

## **Towards universal health coverage: challenges, opportunities and roadmap**

### **Executive summary**

1. Universal health coverage has never been higher on the international health agenda than now. The aspiration to move towards universal health coverage is not new. It is articulated in WHO's constitution of 1948 and is integral to the Alma-Ata declaration of 1978, and more recently in the World Health Report 2010 "Health systems financing: the path to universal coverage". In 2012, the Regional Committee endorsed a resolution which emphasized the key role of health system strengthening in enabling countries to move towards universal health coverage.

2. The World Health Report 2010 refers to universal health coverage as providing all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) that is of sufficient quality, while ensuring that the use of these services does not expose the user to financial hardship. Hence universal health coverage encompasses three dimensions, represented by the proportions of costs, services and population that are covered.

3. The key elements of WHO's comprehensive approach to universal health coverage embrace that concept. The approach is fully aligned with the values and principles of primary health care; it is the basis of the Twelfth General Programme of Work and the five categories of work for 2014–2019; it recognizes the importance of strengthening all elements of the health system; it emphasizes the importance of building partnerships; and it stresses the robust monitoring of progress towards its realization. WHO is currently developing a framework for monitoring progress towards universal health coverage, working in collaboration with all partners including the World Bank.

4. In 2012 the countries of the Region were categorized into three health system groups based on population health outcomes, health system performance and the level of health expenditure. The progress towards universal health coverage among the countries has been assessed based on the three dimensions across the three groups. In respect of financial risk protection, the share of out-of-pocket payment from total health spending has been stable over the last decade but each group of countries has demonstrated diverse trends. In Group 1 countries it decreased from 21% to 17%; in Group 2, it fluctuated around 50%; and in Group 3, it increased from 59% to 69%. The few equity studies carried out in Group 2 countries have shown that a significant proportion of households face financial catastrophe and are pushed into poverty because of the high share of out-of-pocket payment. It is estimated that annually up to 16.5 million individuals face financial catastrophe and up to 7.5 million are pushed into poverty in this way.

5. As far as coverage with needed services is concerned, geographical access is almost 100% for Group 1 countries; varies between 83% and 100% for Group 2 countries; and is between 44% and 97% for Group 3 countries. For Group 1 countries, there is full coverage for communicable and maternal and child care services. However, noncommunicable diseases, injuries and mental health are not fully integrated in the services offered in primary care. In Group 2 countries, immunization coverage is above 90% in most but coverage with antenatal care ranges between 66% and 100%; birth attended by skilled health personnel is between 74% and 100%; and contraceptive prevalence rate is between 38% and 60%. For Group 3 countries, there is wide variation across countries for coverage with needed primary care

services, some of which are unacceptably low. Among Group 1 countries, the citizens have access to a comprehensive package of health services. Several Group 2 countries have developed an essential package of primary health care as well as hospital services. The extent to which these are being implemented is variable. In Group 3, four countries have developed a basic package of health services. Many of these are no more than basic benefit packages.

6. In terms of population coverage, it is important to continually monitor population Groups that are eligible and those that are entitled to receive coverage under the different prepayment arrangements. All citizens in Group 1 countries are covered for their needed care. The extent and nature of coverage provided to the expatriate populations in these countries varies. The expatriates are progressively being covered under private insurance schemes. Despite high levels of eligibility, coverage in Group 2 countries suffers from fragmentation and duplication and the extent of population eligible to be covered varies. In the absence of well-established social health insurance schemes and the presence of underfunded public sector health services, coverage is largely restricted to civil servants and armed forces, and large segments of population remain uncovered by prepayment schemes. In Group 3 countries, while in principle governments are supposed to cover all nationals, coverage is mostly available for public sector employees. National social health insurance schemes are not present, and private and community-based insurance arrangements cover only a very small Group of the population.

7. Several challenges as well as opportunities can influence progress towards universal health coverage in the Region. The key challenges include: the need for sustained commitment, clear vision and a well laid out road map for universal health coverage; lack of financial risk protection arrangement for large segments of population groups; inadequate provision of needed health services; and weak health information systems that are not prepared to monitor universal health coverage. There are opportunities that need to be seized for accelerating progress, such as the global movement in support of universal health coverage with high commitment of development partners, increasing commitment of national policymakers in low-income and middle-income countries, and the greater availability of well-tested strategies and robust tools for supporting universal health coverage than has ever been the case in the past.

8. A set of strategies and a roadmap of actions are proposed for Member States, WHO and partners to accelerate progress towards universal health coverage. The principle of equity and fairness is at the heart of this approach. The purpose is to help countries develop national roadmaps aligned with their own priorities and level of progress. The strategies are to: develop a vision and strategy for advancing progress towards universal health coverage; establish a multisectoral national taskforce to steer the agenda; advocate for commitment and update legislation; strengthen the unit in the Ministry of Health responsible for coordinating universal health coverage; generate local evidence and share international experiences; monitor progress; and establish a regional taskforce of development partners with Member States.

## Introduction

9. Universal health coverage has never been higher on the international health agenda than now. In 2012 alone, four high-level international events unequivocally expressed commitment to universal health coverage – the Bangkok Statement, the Kigali Ministerial Statement, the Mexico City Political Declaration, and the Tunis Declaration. In February 2013, universal health coverage was the topic of a ministerial-level meeting convened by WHO and the World Bank that brought together representatives from ministries of health and finance to share the lessons learnt and challenges faced in moving towards universal health coverage. Including universal health coverage in the post-2015 global and national development agenda received serious consideration by the Global Thematic Consultation on Health, which took place in March 2013 in Botswana. (1)

10. The aspiration to move towards universal health coverage is not new. It is articulated in WHO's constitution of 1948 (2) and is integral to the Alma-Ata Declaration of 1978 and health for all. (3) More recently, the World Health Report 2008 identified universal health coverage as one of four guiding principles of primary health care reform. (4) The 2010 World Health Report "Health systems financing: the path to universal coverage" summarized the lessons learned from countries that have made visible progress in moving towards universal health coverage, focusing on health financing reforms. (5)

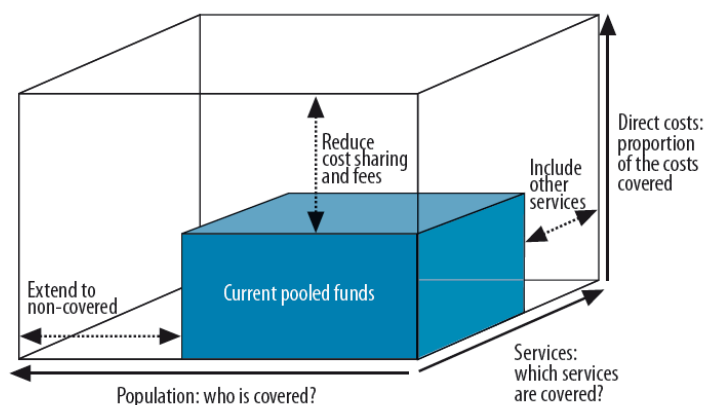
11. At the regional level, Member States of the WHO Eastern Mediterranean Region have consistently expressed their interest in and commitment to the goal of universal health coverage. In 2012, the WHO Regional Committee for the Eastern Mediterranean endorsed a resolution (EM/RC59/R.3) on health systems strengthening, which emphasized the key role of health system strengthening in enabling countries to move towards universal health coverage. (6)

