees exemption. Consolidation of unified scheme. Deploying units across territory	LMIC with UHC
Jamaica	Fees exemption.	Fees exemption	LMIC with UHC

Table A.2   Countries assigned to strategies

Country	Early phase strategies	Late phase strategies	Reason for inclusion
Japan	Insurance for workers. Deploying units across territory	Fees exemption. Expansion of existing regime to rest of population. Deploying units across territory	Early mover to UHC
Kazakhstan	Free minimum benefits package. Fees exemption. Insurance for workers	Expand benefits package. Expansion of existing regime to rest of population. Deploying units across territory	LMIC with UHC
Kenya	Fees exemption. Insurance for workers. Expansion of existing regime to rest of population	Fees exemption. Thinking process/trial and error	Outlier selected due to left-behind focus*
Liberia	Fees exemption. Deploying units across territory	Expand benefits package. Deploying units across territory. Specific programmes to improve efficiency	LIC with a good HAQ index score
Malawi	Free minimum benefits package. PPP. Specific programmes to improve efficiency	Expand benefits package. PPP	LIC with a good HAQ index score
Malaysia	Free minimum benefits package. Deploying units across territory	Fees exemption. Deploying units across territory. Privatisation	LMIC with UHC
Mali	Fees exemption. Expansion of existing regime for workers. Creation parallel regime for the poor	Creation of unified scheme. Thinking process/trial and error	LIC with a good HAQ index score
Mauritius	Insurance for workers	Insurance for workers. Creation parallel regime for rest of population	LMIC with UHC
Mexico	Insurance for workers	Creation parallel regime for rest of population	LMIC with UHC
Nepal	Fees exemption	Fees exemption. Provision of cards. Expansion of existing regime to rest of population	LIC with a good HAQ index score
Netherlands, the	Insurance for workers	Expansion of existing regime to rest of population. Consolidation of unified scheme. Privatisation	HIC with a good HAQ index score
New Zealand	Insurance for workers	Free minimum benefits package. Deploying units across territory	Early mover to UHC
Norway	Expansion of existing regime to rest of population	Expansion of existing regime to rest of population. Deploying units across territory	Early mover to UHC and HIC with a good HAQ index score
Paraguay	Insurance for workers. Deploying units across territory	Fees exemption for public sector users	LMIC with UHC
Peru	Insurance for workers. Consolidation of unified scheme	Expansion of existing regime to rest of population	LMIC with UHC
Romania	Insurance for workers	Free minimum benefits package. Thinking process/trial and error	LMIC with UHC
Russia	Free minimum benefits package	Free minimum benefits package. Expand benefits package. Expansion of existing regime to rest of population	LMIC with UHC
Rwanda	Insurance for workers	Fees exemption. Expansion of existing regime to rest of population	LIC with UHC
Serbia	Free minimum benefits package	Expansion of existing regime to rest of population. Deploying units across territory	LMIC with UHC

Table A.2   Countries assigned to strategies

Country	Early phase strategies	Late phase strategies	Reason for inclusion
Sri Lanka	Deploying units across territory	Creation of unified scheme. Deploying units across territory	LMIC with UHC
Tajikistan	Free minimum benefits package	Free minimum benefits package. Fees exemption. Specific programmes to improve efficiency. Thinking process/trial and error	LMIC with UHC
Tanzania	Fees exemption. Thinking process/trial and error	Expansion of existing regime to workers. Creation parallel regime for rest of population	LIC with a good HAQ index score
Thailand	Deploying units across territory. Specific programmes to improve efficiency	Fees exemption. Expand benefits package	LMIC with UHC
Tunisia	Fees exemption. Expansion of existing regime to rest of population	Thinking process/trial and error	LMIC with UHC
Turkey	Fees exemption. Provision of cards. Insurance for workers	Expand benefits package. Provision of cards. Consolidation of unified scheme. Specific programmes to improve efficiency	LMIC with UHC
Ukraine	Free minimum benefits package	Fees exemption. Specific programmes to improve efficiency. Thinking process/trial and error	LMIC with UHC
United Kingdom	Insurance for workers. Specific programmes to improve efficiency	Free minimum benefits package. Consolidation of unified scheme	Early mover to UHC
Uzbekistan	Free minimum benefits package	Free minimum benefits package. Expand benefits package. Expansion of existing regime to rest of population	LMIC with UHC
Zambia	Fees exemption	Free minimum benefits package. Deploying units across territory	LMIC with UHC

Countries were selected based on the following criteria. First, we excluded those countries with a population of less than two million people, owing to data constraints. Second, we adopted different strategies pertaining to each country's income group to select the following countries: 11 HICs, including the first six to reach UHC and the six that were deemed to have the best healthcare coverage according to the HAQ index (with Norway falling into both groups); the 26 MICs that were classified as having achieved UHC according to STC (2018) as well as Kenya, because although the country has not yet achieved UHC, it is only slightly above the low-income cut-off, has a very high HAQ index score for its wealth, and is rolling out an ambitious healthcare plan aimed specifically at reaching left-behind groups; 11 LICs, including Rwanda, which classified as having achieved UHC by STC (2018) and the additional ten countries that performed best according to the HAQ index. Additionally, we did not include half of the former USSR and former Yugoslav states (Albania, Azerbaijan, Kyrgyzstan, Macedonia, Moldova and Turkmenistan, which are the least populous) because these countries achieved UHC while in the same larger state and tend to have very similar stories.

Table A.3   Constraints and their corresponding Alma-Ata recommendation

Constraint	Description	Alma-Ata recommendation no.
Human resources	Shortage of and poorly trained human resources; no incentives to ensure that they reach left-behind groups	9, 10, 11
State capacity	Lack of efficient administration, delivery and maintenance of services, particularly in reaching left-behind groups (e.g. inexistent/inefficient systems to reach and protect vulnerable groups from health related financial losses)	13
Resource management	Poorly managed allocation of resources	14
Geographical constraints	Lack of supplies, infrastructure, transport, drugs	15
Financial	Lack of financial resources, financial unsustainability, OOP increases	17
Lack of PHC	Imbalance between PHC and hospital care; underutilisation of PHC and community care	Omnipresent
Governance	Fragmented governance across state levels, political instability, legislative gridlock, and/or corruption	Implied, rather than explicitly recommended

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