Report

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Driving universal health reforms through crises and shocks

Final report on the work of the Chatham House Commission for Universal Health

Robert Yates, Sophie Witter, Frini Chantzi and Brooke Hunsaker

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Report summary

Crises and shocks – including disease outbreaks, financial crises and conflicts – can create windows of opportunity to trigger universal health reforms. This report examines when and how such reforms have occurred, and what lessons can be drawn by leaders currently considering UHC reforms.

- Universal health coverage (UHC) is achieved when everyone receives the health services they need, without suffering financial hardship. In principle, all countries are committed to achieving UHC by 2030, in line with Target 3.8 of the Sustainable Development Goals. But global indicators for health coverage and financial protection have been lagging since 2015.
- The series of crises and shocks the world has suffered in recent years – including the 2008 global financial crisis, the COVID-19 pandemic, new or protracted conflicts, rising food and energy prices, and the deepening impacts of climate change – have raised fears that commitments to UHC will be seriously undermined. In light of these concerns, Chatham House established the Commission for Universal Health in 2022 to look at ways to maintain and accelerate progress towards UHC.
- The commission's research, which underpins this report, suggests, perhaps counter-intuitively, that in many countries transitions towards UHC have occurred during times of national crisis, including fiscal crises. Notably, conditions of crisis and shock have had a catalytic role in precipitating UHC reforms. Crises can often create a 'window of opportunity' for transformational reforms that require a particular combination of political, social and economic imperatives in order to be brought to fruition.
- The commission based its findings on a review of secondary literature relating to UHC and crises and shocks. It also conducted case studies of countries where, in the last 30 years, political leaders have launched substantial UHC reforms at least partly in response to different crises. The case studies – which are to be published as a supplementary annex to this report – describe the nature and benefits of the changes to these countries' health systems, and how policy in each case was influenced by the relevant context of crisis or shock.

- The commission also reviewed the literature on the wider benefits, beyond health, that UHC reforms can deliver. These include faster economic growth, increased labour productivity, higher levels of employment, improved social cohesion, and reduced levels of poverty and inequality. Improving access to quality health services and reducing financial burdens on households is also extremely popular, especially with previously excluded population groups, and so UHC reforms can deliver significant political benefits to the leaders that implement them.
- Our report does not suggest that shocks or crises are either necessary or sufficient to set in train a move towards UHC. Several countries are suffering crises that seem very unlikely to trigger health reforms. Others have achieved reforms without undergoing shocks. And fiscal or economic shocks can threaten existing healthcare policies, including UHC, as demonstrated by Greece following the financial crisis of 2008.
- Neither does the report find good evidence that UHC is unaffordable for most countries, or that there are cheaper ways to provide healthcare by relying on private health insurance for the better off and concentrating public financing on the worse off. The latter type of schemes – as have evolved in the US and South Africa, for instance – are usually highly inequitable and not cost-effective. The universal entitlement is key to both equity in access and cost-effectiveness in provision. By pooling resources, UHC offers the possibility of providing better healthcare for more people more cost-effectively than alternative models.
- The affordability of UHC is nonetheless a legitimate concern, particularly for low-income countries and others (such as those with ageing populations), where healthcare needs are rising fast. The report finds that extra resources are indeed required to move sustainably towards UHC, and, based on its research and case studies, endorses the World Health Organization's estimate that an additional 1 per cent of gross domestic product (GDP) for primary healthcare is a realistic target for countries transitioning to UHC.
- The multiple crises of the early 2020s, including the COVID-19 pandemic, provide a window of opportunity to generate increased political will and public financing that are the foundations of successful UHC reforms. The commission finds that, as in the past, some leaders are currently considering launching or expanding ambitious UHC reforms. These tend to be middle-income countries that now have at least the potential fiscal capacity to make the transition to a predominantly publicly financed UHC system. Recent examples of this phenomenon include, in Africa, Egypt, Kenya, South Africa and Tanzania; and, in South Asia, Bangladesh, India and Pakistan.
- Drawing on key lessons from our case studies and other post-crisis UHC reforms, the report offers five overarching policy recommendations for political leaders contemplating launching new UHC reforms in response to today's crises. These are:

    1. **Prioritize reaching full population coverage rapidly,** by providing a universal entitlement to a comprehensive and affordable package of publicly financed health services.

2. **Increase public health financing by around 1 per cent of GDP** to expand the supply and quality of services and generate additional demand by removing financial barriers to services. This will support efforts to ensure universal entitlement to services becomes a reality rather than remaining an aspiration.
3. **Concentrate additional public expenditure on improving cost-effective primary care services and strengthening health systems** in areas such as human resources, essential medicines, infrastructure, information systems and governance.
4. **Remove or drastically reduce user fees** so that health services in the agreed package are provided free at the point of delivery, including ensuring that essential medicines and diagnostics are available free of charge.
5. **Promote universal health reforms as a flagship policy of the government,** and build on the popularity of UHC measures to facilitate government revenue generation policies in other areas, for example through raising taxes and cutting inappropriate subsidies (e.g. reducing funding of fossil fuels). Linking popular UHC reforms to broader fiscal reforms may enable governments to raise more revenue than the additional 1 per cent GDP needed to kick-start their health reforms.

01 Introduction

Universal health coverage provides the fairest and most efficient route to protecting people from ill health, and from impoverishment linked to ill health. This benefits not just individuals; it also contributes to the collective well-being of families, communities and societies. Crises raise the stakes, making political action on UHC more urgent than ever.

Purpose of the Commission for Universal Health

The Chatham House Commission for Universal Health was established in 2022, at a moment when crises and shocks were proliferating around the world. The commission's purpose has been to explore the opportunities that these circumstances may offer for accelerated progress towards universal health coverage (UHC), recognizing the obstacles UHC faces and the importance of maintaining progress towards it.

The commission's primary goal has been to develop and share evidence to support countries to meet their commitments to reach UHC by 2030 (as agreed in the Sustainable Development Goals and reiterated at the UN General Assembly in 2019) and build more resilient health systems to strengthen preparedness for future pandemics.

The work has been taken forward by a team of 47 commissioners (listed in the acknowledgments section at the end of this report), chaired by Helen Clark, former prime minister of New Zealand, and Jakaya Kikwete, former president of Tanzania, and supported by a technical secretariat based at Chatham House. Its messages are aimed particularly at political leaders.

Commissioners have met regularly over the last two years, including five times as a commission, to contribute insights on the key questions and shape messages. Four working groups were also established, tasked with, respectively: addressing definitions and conceptualization; the development of the literature review and conceptual framework; the country case studies; and identifying opportunities for future UHC reforms. Periodic all-commissioner meetings ensured coherence across these strands.

This report presents the findings of the authors and the secretariat team at Chatham House based on their own research, and drawing on the invaluable contributions and insights of the members of the commission.

Overview

Today's political leaders are faced with multiple crises associated with the aftermath of the COVID-19 pandemic, new and protracted conflicts, rising food and energy prices, and the climate emergency. The commission investigated whether some leaders might be looking to implement UHC reforms as part of the response to such crises. The commission therefore held discussions, both within its working groups and with external stakeholders, to assess whether any countries are already implementing UHC reforms and whether others are considering such a strategy.

Our findings suggest that responses to contemporary crises appear to be fostering interest among political leaders in launching or expanding ambitious UHC reforms.

Our work suggests that responses to contemporary crises do appear to be fostering interest among political leaders in launching or expanding ambitious UHC reforms. This tends to be most evident in middle-income countries that have not yet made the transition to a predominantly publicly financed UHC system. One of the primary aims of the commission has been that findings and lessons from previous post-crisis UHC reforms can inform new UHC initiatives. Our findings indicate that crises do appear to be a factor in driving UHC reforms, especially in regions that have previously made slower progress towards UHC – notably in Africa and South Asia.

In South Africa, for instance, the COVID-19 pandemic highlighted deep-seated inequalities in the country's health system, and appears to have spurred President Cyril Ramaphosa into accelerating the legislative process to launch a National Health Insurance (NHI) programme.[1] The NHI Act, which was signed into law in May 2024, will create a tax-financed single-payer health system that will provide a universal entitlement to health services in both the public and private sectors. With no party winning an overall majority in South Africa's general election, conducted shortly afterwards, it is uncertain how and when the act will be implemented or whether it may be amended by the incoming coalition government. In Egypt, in January 2021, President Abdel Fattah El-Sisi directed the government to complete the implementation of the country's National Health Insurance System (NHIS) by 2027 – five years earlier than previously scheduled.[2] Egypt's UHC reforms will prioritize achieving full population coverage by increasing pooled public financing, drawing on mandatory social health insurance contributions and tax financing to replace out-of-pocket (OOP) expenses.[3]

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1 BusinessTech (2020), 'Coronavirus requires universal health coverage: Ramaphosa', 13 July 2020, https://businesstech.co.za/news/government/415875/coronavirus-requires-universal-health-coverage-ramaphosa.
2 Soliman, M. (2021), 'Egypt's Sisi mandates a condensed 10-year deadline for completing universal health insurance', *Ahram Online*, 30 January 2021, https://english.ahram.org.eg/NewsContent/1/64/399957/Egypt/Politics-/Egypt%E2%80%99s-Sisi-mandates-a-condensed-year-deadline-fo.aspx.
3 Elsayed, R. (2023), 'The road to Universal Health Coverage in Egypt: New expectations and hopes', International Health Policies (IHP), 6 April 2023, https://www.internationalhealthpolicies.org/featured-article/the-road-to-universal-health-coverage-in-egypt-new-expectations-and-hopes.

In Tanzania, President Samia Hassan[4] signed the Universal Health Insurance Bill into law in December 2023, committing the government to extending health coverage to all citizens through mandatory social insurance contributions and increased tax financing covering vulnerable households.[5] In Kenya, President William Ruto's government enacted four pieces of UHC legislation in November 2023 – the Social Health Insurance Act, the Primary Health Care Act, the Digital Health Act, and the Facility Improvement Financing Act – with the intention of extending public health coverage to all Kenyans and long-term residents.[6] Kenya's comprehensive reforms also aim to restructure healthcare financing and administration nationwide.

In South Asia, political leaders in larger middle-income countries, which have historically seen low levels of public health spending and high levels of health-related impoverishment, have latterly been showing increased interest in launching or expanding universal health reforms.[7] In September 2023, for example, India's health ministry launched a nationwide campaign to enrol eligible households into the country's vast Ayushman Bharat health insurance programme.[8] Launched by Prime Minister Narendra Modi in 2018, the scheme already covers over 500 million people, and the government is now extending access to more groups of workers: in the budget for 2024 (an election year), it was announced that over 3 million community health volunteers would be eligible for free membership.[9] Meanwhile, state-level governments have been launching universal health reforms. In the union territory of Delhi and the state of Punjab, notably, universal access to free primary care services is provided via hundreds of mohalla clinics.[10] This has become a flagship policy of the Aam Aadmi Party – the governing party in both of these states – in its election campaigning.