12. Building on previous efforts, the current paper provides an outline of the three key dimensions of universal health coverage: direct costs, services and population. The paper reviews where countries of the Region stand in their move towards universal health coverage and summarizes the current challenges and emerging opportunities to move forward. It also proposes a strategy, a roadmap and associated actions to accelerate progress towards universal health coverage, emphasizing the roles and responsibilities of the various stakeholders in achieving this goal. Special emphasis is given to multisectoral engagement and partnerships which are needed in all the countries, irrespective of their levels of socioeconomic development.

### What is universal health coverage?

13. The World Health Report 2010 refers to universal health coverage as providing all people with access to needed health services (including: prevention, promotion, treatment and rehabilitation) that is of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship. Universal health coverage is a practical expression of the concern for health equity and the right to health; and contributes to sustainable development and poverty reduction. The journey towards universal health coverage calls for reforming the entire health system, as well as addressing social and environmental determinants of health.

14. Universal health coverage encompasses three dimensions, represented by a cube; namely, direct costs (proportion of costs covered), services (which services are covered) and population (who is covered) (Figure 1). The three dimensions are sometimes labeled as the "costs", "depth" and "breadth" of coverage, respectively. While the "direct cost" dimension refers to the extent of financial risk protection provided, the "services" dimension refers to the range of services covered by pooled funds. The "population" dimension refers to which categories of the population are eligible, entitled and actually covered by prepayment and pooling arrangements and who is not. While certain population



Source: *The world health report 2010*. (5)

**Figure 1. The three dimensions of universal health coverage**

groups might be eligible to be covered under certain prepayment arrangements, given prevailing constitutional rights or legal provisions by merits of socioeconomic characteristics, it should be noted that being eligible does not necessarily infer entitlement for effective financial risk protection and service coverage and furthermore an actual coverage with needed services. Hence, the need to continually identify which groups of the population are eligible, entitled and actually covered under the different prepayment arrangements.

15. Within the broader health system reform, successful experiences from countries that have moved towards universal health coverage underscore the importance of reforming the health financing system to enhance financial risk protection and promote fair financing, as well as addressing key gaps in other essential elements of the health system, such as health workforce, health information system and essential technologies and medicines. Box 1 summarizes what universal health coverage is and is not.

### How WHO is approaching the goal of universal health coverage

16. WHO's commitment is reflected in its comprehensive approach to supporting Member States in their progress towards universal health coverage. The key elements of the approach embrace the following.

- Universal health coverage is fully aligned with the values and principles of primary health care which upholds, among other things, equity and social justice, solidarity, participation, inter-sectoral action and recognizes the fundamental right to health for all.

#### **Box 1. What universal health coverage is and is not**

- Universal health coverage requires coverage with key interventions addressing the most important causes of morbidity and mortality. It is critical to achieving the unfinished agenda of the Millennium Development Goals, and incorporates the growing need to respond to noncommunicable diseases and injuries.
- Universal health coverage is not only about treatment, it includes access to essential interventions in the areas of prevention and health promotion, treatment and rehabilitation. In terms of prevention and promotion, it includes both personal and population-based health services.
- Universal health coverage involves all health system components and is not just about health care financing.
- Universal health coverage is not about providing a limited minimum package of services or about ensuring free coverage for all possible health interventions. It is about the progressive realization of people's right to health.

- Universal health coverage is the basis of the Twelfth General Programme of Work 2014–2019 which includes five categories of work that collectively contribute to the achievement of universal health coverage: 1) communicable diseases ; 2) noncommunicable diseases; 3) health through the life course which embraces maternal and child health and healthy ageing; 4) health system development; and 5) emergency preparedness.
- WHO emphasizes the fundamental importance of fair financing and financial risk protection to the achievement of universal health coverage. At the same time, equal emphasis is given to the importance of strengthening other elements of the health system – governance and leadership, workforce, information, medicines and technologies, and infrastructure. The interaction between these elements is essential to the provision of quality health services.
- WHO places emphasis on the importance of, and relies heavily on, the building of partnerships. The appreciation that no single partner will be able to achieve this global agenda calls for sustainable partnerships to be built at global and local levels.
- WHO is developing a framework to monitor progress towards universal health coverage, working in collaboration with all partners, including the World Bank.

### **Monitoring progress towards universal health coverage**

#### *Framework and approaches*

17. Universal health coverage is unlikely to be achieved unless it is effectively monitored. As countries declare their commitment and introduce policies aimed at moving towards universal health coverage, there is a need to develop indicators to monitor and evaluate progress towards that goal. (7) WHO and the World Bank are currently working together to develop a globally agreed framework for monitoring and evaluating countries' progress towards universal health coverage.

18. Since the monitoring of universal health coverage is work in progress, the approach that is proposed is an illustrative approach for countries of the Region to consider. Universal health coverage can be considered as both an overall goal and an instrumental objective<sup>1</sup>.

- When universal health coverage is considered as an overall goal, monitoring will require assessment of health system performance, including health status and impact changes. This is a comprehensive exercise that will require a wide range of tools, varied methodological approaches, and building of national capacity to undertake such level of assessment. Once developed this can be offered to countries every five years;
- When universal health coverage is considered as an instrumental objective, the focus of monitoring will be on the three dimensions of universal health coverage. This will be a less demanding exercise and can be undertaken and reported on an annual basis. It nevertheless has to be aligned with or be part of the wider health system performance assessment.

19. This paper addresses the monitoring of universal health coverage as an instrumental objective. A set of measurable indicators to monitor universal health coverage across all countries – regionally as well as globally – has not yet been agreed. Table 1 illustrates a framework of selected indicators covering the three dimensions of universal health coverage that can be applicable to the Eastern Mediterranean Region, as well as other regions, both in the short term and as health information systems become more robust and better able to monitor progress towards this goal. It is worth noting that some of the suggested indicators are actual coverage indicators while others are proxy indicators of coverage.

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<sup>1</sup> Policy objectives that are intermediate to the achievement of broad health system goals.

