



Moving towards universal health coverage: lessons from 11 country studies

Michael R Reich, Joseph Harris, Naoki Ikegami, Akiko Maeda, Cheryl Cashin, Edson C Araujo, Keizo Takemi, Timothy G Evans

In recent years, many countries have adopted universal health coverage (UHC) as a national aspiration. In response to increasing demand for a systematic assessment of global experiences with UHC, the Government of Japan and the World Bank collaborated on a 2-year multicountry research programme to analyse the processes of moving towards UHC. The programme included 11 countries (Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam), representing diverse geographical, economic, and historical contexts. The study identified common challenges and opportunities and useful insights for how to move towards UHC. The study showed that UHC is a complex process, fraught with challenges, many possible pathways, and various pitfalls—but is also feasible and achievable. Movement towards UHC is a long-term policy engagement that needs both technical knowledge and political know-how. Technical solutions need to be accompanied by pragmatic and innovative strategies that address the national political economy context.

Introduction

In the past 15 years, many countries have adopted universal health coverage (UHC) as an aspiration for national policy. The goals of UHC are typically defined by three dimensions: the population that is covered by pooled funds; the proportion of direct health costs covered by pooled funds; and the health services covered by those funds.¹ These dimensions help to define where a country seeks to move its health system, and many reports about this subject have been published. However, comparatively little information exists about how a country can move its health system towards UHC.

In response to growing demand for a systematic assessment of global experiences with UHC, the Government of Japan and the World Bank collaborated on a 2-year multicountry research programme to analyse the processes of moving towards UHC.² The programme included 11 countries (Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam), representing diverse geographical, economic, and historical contexts. The objective was to identify common challenges and opportunities and useful insights in how to move towards UHC.

The 11 countries were selected intentionally to represent a range of income levels and health systems. All selected countries have committed to UHC as a key national aspiration, but are at different points in the process, as the table shows. Group 1 countries are still setting the national policy agenda for moving towards UHC; group 2 countries have made substantial progress toward UHC but still face substantial gaps in coverage; group 3 countries have recently achieved many UHC policy goals but face new challenges in deepening and sustaining coverage; and group 4 countries have mature health systems with UHC but still need to adjust their national policies to meet changing circumstances. The study included an in-depth analysis of Japan's experience in achieving population coverage in 1961 and its subsequent 50-year history in maintaining and adjusting universal coverage.³

The study analysed each country with a common analytical framework, and focused on three themes: the political economy and policy process for the adoption, expansion, and maintenance of UHC; health financing policies to enhance health coverage; and policy approaches for meeting the human resources requirements for UHC. These themes were selected because financing and human resources represent two essential inputs for a health system, and because political economy has a key role in shaping policy decisions. This Health Policy report summarises the results of the multicountry study.

Political economy

The international development community increasingly recognises that carefully crafted technical solutions can have little practical effect if political economy concerns are ignored, especially for social and economic reforms.⁴⁻⁶ Because UHC reforms intentionally redistribute resources in the health sector and across households, these policies inevitably involve political trade-offs, conflicts, and negotiations. This study assessed three political economy challenges of moving towards UHC: adoption of UHC goals; expansion of health coverage; and reduction of inequities in coverage.

Adoption of UHC goals

UHC goals are often adopted in conjunction with a major social, economic, or political change. For example, UHC became a national priority following a period of financial crisis in Indonesia, Thailand, and Turkey; at the time of re-democratisation in Brazil; and during post-World War 2 reconstruction efforts in France and Japan. In these countries, periods of major upheaval created opportunities to break through interest group resistance to reforms, and allowed innovative approaches to be advanced and adopted. In some countries, they also generated broad-based social movements and opportunities for political leaders to mobilise support from diverse groups and create a sense of national

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Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, MA, USA

(Prof M R Reich PhD);

Department of Sociology, Boston University, Boston, MA, USA (J Harris PhD); Keio University, Tokyo, Japan

(N Ikegami MD); Results for Development Institute,

Washington, DC, USA

(C Cashin PhD); Health,

Nutrition and Population

Global Practice, The World Bank, Washington, DC, USA

(A Maeda PhD, E C Araujo PhD,

T G Evans DPhil); and House of Councillors, The National Diet

of Japan, Tokyo, Japan

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	Group 1	Group 2	Group 3	Group 4
Status of UHC policies and programmes	Agenda-setting; piloting new programmes and developing new systems	Initial programmes and systems in place, implementation in progress; need for further systems development and capacity building to address remaining population not yet covered	Strong political leadership and citizen demand lead to new investments and UHC policy reforms; systems and programmes develop to meet new demands	Mature systems and programmes; continuous adjustments required to meet changing demands and rising costs
Status of health coverage	Low population coverage, at the early stage of UHC	Substantial share of population gain access to services with financial protection, but population coverage is not yet universal and coverage gaps remain in access to services and financial protection	Universal population coverage achieved but countries are focusing on improving financial protection and quality of services	Universal coverage with comprehensive access to health services and effective financial protection
Participating countries	Bangladesh and Ethiopia	Ghana, Indonesia, Peru, and Vietnam	Brazil, Thailand, and Turkey	France and Japan

Data from Maeda et al.² UHC=universal health coverage.

