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World Health  
Organization



# The path towards universal health coverage

**Handbook for Parliamentarians No. 35**

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# Foreword

Universal health coverage (UHC) means that all people have access to the health services they need, when and where they need them, without financial hardship.<sup>1</sup> UHC can be seen as the practical expression of the right to health, which was established in 1948 by the *Universal Declaration of Human Rights* and is enshrined in many national constitutions and domestic laws.

Today, UHC is one of the key health targets of the Sustainable Development Goals (SDGs), with an explicit focus on reaching marginalized groups and others who have trouble accessing or affording health-care services.<sup>2,3</sup> The benefits of UHC cut across these health targets and contribute to promoting health security and equity. UHC also contributes to other goals including social inclusion, reducing inequalities, gender equality, poverty eradication, economic growth and human dignity.

In 2019, world leaders at the United Nations General Assembly adopted an action-oriented political declaration on UHC,<sup>4</sup> while legislators at the Inter-Parliamentary Union (IPU) Assembly adopted a resolution calling for parliaments to take all legal and policy measures to achieve UHC.<sup>5</sup> These commitments give parliamentarians an increasingly strategic and substantive role to play in making UHC a reality for all.

The COVID-19 pandemic underscored the importance of UHC. Around the world, many people – particularly vulnerable populations – could not access testing, vaccines or treatments, while many others experienced financial hardship because of their health-care needs. The pandemic significantly slowed progress towards UHC, deepening inequalities and exacerbating vulnerabilities. People from marginalized and underserved communities – especially women and girls – were hit harder than most. UHC would help to reduce these inequalities by strengthening nations' health-care capacities and infrastructure, thereby building resilience to handle health crises, preventing disease and promoting health.

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1 World Health Organization (WHO), "Universal Health Coverage": [www.who.int/health-topics/universal-health-coverage#tab=tab\\_1](http://www.who.int/health-topics/universal-health-coverage#tab=tab_1).

2 Ibid.

3 United Nations, *Transforming our world: the 2030 Agenda for Sustainable Development*, A/Res/70/1 (2015): [www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A\\_RES\\_70\\_1\\_E.pdf](http://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf).

4 United Nations, *Political declaration of the high-level meeting on universal health coverage*, A/Res/74/2 (2019): [daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/Res/74/2&Lang=E](http://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/Res/74/2&Lang=E).

5 Inter-Parliamentary Union (IPU), *Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health*, resolution adopted by the 141st IPU Assembly (2019): [www.ipu.org/file/8200/download](http://www.ipu.org/file/8200/download).

This handbook is the result of a long-standing partnership between the IPU and the World Health Organization (WHO). It offers practical recommendations to support parliamentarians in using their law-making, budgeting and oversight roles to advance UHC in their countries. A world in which health is a basic human right is the world we are working to build. The role of parliamentarians is crucial because, without UHC, the hope for healthy, thriving populations will remain just that: a hope.

A blue ink signature of Martin Chungong, featuring a stylized, flowing script.

Martin Chungong  
IPU Secretary General

A blue ink signature of Dr. Tedros Adhanom Ghebreyesus, featuring a stylized, flowing script.

Dr. Tedros Adhanom Ghebreyesus  
WHO Director-General

# 1. About this handbook



A man is brought for malnutrition treatment at Al-Sevre hospital on the World Malaria Day in Taiz, Yemen. © Abdulnasser Alseddik/Anadolu Agency via AFP

## 1.1 What this handbook is for

Parliaments are crucial to the health of the people they represent, playing different and complementary roles in operationalizing related national and international commitments. They enact legislation, review and approve budgets, and hold governments to account for progress towards UHC. They work to reduce inequalities and remove barriers that prevent people from enjoying good health and well-being throughout their lives. And they are instrumental in implementing IPU and United Nations resolutions.



This handbook is intended to help parliaments and parliamentarians fulfil these roles, by:

- explaining what UHC is and why it is important
- exploring the unique contribution that members of parliament (MPs) make to achieving UHC, focusing on their legislative role (including developing, drafting, enacting and implementing UHC legislation), as well as their role in financing for UHC, and in oversight and accountability
- offering practical, actionable recommendations on how MPs can advance UHC in their respective countries and contexts

## 1.2 Who this handbook is for

This handbook is designed for anyone interested or involved in enacting legislation in their country. It may be used by:

- parliaments and parliamentarians
- parliamentary staff and advisers
- government officials (e.g. executive authorities such as the ministry of health), members of civil society, communities, academics, constituency staff, and anyone else who might want to encourage or work with parliaments and parliamentarians to advocate for or facilitate UHC
- the IPU, the World Health Organization (WHO), and other multilateral organizations working with parliaments and parliamentarians on UHC
- other organizations and interest groups working to accelerate progress towards UHC

## 1.3 How to use this handbook

Each section of this handbook is designed as a stand-alone resource, providing a brief explanation of the relevant issue and how it can be used to advance UHC, along with useful information and recommendations from WHO and the IPU, actions for MPs to consider, country examples, and key takeaways and messages. Not all of these will suit the needs of every country. But they serve as ideas and examples that could be developed or adapted. Readers who require a better understanding of UHC can also refer to the resources and reference materials listed in this handbook.