**Table 1. Illustrative indicators for monitoring universal health coverage**

Universal health coverage dimension	Indicators	Sources of information
Direct costs (coverage of financial risk protection) – “cost”	<ul style="list-style-type: none"> <li>Percentage of households that incur catastrophic health expenditure</li> <li>Percentage of households that become impoverished due to out-of-pocket health spending</li> <li>Share of out-of-pocket health spending as a percentage of total health expenditure</li> </ul>	<ul style="list-style-type: none"> <li>Health expenditure and utilization surveys</li> <li>National health accounts analysis</li> </ul>
Service (coverage with needed health services) – “depth”	<ul style="list-style-type: none"> <li>Percentage of population that is covered for essential health interventions:               <ul style="list-style-type: none"> <li><i>Communicable diseases</i> <ul style="list-style-type: none"> <li>– Measles vaccination coverage</li> <li>– DOTS coverage<sup>a</sup></li> <li>– Percentage of tuberculosis patients living with HIV on antiretroviral therapy<sup>b</sup></li> </ul> </li> <li>Reproductive health                   <ul style="list-style-type: none"> <li>– Antenatal coverage</li> <li>– Births by skilled birth attendants</li> <li>– Contraceptive prevalence rate</li> </ul> </li> <li><i>Noncommunicable diseases and mental health</i><sup>c</sup></li> <li>Core indicators                   <ul style="list-style-type: none"> <li>– Percentage of tobacco users receiving advice by health professionals to quit</li> <li>– Percentage of people with diagnosed hypertension receiving treatment</li> <li>– Percentage of confirmed diabetics referred for periodic eye examination</li> </ul> </li> <li>Expanded/more complex indicators                   <ul style="list-style-type: none"> <li>– Proportion of eligible women screened for breast cancer, as directed by national programmes or policies<sup>d</sup></li> <li>– Proportion of eligible persons (defined as aged 40 years and over with a 10-year cardiovascular risk <math>\geq 30\%</math>, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes<sup>e</sup></li> <li>– Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate–severe depression) who are using services<sup>f</sup></li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Ministry of Health, Health information system</li> <li>Public health programme information system</li> <li>Population-based household surveys</li> </ul>
Population (eligibility, entitlement and actual coverage) – “breadth”	<ul style="list-style-type: none"> <li>Percentage of population that is eligible, entitled and actually covered under prepayment arrangements</li> <li>Tax-funded (general government revenue-based) arrangement</li> <li>Social insurance schemes</li> <li>Private insurance schemes</li> <li>Other prepayment schemes</li> </ul>	<ul style="list-style-type: none"> <li>Records of:               <ul style="list-style-type: none"> <li>Ministry of Health</li> <li>Other ministries providing health care</li> <li>Social insurance organizations</li> <li>Private insurance companies</li> <li>Health expenditure and utilization surveys</li> <li>OASIS (Organizational Assessment for Improving and Strengthening Health Financing)</li> </ul> </li> </ul>

<sup>a</sup> Source: WHO Regional Office for the Eastern Mediterranean. DOTS quarterly online (DQonline), 2012.

<sup>b</sup> Source: *Global tuberculosis control report, 2012*. Geneva, World Health Organization, 2012.

<sup>c</sup> The proposed indicators under “noncommunicable diseases and mental health” represent the best estimate of service coverage related to noncommunicable diseases and mental health. Other indicators are being considered.

<sup>d</sup> Modified based on the *Global action plan for the prevention and control of noncommunicable diseases 2013–2020*. Geneva, World Health Organization, 2013.

<sup>e</sup> Source: *Global action plan for the prevention and control of noncommunicable diseases 2013–2020*. Geneva, World Health Organization, 2013.

<sup>f</sup> Source: *Comprehensive mental health action plan 2013–2020*. Geneva, World Health Organization, 2013.

### *Measuring coverage of financial risk protection*

20. The two indicators recommended and used by WHO and the World Bank for tracking the level of financial risk protection in health are the incidence of catastrophic health expenditure and the incidence of impoverishment due to out-of-pocket health payments. The former shows the number of individuals of all income levels who suffer financial hardship (spending more than 40% of their disposable income), because of relatively large health payments in a given time period. The latter captures the fact that relatively small payments can have severe financial consequences as well, particularly for people already close to the poverty line. Incidence of catastrophic health expenditure and impoverishment can be estimated from household surveys, which also allow an assessment of inequalities across population groups.

21. In the absence of these two indicators, the share of out-of-pocket spending as a percentage of total health expenditure can be used as a proxy. These are payments (also called direct payments) made by individuals and households at the point of receiving health services and which are not reimbursed by a third-party. A high share of out-of-pocket spending undermines the health system goal of financial risk protection and constitutes a major impediment to the move towards universal health coverage. Evidence suggests that where the share of out-of-pocket payments is higher than 20% of total health expenditure, households encounter an increased risk of financial catastrophe and impoverishment, which undermines the timely demand and use of needed care. (5)

### *Measuring coverage with needed health services*

22. This dimension focuses on coverage with priority services that address the major burden of ill-health in the population. It is important to note that such coverage includes individual-level services as well as population-wide interventions. There are internationally-agreed indicators for such coverage. These include, for example, the indicators for monitoring the health-related Millennium Development Goals and the indicators in the global monitoring framework included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020. Inequalities across these indicators should also be measured, as this is one of the fundamental concerns on the path to universal health coverage. Countries will need technical support in increasing their capacity to collect data disaggregated along sociodemographic classifiers, such as income, region, locale and other categories of population, in order to allow for monitoring of health equity.

### *Measuring coverage of population under prepayment arrangements – eligibility, entitlement and actual coverage*

23. Extending population coverage (the percentage of the population that is eligible to receive, entitled to receive and actually receive an essential package under different prepayment arrangements) will be critical for countries to monitor progress towards universal health coverage. This will not be easy for several reasons: the package of services offered will vary across prepayment arrangements; the same household or individual may be covered under more than one prepayment arrangement; and such information may not be readily available through routine health information systems or population-based household surveys. In theory, the entire population may be covered under government tax-funded schemes. However, this may not be the case in practice. It will be difficult to ascertain who is and is not covered under such circumstances.

24. Despite these limitations, effective monitoring of progress towards universal health coverage will require securing and verifying information from the records of the Ministry of Health, other ministries that are financing and providing health care, social insurance organizations, private insurance companies and health expenditure and utilization surveys, in order to identify population groups,

especially vulnerable groups, that are covered. Countries that have achieved universal health coverage have been able to demonstrate that all population groups are not just eligible and entitled but are also actually covered.

### **Where countries of the Region stand in their progress towards universal health coverage**

25. This section provides an overview of current status of countries in their journey towards universal health coverage. Countries of the Region have been categorized into three groups based on: population health outcomes, health system performance and the level of health expenditure.<sup>2</sup> The analysis is based on the three dimensions of universal health coverage (Figure 1) for assessing progress, presents the best available evidence in appraising the situation, and recognizes the existing gaps in information.