Table: The 11 countries included in the UHC study

solidarity to promote major reforms. For example, the adoption of UHC policies in Turkey and Thailand benefited from strong executive leadership from the ministers of health and the heads of state, who worked to create broad popular support. In Brazil and Thailand, social movements had a catalytic role in putting UHC on the political agenda and in encouraging government leadership to adopt and implement reforms.^{7,8} In all cases, new programmes built on past experiences and institutions, which provided opportunities to build capacity for managing and developing programmes.

However, past experiences and new opportunities alone are not enough; strategic management of interest group pressures is essential to enable reforms to be successful. Turkey's experience is illustrative of this requirement: reformers first developed a roadmap for reform, which began with the identification of interest groups likely to be opposed to it. With a clear understanding of their motivations and potential effects on the political process, the government developed strategies to manage opposition from civil servants, trade unions, social security, and health workers. They sought to increase public support for reform by abolishing the practice of holding patients hostage for past-due bills at hospitals, reorganising facilities to make more room for patient care, and expanding emergency services. Additionally, they developed a new health workers' union and established pay-for-performance incentives, both of which helped to fracture the existing associations' support base.⁹ Design decisions made during the adoption of Ghana's National Health Insurance System had undesirable long-term consequences: use of fee-for-service financing arrangements for health care and medicine have, over time, contributed to problems with the programme's financial sustainability, which illustrates the way in which past decisions can affect future trajectories.¹⁰ In Indonesia, local governments filed a lawsuit with the country's Constitutional Court over the 2004 Social Security Law, claiming that it upended principles of decentralisation. However, the Court upheld the law, which had been heralded as a landmark legislative achievement that set UHC attainment as a goal.¹¹

The 11 country studies also suggest that economic growth was not a necessary condition for the adoption of UHC policies, although growth was important in supporting the subsequent expansion of coverage. Brazil's commitment to UHC was spurred on by the movement for democracy and occurred in a difficult economic environment, including periods of slow growth. Thailand committed itself to the Universal Coverage Scheme in 2002, after the Asian financial crisis when the economy was still fragile.

Expansion of health coverage

All 11 countries in this study used an incremental approach to the expansion of health coverage. This step-by-step approach depended on efforts to gain political support from (and sometimes confront) specific interest groups, and relied on developing institutional and technical capacities to move towards UHC.

The development of capable and adaptive governance arrangements is a hallmark of group 3 and 4 countries that have achieved UHC. Countries like Thailand have made accountability a priority by separating the health-care purchaser and provider functions, by developing quality standards and a strong capacity for strategic goal-setting and for the assessment of new technologies and pharmaceutical products to be included in benefit packages, and by checking interest group pressures through the creation of an oversight board that includes substantial participation by civil society.¹² Even though France has a longstanding UHC programme, the country similarly continues to develop mechanisms aimed at improving governance of its health system. Recently, it set up a comprehensive health expenditure monitoring system that includes a mechanism that alerts authorities to overspending and introduced a pilot pay-for-performance mechanism for office-based family doctors, aimed at improving efficiency and quality of care.¹³ Governance initiatives in Brazil have recently involved experimentation with new forms of contracting for primary health care at the state level, with the aim of improving efficiency and quality.¹⁴

In expanding coverage, countries have also often learned from past experiences and by taking corrective actions, as

shown by the experiences of group 2 countries. For example, Ghana recently celebrated the tenth anniversary of its National Health Insurance Scheme and used the opportunity to critically reassess aspects of the system's operation. The system has achieved 36% coverage of the population and now confronts financial sustainability as a major concern, since total expenditure has been outpacing revenues.¹⁰ In Vietnam, the Ministry of Health and Vietnam Social Security have done a thorough assessment of the national health insurance system to propose adjustments in an upcoming revision of the Health Insurance Law.¹⁵ Peru has sought to address gaps in coverage by establishing service exchange agreements between existing health insurance programmes that at present serve different segments of the population.¹⁶

Reduction of inequities in coverage

Nearly all of the nine countries that are implementing or have implemented social health insurance provided insurance coverage to civil servants and formal sector workers first because these groups are politically influential, live in urban areas near existing health facilities, and have institutional relationships with the government through the payment of taxes. Expansion of coverage to poor and vulnerable populations often needs strong governmental commitment to give voice to marginalised groups and overcome interest group politics. Group 3 countries (Brazil and Thailand) are examples of nations in which social movements have combined with political leadership to play a catalytic role in overcoming political challenges to reduce inequities in coverage.