## 2. Introducing universal health coverage



Health workers give medication during treatment of a COVID-19 patient. © Burak Akbulut/Anadolu Agency via AFP

### 2.1 What universal health coverage is (and is not) about

With UHC, everyone would have affordable access to the full spectrum of health services they need – from health promotion to prevention, treatment, rehabilitation and palliative care.

UHC has been termed “a practical expression of the right to health”,<sup>6</sup> and the **human right to health** is highlighted in several post-Second World War international instruments, including the *Constitution of the World Health Organization*<sup>7</sup> and the *Universal Declaration*

6 WHO, *Health in the Post-2015 Development Agenda* (Geneva: WHO, 2013): [apps.who.int/iris/bitstream/handle/10665/85535/9789241505963\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/85535/9789241505963_eng.pdf).

7 WHO, *Constitution of the World Health Organization*, adopted by the International Health Conference, New York (1946): [apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf](https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf).

## Key messages on UHC

- Universal health coverage (UHC) means that everyone receives quality health services, when and where they need them, without incurring financial hardship.
- The objectives of UHC are to achieve equity in health service use, quality health care and financial protection.
- UHC is a commitment made by countries under target 3.8 of the 2030 Agenda for Sustainable Development and is grounded in international human-rights law.
- Efforts to achieve UHC should be guided by the pledge made by countries under the 2030 Agenda to “leave no one behind” (LNOB) and to “reach those furthest behind first”.
- UHC is relevant everywhere: all countries can help reduce the gap between need and use of quality health services.
- UHC cannot be achieved in institutional silos: it is a multisectoral issue that requires parliaments to exert their various roles (law-making, budgeting and oversight) across various sectors and with the involvement of a broad range of stakeholders (such as civil society, academia and the private sector).
- Strong health systems, oriented towards primary health care (PHC), are essential to achieving UHC.
- Progress towards UHC not only improves health and reduces financial hardship – it can also help to create employment and economic opportunities, reduce poverty, and build a fairer and more stable society.
- There is no perfect moment to move forward with reform: political opportunities must be seized and partnerships sought with social movements to advance the UHC agenda.

of Human Rights.<sup>8</sup> The right to health creates a legal obligation for states to ensure the availability, accessibility, acceptability and quality of health-care services and the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equity.

UHC aims to achieve **equity** in health service use, **quality health care** and **financial protection**:

- **Equity** in service use implies the absence of discrimination towards certain individuals or groups (based on social group, economic level, ethnicity, sexuality, religion and sex, among other factors) in accessing the full spectrum of health services.

Applying the principle of equity helps to reduce the gap between need and use by identifying and addressing socioeconomic, geographic, gender-related and other types of inequalities.

<sup>8</sup> United Nations, *Universal Declaration of Human Rights*, A/RES/217(III) (1948): [daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/RES/217\(III\)&Lang=E](https://access-ods.un.org/access.nsf/Get?OpenAgent&DS=A/RES/217(III)&Lang=E).

- **Quality health care** refers to the degree to which health-care services for individuals and populations increase the likelihood of desired health outcomes.
- When quality health care is provided, the resulting good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.
- **Financial protection** is achieved when people do not experience financial barriers when seeking health care and, if they must pay out of pocket (OOP) to obtain health services, such payments are not a source of financial hardship.

Although no country can sustainably provide all services free of charge, sufficient financial protection mechanisms reduce the risk that people will have to choose between spending on health and spending on other basic needs such as food, housing and utilities, nor will they be forced to use up their life savings, sell assets or borrow – destroying their futures, and often those of their children – to obtain the services and health products they need. Where there is good financial protection, people are neither pushed nor further pushed into poverty when suffering a disease, illness or accident.