In Bangladesh, Prime Minister Sheikh Hasina has demonstrated her administration's political commitment to expanding health coverage by co-hosting UHC events with the Chatham House Commission for Universal Health in Dhaka in May 2023 and at the United Nations General Assembly in September 2023.[11] At these events, Hasina emphasized UHC as a constitutional obligation, pledging to provide essential healthcare for the entire population of Bangladesh through public provision by 2030. Launching her election manifesto in December 2023,

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4 Samia Hassan, previously vice-president of Tanzania, became head of state following the death of the then president, John Magufuli, in 2021, during the COVID-19 pandemic.
5 Wambura, B. (2023), 'Samia assents to Universal Health Insurance Bills', *The Citizen*, 6 December 2023, https://www.thecitizen.co.tz/tanzania/news/national/samia-assents-to-universal-health-insurance-bill-4454922.
6 Shikanda, H. (2023), 'Rutocare: What the new health laws mean for you', *Nation*, 20 October 2023, https://nation.africa/kenya/health/-rutocare-what-the-new-health-laws-mean-for-you-4407420.
7 Beattie, A., Yates, R. and Noble, D. (2016), *Accelerating progress towards universal health coverage for women and children in South Asia, East Asia and the Pacific*, UNICEF Regional Office South Asia, https://www.unicef.org/rosa/media/4581/file.
8 Jha, D. (2023) 'New health campaign 'Ayushman Bhav' to mark PM Modi's birthday', *Times of India*, 12 September 2023, https://timesofindia.indiatimes.com/india/new-health-campaign-ayushman-bhav-to-mark-pm-modis-birthday/articleshow/103588181.cms.
9 Aggarwal, R. (2024), 'Interim Budget: Ayushman Bharat cover to be extended to all ASHA workers', *Business Standard*, 1 February 2024, https://www.business-standard.com/budget/news/interim-budget-ayushman-bharat-cover-to-be-extended-to-all-asha-workers-124020100321_1.html.
10 Singh, A. (2023), 'After Delhi, Punjab gets 500 mohalla clinics', The New Indian, 28 January 2023, https://www.newindian.in/after-delhi-punjab-gets-500-mohalla-clinics/
11 UNICEF Bangladesh (2023), 'Government commits to accelerate universal health coverage', press release, 11 May 2023, https://www.unicef.org/bangladesh/en/press-releases/government-commits-accelerate-universal-health-coverage.

she announced: 'A Universal Health System will be established to ensure equal healthcare for all citizens', and 'Primary health care and medicine distribution free of cost will be continued through community clinics.'[12]

In Pakistan in 2021, at the height of the COVID-19 pandemic, the then prime minister Imran Khan announced his intention to launch a welfare state based on a universal right to food security and access to health services.[13] His subsequent removal from office in 2022 meant that he was unable to take these pledges forward, but the strong showing by former members of his (banned) party in the 2024 general election suggests that UHC reforms could return to the political agenda.

It might appear unaffordable and infeasible for many countries to contemplate launching ambitious UHC reforms in the current context. However, the evidence from our research would suggest the opposite: economic and political crises may actually provide a window of opportunity for bold action on universal health.

Why focus on UHC now?

> Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.
>
> **World Health Organization**[14]

UHC consists of three interrelated components: (i) quality health services according to need; (ii) financial protection from direct payment for health services when consumed; and (iii) coverage for the entire population. The right to the highest attainable standard of physical and mental health is enshrined in several international legal instruments. It is a fundamental human right, which governments have committed to fulfil under the UN Sustainable Development Goals.[15]

But the world is failing to make significant progress towards UHC by 2030. Improvements to health services coverage have stagnated since 2015, and the proportion of the population facing catastrophic levels of OOP health spending has increased.[16] As the World Health Organization (WHO) Council on the Economics of Health for All has highlighted, proactively addressing social and economic determinants of health is a long-term investment, not a short-term

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12 Bdnews24.com (2023), 'Awami League puts focus on social security, women's empowerment in election manifesto', 27 December 2023, https://bdnews24.com/politics/bl3fek4hjn.
13 Global Village Space (2021), 'New year's resolution for 2021 to make Pakistan a welfare state: PM Khan', 1 January 2021, https://www.globalvillagespace.com/new-years-resolution-for-2021-to-make-pakistan-a-welfare-state-pm-khan.
14 World Health Organization (2023), 'Universal health coverage (UHC)', Fact sheet, 5 October 2023, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).
15 United Nations (2015), *Transforming our world: the 2030 Agenda for Sustainable Development*, https://sdgs.un.org/publications/transforming-our-world-2030-agenda-sustainable-development-17981.
16 World Health Organization/World Bank (2023), *Tracking Universal Health Coverage: 2023 Global monitoring report*, Geneva: World Health Organization, https://www.who.int/publications/i/item/9789240080379.

cost, because it avoids the high costs of inaction.[17] The decline in global GDP of 3.1 per cent in 2020 – i.e. the first year of the COVID-19 pandemic – could have been significantly lower if adequate prior investments had been made in disease prevention and response systems.[18]

UHC serves as a cornerstone for broader economic resilience, fostering progress beyond pure economic growth. WHO estimated in 2018 that investments in extending access to UHC in the period 2019–23 could yield a return of 9:1, taking account of life expectancy gains and the intrinsic value of lives saved.[19] A one-year increase in life expectancy has been estimated to boost GDP per capita by 4 per cent.[20] In 2000–11, improvements in health contributed to an estimated yearly growth in income of 1–2 per cent across low- and middle-income countries.[21] UHC can also release precautionary savings that households have had to make in the absence of financial protection in relation to healthcare, as was observed in China.[22] UHC is particularly important for the significant population working in the informal economy with no financial safety nets or job security. Globally, 61 per cent of the labour force work in the informal sector. Illness means these workers can lose their source of income, and their very survival is threatened. In India alone, 93 per cent of the workforce is informal (some 500 million people). For them, especially women, health is key to economic security and well-being.[23]

Historically, global crises and shocks have often shifted the understanding of health as an important right and changed political incentives in relation to it. In the aftermath of the First World War, for example, the 1918–20 'Spanish flu' pandemic spurred a global reappraisal of public health policies.[24,25] Crises create a potential 'window of opportunity' to embark on a new path and overcome obstacles previously regarded as insuperable.[26] The world is emerging from the COVID-19 pandemic into an era characterized by what is often termed 'polycrisis' affecting current and future generations, including multiple armed conflicts as well as social, economic, environmental and epidemiological challenges. This demands a radical reappraisal to underpin new health, social and economic

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17 World Health Organization (2023), *Health for All – Transforming Economies to Deliver What Matters: Final Report of the WHO Council on the Economics of Health for All*, Geneva: World Health Organization, https://www.who.int/publications/i/item/9789240080973.
18 World Bank (2023), *Atlas of Sustainable Development Goals 2023,* Chapter 8, https://datatopics.worldbank.org/sdgatlas/goal-8-decent-work-and-economic-growth/?lang=en.
19 World Health Organization (2022), *A healthy return: Investment case for a sustainably financed WHO*, Geneva: World Health Organization, p. 25, https://www.who.int/about/funding/invest-in-who/investment-case-2.0.
20 World Health Organization (2016), *Working for health and growth: Investing in the Health Workforce*: *Report of the High-Level Commission on Health, Employment and Economic Growth*, Geneva: World Health Organization, https://www.who.int/publications/i/item/9789241511308.
21 Atun, R. et al. (2016), *Poverty Alleviation and the Economic Benefits of Investing in Health: Systematic Analysis and Policy Implications*, Forum for Finance Ministers 2016, https://www.hsph.harvard.edu/drph/wp-content/uploads/sites/1496/2016/10/L-MLIH_Health-economic-growth-and-development_Atun-and-Kaberuka_4-11-16.pdf.
22 Yip, W. et al. (2023), 'Universal health coverage in China part 2: addressing challenges and recommendations', *The Lancet Public Health*, 8(12), pp. 1035–42, https://doi.org/10.1016/S2468-2667(23)00255-4.
23 International Labour Organization (2018), *Women and Men in the Informal Economy: A Statistical Picture*, Geneva: International Labour Office, https://www.ilo.org/global/publications/books/WCMS_626831/lang--en/index.htm.
24 Kamradt-Scott, A. (2020), 'The Politics of Pandemic Influenza Preparedness', in McInnes, C., Lee, K. and Youde, J. (eds), *The Oxford Handbook of Global Health Politics*, Oxford: Oxford University Press, https://doi.org/10.1093/oxfordhb/9780190456818.013.32.
25 Spinney, L. (2017), 'How the 1918 Flu Pandemic Revolutionized Public Health', *Smithsonian Magazine*, https://www.smithsonianmag.com/history/how-1918-flu-pandemic-revolutionized-public-health-180965025.
26 Cairney, P. (2019), *Understanding Public Policy: Theories and Issues*, 2nd edition, London: Bloomsbury Publishing.

policies, and a reorientation of economies worldwide around the goal of Health for All. In this context, the Commission for Universal Health has sought to work with governments to promote UHC as a legal responsibility and political priority that goes beyond health, to include intergenerational, economic, societal, environmental and political benefits.

What are the benefits of UHC?

UHC significantly enhances people's lifelong well-being. Improved health at each life stage not only benefits individuals, but also contributes to the collective well-being of families, communities and societies.[27] Prevention and promotion strategies efficiently reduce morbidity and mortality while curbing disease transmission, thus protecting both individuals and the broader community and healthcare system.

Health security is a key component of UHC, and is vital for disease outbreak prevention and preparedness. It can therefore confer regional and global benefits by curbing disease spread, thus supporting efforts to tackle rising levels of antimicrobial resistance.[28] Meeting international legal obligations for risk reduction and emergency preparedness prevents health system collapse during emergencies, ensuring that essential UHC elements benefit affected populations.[29, 30]

By providing protection and pooling health and health financing risks across population groups, UHC additionally underpins social development across the life course (including educational development), reduces inequities, including gender-based inequalities, and can improve social cohesion and peacebuilding, contributing to resilience and avoiding or mitigating future crises.[31, 32]

There are a number of key mechanisms through which health coverage and health can help address poverty and support economies.[33] These include financial protection by avoiding catastrophic expenditure and impoverishment when people access healthcare. Education is another important pathway: better health improves educational attainment, with long-term benefits in terms of jobs and pay. Better health also contributes directly to worker productivity through reduced absenteeism and better performance. There is, too, a notable effect on investment, linked to the effect of longer life expectancy and higher incomes in boosting savings. Finally, there can be a demographic mechanism, with better

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27 Clarke, L. and Le Masson, V. (2017), *Shocks, stresses and universal health coverage: Pathways to address resilience and health*, Working paper 526, London: Overseas Development Institute, https://odi.cdn.ngo/media/documents/11931.pdf.
28 Alsan, M. et al. (2015), 'Out-of-pocket health expenditures and antimicrobial resistance in low-income and middle-income countries: an economic analysis', *The Lancet Infectious Diseases*, 15(10), pp. 1203–10, https://doi.org/10.1016/S1473-3099(15)00149-8.
29 Alwan, A. (2013), 'Universal health coverage in the context of emergencies', *Eastern Mediterranean Health Journal*, 19(8), pp. 685–86, https://apps.who.int/iris/handle/10665/118525.
30 Kluge, H. et al. (2018), 'Strengthening global health security by embedding the International Health Regulations requirements into national health systems', *BMJ Global Health*, 3(1), p. e000656, https://doi.org/10.1136/bmjgh-2017-000656.
31 World Health Organization (2023), 'Human Rights', Fact sheet, 1 December 2023, https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.
32 Price, R. (2020), *Health programmes and peacebuilding in FCAS*, K4D Helpdesk Report 827, Brighton: Institute of Development Studies, https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/15393.
33 Atun et al. (2016), *Poverty Alleviation and the Economic Benefits of Investing in Health*.

health contributing to changed family structures and hence growth opportunities. Moreover, healthcare is one the biggest sectors of the economy globally, already providing an estimated 65 million jobs in 2020.[34]

Ensuring equitable access to healthcare and protection from healthcare costs has proved popular with electorates and delivered benefits for the politicians who led these reforms.[35,36] Conversely, failure to provide social protection to populations can drive disillusionment with the political system, fuelling populism and undermining the political process.[37]

Failure to provide social protection to populations can drive disillusionment with the political system, fuelling populism and undermining the political process.