This incremental approach to expansion of health coverage typically leads to the establishment of several risk pools for different population groups with varying amounts of coverage.¹⁷ Once established, these different pools are politically difficult to integrate or harmonise because integration involves redistribution of resources across organised interest groups. Group 2 countries are seeking to address this issue: Ghana and Vietnam have established a national health insurance scheme as a platform to create a unified risk pool, and Indonesia and Peru are also taking substantial steps to integrate or harmonise multiple risk pools.

Health financing

This study reviewed national experiences in three areas of health financing: mobilisation of revenues to expand and sustain coverage; establishment of effective pooling and redistributive mechanisms to ensure equity and financial protection; and building of capacities to manage expenditures.

Raising revenues

All countries in the study have faced challenges in finding sufficient government finances to support UHC policies and programmes, since expansion of coverage calls for a significant increase in public spending. Countries found

Panel 1: Financial earmarking and commitment to UHC in the 11 countries

Political commitment to UHC accompanied by earmarking

- France: earmarked taxes (initially payroll tax; since 1998 earmarked taxes on income and capital)
- Ghana and Brazil: earmarked portion of value-added tax and social security contributions; in Brazil, the minimum to be allocated to the Ministry of Health and to state and municipal health secretariats is defined by Constitutional Amendment no. 29/2000*

Political commitment without earmarked commitment

- Japan, Thailand, Turkey, and Vietnam: no earmarked amounts, but high priority in the budget
- Bangladesh, Ethiopia, Indonesia, and Peru: no earmarked amounts, and varying priority in the budget

Summarised from the 11 country summary reports, available online,¹⁸ and in Maeda et al.: UHC=universal health coverage. *To the Ministry of Health, the equivalent of the health budget from the previous fiscal year adjusted by the nominal change in gross domestic product; to states, 12% of the budget; and to municipalities, 15% of the budget.

different approaches to securing the necessary budgetary allocation to implement UHC. Priority in the government budget for health, along with macroeconomic growth, has enabled countries to expand population coverage and provide better financial protection. However, often governments do not accompany their political commitment to UHC with an explicit financial pledge. Only three of the 11 countries (Brazil, France, and Ghana) have used government earmarks, which explicitly set aside funds from the budget for health care. Other countries have achieved UHC without earmarks (panel 1), but have consistently kept their budgetary allocation to the health sector high on the national political agenda.

Although public financing has played an important part in the expansion of UHC, countries in the study used diverse approaches to manage the role that private provision and private insurance plays. In some cases, private providers have had important roles as contracting providers, as is the case in Thailand, Brazil, and Indonesia. Owing to the large size of the informal sector in Bangladesh, the private health insurance market remains very small, although most doctors practise in the largely urban private sector.¹⁹ In Ethiopia, private providers receive just 16% of total health expenditure.²⁰ France has intentionally restricted private health insurance to a supplemental role, involving the coverage of costs associated with copayments.¹³ In Brazil, however, about 25% of the population has private health insurance, even though health care is free through the Unified Health System. Although many people use the Unified Health System, with vaccines and complex high-cost care being popular services, they frequently enjoy shorter wait times, better access, and more sophisticated facilities through the private system financed through private health insurance. The development of two tiers in

Brazil's health-care system emphasises the challenges involved with the management of inequities that arise with parallel public and private provision and financing. In Japan, the private sector has had a major role in assuring access and providing services, but without the dichotomised system of Brazil, through the use of a single fee schedule for both private and public sectors.

Although all the countries in the study are seeking to diversify sources of revenue for UHC, they have used different strategies to move towards UHC. France and Japan are seeking to reduce their reliance on payroll premium contributions (because payroll premium contributions are no longer generating sufficient revenue as a consequence of ageing populations), and they are turning to other forms of tax revenues. Brazil has allowed the growth of private voluntary health insurance, and over time the share of private spending has increased, and Brazil now has the highest share of out-of-pocket spending (30%) of the group 3 and 4 countries.²¹ Countries with a large informal sector, such as Thailand, have found it difficult to expand coverage through payroll taxes alone and have increased their use of general revenues. By contrast, low-income countries such as Bangladesh and Ethiopia are seeking ways to expand their narrow tax base by introducing new payroll taxes under a social insurance programme. However, this approach has substantial equity implications (as noted previously), since it could steer government resources towards workers in the formal sector and away from less affluent farmers and informal sector workers.