Figure 2.1 Truths and misconceptions about universal health coverage

UHC is about	UHC is not
<ul style="list-style-type: none"> <li>✔ The full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care</li> <li>✔ Addressing all components of the health system: financing, legislation, service delivery systems, workforce, facilities, communications networks, technologies, information systems, quality assurance and governance</li> <li>✔ Both individual and population-based services (e.g. public-health campaigns)</li> <li>✔ Policies that are inclusive of all individuals and groups and progress that is assessed at a population level</li> <li>✔ Protecting people from the financial consequences of paying for health services out of their own pockets at the point of use</li> <li>✔ Ensuring an equitable expansion of service coverage and financial protection as more resources become available</li> <li>✔ Taking steps towards economic and other development priorities, poverty reduction, social inclusion and cohesion, and equity</li> </ul>	<ul style="list-style-type: none"> <li>✗ Only treatment services</li> <li>✗ Only health financing</li> <li>✗ Only individual services</li> <li>✗ Providing benefits to only certain groups or assessing progress among only those served by a certain programme</li> <li>✗ Free coverage for all health interventions, regardless of cost</li> <li>✗ Only ensuring a minimum package of health services</li> <li>✗ Only health</li> </ul>

## Questions for parliamentarians to consider

Do you have explicitly stated health policy goals?

- **If yes:** Are they consistent with UHC, i.e. aimed at narrowing the gap between the need for and use of services while protecting people from financial hardship?
- **If no:** Would the use of the UHC label help politically, including to more effectively communicate to others in government and the population about what your policies are?

Does your country have a national UHC strategy or implementation plan?

- **If yes:** Does the UHC plan focus on equal access, quality health services and financial risk protection? Is strong, person-centred PHC a core strategy for implementation of UHC?
- **If no:** Have discussions started or plans been drafted?

## 2.2 Why universal health coverage is important

UHC is one of the targets of the **Sustainable Development Goals** (SDGs) adopted in 2015. Under SDG 3 on good health and well-being, target 3.8 calls specifically for UHC. By making progress towards UHC, countries will also advance on other health-related targets and other SDGs.

UHC directly benefits the health system, as well as positively impacting the economy and society – and, in turn, constituencies – more broadly.

Direct benefits of UHC include:

- improved life expectancy, reduced prevalence of diseases and malnutrition, and fewer and shorter hospital stays
- essential health-care services that people can access when and where they need them without suffering financial hardship
- health-care services that are non-discriminatory and physically accessible
- the right to accurate health information
- increased user satisfaction
- elimination of catastrophic health expenditures and other OOP payments
- reduction in extreme poverty and boosting of shared prosperity

More broadly, UHC:

- creates new employment and economic opportunities, both directly through health-care service jobs, and indirectly by improving access to health-care services and health outcomes for children and their families, allowing them to remain in education for longer
- reduces poverty, improves national productivity and increases government tax revenue because the population is healthy and better able to work
- enables gender equality and enhances women's rights by bringing about social change and helping to create equal opportunities for women and men
- strengthens a country's capacity to respond to future health emergencies
- increases savings for individuals, households and the entire country through more efficient and fairer use of government resources to provide health services to all people, with less dependence on OOP payments
- serves as a powerful social equalizer, contributing to a fair, stable and cohesive society by ensuring that PHC services are affordable and reach everyone
- addresses the needs of constituents, who often seek improved access to health care for themselves and their family members

## 2.3 How to achieve universal health coverage

UHC is globally relevant: all countries can do something to reduce the gap between need and use of quality health services. To achieve UHC, countries must move forward in at least three areas:

- Expanding priority services in line with the population's needs
- Including more people
- Reducing OOP payments

### Key resource

- The WHO *UHC Compendium* includes tools to assist countries in making decisions around what to include in a guaranteed package of services: [www.who.int/universal-health-coverage/compendium](http://www.who.int/universal-health-coverage/compendium).

In each of these areas, countries face a critical choice: which services to expand first, whom to include first, and how to shift from OOP payments towards prepayment. These decisions must be

guided by a commitment to fairness and equity, and by the individual right to health care in line with the 2030 Agenda's transformative LNOB pledge.<sup>9,10</sup>

To this end, it is essential to understand and address the barriers faced by people – especially the most vulnerable groups – in actually accessing health-care services. Just because services are available and financially accessible in theory, this does not necessarily mean they will be used in practice. Various barriers can prevent people from accessing health care. For instance, these may be linked to the availability, accessibility (financial, geographic, organizational and informational), acceptability or effective coverage of services. Participatory approaches in policymaking and implementation are therefore essential to understanding these barriers and ensuring that the voices of those left furthest behind are heard.

More broadly, operationalizing the commitment to LNOB nationally requires a comprehensive approach that involves a series of steps, including determining who is being left behind and why, identifying effective measures to address root causes, monitoring and measuring progress, and ensuring accountability for LNOB.<sup>11</sup>

The LNOB approach also calls for reforms towards UHC to be underpinned by the concept of progressive universalism, by which the reforms benefit the most disadvantaged subpopulations at least as much as – but ideally more than – more advantaged groups.<sup>12,13</sup>

UHC cannot be achieved by clinging to institutional silos. It is a multisectoral, comprehensive, sustainable development framework that demands collaborative action on a range of policy issues across sectors, across government (nationally and subnationally), with non-governmental stakeholders and with communities themselves. And it requires policymakers to commit to investing in UHC.