A further benefit of UHC is that, while increasing access to healthcare for all, it offers the possibility of providing better healthcare more cost-effectively than alternative models. It is sometimes argued that, as many people can afford to pay for their healthcare, it would be best to let them do so through private insurance provided by employers and their own contributions while concentrating publicly financed resources on meeting the needs of the worse off. This is the type of health system that has evolved in South Africa and – following the passing of the 2010 Affordable Care Act, known as 'Obamacare' – the US.

In the case of the US, 14 years after the introduction of the Affordable Care Act, there are still massive problems for millions of Americans in accessing affordable healthcare. The US in 2021 spent 17.8 per cent of GDP on healthcare, almost twice the average for high-income countries. Yet, in spite of Obamacare, in 2021 8.6 per cent of the population remained without insurance. Moreover, most measures of health outcomes such as life expectancy or child and maternal mortality are significantly lower than in other high-income countries. Affordability is still a major reason why almost half of adults in the US avoid or delay accessing healthcare that they need.[38]

The difficulties of the US system are twofold. First, the system tends to discourage access through the cost of insurance, the prevalence of the copayments required from patients by insurance companies, and restrictions on procedures or medicines that insurers are prepared to reimburse. This affects not just the poor, but also people well up the income scale. Second, on the supply side, the system encourages high-cost services not necessarily related to patient needs. Doctors are paid by fee-for-service, which prioritizes high-cost procedures over cheaper approaches. Moreover, the overheads inherent in running an insurance-based system with multiple players generates a vast quantity of transaction costs and paperwork

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34 Boniol, M. et al. (2022), 'The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage?', *BMJ Global Health*, 7 (009316), https://doi.org/10.1136/bmjgh-2022-009316.
35 Fontana, G., Nicholson, D., Warburton, W. and Yates, R. (2015), *Delivering Universal Health Coverage: A Guide for Policymakers,* Report of the WISH Universal Health Coverage Forum 2015, https://wish.org.qa/reports/#6241.
36 Clarke and Le Masson (2017), *Shocks, stresses and universal health coverage*.
37 See, for example, Oude Groeniger, J., Gugushvili, A., de Koster, W. and van der Waal, J. (2022), 'Population health, not individual health, drives support for populist parties', *PNAS Nexus*, 1(3), https://doi.org/10.1093/pnasnexus/pgac057.
38 Commonwealth Fund (2023), 'U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes', Issue brief, 31 January 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

for hospitals, clinicians and patients. It has been argued that if a single-payer UHC system replaced the current model, the same healthcare outcome could be achieved with an annual saving of over $600 billion.[39]

The same argument applies to concerns about the affordability of publicly financed UHC in view of the healthcare issues raised by the prospect of rapidly ageing populations – a trend that will be seen in many developing countries over the coming years. It will be even more important to find cost-effective and equitable means of effectively meeting the increasing demand for health and social care this represents. Versions of publicly financed UHC, including essential public health functions, rather than voluntary insurance models, are far more likely to achieve this.[40]

39 Galvani, A. and Fitzpatrick, M. (2020), 'Cost-effectiveness of transitional US plans for universal health care', *The Lancet*, 395, p. 1692, https://doi.org/10.1016/S0140-6736(20)30857-6.
40 See also World Health Organization (2010), *The World Health Report: Health Systems Financing: the Path to Universal Coverage*, Geneva: World Health Organization, https://www.who.int/publications/i/item/978924156402.

02 Approach of the commission

Drawing on literature and country case studies, our work examines how and when shocks and crises have enabled UHC reforms, and what lessons can be drawn from global experience to support future transitions to UHC.

Focus and core questions

For the purposes of understanding the role of crises in potentially enabling UHC reforms, the research team, supported by the Commission for Universal Health, focused on acute events at national and subnational levels, and examined the relationships between crisis situations and the likelihood of UHC reforms. It hypothesized that crisis events may create a window of opportunity for policy realignment and reforms.[41] Encompassing conflict-related situations, public health emergencies, natural disasters, and economic and social crises, the analysis sought instances of substantial policy shifts targeting increased UHC.

Our key questions were:

1. What is the relationship between UHC reforms and crises and shocks of various kinds? To what extent, and how, have shocks and crisis triggered or enabled UHC reforms?
2. What contextual factors and strategies have enabled crises and shocks to be used to catalyse or enable UHC reforms? What lessons can we draw from global experience to support future UHC reforms?

41 Hiam, L. and Yates, R. (2021), 'Will the COVID-19 crisis catalyse universal health reforms?', *The Lancet*, 398 (10301), pp. 646–48, https://doi.org/10.1016/S0140-6736(21)01650-0.

The analytical framework considered the relationship between context, shocks and the impact that these have, using Kingdon's 'multiple streams' approach to analysis of problem, policy and politics.[42] Following Kingdon, the central hypothesis was that for reforms to be implemented successfully, perceptions of the urgency of the problem, the availability of policies to address that problem, and a supportive constellation of actors need to converge, creating windows of opportunity for change. This guided the analysis to focus on the following:

- **Context and problem:** To what extent and how have shocks and crisis triggered or enabled reforms towards UHC? What was the state of health coverage prior to the crisis or shock? What contextual factors enable crises and shocks to be used to catalyse or enable UHC reforms? What contextual factors make reform more challenging?
- **Policy and institutional reforms:** How have countries' policies and strategies, in response to crises and shocks, transitioned towards UHC? What are the characteristics and trajectories of UHC policy and institutional reforms in countries experiencing shocks? How have crises influenced these trajectories, and what lessons do these generate?
- **Stakeholders and politics:** Which stakeholders supported or opposed policy reforms, and why? How were their positions influenced by crisis – i.e. how did it change their interests, power and ideological framings? How were these different stakeholders managed in order to ensure the eventual reforms were effective?
- **Outcomes:** To what extent, and how, have the reforms improved progress towards UHC? What lessons can be drawn to support future UHC reforms in other countries experiencing crises and shocks?

Literature review

We undertook a rapid scoping of grey and published literature on UHC reforms following crises and shocks, focusing on understanding factors that favour or block reforms, and drawing lessons on strategies for making effective use of potential windows of opportunity. This literature review provides background for the lessons learned from the country case studies developed by the commission.

Search terms included:

- Crisis; OR shock; OR conflict; OR natural disaster; OR epidemic; OR pandemic; OR disease outbreak; health emergencies; humanitarian
- AND universal health coverage; OR health systems; OR health services; OR healthcare; OR health security; OR public health; OR health reforms; OR health financing; OR political economy

42 Kingdon, J. (1984), *Agendas, Alternatives, and Public Policies*, Boston: Little, Brown & Co.

Databases included Google Scholar and PubMed. The team also searched the websites of organizations active in this area of work, including the World Health Organization (WHO), the World Bank and the Organisation for Economic Co-operation and Development (OECD), and identified relevant work in the reference lists of included studies. Members of the Commission for Universal Health were also approached to provide an overview of known literature.

Selection criteria for identified literature reflected the definitions and boundaries laid out above, and included empirical studies (multiple or single case studies) as well as conceptual literature if it focused on the issues of interest. No language or time restrictions were imposed, but only English-language search terms were used.

Data extraction: An initial descriptive analysis of the data was conducted by extracting data from documents, using a thematic content-analysis approach. An extraction matrix and a coding tree were developed for this purpose, mostly based on pre-identified themes but also with additions of emerging codes and themes as the extraction was under way (deductive/inductive approach).

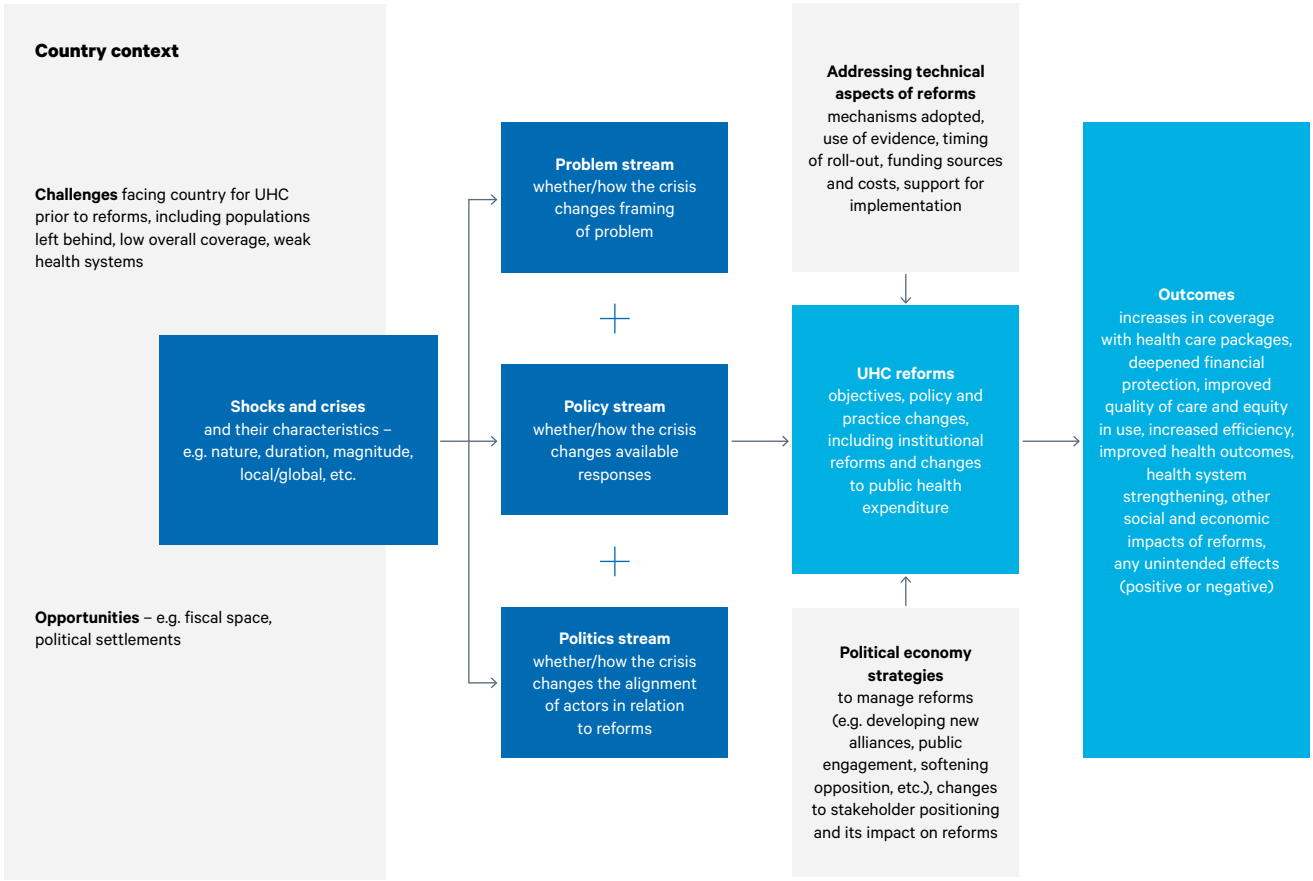
Analysis: Findings are structured around the analytical framework developed (Figure 1), which emphasizes trying to assess (i) how crises and shocks of different types modify the political, ideological and technical options for reforms; and (ii) the interaction of political economy and technical strategies for advancing the reform agenda post-crisis.