Management of effective risk pooling and redistribution of resources

The study shows that providing universal coverage for the entire population needs different forms of cross-subsidisation, both from rich to poor and from low-risk groups (eg, the young) to high-risk populations (eg, the elderly). The consolidation of insurance schemes has improved cross-plan fairness in some group 3 countries: Turkey, for example, undertook major reforms to consolidate several insurance programmes and achieve integration and cross-subsidisation. Brazil's 1988 constitution consolidated multiple programmes under the Unified Health System, financed through general taxation. Thailand consolidated two major programmes in 2001 under its Universal Coverage Scheme, which covers the largest number of beneficiaries and ensures equitable financial risk protection in beneficiaries within this group. However, Thailand still maintains three separate insurance programmes, and per-beneficiary expenditure across the three is highly skewed because of the lack of redistribution across them.

Japan has maintained several risk pools, but achieves substantial fairness through a combination of standardised benefits and standardised provider payments across its 3300 insurance plans, intergovernmental transfers of subsidies, and transfers between funds to maintain equity

in contributions and expenditures. However, these redistributive mechanisms are not keeping pace with Japan's rapidly ageing population, and disparities are widening in the premium rates collected by different risk pools and plans.²² Japan has not been able to create an integrated risk pool, in large part because better-off entrenched groups do not want their premium rates increased, which illustrates the political economy challenges of improving fairness in a fragmented system.

Controlling cost pressures

Management of expenditures is essential at all stages of UHC. Even countries that achieved UHC a long time ago still face ongoing cost pressures and must make difficult decisions on issues such as which drugs to include and exclude in benefit packages, as exemplified by the debate over sofosbuvir for hepatitis C—in France and the UK.²³ All of the study's 11 countries face substantial resource constraints in achieving or maintaining universal coverage. The study showed that open-ended fee-for-service payment systems typically lead to cost-escalation. Many countries respond by introducing measures to contain costs. However, these measures can erode coverage and undermine financial protection.

Countries that carefully manage the total resources in the system and strategically use policy levers to increase efficiency are more successful in managing costs without eroding coverage, as shown by the experience of several countries. For example, Thailand and Turkey used strong negotiation strategies with pharmaceutical companies and leveraged provider payment systems to bring more benefits to more people. With the support of international partners when the country's health-care system was at an earlier stage of development, Thailand developed robust institutional capacity to undertake health technology assessment, which is now used to assess the cost-effectiveness of technological and medical interventions being considered for inclusion in the benefit package of its UHC programme.²⁴ In France, 20 years of budget deficits have started to decline in the past few years by setting national spending targets, reforming provider payment systems for both primary and acute care, and strengthening state regulation of health insurance spending through rigorous monitoring mechanisms.

Japan has contained costs and achieved policy goals in service delivery through a biennial revision of its unified fee schedule, which is a two-step approach of setting a global revision rate, then fine-tuning item-by-item revisions and setting conditions for billing.²⁵ Japan also provides financial protection to households by capping copayments and providing coverage for catastrophic health expenditures.

Human resources in health

All 11 countries in the study have faced major challenges in the production, performance, and distribution of health workers in relation to UHC goals. One core lesson of this

study is that countries need to match their commitment to UHC with their capacity to deliver health services, which in turn depends on the availability of a qualified and motivated health workforce. The shortage of health workers is a global challenge, but this problem is especially acute for countries in early stages of UHC adoption and implementation (ie, those in groups 1 and 2). These countries need to rethink traditional models of health worker education and their deployment in service delivery.