#### *Direct costs: proportion of the costs covered (financial risk protection)*

26. It is estimated that this Region spent approximately US\$ 125 billion on health in 2011. This figure constitutes 1.8% of the total world health spending for around 8.7% of the world population. Almost 40% of health expenditure is being spent out-of-pocket. (9)

27. Although the share of out-of-pocket as a percentage of total health spending has been stable over the past decade at the regional level, the three groups of countries have demonstrated diverse trends (Figure 2). Group 1 countries have continued to reduce share of out-of-pocket payments in their total health spending, which decreased from 21% to 17%. For Group 2 countries the share of out-of-pocket spending has fluctuated around 50%, while Group 3 countries have witnessed a sustained increase in the share of out-of-pocket spending from 59% to 69%. (9) Wide variations have been observed between and within countries, especially those belonging to Groups 2 and 3.

28. The few studies on equity carried out in selected Group 2 countries have shown that a significant proportion of households face financial catastrophe and are pushed into poverty due to high out-of-pocket payment. Studies carried out in Tunisia<sup>3</sup> and Morocco<sup>4</sup> showed that 2%–4.5% of the population face financial catastrophe and risk impoverishment due to out-of-pocket health care payments. In the occupied Palestinian territory (10) and Jordan<sup>5</sup>, this percentage amounts to 0.82% and 0.60%, respectively. Some vulnerable groups, especially the poor face even higher risks. (11) As part of a multicountry study, the following figures have been reported for the proportion of households experiencing catastrophic expenditures: Djibouti 0.32%, Egypt 2.8%, Lebanon 5.17%, Morocco 0.17% and Yemen 1.66%. (12)

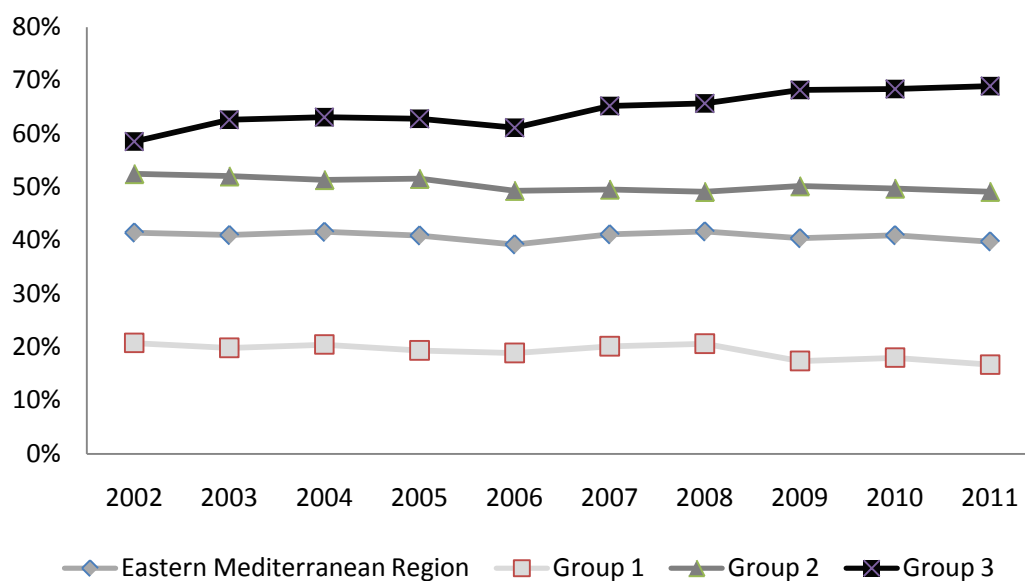
<sup>2</sup> Group 1 comprises countries where socioeconomic development has progressed considerably over the past decades, supported by high income (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates); Group 2 comprises largely middle-income countries which have developed extensive public health service delivery infrastructure but face resource constraints (Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic and Tunisia); Group 3 comprises countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability, and other complex development challenges (Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan and Yemen). (8)

<sup>3</sup> Arfa C, Souiden MA, Achouri N, unpublished data, 2008.

<sup>4</sup> Ezzrari A, El Allami El Fellousse LA, unpublished data, 2007.

<sup>5</sup> Abu Saif J, unpublished data, 2010.





**Figure 2. Share of out-of-pocket payment in total health expenditure, 2002–2011**

29. By extrapolating the findings from the country studies, it is estimated that up to 16.5 million individuals annually face financial catastrophe, and up to 7.5 million are pushed into poverty due to out-of-pocket payments in the Region. This compares to about 150 and 100 million people globally suffering financial catastrophe and impoverishment annually, respectively. (5) Despite some limitations due to the quality of data used in these studies, these findings are too significant to be discarded.

*Services: which services are covered? (service coverage)*

30. Coverage with needed health services concentrates on two aspects of service provision: first, the existence of health infrastructure and workforce which are critical inputs for the delivery of needed services; and second, coverage with essential primary care services and the associated benefit package.

#### **a) Existence of health infrastructure and workforce**

31. Two measures of health infrastructure are presented: density of primary health care facilities per 10 000 population and hospital beds per 10 000 population. Based on country reports, the density of primary health care facilities varies between 0.2 and 2.6 for Group 1 countries, 0.6 and 2.9 for Group 2 countries, and 0.5 and 1.7 in Group 3 countries. (13) As regards hospital beds, the density ranges between 11 and 21 for Group 1 countries, 5.2 and 37.0 for Group 2 countries, and 4.4 and 14.2 for Group 3 countries (Table 2). These predominantly represent the situation in the public sector, with the exception of Lebanon, and reflect wide variations within each group.

**Table 2. Health infrastructure and workforce in the countries of the Eastern Mediterranean Region**

Country	Primary health care facilities per 10 000 population	Hospital beds per 10 000 population	Physicians per 10 000 population	Nurses and midwives per 10 000 population
Group 1	0.2–2.6	11–21.0	14.7–34.9	22.6–61.9
Group 2	0.6–2.9	5.2–37.0	3.1–25.5	9.0–43.7
Group 3	0.5–1.7	4.4–14.2	0.3–8.0	0.8–6.5

Source: *Demographic, social and health indicators for the countries of the Eastern Mediterranean, 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012. (13)

32. In some Group 1 countries, although the low density of primary health care facilities reflects higher investment and reliance on hospitals, the comprehensiveness of primary health care services provided at these facilities, the large catchment population served, the extended hours of operation and the good quality of services make these accessible to the majority of population. In Group 2, Lebanon and Libya are two countries that have invested heavily in hospital care and at present have one hospital bed for every 300 persons. In general, there has been greater emphasis on expanding hospitals than primary health care facilities across the three groups of countries.