Country case studies

In addition to the literature review, the authors developed country case studies, drawing on commissioners' knowledge of countries where crises and shocks of various types have triggered UHC reforms. The selected countries – Brazil, China, Cyprus, Rwanda, Thailand, Ukraine and Uruguay – span a number of regions and income levels. The studies, to be published as an annex to this report,[43] were written up by commissioners and the authors, based on personal experiences and published sources, following a similar structure to that set out in Figure 1. Although the selection of countries for the case studies is biased towards states that have successfully introduced UHC reforms in the aftermath of crisis, this bias is offset by the broader literature drawn on.

43 Yates, R., Witter, S., Chantzi, F. and Hunsaker, B. (2024, forthcoming), *Country case studies: Annex to the final report on the work of the Chatham House Commission for Universal Health*, London: Royal Institute of International Affairs.

Figure 1. Conceptual framework for study



03 Findings

Crises and shocks affect the way problems are understood, the policy options available to address them, and the political support for different approaches. Skilful leadership is needed to navigate the technical and political aspects of UHC reforms in turbulent times, and to build institutions that can entrench the reforms.

In this chapter, we highlight key findings following the framework laid out in Figure 1, starting with the nature of the crises and shocks, the contextual factors that influence their impact, and an investigation of how they change the problem, policy and politics streams in relation to UHC reforms. Finally, we analyse how these feed through into the technical and political negotiations around UHC reforms and their outcomes.

Shock characteristics and impacts

A 2019 cross-country analysis by McDonnell et al. found that 71 per cent of 49 countries studied made progress towards UHC after experiencing 'state fragility'.[44] The literature suggests the nature of the shock experienced – e.g. epidemic, natural disaster, conflict, political or economic crisis, or a combination of such factors – is important in shaping responses. The magnitude, duration and origins (internal or external) of shocks are also important. Key points from the literature and case studies include:

- Shocks can open a 'window of opportunity' for UHC reforms, although political leadership is needed to take that opportunity forward.
- Shocks seem to play an important – although not universal – part in promoting UHC reforms.

44 McDonnell, A., Urrutia, A. and Samman, E. (2019), *Reaching universal health coverage: a political economy review of trends across 49 countries*, Working paper 570, London: Overseas Development Institute, https://odi.cdn.ngo/media/documents/200623_uhc_paper_final.pdf.

- UHC can also be an important buffer in resisting shocks.
- Policies adopted in response to shocks should, at a minimum, not exacerbate their negative impacts on population health.
- Crises can support UHC reforms by (i) increasing the salience of problems (for example, by highlighting ways in which current health systems are failing); (ii) creating awareness of new policy options to address them; and (iii) changing the political landscape in ways that enable reforms (for example, through the emergence of new parties with reformist agendas).

Our report does not suggest that shocks or crises are either necessary or sufficient to set in train a move towards UHC. Several countries are currently suffering crises that seem very unlikely to trigger health reforms. Others have achieved reforms without undergoing shocks. Importantly, too, fiscal or economic shocks can threaten existing healthcare policies, including UHC, as demonstrated in the case of Greece following the financial crisis of 2008.[45] Rather, we argue that crises and shocks have often precipitated the combination of circumstances, as outlined by Kingdon, that can bring about transformational change.

In some countries, recovery from conflict may be a powerful motivation for instituting UHC reforms, because governments can see UHC as a way of creating stability and therefore use healthcare as a way of building unity or legitimacy after conflict.

The precise nature of the 'window of opportunity' varies from country to country, and there is no common starting point for UHC reform.[46,47] For example, financial crises opened the window for policy reform in Indonesia, Thailand and Turkey; in Brazil, reform followed a period of re-democratization; France and Japan undertook reforms during the reconstruction efforts after the Second World War.[48,49] Some historians have argued that reductions in inequality have often emerged after war, revolution, state collapse and disease outbreaks.[50] Conflicts and similar shocks can break the institutional inertia and open new possibilities, as was shown in Ukraine after 2014.

In some countries, recovery from conflict may be a powerful motivation for instituting UHC reforms, because governments can see UHC as a way of creating stability and therefore use healthcare as a way of building unity or legitimacy after conflict.[51] This was particularly starkly demonstrated after the 1994 genocide in Rwanda, where the new leadership expanded UHC as part of the country's state-building efforts.

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45 Economou, C. et al. (2015), 'The impact of the crisis on the health system and health in Greece', in Maresso, A. et al. (eds), *Economic crisis, health systems and health in Europe: Country experience*, Copenhagen: European Observatory on Health Systems and Policies, https://www.ncbi.nlm.nih.gov/books/NBK447857.
46 Kelsall, T., Hart, T. and Laws, E. (2016), *Political settlements and pathways to universal health coverage*, Working paper 432, London: Overseas Development Institute, https://odi.org/en/publications/political-settlements-and-pathways-to-universal-health-coverage.
47 Regan, L., Wilson, D., Chalkidou, K. and Chi, Y. L. (2021), 'The journey to UHC: how well are vertical programmes integrated in the health benefits package? A scoping review', *BMJ Global Health*, 6(e005842), https://gh.bmj.com/content/6/8/e005842.
48 Kelsall, Hart and Laws (2016), *Political settlements and pathways to universal health coverage*.
49 Reich, M. et al. (2016), 'Moving towards universal health coverage: lessons from 11 country studies', *The Lancet*, 387(10020), pp. 20–26, https://doi.org/10.1016/S0140-6736(15)60002-2.
50 Scheidel, W. (2017), *The Great Leveler: Violence and the History of Inequality from the Stone Age to the Twenty-First Century,* The Princeton Economic History of the Western World, New Jersey: Princeton University Press.
51 McDonnell (2019), *Reaching universal health coverage*.

There are several further examples of transformative UHC reforms after economic crises. In 1938, after the Great Depression, New Zealand's Social Security Act was an important milestone in the country's commitment to UHC.[52] In Latin America, for countries such as Brazil and Mexico, economic crisis became a catalyst for economic and social reforms to reduce socioeconomic disparities and make UHC a reality;[53,54] this trajectory is also illustrated in the case of Cyprus.

Natural disasters are another potential catalyst for change, especially if a government's response is judged to be poor. In Turkey, or example, mass public outrage in the aftermath of the 1999 Marmara earthquake was a precipitating factor in the rise to power, in the early 2000s, of the populist Recep Tayyip Erdoğan, who promoted UHC as a central campaign promise.[55]

Such shocks can also threaten existing achievements, although in general UHC is robust when effectively established.[56] Large-scale natural disasters have complex and cascading impacts, with the potential to render entire segments of national health systems inaccessible or inoperable. If governments do not ensure that longer-term recovery measures are undertaken effectively, this can create further societal instability.[57]

Conflict is one of the principal threats to UHC and health security. Conflicts challenge all UHC dimensions (service coverage, financial protection and population coverage): available funding for health decreases as spending is diverted to defence and security; while health system capacity is eroded at a time of increasing need, including for displaced and refugee populations.[58]

However, UHC can also be a buffer against shocks by offering general protection in terms of access to healthcare, and by reducing the vulnerability of the most marginalized groups to the impacts of natural disasters or climate change.[59]

The commission sought to investigate the effects of crises and shocks on the problem, policy and politics streams related to UHC reforms. A 2022 comparative case study on health financing reforms following shocks in Thailand and Nepal adopted a similar framing, and highlighted the significance of the alignment of three key streams – problem (perception of difficulties in healthcare access), policy (technical solutions) and political (new government and radical political change) – that collectively opened windows of opportunity for reforms that could be used by reformers.[60] While limited studies have adopted this perspective,

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52 Hiam and Yates (2021), 'Will the COVID-19 crisis catalyse universal health reforms?'.
53 Atun, R. et al. (2015), 'Health-system reform and universal health coverage in Latin America', *The Lancet*, 28(385), pp. 1230–47, https://doi.org/10.1016/S0140-6736(14)61646-9.
54 Rivarola Puntigliano, A. (2020) 'Pandemics and Multiple Crises in Latin America', Latin American Policy, 11(2), pp. 313–19, https://doi.org/10.1111/lamp.12201.
55 Gupta, V., Kerry, V. B., Goosby, E. and Yates, R. (2015), 'Politics and Universal Health Coverage – The Post-2015 Global Health Agenda', *The New England Journal of Medicine*, 2015(373), pp. 1189–92, https://www.nejm.org/doi/abs/10.1056/NEJMp1508807.
56 McDonnell et al. (2019), *Reaching universal health coverage*.
57 Clarke and Le Masson (2017), *Shocks, stresses and universal health coverage.*
58 Mataria, A. et al. (2009), 'The health-care system: an assessment and reform agenda', *The Lancet,* 373(9670), pp. 1207–17, https://doi.org/10.1016/S0140-6736(09)60111-2.
59 Clarke and Le Masson (2017), *Shocks, stresses and universal health coverage*.
60 Witter, S. (2022), *Political economy analysis of health financing reforms in times of crisis: Reflections across the Nepal and Thai case Studies*, Rebuild Consortium, https://www.rebuildconsortium.com/wp-content/uploads/2022/11/Sophie-PEA.pdf.

various frameworks highlight the importance of the interaction of events with context, institutions, interests, individuals and ideas to produce moments of convergence for reforms at different points in the policy cycle.[61]

In relation to the problem stream, two main arguments typically influence the potential for health system change: the first concerns healthcare costs spiralling out of control, necessitating restraint; the second revolves around a healthcare system's inequity or inefficacy in delivering appropriate care.[62] The latter may arise during political changes, allowing popular expressions of discontent, or through a visible system failure during a crisis, as seen in the case of China, where the SARS epidemic in 2002–04 highlighted public health failings, putting pressure on the government to respond, and Ukraine after 2014, where the health system struggled with large population movements following Russia's invasion and annexation of Crimea.

Crises may also alter the margins of policy responses that are possible (for example, changing the resources available to respond to perceived needs, as was the case with the financial crises noted above). The debt crisis and structural adjustment of the 1980s–90s drove health reforms, often required by international financial institutions, involving charging users at the point of use and other contributory models. The balance of support and opposition in both political and policy spheres is important in explaining why UHC reforms progress, or are blocked.[63]

The politics stream, as treated in this report, explores the impact of crises on the alignment of actors involved in UHC reforms. It examines the configuration of champions and veto players within groups, and examines how the crisis may alter this dynamic.[64] Political instability is highlighted as a recurring factor leading to democratization, with UHC serving as a powerful instrument to create unity and legitimacy, or increase support.[65]

Contextual factors

Studies of reforms promoting UHC have identified a wide range of influential contextual factors, relating to economic development, growth and fiscal space, political factors, ideology and framing, social contexts and pre-reform health system features. These have strong interlinkages and condition responses to shocks. Key points here include:

— Low national income per capita is not necessarily a barrier to moving towards UHC, and in some cases has acted as a spur to reforms. Nevertheless, income growth, resource allocation to health and pooled health expenditure are important to sustaining progress.