Expansion of the production of health workers needs to be accompanied by appropriate governance and regulatory reforms to ensure the quality and appropriate skills of health workers, which is especially important for group 1 and 2 countries. These countries face a health workforce shortage and have seen a rapid proliferation of private and public education institutions without adequate quality regulation. In Bangladesh, unqualified health professionals account for 94% of the total health workforce.²⁶ This situation—in the context of broader workforce shortages—has made training of lower cadres of health workers who serve rural communities a priority.¹⁹ In Peru, more than 70% of health professionals train in private universities. However, researchers found that just two of 234 health professional training programmes in universities in Peru completed the accreditation process with the national council of accreditation.²⁷ To address the problem of unqualified workers in Indonesia has meant reformation of the accreditation process used by professional programmes and standardisation of certification processes after matriculation.¹¹

Other countries have successfully expanded their health workforce by broadening the recruitment pool and offering flexible career opportunities and non-traditional entry points to health workers. New categories of health workers can have shorter periods of education and therefore can be trained and deployed more quickly compared with those who follow more traditional training programmes. Examples include Ethiopia's health extension workers and Brazil's community health workers. These strategies can help to build up the workforce in underserved areas and thereby strengthen the delivery of health services. However, they also require changes in the way health care is delivered, a redefinition of the scope of practice and functions of different categories of health workers, and revision of regulation on education and standards of training and practice. These reforms can confront resistance from existing professions, showing the political economy dimensions of change.

All 11 countries in the study are grappling with a maldistribution of health workers. Countries in groups 1 and 2 face especially difficult problems in the recruitment and retention of health workers in rural and remote regions. Countries in group 3 have reduced geographical disparities in the distribution of health workers and their experiences offer useful insights. Rural–urban disparities in health worker distribution can be reduced by several different strategies, including balancing of monetary and

non-monetary incentives and improved working conditions and supportive supervision in health facilities.²⁸ Interventions include recruitment of students from underserved areas, such as through scholarships and quotas and introduction of rural service components in the curricula; rotating between hospitals and primary care sites; and offering monetary and non-monetary support for career development. Compulsory service is another policy to encourage deployment in underserved areas. Countries in group 3 have used a combination of these policies. Many group 2 countries are developing and implementing policies with a multipronged approach. Another approach to improve geographical distribution balance is to invest in community-based primary-care workers. Although more work remains to be done to improve quality and knowledge, Ethiopia's Health Extension Program has deployed more than 35 000 community health workers to the village level to

Panel 2: Useful “how to” lessons from the 11 country case studies

Political economy

- 1 Do not wait for the perfect moment to move forward on reform. Economic growth can provide fiscal space for implementation, but it is not needed for policy adoption.
- 2 Take advantage of political opportunities, such as those provided by crises, to advance universal health coverage (UHC) adoption and develop a strategy to manage interest group pressure.
- 3 Use supportive social movements to advance the UHC agenda and check interest group pressures.

Health financing

- 1 Explore different sources of revenue to support the expansion of UHC, including explicit budget earmarks and other government financial commitments.
- 2 Recognise that early decisions can affect both the financial sustainability and equitable impact of UHC and can prove difficult to change once institutionalised. Take care, therefore, when making decisions related to types of payment arrangements, regulation of the private sector, and the development of single versus multiple risk pools.

Human resources for health

- 1 Consider flexible career paths and non-traditional points of entry, especially those aimed at health workers from rural and underserved communities, in order to complement existing modes of health-care worker education and deployment, which can help to address health-care worker shortages.
- 2 Use a comprehensive and multipronged approach to address the maldistribution of health workers, including education policies, labour market regulations, and monetary and non-monetary incentives.

These selected lessons are derived from the country case studies and synthesis report, based on Maeda et al.²

provide basic services and train people in healthy lifestyle practices and reasonable care-seeking behaviour.²⁹ Investments in the hospital sector tend to skew the health workforce distribution toward urban areas, whereas investments in primary care health workers tend to expand health service availability in underserved communities, as shown by the experiences of all group 3 countries.

Conclusions

This study shows that movement towards UHC is a long-term policy engagement that needs both technical knowledge and political know-how. Countries need political leaders with vision and commitment who are ready to invest in the development of solid institutional foundations, administrative capacity, and good governance. Technical solutions need to be accompanied by pragmatic and innovative strategies that address the national political economy context. This multicountry study shows that UHC is a complex process, fraught with challenges, many possible pathways, and various pitfalls—but is also feasible and achievable. As presented in panel 2, the study identified a series of “how to” lessons for political economy, health financing, and human resources for health to assist countries in moving towards UHC. Overall, countries have a better chance of moving forward if they have leaders who show political commitment to reform, a clear understanding of the political economy challenges, and a willingness to learn from experience and adapt. This combination of factors supports national leaders in their efforts to design and implement coverage-enhancing reforms that are inclusive and sustainable in the long run.

Contributors

MRR and AM prepared the original draft of the report, with substantial inputs from CC and ECA. JH, NI, KT, and TGE subsequently added to, revised, and edited the draft. All authors have seen and approved the final version.

Declaration of interests

We declare no competing interests.

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