33. In Group 3 countries, access to primary health care services is a challenge due to lack or destruction of health infrastructure, geographical inaccessibility and insecurity. In Group 2 countries it is estimated that over 80% of people have geographical access to primary health care services. However, the big challenges are quality and financial affordability. In the case of Group 1 countries, although access to primary health care services is nearly 100%, there are opportunities to improve the provision of noncommunicable disease and mental health services. The inadequate focus of primary health care programmes on the quality, specific needs of the ageing population and responsiveness to the changing disease burden is a challenge across the three groups of countries.

34. Two indicators of the health workforce have been employed: number of physicians per 10 000 population and number of nurses and midwives per 10 000 population. The density of physicians varies from 14.7 to 34.9 for Group 1 countries, 3.1 to 25.5 for Group 2 countries, and 0.3 to 8.0 in Group 3 countries. In the case of nurses and midwives the density ranges from 22.6 to 61.9 for Group 1 countries, 9.0 to 32.5 for Group 2 countries, and 0.8 to 6.5 for Group 3 countries (Table 2).

35. Most Group 3 countries are among those classified as facing a crisis situation in regard to human resources for health. The average health workforce density of around 1 per 1000 population is well below the benchmark of 2.3 per 1000 population suggested in the World Health Report 2006. (14) Group 2 countries have an average health workforce density ratio of around 5.2 per 1000 population. The most important challenge is the inability of the system to coordinate and optimize production, deployment and productivity. Group 1 countries have an average health workforce density of 7 health workers per 1000 population, which is considered satisfactory and compares favourably with the global average for middle-income countries. However, these countries continue to rely heavily on an expatriate workforce, which in the case of nurses can be up to 90% in some countries. (8)

**Table 3. Coverage with essential primary health care services**

Country groups	Communicable diseases			Maternal/reproductive health problems		
	Measles vaccination coverage	DOTS coverage <sup>a</sup>	ART coverage (%) >15 yrs <sup>b</sup>	Antenatal coverage	Births by skilled birth attendants	Contraceptive prevalence rate
Group 1	98–100	100	NA	98–100	98–100	24–37
Group 2	91–99	100	13-56 (data from 4 countries)	66–100	74–100	38–60
Group 3	64–88	47–100	9-35 (data from 6 countries)	17–79	19–87	4–38

Source: *Demographic, social and health indicators for the countries of Eastern Mediterranean Region, 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.

<sup>a</sup> Source: WHO Regional Office for the Eastern Mediterranean. DOTS quarterly online (DQonline), 2012.

<sup>b</sup> Source: *Global report: UNAIDS report on the global AIDS epidemic*. Geneva, UNAIDS, 2013.

### **b) Coverage with essential primary care services and benefit package**

36. Coverage with essential health services varies across countries but there are important gaps that need to be addressed in all countries, regardless of level of socioeconomic development, when both population health interventions as well as individual-based health services in primary health care are considered. Seven programme interventions have been reviewed: measles vaccination, DOTS, tuberculosis care, antenatal care, birth attendance, contraceptive availability, and prevention and care for noncommunicable diseases and mental health.

37. For Group 1 countries, there is full coverage with communicable and maternal and child care services. In Group 2, immunization coverage is above 90% in most countries, but coverage with other services varies. In Group 3 there is wide variation across countries with regard to all services, and coverage with some of these services is unacceptably low (Table 3). For all Groups, there are important, albeit variable, gaps in integration of noncommunicable diseases, mental health and injuries services, especially prevention, into primary health care. (15) This is clear from the coverage rates reported by countries. For noncommunicable diseases, only 18% of countries report full availability of essential medicines and comprehensive provision of prevention, screening and management services in primary health care, while 55%–59% of countries report that these measures are not implemented (unpublished data, 2013). Availability and coverage of rehabilitative and palliative services has only recently started to receive serious attention.

38. For Group 1 countries, people have access to a comprehensive package of health services but quality of care could benefit from some improvements. Although health care services are mainly delivered by the public sector, the private sector is expanding and offers high-tech services. Increasingly, the expatriate population is receiving services under private health insurance schemes, which are being piloted or scaled up in order to extend coverage and reduce the disparities in access (Table 4).

39. Several Group 2 countries, including Egypt, Islamic Republic of Iran, Jordan, Lebanon and Morocco, have developed an essential package of primary health care services. The extent to which these are being implemented varies. In other countries, such as Libya and Tunisia, although an explicit package is not defined, the population has access to basic and specialized services. Among Group 3 countries, Afghanistan, Pakistan, Somalia and Sudan have developed a basic package of health services. With the exception of Afghanistan, these have only partially been implemented. Details about contents of the basic package of health services for each group of the country are given in Table 4.

*Population: who is covered? (eligibility, entitlement and actual coverage by prepayment arrangements)*

40. The definition of universal health coverage calls for ensuring that “all people” are covered by the two dimensions of financial risk protection and services. Hence, the third dimension of universal health coverage that needs to be extended to promote social health protection is that of the “population”.

41. The population groups that are covered could consist of those employed in the formal public and/or private sector, including or excluding their families; those in the informal sector in rural and/or urban settings; vulnerable groups such as the poor; displaced population groups; children or elderly groups of the population; or those suffering from certain health conditions. The criteria for classification are multiple and are not necessarily mutually exclusive, leading in some instances to inescapable fragmentation and duplication which may compromise efficiency and equity.

42. All citizens in Group 1 countries are covered for needed care. The extent and nature of coverage provided for the expatriate populations in these countries vary. Private insurance schemes are already in use to cover the expatriate populations in Saudi Arabia and the United Arab Emirates. Oman has covered its expatriate population by its national health system. Despite high levels of eligibility, coverage in Group 2 countries suffers from fragmentation and duplication. The extent of the population eligible to be covered varies substantially across the various groups of countries – Lebanon and Libya (100%); occupied Palestinian territory and Tunisia (100% with duplication) and Morocco (66.5%). In the absence of well-established social health insurance schemes and underfunded public sector health services, coverage is largely restricted to civil servants and armed forces, and large segments of the population in Group 2 countries remain uncovered from prepayment schemes. In Group 3 countries, eligibility and entitlement are distinct. While in principle government arrangements are supposed to cover all nationals, this is mostly available for public sector employees only. Social health insurance schemes are not present at the national level although some labour groups have such coverage. Finally, limited private and community-based insurance arrangements exist in some countries but these benefit a very small section of the population. Table 5 provides an overview of the main coverage arrangements in the three groups of countries.