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61 Fox, A. and Reich, M. (2015), 'The Politics of Universal Health Coverage in Low- and Middle-Income Countries', *Journal of Health Politics, Policy and Law,* 40(5), pp. 1023–60, https://doi.org/10.1215/03616878-3161198.
62 McKee, M. et al. (2013), 'Universal Health Coverage: a quest for all countries but under threat in some', *Value in Health*, 16(1), pp 39–45, https://doi.org/10.1016/j.jval.2012.10.001.
63 Kelsall, Hart and Laws (2016), *Political settlements and pathways to universal health coverage*.
64 McKee et al. (2013), 'Universal Health Coverage'.
65 McDonnell et al. (2019), *Reaching universal health coverage*.

- Shocks are highlighted as a direct factor behind some UHC reforms, although this relationship is mediated by many others, such as leadership willing to recognize the window of opportunity arising from the shock. In addition, shocks can be a trigger for other components, such as transfers of political power that advance UHC. These reforms have emerged from a variety of political systems, and through combinations of elite and grassroots pressures.
- Prevailing ideologies and interests constrain reform options, but crises can create reform opportunities, especially if aligned with factors such as electoral cycles.
- The broader social context significantly influences the success or hindrance of UHC reforms, with the degree of societal division and governance capacity playing crucial roles.
- The initial challenges in a country's health system, including its structure, greatly influence the margin for responses to shocks. A key challenge is to ensure the development of a strong healthcare infrastructure reaching all areas that can support effective UHC reforms. The existence of strong vested interests in the sector, who are able to shape institutions and policies to their benefit, can also severely constrain reform choices.

Economic factors and fiscal space

UHC adoption can occur in challenging times, potentially spurred by crises, but sustaining coverage requires financial commitment and thoughtful design.

Economic growth is cited in the reviewed literature as a supportive factor for UHC reforms. It is not essential, however: numerous countries have successfully pursued UHC during periods of resource constraints. In some instances, these limitations have even spurred the urgency and shaped the content of reforms. Countries often cite limited resources as constraining a move towards UHC, but they need not be a major determining factor. Instead, decisions are influenced by a willingness to make trade-offs; and recent economic growth facilitates such trade-offs, making UHC progress more likely. While low-income countries face significant resource constraints, more than half of the 49 countries studied by McDonnell et al. were not heavily resource-constrained but still had underperforming health systems. In these cases, policymakers often cited resources as a constraint, but the authors concluded that the real challenge was lack of political will.[66]

Distinguishing between UHC adoption and maintenance, one study, drawing on 11 country studies, found that economic growth was not a prerequisite for UHC policy adoption, although it supported subsequent expansion.[67] Brazil committed to UHC amid pro-democratic movements and economic challenges. Thailand embarked on reforms in the wake of the 1997 Asian financial crisis. In the UK, the National Health Service (NHS) came into existence in 1948, during post-war austerity. Adoption can occur in challenging times, potentially spurred by crises, but sustaining coverage requires financial commitment and thoughtful design.

66 McDonnell et al. (2019), *Reaching universal health coverage*.
67 Reich et al. (2016), 'Moving towards universal health coverage'.

Poverty may hinder UHC when associated with a dysfunctional state and health system.[68] Nevertheless, low-income countries have successfully implemented UHC policies in the past. Research indicates that political commitment, higher tax revenues and greater democracy correlate with a higher share of GDP allocated to public health spending. The expansion of healthcare coverage is typically part of a broader process linked to economic convergence, where developing countries catch up with developed ones, leading to the enhancement of their social welfare systems.[69]

Income growth, coupled with a simultaneous boost in health spending and a rise in the proportion of pooled health spending, is necessary but not sufficient to progressing UHC.[70] Taking UHC reforms forward necessitates changes in tax policy and resource allocation, along with significant economic growth.

In a report to the 2019 UN High-Level Meeting on UHC, WHO endorsed the investment, by governments in all countries, of an additional 1 per cent of GDP for primary healthcare as a prerequisite for moving towards UHC,[71] a target subsequently noted in the meeting's political declaration. Our case studies support this additional 1 per cent of GDP as a realistic and appropriate target for countries transitioning to UHC. This is particularly relevant for low- and middle-income countries where public health spending is currently less than 2 per cent of GDP, which is the case in all the large countries in South Asia and most countries in sub-Saharan Africa. Public health spending in China and Thailand was equivalent to 1 per cent and 1.6 per cent of GDP, respectively, at the start of the century, and both countries launched their UHC reforms in the early 2000s with increases of public financing of the order of 1 per cent of GDP.[72] Similarly, between 1948 and 1951, UK healthcare spending as a share of GDP rose by 1.24 percentage points, from 2.24 per cent to 3.48 per cent.[73]

Political and social factors

Political leadership is a key factor in enabling or blocking UHC reforms. Shocks represent an opportunity for radical change, but leaders need to engage with this opportunity if UHC policies are to succeed.

Countries move towards UHC via diverse paths and health systems, yet their trajectories often have common features.[74] One is a political process, driven by social forces, that establishes public programmes or regulations enhancing care access and equity, as well as pooling financial risks. For example, Thailand's

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68 Stuckler, D., Feigl, A., Basu, S. and McKee, M, (2010), *The political economy of universal health coverage*, Background paper for the global symposium on health systems research, Technical Report, Geneva: World Health Organization, https://researchonline.lshtm.ac.uk/id/eprint/2157.
69 McKee et al. (2013), 'Universal Health Coverage'.
70 Savedoff, W., de Ferranti, D., Smith, A. and Fan, V. (2012), 'Political and economic aspects of the transition to universal health coverage', *The Lancet*, 8(380), pp 924-32, https://doi.org/10.1016/S0140-6736(12)61083-6.
71 World Health Organization (2019), *Primary Health Care on the Road to Universal Health Coverage: 2019 Global Monitoring Report,* Geneva: World Health Organization, https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf.
72 World Health Organization (2024), 'Global Health Expenditure Database: Health Expenditure Profile', https://apps.who.int/nha/database/country_profile/Index/en.
73 UK Public Spending (2024), 'A Century of Health Care Spending', chart 2.41, https://ukpublicspending.co.uk/healthcare_spending.
74 Ibid.

2001 UHC reforms were the result of longer-term political shifts.[75] The country's 1997 constitution enshrined health as a fundamental right and allowed for the creation of new parties, which opened the political system for disadvantaged groups. At the 2001 general election, Thaksin Shinawatra's Thai Rak Thai party, rooted in low-income rural populations, secured a significant majority on a platform advocating populist, progressive and radical social reforms in education and health.

While UHC decisions in most countries originate from central governments, in approximately a fifth of cases studied by McDonnell et al. decisions are influenced from below, driven by grassroots movements, organized labour or local government.[76] This suggests a complementary role for government and civil society in driving UHC progress. The correlation between democratization and health interventions indicates that democratization can encourage and put pressure on governments to expand health coverage. However, the challenges posed by multiple stakeholders may in some cases impede UHC progress. There is also evidence that governments institute healthcare programmes to bolster legitimacy, especially in situations where elections have lacked true democratic processes, as seen in Rwanda and China.[77,78]

Extensive evidence links organized labour strength and social democratic parties' electoral power to social welfare expansion. Conversely, weak organized labour is cited as a factor in the absence of UHC in the US, and in variations in levels of public healthcare investment across Europe.[79]

A country's transition to democracy marks a pivotal moment on the path to UHC, creating a window of opportunity often tied to achieving independence or the end of authoritarian rule. Experiences show the complementary roles of government and civil society in driving UHC progress, exemplified by decisive steps taken during the first democratically competitive elections in Mexico, inaugural elections overseen by a new electoral commission in Kenya, or elections after franchise expansion in Sri Lanka.[80]

Our case studies demonstrate that strong development policies can emerge from a variety of political systems. Success (or failure) hinges not only on political mobilization and economic models, but also on the extent to which vested interests can be challenged. Economic models that are reliant on extensive foreign investment and global market integration may limit tax-raising capacity, a critical element for UHC establishment. The influence of vested interests becomes a decisive factor in shaping UHC reform success or failure, with specific interest groups and social movements playing pivotal roles.[81,82,83]

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75 Bertone, M., Witter, S. and Pholpark, A. (forthcoming), *Political economy analysis of health financing reforms in times of crisis: Identifying windows of opportunity for countries in the South East Asia Region*.
76 McDonnell et al. (2019), *Reaching universal health coverage*.
77 Ibid.
78 Duckett, J. and Munro, N. (2022). 'Authoritarian Regime Legitimacy and Healthcare Provision: Survey Evidence from Contemporary China', *Journal of Health Politics, Policy and Law*, 47(3), pp. 375–409, https://doi.org/10.1215/03616878-9626894.
79 McKee et al. (2013), 'Universal Health Coverage'.
80 McDonnell et al. (2019), *Reaching universal health coverage*.
81 Kelsall, Hart and Laws (2016), *Political settlements and pathways to universal health coverage*.
82 McKee et al. (2013), 'Universal Health Coverage'.
83 McDonnell et al. (2019), *Reaching universal health coverage*.

Box 1: Enabling and disabling factors in the transition to UHC

According to Kelsall, Hart and Laws' 2016 multi-country study,[84] enabling factors for movement towards UHC include a crisis or political transition, a homogeneous social structure, strong labour movements, left-wing or populist governments, the constructive engagement of international health actors, and a strong body of pro-UHC technical advocates.

Conversely, having a large number of veto points in the political system, politically weak ministries of health, relatively heterogeneous social structures (such that groups are unlikely to feel solidarity with one another) and strong groupings of medical, pharmaceutical and insurance stakeholders are all highlighted as disabling factors.[85]

The political settlement – defined as the underlying balance of power and institutions on which the political order is based – interacts with the policy domain, where ideas, interest groups and coalitions related to health compete for influence. This interaction shapes the degree and nature of political commitment to UHC. And the political commitment can be manifested in diverse policy pathways for UHC, influencing factors such as the composition of the tax- or insurance-based model and service package, incorporation of population groups, and the mix of public, private and non-state provision.[86]

Political ideologies, interacting with elite interests and redistributive aspects, enable or inhibit UHC reforms.[87] Interconnected drivers influencing health reforms include the distribution of costs and benefits, power dynamics, electoral considerations, political ideologies, elite interests and policy diffusion. 'Regional factors may also be important: the barrier for introducing UHC reforms is lower when neighbouring and peer countries have already progressed towards UHC.[88]

Studies also emphasize that achieving UHC is more challenging in societies that are divided along ethnic, religious, linguistic and economic lines, leading to lower willingness to redistribute and show social solidarity.[89,90] While diversity often correlates with lower health outcomes, exceptions exist. Rwanda's healthcare reforms after the 1994 genocide fostered solidarity between diverse groups, and countries such as Zambia and Sri Lanka achieved good health outcomes despite high diversity.[91]

84 Kelsall, Hart and Laws (2016), *Political settlements and pathways to universal health coverage*.
85 Ibid.
86 Ibid.
87 Mhazo, A. and Maponga,C., (2022), 'The importance of prioritizing politics in Good Governance for Medicines Initiative in Zimbabwe: a qualitative policy analysis study', *Health Policy and Planning*, 37(5), pp. 634–43, https://doi.org/10.1093/heapol/czac007.
88 McDonnell et al. (2019), *Reaching universal health coverage*.
89 Stuckler, Feigl, Basu and McKee (2010), *The political economy of universal health coverage*.
90 McKee et al. (2013), 'Universal Health Coverage'.
91 McDonnell et al. (2019), *Reaching universal health coverage*.