*Coverage of direct costs, services and population: the three dimensions of universal health coverage*

43. There is close interrelation between financial risk protection, service and population coverage. Sufficient progress towards universal health coverage can only be made when there is demonstrable improvement in all its three dimensions. The greatest challenge to progressing towards universal health coverage is in Group 3 and many Group 2 countries, as: most lack mechanisms of financial risk protection; most do not have access to essential care of acceptable quality; and, despite eligibility criterion, many vulnerable population groups remain not actually covered. Consequently, significant categories of the populations in these countries find themselves at a higher risk of either avoiding the use of services or being exposed to financial hardship and impoverishment. In many Group 2 countries, although the percentage of population covered may appear to be high, reaching almost 90% in some, the service package offered lacks the depth to cover essential services, thereby compelling individuals to directly pay for the needed services and get exposed to a higher risk of financial catastrophe and impoverishment. In Group 1 countries, the citizens are well-covered in terms of the three dimensions of universal health coverage but the same cannot be said for sections of the expatriate populations that reside in these countries.

**Table 4. Service coverage by benefit package of health services**

Countries	Access <sup>a</sup>	Essential elements of package	Who provides	Who pays <sup>b</sup>
Group 1 countries	98%–100%	<p>Comprehensive health services<sup>c</sup> provided to the citizens of Gulf Cooperation Council countries which includes coverage for various population age groups and a range of services, including routine and emergency health services, emergency services, occupational and dental health care services</p> <p>Services for noncommunicable diseases and mental health are provided but not systematically integrated and gaps are documented.</p>	Ministries of health, Supreme Health Council (Qatar), health authorities, ministries of defence, petroleum, armed forces, national guards; private providers	Central government general revenue; general organization for social insurance; private employer-based insurance; households
Group 2 countries	83%–100%	<p>Essential package of health services, explicit<sup>d</sup> or implicit<sup>e</sup>, available in most countries</p> <p>Includes primary preventive and curative care, hospital care, medicines, laboratory /diagnostic services, dental care, chronic care, and referrals to tertiary care with some variations across countries</p> <p>In several countries, despite the existence of a benefit package it is only partially implemented and large segments of the population prefer to use private providers by making direct payments</p>	Ministries of health; ministries of higher education through university hospitals; other ministries such as social affairs, defence, labour; armed forces; municipalities; parastatal organizations; non-profit organizations; for-profit private sector; UNRWA (covering 5 million Palestinian refugees)	Government revenues transferred from Ministry of Finance to ministries; mandatory social health insurance organizations; private health insurance schemes; households; charities; external resources; other sources
Group 3 countries	44%–97%	<p>Maternal, neonatal and child health; nutrition; family planning; immunization; communicable disease surveillance and control (tuberculosis, HIV/AIDS, malaria, acute respiratory infections, diarrheal diseases); mental health; primary eye care; health education; environmental health promotion; first aid and blood transfusion, with some variation across countries</p> <p>Care for noncommunicable diseases is not explicitly included in the benefit package</p>	Ministries of health, ministries of interior and labour through primary health care facilities; armed forces; nongovernmental organizations contracted through vertical programmes; community health workers' programmes; direct provision by private practitioners, nongovernmental organizations and traditional health care providers	Government revenues transferred from Ministry of Finance to ministries or provincial departments of health; parastatal bodies and private employers; external donors and international nongovernmental organizations; households

<sup>a</sup> Access to local health services (rural and urban both) in percentage (%)

<sup>b</sup> Source: WHO. Global health expenditure database. [www.who.int/nha/expenditure\\_database/en/](http://www.who.int/nha/expenditure_database/en/)

<sup>c</sup> Comprehensive package of services

<sup>d</sup> Package of health services are documented, part or all are implemented

<sup>e</sup> Package of health services are not documented, but implementation may be different from one to another primary health care facility

**Table 5. Summary of population covered under prepayment arrangements**

Country	Government revenue	Social health insurance schemes	Private health insurance schemes	Other prepayment arrangements	Population covered
Group 1	All citizens are covered	Under consideration, not being implemented	Expatriate resident population but implementation is variable	–	100% for citizens
Group 2	In principle all citizens are eligible; in practice mainly public sector employees are eligible and actually covered	Covers formal sector employees, parastatal organizations, vulnerable population groups	Formal private sector employees – varies in scope from limited to substantial	–	40%-90% population [lacks depth of coverage]
Group 3	In principle all citizens are eligible; in practice mainly public sector employees are eligible and actually covered	No national programmes as yet; implementation in certain geographic areas or in labour sectors	Formal private sector employees but limited in scope	Limited community health insurance schemes	Around 26%

### Challenges to the move towards universal health coverage

44. Progress towards universal health coverage in the Region faces many challenges and at the same time can benefit from emerging opportunities. These are generally cross-cutting in nature and apply to most countries irrespective of their socioeconomic and health development. This section provides a summary of the challenges and opportunities that countries need to sense in order to expedite progress towards universal health coverage.<sup>6</sup>

45. The need for high-level political will and commitment to move towards universal health coverage with quality health care is the predominant challenge in most countries. Once such commitment is secured, policy-makers need to evolve a comprehensive vision, evidence-based strategy and a well-laid out roadmap.

46. Several Group 2 and 3 countries suffer from limited fiscal space, undermining the capacity of the government to adequately finance the health sector. This is compounded by the low priority given to health in government budgets. Allocations as low as 3% and 4% of government budget to health are common in a number of countries. In this regard, members of the Organization of African Unity (OAU) pledged to set a target for allocating at least 15% of the government budget to health in the Abuja Declaration in 2000. (16) Furthermore, in 2010 a Regional Committee paper suggested practical mechanisms for mobilizing more resources for health and proposed targets for allocation of government resources for health, including 8% allocation for the Ministry of Health. (17)

47. The high share of out-of-pocket payments in several Group 2 and 3 countries exposes households to the risk of financial catastrophe and impoverishment and is an impediment to equitable health systems and the move towards universal health coverage.

<sup>6</sup> For a detailed discussion, see *Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action*. (8)

48. Wastage of resources is a major source of inefficiency due to imbalances in workforce production, inappropriate skills mix, problems of procurement, use of inappropriate technology and disproportionate spending on hospitals compared to primary care. Information on the level of abuse and fraud from within the Region is lacking but it is estimated that globally between 20% and 40% of all resources are lost due to overall system inefficiencies. (5)

49. Inadequate provision of needed health services poses a challenge in the public as well as the private health sector that can be summarized as follows.

- Infrastructure: many Group 3 countries face geographic inaccessibility to health services. In addition, health care facilities are not functional due to lack of human resources, essential medicines and equipment, monitoring and supervision.
- Health workforce: the lack of a well-trained workforce and the maldistribution of the workforce, particularly in countries with a human resources crisis, inhibit a move towards universal coverage.
- Quality of services: the poor quality and image of public sector services are among the most important reasons for the underutilization of primary health care services, particularly in Group 2 and 3 countries.
- Package of services: the unavailability of a defined essential package of services, essential medicines and products and necessary treatment guidelines affect quality of care.
- The private health sector rivals the public sector in provision of primary care services in several Group 3 and 2 countries, and increasingly in Group 1 countries. The proportion of private sector outpatient services used by the population in some countries ranges from 33% to 86%. The range of services provided is variable, regulation is poor and there is insufficient information on financial burden to the users of these services.

50. Large segments of some population groups are not covered by prepayment arrangements. A major challenge to progressing towards universal health coverage is to extend coverage to those in the informal sector<sup>7</sup> in Group 3 and Group 2 countries, which includes large segments of the poor, rural and displaced populations. Ensuring fair and equitable coverage to the expatriate population is a particular challenge in Group 1 countries. An additional challenge is to increase the depth of coverage by broadening the benefit package for those who fall under different prepayment arrangements. In certain countries, the same household members are covered under more than one health insurance scheme thereby leading to system inefficiencies.

51. Health information systems are not prepared to monitor universal health coverage. Progress towards universal health coverage cannot be achieved unless it is well monitored. A global challenge is to agree on a unified framework for monitoring universal health coverage. In the Region, the capacity of countries to collect information on the three dimensions of universal health coverage varies and special efforts will be needed to establish data collection mechanisms that go beyond the routine reporting systems. Two related aspects will require particular consideration: monitoring the extent to which those who are eligible are actually covered, especially those in the informal sector, and monitoring equity in the provision and financing of services by collecting data disaggregated by income, locale and gender.

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<sup>7</sup> The informal sector covers a wide range of labour market activities that combine two groups of different nature: 1) coping strategies (survival activities) such as casual jobs, temporary jobs, unpaid jobs, subsistence agriculture, multiple job holding; 2) unofficial earning strategies (illegality in business) which includes two further categories: a) unofficial business activities such as tax evasion, avoidance of labour regulation and other government or institutional regulations, no registration of the company; b) underground activities: crime, corruption, activities not registered by statistical offices. Source: World Bank. *Concept of informal sector* <http://lnweb90.worldbank.org/eca/eca.nsf/1f3aa35cab9dea4f85256a77004e4ef4/2e4ede543787a0c085256a940073f4e4> Accessed 10 August 2013.

## **Seizing the opportunity for accelerating progress towards universal health coverage**

52. There is a global movement in support of universal health coverage. The 2010 World Health Report on health systems financing led to requests for technical support and advice from a large number of countries to move towards universal health coverage. (18) The analyses of the challenges and the roadmap proposed to move towards universal health coverage have struck a chord with many countries, rich and poor.

53. The commitment of WHO and the World Bank to supporting countries in their quest for universal health coverage was emphasized by the World Health Assembly in 2012 and in 2013. (19, 20) Also, in December 2012, the United Nations General Assembly called upon Member States to value the contribution of universal health coverage to achieving all interrelated Millennium Development Goals, with the ultimate outcome of more healthy lives and sustainable development. Universal health coverage is increasingly being considered as integral to the post-2015 sustainable development agenda, and essential to the achievement of the MDGs. (21)

54. The commitment of national policymakers in low and middle-income countries has increased. Several middle-income countries, including Turkey, Thailand and Mexico, have shown remarkable progress in achieving universal health coverage during the past decade; and many more, such as Indonesia, Morocco and India, have expressed commitment to do so over the next decade. Momentum is gathering among low and middle-income countries to accelerate progress towards universal health coverage, providing an opportunity that should not be missed.

55. Strategies and refined tools in support of universal health coverage are available. The Alma-Ata Declaration on Primary Health Care set powerful moral and philosophical foundations that underscored the importance of health action that is rooted in the community, responsive to the community's needs and attuned to its economic, social and cultural aspirations. The availability of a wide array of health system tools and metrics in areas such as health financing provides a far better opportunity to realize universal health coverage than would have been possible at the time of Alma-Ata.

## **Strategy and roadmap to accelerate progress towards universal health coverage**

56. The principle of equity and fairness is at the heart of the approach towards universal health coverage and is central to the proposed strategies. The strategy and the associated roadmap highlight the actions to be taken by countries, and the support to be provided by WHO and development partners in order to help countries make progress towards universal health coverage. The purpose is to help countries translate these strategies into national roadmaps towards universal health coverage aligned to their own priorities and current level of progress.

### **a) Develop a vision and strategy for advancing progress towards universal health coverage**

57. The vision, strategy and associated actions – should ensure: the provision of essential health services of acceptable quality; reliance on prepayment arrangements; and progressive expansion to cover different population groups, including the rural and poor informal sectors.

#### *What Member States need to do*

- Review the current status of coverage by different prepayment arrangements, including: coverage of financial risk protection, coverage with needed health services and population coverage; and identify appropriate country-specific options of prepayment arrangements for implementation at the national level.



- Establish/strengthen mechanisms of social health protection by implementing country-specific prepayment arrangements that progressively cover the entire population, with financial risk protection and needed services, including the poor and those in the informal sector.
- Expand/strengthen service provision based on the principles of family practice, including developing a package of essential services while paying attention to quality of care.
- Consider moving from passive purchasing arrangements to innovative strategic purchasing arrangements in order to enhance efficiency and equity. The strategic purchasing approach will give due consideration to splitting the provision and financing functions of the health system.
- Track and monitor progress on which population groups are covered under different prepayment arrangements and the extent of financial risk protection and service coverage.

#### *How WHO and partners can provide support*

- Support feasibility and actuarial studies for development of context-specific efficient, equitable and sustainable prepayment arrangements.
- Facilitate national policy dialogue with ministries of finance, economy and planning, as well as, ministries of health, to develop evidence-based strategies, taking into consideration the different health financing options for universal health coverage that are available.
- Provide advice on overcoming the bottlenecks in current health financing institutional set-up and organizational practice; elements that impede the efficient and equitable performance of national prepayment arrangements.
- Support countries in their effort to establish effective family practice programmes as the principal vehicle for delivering quality primary health care services.
- Develop policy briefs and evidence-based publications on related topics, such as strategic purchasing, benefit packages, and social health insurance and other prepayment arrangements, and share them with policy-makers.

#### **b) Establish a multisectoral national taskforce to steer the universal health coverage agenda**

58. A national-level multisectoral committee represented by the different constituencies is essential to guide the development of a vision, strategy and a 5–10 year roadmap for accelerating progress towards universal health coverage.

#### *What Member States need to do*

- Establish a high-level multisectoral national task force or steering committee of relevant stakeholders that evolves the vision, strategy and roadmap for progressing towards universal health coverage.
- Ensure that the high-level multisectoral task force is, preferably, led by the Ministry of Health and has representatives from: the ministries of finance, planning and labour; social health insurance organizations, private health insurance organizations; association of private providers; and other interest groups.
- Adapt the standard terms of reference of the task force and hold regular meetings to develop consensus on vision, strategy and roadmap.