Health system challenges

Inadequate state capacity emerges as an important barrier to UHC implementation.[92] This issue is particularly pronounced in poorer countries where state administration struggles with effective programme and resource targeting, and it is exacerbated in some ethnically diverse states, even with the same controls in place. Free healthcare policies after the civil war in Nepal encountered challenges tied to the overall health system's capacity, influenced by resource constraints, political instability and fragmented policymaking.[93] The country's federalization policy, in shifting responsibilities to local levels, posed challenges for health system capacity, and so hindered UHC reforms.[94] Conversely, Thailand's successful UHC reforms were underpinned by earlier investments in health system strengthening, including public health infrastructure and human resources policies. The well-established primary care and referral network with national coverage in Thailand was a key factor supporting the effectiveness of reforms.

The presence of powerful vested interests, such as a medical profession relying on informal payments or a well-funded private insurance industry lobbying politicians, can impede UHC progress.

The presence of powerful vested interests, such as a medical profession relying on informal payments or a well-funded private insurance industry lobbying politicians, can impede UHC progress, as evidenced by the challenges of reforms to the US healthcare system, but also arising in middle-income countries such as South Africa.[95] A reliance on private finance in early healthcare system development may embed vested interests, complicating later efforts to expand the public sector's role. These initial conditions create 'path dependency', where past choices and present circumstances shape future paths.

Interaction of technical and political economy components

In this section, we examine pathways to UHC reforms after crises, and how these were shaped by political economy factors and strategies. We highlight the close interconnection of technical and political considerations, and how some of the most effective actors involved in driving UHC reforms forward were able to deploy strategies to manage them. Key points include:

- The literature on UHC trajectories confirms the absence of a single path or sequence of factors, while emphasizing prerequisites such as growth in public health financing, development of capabilities such as strong and adaptive governance, and politically adept technical expertise.
- Achieving universality and equity, often through establishing constitutional entitlements, is a common theme (as seen, for example, in the case of Brazil).
- Health reforms preceding UHC are often contested, but once countries move towards universal coverage, there is an element of irreversibility.

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92 Ibid.
93 Witter, S. et al. (2019), 'Health system strengthening – Reflections on its meaning, assessment, and our state of knowledge', *Int J Health Plann Mgmt*, 34(4), pp. 1980–89, https://doi.org/10.1002/hpm.2882.
94 McKee et al. (2013), 'Universal Health Coverage'.
95 Ibid.

— There are evident variations in the sequence and pace of post-crisis health reforms, with no clear patterns regarding the effectiveness of different strategies. Lessons with regard to path dependency highlight the importance of avoiding reforms that entrench interest groups who are resistant to UHC.

— Several studies emphasize the pivotal role of 'change teams' in propelling reforms forward, and the need for active management of key stakeholder groups. Strategies to manage change include: building coalitions and consensus through dialogue; making concessions in order to soften opposition to reforms; increasing the legitimacy of reforms by appealing to important values and evidence; and changing rules on decision-making to reduce opportunities for blocking of reforms by opponents with vested interests.

UHC reforms

Strategies for extending UHC to marginalized groups often involve targeted inclusion, for example by expanding primary healthcare facilities in underserved areas, providing health insurance cards to specific groups, and creating parallel insurance schemes for people not already covered.[96] In Latin America, government financing facilitated the introduction of interventions to expand insurance coverage, define and enlarge benefits packages, and scale up health service delivery.[97] Countries such as Brazil and Cuba implemented tax-financed UHC systems, combined with demand-side interventions targeting poverty and improving access for the most disadvantaged populations.

According to Atun et al., the journey to UHC in the countries they studied followed three paths. The first, as illustrated by Brazil, Costa Rica and Cuba, involved pooling funding from various sources to create an integrated healthcare service network and a unified health system with equal benefits. The second, exemplified by Argentina, Chile, Colombia, Mexico, Peru, Uruguay and Venezuela, entailed the development of parallel insurance and service delivery subsystems, resulting in segregation by employment status. The complementary third path, followed by all the studied countries except Venezuela, explicitly outlined citizens' entitlements to specific health services.[98]

Compulsion and redistribution are crucial for creating effective risk pools and avoiding adverse selection and exclusion.[99] Key underpinning elements include an increase in pooled health expenditure, growth in national income or government fiscal space, and a move towards risk-sharing.[100] Public financing, augmented by feasible social health insurance not solely contingent on employment, supplemented by development financing where necessary, has emerged as a critical element for countries progressing towards UHC.[101]

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96 Ibid.
97 Atun et al. (2015), 'Health-system reform and universal health coverage in Latin America'.
98 Ibid.
99 Tandon, A., Eozenou, P. and Neelsen, S. (2023), 'Compulsion and redistribution remain key tenets for financing universal health coverage', *Social Science & Medicine*, 45, 115744, https://doi.org/10.1016/j.socscimed.2023.115744.
100 Savedoff, de Ferranti, Smith and Fan (2012), 'Political and economic aspects of the transition to universal health coverage'.
101 Kutzin, J., Yip, W. and Cashin, C. (2016), 'Alternative Financing Strategies for Universal Health Coverage', in Scheffler, R. (ed.) *World Scientific Handbook of Global Health Economics and Public Policy* pp. 267–309, https://doi.org/10.1142/9789813140493_0005.

Whereas public financing is more efficient and equitable than private financing in moving towards UHC, many successful UHC systems rely on a mixed economy of public and private providers. However, in many low- and middle-income countries, this mixed market does not function well, and is characterized by underfunded, low-quality public services and a poorly regulated market of private providers supplying services of variable quality that represent poor value for money for consumers.[102] In such an environment, governments can adopt a dual strategy of improving the quality of public services and also using public funding to purchase services from accredited private providers and strengthen regulatory systems.

Globally, there is a well-known negative relationship between public financing and OOP spending on health. Low public spending on healthcare results in inadequate public facilities, leading to supplementary OOP payments by patients. Countries making significant UHC progress generally maintain OOP spending levels below 20 per cent of current health spending, a threshold recommended by WHO.[103] Where public financing is limited, targeted provision of strong, effective healthcare to meet the needs of the poor is necessary, as seen in Brazil, Malaysia and Sri Lanka.[104]

Many low- and middle-income countries have adopted legal commitments to achieve UHC.[105] However, a legal commitment alone is insufficient: it must be translated into policies establishing a comprehensive, largely publicly financed system. When legal commitments are lacking, healthcare tends to expand gradually, leaving large segments of the population vulnerable for extended periods.

The technical content of UHC reform plays a crucial role in its political economy. Core reforms often relate to compulsory pooling of financial risks, which directly affect the public and are potentially politically controversial. However, once enacted, such reforms may be hard to reverse, as this would involve withdrawing benefits from substantial population groups.[106]

Other technical components emerging from comparative studies include the importance of primary healthcare development; well-developed essential healthcare packages; adequate staffing and quality of competences; efficiency through improved priority-setting processes and procurement systems; strong public financial management; strategic purchasing; an effective mix of provider payments to control expenditure and provide incentives for cost-effective provision; robust information systems; and learning health systems.[107]

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102 Nishtar, S. (2010), 'The mixed health systems syndrome', *Bulletin of the World Health Organization*, 88(1), pp. 74–75, https://doi.org/10.2471/BLT.09.067868.
103 World Health Organization (2010), *The World Health Report 2010*.
104 Tandon, Eozenou, and Neelsen (2023), 'Compulsion and redistribution remain key tenets for financing universal health coverage'.
105 Stuckler, Feigl, Basu and McKee (2010), *The political economy of universal health coverage*.
106 Bertone, Witter and Pholpark (forthcoming), 'Political economy analysis of health financing reforms in times of crisis'.
107 Tandon, Eozenou, and Neelsen (2023), 'Compulsion and redistribution remain key tenets for financing universal health coverage'.

Approximately 60 per cent of the countries studied by McConnell et al. incorporated and strengthened primary healthcare within their UHC strategy, including India, Japan, Kazakhstan, Kenya, Liberia, Malaysia, Sri Lanka, Tunisia and Zambia;[108] this route is also seen in cases such as Uruguay.

A number of key lessons from Latin America were drawn by Frenk (2014), as reproduced in Box 2.

Box 2. Lessons from UHC expansion in Latin America

Action 1. Avoid the establishment of separate coverage schemes for different populations groups and, if they already exist, design initiatives to reduce segmentation.

Action 2. Continue to implement social protection schemes that reduce the burden of out-of-pocket payments.

Action 3. Increase financing for health and, over time, increase the proportion of universal health coverage financing from general government revenues.

Action 4. Design upstream interventions to address the determinants of health and downstream initiatives to deal with both the unfinished agenda and the emerging challenges related to non-communicable diseases, injuries, and mental diseases.

Action 5. Establish effective mechanisms to monitor and assure quality of care, both in its technical and its interpersonal dimensions.

Action 6. Improve the training, availability, and distribution of human resources for health.

Action 7. Strengthen the key health system functions (stewardship, financing, and delivery) to expand choice, increase effectiveness and efficiency, promote equity, and improve accountability for results.

Action 8. Design policies to strengthen the role of the state as the key steward of the national health system.

Action 9. Invest in information systems, health systems research, and rigorous assessment.

Action 10. Promote the introduction of transparency and accountability procedures, and stimulate the participation of civil society organisations in the design, implementation, and monitoring of universal health coverage initiatives.

Source: Frenk (2014).[109]

The development of capable and adaptive governance arrangements is a hallmark of countries that have successfully achieved UHC. Countries such as Thailand prioritize accountability by implementing measures that separate the healthcare purchaser and provider functions, establish quality standards, develop a robust

108 McDonnell et al. (2019), *Reaching universal health coverage*.
109 Frenk, J. (2014), 'Leading the way towards universal health coverage: a call to action', *The Lancet*, 385(9975), pp. 1352–58, https://doi.org/10.1016/S0140-6736(14)61467-7.

capacity for strategic goal-setting, and assess new technologies and pharmaceutical products for inclusion in benefit packages. To counteract interest group pressures, an oversight board with substantial civil society participation has been created.[110]

In Thailand, reform advocates made strategic use of available evidence to generate locally relevant knowledge, drawing from both experience and the international literature, and were directly engaged in political processes or closely associated with them, demonstrating political acuity in the use of evidence. This approach ensured that evidence was swiftly available for decision-making while preventing decision-makers from becoming mired in excessive detail, which may be paralysing at times when rapid reforms are necessary.[111]

Sequencing and pace of reforms

Sequencing approaches differ across countries.[112] For instance, Thailand built coverage extension on earlier health system strengthening, while others prioritized boosting demand initially and later invested in the supply side.[113]

Whether to pursue gradual or rapid health system reforms is an inherently political, not technical, decision. Right-wing politicians often prefer gradual expansion based on voluntary insurance, seeking to neutralize more radical demands. By contrast, left-wing parties tend to view expansion as both an expression of political ideology and a means to secure popular support. Coalition governments, with their characteristic broader policy debates, can provide space for a wider range of actors, often favouring social insurance and gradual expansion.

Governments typically do not start with the goal of achieving UHC. Rather, UHC is reached through iterative reforms over time.

Governments typically do not start with the goal of achieving UHC. Rather, UHC is reached through iterative reforms over time. Sometimes, a considerable period of time elapses between the initiation of reforms and the realization of UHC. Once achieved, however, UHC tends to be stable.[114] A historical example of this longer trajectory is the UK, where mandatory health insurance for workers in 1911 expanded over decades, culminating in the National Health Service Act in 1946.

Similar patterns are observed in lower-income settings. In Thailand, the government initially moved into healthcare provision in 1975 to enhance care for the rural poor. In subsequent decades, coverage was extended to public sector workers and those in formal employment. After 2000, Thailand moved to UHC by offering a defined range of treatments, initially with limited user fees that were later eliminated.[115]

Equity often becomes a focal point in later reform stages, particularly if the formal sector is covered first and reforms then slow down, excluding informal and poorer groups. Early interventions in the countries studied by McDonnell et al. covered vulnerable groups in about a third of cases, but later-phase strategies (89 per cent) consistently integrated the goal of reaching those left behind.[116] The focus often

110 Reich (2016), 'Moving towards universal health coverage'.
111 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.
112 Ibid.
113 McDonnell et al. (2019), *Reaching universal health coverage*.
114 Ibid.
115 Ibid.
116 Ibid.

shifted to expanding coverage to people in poverty, with specific attention to rural populations in several countries or targeting vulnerable groups such as children, pregnant women and people with disabilities.

Thailand's post-crisis Universal Coverage Scheme (UCS) reform in 2001–02 was notable for rapid decision-making and implementation, capitalizing on a window of opportunity and preventing the consolidation of opposition. Subsequently, the pace of reform slowed, with gradual and incremental implementation characterized by flexibility. The context for reform in Nepal was different in the years following the 2006 Comprehensive Peace Agreement. Healthcare reforms in Nepal were iterative and took place over a more extended period, reflecting less opposition from organized groups and a less deliberate reform process.[117]

'Adaptive learning' played a crucial role in the success of reforms in both Nepal and Thailand. This flexible approach enabled continuous improvements, responses to criticisms, and adaptation to emerging evidence.[118] The evolution of China's health reforms also highlights the importance of adaptive learning in avoiding early mistakes becoming entrenched and hardening opposition to reforms.

Consideration of path dependencies is essential. In Thailand, purchasing and provider payment reforms were strategically significant, with capitation (per-person fixed annual payments) chosen early on in an effort to overcome challenges associated with transitioning from fee-for-service payments.[119] Early decisions on payment arrangements, private sector regulation and the development of risk pools can have lasting effects on the financial sustainability and equitable impact of UHC. Some countries, such as Ghana, have faced difficulties updating their initial healthcare benefits package, emphasizing the need for careful decision-making in these areas.[120, 121]

Stakeholders and political economy strategies used to manage reforms

UHC is inherently political, necessitating a thorough understanding of key actors and effective management strategies. Stakeholders in UHC reforms can be categorized based on their interest, position on the issue, and their power and influence. Key stakeholder groups include a 'change team', political leadership, bureaucratic actors, budget-related groups, beneficiaries, external actors and other interest groups.[122]

A well-equipped change team, adept in both political and technical aspects, plays a crucial role in identifying windows of opportunity, particularly following crises, and mobilizing the necessary resources for reform. Witter underscores the significance of a dedicated reform group in Thailand within the Ministry of Public Health and the Health Systems Research Institute.[123] The shape of the post-crisis

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117 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.
118 Ibid.
119 Ibid.
120 McDonnell (2019), *Reaching universal health coverage*.
121 Reich (2016), 'Moving towards universal health coverage'.
122 Campos, P. and Reich, M. (2019), 'Political Analysis for Health Policy Implementation', *Health Systems & Reforms*, 5(3), pp. 224–35, https://doi.org/10.1080/23288604.2019.1625251.
123 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.

UHC reform resulted from a convergence of political commitment, civil society mobilization and technical expertise. The change team seized the moment of political opportunity of 2000–01, aligning with the Thai Rak Thai party's openness to radical social reforms. They conducted a comprehensive assessment of the financial and practical feasibility of UHC, gaining support from future prime minister Thaksin Shinawatra. The establishment of a 'war room' committee further facilitated coordination, monitoring and problem-solving during policy implementation.[124]

Thailand's UHC change team successfully mobilized crucial resources across bureaucratic, political and social spheres, employing effective strategies to drive the reform forward. Harris (2015) characterizes this as an instance of 'developmental capture', where networks of reformist bureaucrats within the state aim to advance inclusive state social and developmental policies for the broader population.[125] Described as 'the triangle that moves the mountain', the strategy involves the simultaneous and synergistic mobilization of civil society and public support, political backing and the use of evidence and technical expertise. The case of Cyprus also underscores the pivotal role of popular pressure for reform following the economic crisis of the late 2000s.

UHC champions may have limited influence over the political settlement, but they can still influence UHC through the policy domain.[126] Their understanding can help them to design strategies that align policies, funding and governance arrangements with the strengths and weaknesses in the current political settlement.

Political leaders at national and sub-national levels with vision and commitment are key for UHC reforms, but so too are mobilized interest groups and social movements. Government officials, political parties, the medical profession, organized labour, insurance and pharmaceutical companies, industrialists, the media and the general public are all key stakeholder groups.[127] As regards organized opposition, a coalition involving clinicians, pharmaceutical companies and insurance systems, who perceive they benefit from the status quo, often resists publicly financed UHC.[128] Conversely, trade unions, nurses and community health workers typically support enhanced public financing.

Reflecting on the UHC policies of Turkey and Thailand, Reich et al. (2016) emphasize the importance of both strong executive leadership and broad public support. Social movements played a pivotal role in Brazil and Thailand by placing UHC on the political agenda. Successes in these cases built on past experiences and institutions, offering opportunities to develop programmatic capacity. However, the authors underscore that relying solely on past experiences and new opportunities is insufficient; effective management of pressures from interest groups is crucial. In Turkey, reformers developed a comprehensive roadmap, identifying and strategically managing opposition from various groups, including

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124 Evans, T. et al. (2012), *Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2011)*, Nonthaburi, Health Insurance System Research Office, https://tile.loc.gov/storage-services/service/gdc/gdcovop/2013341727/2013341727.pdf.
125 Harris, J. (2015), 'Developmental Capture of the State: Explaining Thailand's Universal Coverage Policy', *Journal of Health Politics, Policy and Law*, 40(1), pp. 165–93, https://doi.org/10.1215/03616878-2854689.
126 Kelsall, Hart and Laws (2016), *Political settlements and pathways to universal health coverage*.
127 Ibid.
128 McKee et al. (2013), 'Universal Health Coverage'.

civil servants, trade unions, social security and health workers. Public support was enhanced through measures such as abolishing the practice of detaining patients in hospital for non-payment of healthcare bills, reorganizing facilities for better patient care, expanding emergency services, establishing a new health workers' union and introducing pay-for-performance incentives to improve quality of care.[129]

The crucial role of evidence and information is highlighted in case studies of the UHC reforms in Thailand, Nepal and Indonesia.[130, 131]

Coalition building and enhancing policy legitimacy through approaches such as the Millennium Development Goals (MDGs) and rights-based methods (in Nepal) or traditional social values (in Thailand) are also highlighted. Uruguay's successful UHC reforms relied on a diverse coalition, including non-medical workers, medical organizations, private providers and service users. Involving multiple stakeholders in policy design and implementation ensured the continuity of reforms beyond political cycles.

Mobilizing support, especially from civil society, and addressing opposition by meeting some of their demands were identified as significant strategies in both Thailand and Nepal.

Mobilizing support, especially from civil society, and addressing opposition by meeting some of their demands were identified as significant strategies in both Thailand and Nepal. However, strategies to manage the opposition seemed more pronounced in Thailand, possibly anticipating resistance from the beneficiaries of existing schemes, from the Ministry of Public Health in view of its changing role, as well as from private providers.[132]

Case studies of UHC reforms from lower-income settings are more likely to highlight the influence of global development trends and role of donor organizations, albeit framed within a narrative of national ownership.[133, 134, 135] Development partners played a vital role in providing technical and financial support, including evidence-gathering, and supporting policy adoption and adaptation. In Nepal, external actors had a more significant role, given the country's weaker economic situation and greater aid dependency, necessitating consensus-building among donors. Thailand engaged with international actors differently; the change team leveraged international learning early on, and drew on external approval of the country's work on UHC to embed reforms,[136] notwithstanding initial concerns about affordability by institutions such as the World Bank.[137]

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129 Reich et al.(2016), 'Moving towards universal health coverage'.
130 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.
131 Saputry, N., Darmawan, A., Toyamah, N. and Filaili, R. (forthcoming), *Political Economy Analysis of Health Financing Reforms in Times of Crisis: Identifying Windows of Opportunity for Countries in the SEA Region*, Indonesia Case Study Report for WHO (in draft).
132 Ibid.
133 Rizvi, S. et al. (2020). 'The political economy of universal health coverage: a systematic narrative review', *Health Policy and Planning*, 35, pp. 364–372, https://doi.org/10.1093/heapol/czz171.
134 Witter et al. (2019), 'Health system strengthening'.
135 Bertone, M. P., Wurie, H., Samai, M. and Witter, S. (2018). 'The bumpy trajectory of performance-based financing for healthcare in Sierra Leone: agency, structure and frames shaping the policy process', *Global Health*, 14(99), https://doi.org/10.1186/s12992-018-0417-y.
136 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.
137 The World Bank (2013), Poverty, Health and the Human Future, Speech, Jim Yong Kim, World Bank Group President, World Health Assembly, Geneva, Switzerland, 21 May 2013, https://www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly.

International targets, notably the MDGs, provided normative impetus for UHC in various case studies, such as Nepal, where lagging behind on MDG 5 (targeting reduced maternal mortality, together with universal access to reproductive health) led to a focus on maternal healthcare.[138] McDonnell et al. (2019) found a similar effect concerning the 1978 Alma-Ata Declaration,[139] indicating that countries launching early healthcare strategies after Alma-Ata were more likely to align with its recommendations.[140]

In Thailand, changes in decision-making processes to overcome challenges was highlighted by researchers as a key strategy on the part of reformers. Establishing bodies such as the National Health Security Board and the National Health Assembly not only garnered support for reforms, but also influenced the scope of future reforms. Dialogue in Thailand involved seeking common goals, reflecting opposition demands, and emphasizing compromise, negotiation and strategic participation. Flexibility and a 'win-win' narrative were crucial, while maintaining focus on reform goals prevented drift.[141]

The literature suggests that dissatisfaction and political pressure for radical change persist until countries achieve universality in their health coverage. Post-universality, health becomes a significant government component but with more confined debates. Rather than ideological questions, discussions focus on iterative reforms and operational aspects of the health system.[142]

UHC and wider outcomes

The outcomes of UHC reforms are critical indicators of success, and are described in a number of studies. There is a problem relating to the counterfactual. As UHC tends to be a whole-of-system reform, there is no control to assess what would have happened in its absence. Nonetheless, key points emerging from the literature include the following:

- Literature and case studies all illustrate the potential for UHC reforms to significantly increase health coverage, improve the quality of care and financial protection, as well as reducing health and wider inequalities and improving health outcomes, such as life expectancy.
- Countries in the case studies conducted for this report have typically injected around 1 per cent of GDP of additional public financing into their health systems to improve the supply side and improve access during their UHC reforms.

138 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.
139 The WHO-sponsored Alma-Ata Declaration of 1978 identified primary health care as the key to the attainment of the goal of Health for All.
140 McDonnell et al. (2019), *Reaching universal health coverage*.
141 Witter (2022), *Political economy analysis of health financing reforms in times of crisis*.
142 Ibid.

All the case studies conducted as part of the work for this report demonstrate the improved service coverage achieved by UHC reforms, alongside measures that boost the capacity of the system to sustain services, such as increasing public staffing and infrastructure (as, for instance, in Cyprus) and strengthening information systems (as in Ukraine).