- Develop a medium-term strategy and roadmap that is aligned with the national health plan for progressing towards universal health coverage.

*How WHO and partners can provide support*

- Provide evidence on the role multisectoral committees in promoting universal health coverage.
- Develop standard terms of reference for such a committee and share it with countries for national adaptation.
- Assist in preparing a situation analysis on the status of universal health coverage in all Member States and identify strengths, weaknesses, opportunities, challenges and priorities to move forward.
- Provide technical support in developing the vision, strategy and roadmap in the form of a master plan.
- Support national meetings at different stages to acquire consensus among relevant stakeholders during the initial process.
- Support countries to implement the recommendations of the 59th session of the Regional Committee paper on global experiences of the role of multi-sectoral committees in steering the universal health coverage process.

**c) Advocate for commitment and update legislation for universal health coverage**

59. High-level and sustained government commitment towards universal health coverage needs to be obtained through advocacy and legislation.

*What Member States need to do*

- Reflect government commitment towards universal health coverage in the national health policy, sector strategy or strategic planning, or whenever possible incorporate it in the national constitution.
- Review the current legislation and revise it in order to establish necessary mechanisms, such as social health insurance and other prepayment arrangements that support expansion of universal health coverage.

*How WHO and partners can support*

- Present and widely disseminate WHO's global universal health coverage strategy and approach in high level forums at the regional and national levels, such as regional committees and national policy-level seminars.
- Provide technical support for developing legislation for universal health coverage that upholds the values of fairness and equity, their enactment, and once enacted, translate these into appropriate regulations and institutional mechanisms.

**d) Strengthen the unit in the Ministry of Health responsible for coordinating universal health coverage**

60. A focal unit in the Ministry of Health is necessary to undertake situation analysis and propose evidence-based options to the national taskforce or steering committee for decision. This responsibility could be given to the health policy or planning unit or the health economics unit.

*What Member States need to do*

- Assign and strengthen the health policy, planning or economics unit in the Ministry of Health to function as the secretariat and undertake the required technical level work for the national task force/steering committee on universal health coverage.
- Equip the unit with the technical and financial resources to function as the secretariat and undertake or outsource analytical studies, prepare a draft strategy and plan, and monitor progress towards universal health coverage.

*How WHO and partners can support*

- Review the capacity of the technical unit identified by the Ministry of Health and support capacity development efforts.
- Organize specialized workshops, participation in training programmes and study tours to countries with successful universal health coverage experiences.
- Support national level activities to develop capacity of health professionals, civil servants, civil society representatives and academic institutions in advocacy and technical tools for advancing progress towards universal health coverage.
- Provide technical support in costing national master plans and in undertaking resource and gap analyses in order to make realistic assessment of what it takes to progress towards universal health coverage.

**e) Generate local evidence and share international experiences in universal health coverage**

61. Evidence will be needed to inform the national vision and strategy for universal health coverage, and global experience of the best practices in advancing towards universal health coverage should be shared.

*What Member States need to do*

- Set aside or mobilize resources to undertake different studies, such as national health accounts analysis; household income, expenditure and utilization surveys; OASIS (Organizational assessment for improving and strengthening health financing); workforce projection studies and health system performance reviews.

*How WHO and partners can support*

- Provide technical support and capacity development for analytical work and health policy and systems research to inform universal health coverage strategies and plans.
- Organize regional and national conferences and support study tours to share evidence and lessons from countries that have successfully advanced towards universal health coverage.

**f) Monitor progress towards universal health coverage**

62. A framework will be needed, together with the necessary tools, for monitoring progress towards universal health coverage and for taking corrective action.

### *What Member States need to do*

- Based on the global/regional framework, prepare a national framework that covers the three dimensions of universal health coverage: direct costs, services and population.
- Assign health information units in the Ministry of Health to: monitor progress towards universal health coverage based on the agreed framework; identify indicators, sources of information and institutions; and work in close collaboration with the focal unit to coordinate related work to universal health coverage.
- Prepare annual/biennial reports that provide an objective assessment of the progress made and constraints faced, and propose strategies for future action.

### *How WHO and partners can support*

- Develop a framework that allows monitoring of universal health coverage at the national, and in some cases sub-national, level with a focus on monitoring of health equity.
- Propose a minimum set of indicators based on the agreed framework that would be feasible and relevant for monitoring progress towards universal health coverage.
- Develop and/or adapt tools and instruments for collecting information from health information systems or through additional means and build national capacity in the use of these tools.
- Provide a template for reporting progress towards universal health coverage.

### **g) Establish a regional taskforce of development partners with Member States**

63. A regional universal health coverage taskforce/network, which would be convened by WHO with the participation of development partners, will support the development of a unified approach to support countries in their effort towards universal health coverage.

### *What Member States need to do*

- Actively participate in the meetings and activities of the regional taskforce on universal health coverage.
- Share experiences as well as demonstrate solidarity by providing technical and financial support to universal health coverage in the Region.

### *How WHO and partners can support*

- Develop the terms of reference of the taskforce and organize meetings to agree on strategies and approaches for countries, irrespective of their level of progress towards universal health coverage.
- Mobilize resources to provide sustained technical support to countries in their efforts to progress towards universal health coverage.
- Support countries facing resource challenges by advocating with funding agencies the need for additional resources to make visible progress towards universal health coverage.

### **Concluding messages**

64. The paper highlights key messages that Member States need to consider in accelerating progress towards universal health coverage.

- A comprehensive vision, evidence-based strategy and a well laid out roadmap are essential for making progress towards universal health coverage. Every country can do something to progress towards universal health coverage, irrespective of its level of development, if there is a clear vision, strategy and roadmap.
- Countries that adopt a multisectoral approach by engaging relevant stakeholders are much more likely to make accelerated progress towards universal health coverage.
- Moving away from out-of-pocket direct spending towards prepayment arrangements, with pooling in the form of social health insurance, general government revenues or both, is essential for increasing financial risk protection.
- Financial risk protection, service and population coverage are closely intertwined. Progress towards universal health coverage can only be made when there is demonstrable improvement in all three dimensions.
- It is feasible for all countries to expand coverage by developing effective strategies that reform the health system as a whole, by increasing production of workforce, access to essential medicines and provision of quality health services, and by offering financial risk protection;
- Progress towards universal health coverage can only be achieved if it is well monitored and measured as it can help identify constraints and take timely corrective action.
- All countries can move forward towards universal health coverage in the short run by demonstrating sustained political commitment. WHO and all development partners are equally committed in supporting countries in their quest for universal health coverage.

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