Thailand's UHC reforms, in the first decade of UCS implementation, resulted in improved access to essential health services for citizens, especially for the poor, along with a decrease in catastrophic expenditures and household impoverishment for health service users, and increased satisfaction of both UCS beneficiaries and healthcare providers.[143] And over the period 2000–19, the country's health expenditure per capita grew significantly, from $62 to $296, accompanied by substantial increases in government spending on health (which rose as a percentage of total health expenditure from 55 to 72 per cent). Meanwhile, OOP payments dropped from 43 per cent of total health spending to less than 9 per cent, providing better financial protection for service users.[144]

China's UHC reforms demonstrate the extensive benefits of well-designed reforms, including notable increases in coverage. Medical insurance coverage surged from 50 per cent in 2006 to 96 per cent in 2015 for urban residents, and from 48 per cent to 98 per cent for rural residents. OOP health costs plummeted from 61 per cent of total health expenditure in 2003 to 29 per cent in 2018, while government health spending rose from 1.3 per cent of GDP in 2003 to 2.5 per cent in 2013.

Uruguay also experienced substantial increases in coverage, leading to a reduction in OOP spending from 22 per cent in 2005, when the country embarked on its UHC reform programme, to 15 per cent in 2022.

Greater government expenditure on health has been an important element in expanding UHC, although increases have in many cases been modest. Overall health spending in Uruguay rose from 8.5 per cent of GDP in 2005 to 9.5 per cent in 2018, with public spending on health increasing to 6 per cent of GDP. In Rwanda, a significant expansion in health coverage saw health expenditure, as a share of GDP, grow from 1.6 per cent in 2005 to 2.9 per cent in 2020.

However, UHC is not necessarily about spending more. Rather, it is about spending the same money better: pooling payments potentially enables more cost-effective purchasing and allocation. While few studies directly compare health system costs before and after UHC reforms, cross-sectional analyses consistently support the idea that systems with higher public financing and effective coverage yield better outcomes for similar expenditures, reflecting greater efficiency.[145]

This feeds through into health gains. Over the period 1995–2008, a 10 per cent increase in government health spending across 153 countries was associated with average reductions of 7.9 deaths per 1,000 for children aged under five years,

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143 Evans et al. (2012), 'Thailand's Universal Coverage Scheme: Achievements and Challenges'.
144 World Health Organization (2024), 'Global Health Expenditure Database: Health Expenditure Profile', https://apps.who.int/nha/database/country_profile/Index/en
145 Moreno-Serra, R. and Smith, P. C. (2012), 'Does progress towards universal health coverage improve population health?', The Lancet, 380, pp. 917–23, https://doi.org/10.1016/S0140-6736(12)61039-3.

and adult mortality by 1.3 deaths per 1,000.[146] There can also be gains in relation to equity: in Thailand, for example, the introduction of a universal coverage scheme resulted in equalization of infant mortality rates across poorer and richer provinces between 2001 and 2005.[147] An OECD study also highlights positive correlations between population health coverage and life expectancy, with a clear negative relationship between OOP payments and life expectancy, under-five mortality and maternal mortality.[148]

UHC can play a protective role against shocks, with evidence that countries that have made greater progress towards UHC experienced significantly smaller declines in childhood immunization coverage in 2020 during the COVID-19 pandemic.[149] UHC also contributes to system resilience amid extreme shocks. The case of Ukraine, following Russia's 2022 invasion, is notable in this respect.[150]

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146 Ibid.
147 Gruber, J., Hendren, N. and Townsend, R.M., (2014), 'The Great Equalizer: Healthcare Access and Infant Mortality in Thailand', *American Economics Journal: Applied Economics*, 6, pp. 91–107, https://doi.org/10.1257/app.6.1.91.
148 Pearson, M., Colombo, F., Murakami, Y. and James, C. (2016), 'Universal health coverage and health outcomes', Paris: OECD, https://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf.
149 Kim, S., Headley, Y. and Tozan, Y. (2022), 'Universal healthcare coverage and health service delivery before and during the COVID-19 pandemic: A difference-in-difference study of childhood immunization coverage from 195 countries', *PLoS Medicine*, 19(8), https://doi.org/10.1371/journal.pmed.1004060.
150 See Habicht, J., Hellowell, M. and Kutzin, J. (2024), 'Sustaining progress towards universal health coverage amidst a full-scale war: learning from Ukraine', *Health Policy and Planning*, czae041, https://doi.org/10.1093/heapol/czae041.

04
Key messages and policy recommendations

Addressing UHC challenges is urgent, and can deliver multiple benefits. Rapid UHC reforms that deliver full population coverage are feasible and affordable. The key to success is to learn from experience in managing the politics of reform.

Drawing on the work of the Commission for Universal Health, we highlight six key messages for political leaders considering launching UHC reforms in contexts of crisis and shock:

1. Action on universal UHC is urgent

- There is a global commitment to achieving UHC whereby everyone receives the quality health services they need without suffering financial hardship. However, global indicators for health coverage and financial protection have been lagging since 2015.
- The COVID-19 pandemic and other recent crises have deepened poverty and inequality, while demonstrating the importance of national health systems as a critical foundation for UHC and health security interventions.
- The cost of ensuring UHC and health security is low compared with the cost of responding to crises.
- Given the multiple threats now facing societies, including from climate change, it is an urgent task to strengthen our health systems and their resilience now.

2. Crises, shocks and other 'focusing events' can create a window of opportunity for radical reform

— Our study shows the historical links between crises of various kinds and UHC reforms, but also the need for leaders who are willing to recognize the window of opportunity and drive health reforms forward through these events.

— Crises can support reforms by (i) increasing the salience of problems (for example, by highlighting ways in which current health systems are failing); (ii) creating awareness of new policy options to address them; and (iii) changing the political landscape in ways that enable reforms – through the emergence of new parties with reformist agendas, for instance.

3. There are substantial potential benefits from UHC reforms

— Literature and case studies all illustrate the potential for UHC reforms to significantly increase health coverage, improve the quality of care and financial protection, as well as reducing health and wider inequalities and improving health outcomes.

— UHC can also build resilience and protect against shocks, including climate change. There are also substantial wider economic, social and political benefits from UHC. Economic benefits include improved workforce productivity, increased economic growth and reduced poverty. Social benefits include increased social cohesion. Politically, UHC can deliver electoral gains and expand trust in political systems.

4. We know (broadly) what action is needed

— Case studies demonstrate the benefits of a comprehensive approach to UHC reforms that includes investment in supply-side readiness and addressing barriers to demand, while engaging communities and allowing for iteration to react to challenges that emerge over time.

5. UHC reforms are affordable and deliver benefits quickly

— A small increase in public finance is needed in order to undertake UHC reforms, but in large part the reforms involve a substitution of public for private funding, which generates gains through improved efficiency and equity as a result of better purchasing and allocation of resources.

— Countries studied have typically injected around 1 per cent GDP of additional public financing into their health systems to improve the supply side and improve access during the UHC reforms reviewed.

6. Managing the reform process is key

— UHC is an intensely political process, involving redistribution of resources, which therefore requires a good understanding of the key actors and strategies to manage them, including managing opposition from vested interest groups.

Recommendations

There is no single blueprint for UHC reforms, and one size will not fit all. In developing an effective UHC strategy, each country needs to consider its own context: this means paying close attention to the progress it has made so far towards UHC, and how the health sector is currently functioning, as well as taking careful account of country-specific economic, social and political factors. However, there are important lessons to be learned from the experiences of countries that have implemented successful UHC reforms in the aftermath of crises and shocks, summarized in these five overarching policy recommendations:

Recommendation 1: Prioritize reaching full population coverage quickly, by providing a universal entitlement to a comprehensive (but affordable) package of publicly financed health services. This is preferable to creating fragmented health insurance schemes for different socio-economic groups and expecting people in the informal sector to pay health insurance contributions.

Recommendation 2: Increase public health financing by around 1 per cent of GDP to expand the supply and quality of services and generate additional demand by removing financial barriers to services. This will support efforts to ensure universal entitlement to services becomes a reality rather than remaining an aspiration.

Recommendation 3: Concentrate additional public expenditure on improving cost-effective primary care services and strengthening health systems in areas such as human resources, essential medicines, infrastructure, information systems and governance.

R**ecommendation 4: Remove or drastically reduce user fees** so that health services in the UHC package are provided free at the point of delivery, including ensuring that essential medicines and diagnostics are available free of charge.

Recommendation 5: Promote universal health reforms as a flagship policy of the government, and build on the popularity of UHC measures to facilitate revenue generation policies, for example through raising taxes and cutting inappropriate subsidies (e.g. fossil fuel subsidies[151]). Linking popular UHC reforms to broader fiscal reforms may enable governments to raise more revenue for health services than the additional 1 per cent of GDP needed to kick-start their health reforms.

151 See, for example, Gupta, V., Dhillon, R. and Yates, R. (2015), 'Financing universal health coverage by cutting fossil fuel subsidies', *The Lancet Global Health*, 3(6), pp. E306–07, https://doi.org/10.1016/S2214 109X(15)00007-8.

About the authors

Robert Yates is a political health economist specializing in universal health coverage (UHC) and progressive health financing. He is director of the Global Health Programme at Chatham House. He is also an honorary associate professor at the London School of Hygiene and Tropical Medicine. Robert's principal area of expertise is in the political economy of UHC, with a focus on advising political leaders and governments on how to plan, finance and implement national UHC reforms. He has previously worked as a senior health economist with the UK's then Department for International Development (DFID) and the World Health Organization, advising numerous governments in Asia, Africa and Europe on health financing policy and health systems reforms.

Professor Sophie Witter is professor of international health financing and health systems at the Institute for Global Health and Development at Queen Margaret University, Edinburgh, and research co-director of the ReBUILD for Resilience research consortium. She has worked in health system research and development for 35 years, focusing on addressing financial barriers to access, health financing strategies, providing effective incentives for health workers, health system strengthening and resilience, developing learning health systems, evaluation of complex interventions, political economy of health financing reforms, and getting research into practice. Over the past decade, Sophie's work has focused on fragile and conflict-affected settings, including challenges posed by the growing number of refugee and displaced populations.

Effrosyni (Frini) Chantzi was a research analyst in the Global Health Programme at Chatham House until the end of 2023. She is now a policy adviser with the Health and Social Care Spending team at HM Treasury, where she leads political analysis on health systems financing and spending strategies. During her time at Chatham House, Frini contributed to research on universal health coverage, the political economy of health reforms, and pandemic preparedness. She supported the work of research consortiums and international development agencies, including the Chatham House Commission for Universal Health, UNICEF and UHC2030. Previously, Frini worked on the peace and security agenda, evaluating social protection policies for UN Women in Europe and Central Asia. She was also part of the UK National Preparedness Commission focusing on biosecurity in emergency settings.

Brooke Hunsaker is a research associate in the Global Health Programme at Chatham House. Her work focuses on universal health coverage and access to healthcare. She has expertise in health economics, economic evaluation, policy analysis, and public health monitoring and evaluation. Brooke's previous roles include as a global health consultant at UNAIDS, an economic evaluator for a Tanzania-based menstrual health NGO, a COVID-19 case investigator/vaccine clinic lead, and a health policy specialist focused on tobacco prevention policy.

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Cover image: Residents of the Huay Kwang community register for nasal swab tests for COVID-19 at a mobile clinic in a sports stadium in Bangkok, Thailand, on 13 May 2021.

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The Royal Institute of International Affairs
Chatham House
10 St James's Square, London SW1Y 4LE
T +44 (0)20 7957 5700
contact@chathamhouse.org | chathamhouse.org

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