Achieving UHC also depends on building implementation capacities and providing resources subnationally in a sustainable manner. In fact, while conceptualization and oversight for UHC are usually done nationally, subnational levels (including local communities) and institutions play a central role in implementation.

All of the above can only be achieved through health systems that are strong, resilient, functional, well governed, responsive, accountable, integrated, community-based, people-centred and capable of delivering quality services. These systems must be supported by a competent health-care workforce, adequate health-care infrastructure,

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9 United Nations, *Transforming our world: the 2030 Agenda for Sustainable Development*, A/RES/70/1 (2015).

10 United Nations, *Leaving No One Behind: Equality and Non-Discrimination at the Heart of Sustainable Development* (New York: United Nations, 2017): [unsceb.org/sites/default/files/imported\\_files/CEB%20equality%20framework-A4-web-rev3.pdf](https://unsceb.org/sites/default/files/imported_files/CEB%20equality%20framework-A4-web-rev3.pdf).

11 WHO, *The Innov8 approach for reviewing national health programmes to leave no one behind: Technical handbook* (Geneva: WHO, 2016): [www.who.int/publications/i/item/9789241511391](http://www.who.int/publications/i/item/9789241511391).

12 Results for Development, "Health 2015: A conversation with Davidson Gwatkin on progressive universalism" (2014): [r4d.org/blog/health-2015-conversation-davidson-gwatkin-progressive-universalism](http://r4d.org/blog/health-2015-conversation-davidson-gwatkin-progressive-universalism).

13 Davidson R. Gwatkin, "Universal health coverage: friend or foe of health equity?", *The Lancet*, 377/9784 (2011): [www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962058-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2962058-2/fulltext).

enabling legislative and regulatory frameworks, and sufficient and sustainable funding.<sup>14</sup> In other words, health systems strengthening is the means of achieving the objectives of UHC.<sup>15</sup>

As the COVID-19 pandemic demonstrated, strong health systems benefit both UHC and health security.<sup>16</sup> Health systems strengthening should be oriented towards PHC, which is considered to be the most inclusive, effective and efficient approach to enhancing people's physical and mental health, as well as their social well-being<sup>17</sup> (see Box below). Countries can use established measures and initiatives to support their efforts in operationalizing PHC.<sup>18</sup>

In the end, decisions on how to move towards UHC (such as what to include in a guaranteed package of services) will depend on context-specific considerations such as the existing health system, the burden of disease and available resources. Each country will have to find its own path towards UHC. But in every case, efforts will need to be backed by legislation, resources and robust monitoring.

## The importance of primary health care

UHC should be based on strong, integrated, people-centred **PHC** – a whole-of-society, whole-person approach to health and well-being that covers the entire lifespan, not just a set of specific diseases.

PHC includes:

- providing quality comprehensive care – from promotion and prevention to treatment, rehabilitation and palliative care – as close to people's everyday environment as possible
- addressing the broader determinants of physical, mental and social health and well-being – including social, economic, environmental and behavioural factors – through evidence-informed public policies and actions across all sectors
- putting people and communities at the centre of health systems, and empowering people to take charge of their own health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and care givers to others<sup>19</sup>

14 United Nations, *Political Declaration of the High-level Meeting on Universal Health Coverage: "Universal health coverage: moving together to build a healthier world"* (2019), OP 9: [www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf](http://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf).

15 Joseph Kutzin and Susan P. Sparkes, "Health systems strengthening, universal health coverage, health security and resilience", *Bulletin of the World Health Organization*, 94 (2016), 2: [www.who.int/publications/i/item/health-systems-strengthening-universal-health-coverage-health-security-and-resilience](http://www.who.int/publications/i/item/health-systems-strengthening-universal-health-coverage-health-security-and-resilience).

16 Ibid.

17 United Nations, *Political Declaration of the High-level Meeting on Universal Health Coverage: "Universal health coverage: moving together to build a healthier world"* (2019), OP 13.

18 WHO and United Nations Children's Fund (UNICEF), *Operational Framework for Primary Health Care: Transforming Vision Into Action* (Geneva: WHO, 2020): [www.who.int/publications/i/item/9789240017832](http://www.who.int/publications/i/item/9789240017832).

19 WHO, *Primary health care* (Geneva: WHO, 2021): [www.who.int/news-room/fact-sheets/detail/primary-health-care](http://www.who.int/news-room/fact-sheets/detail/primary-health-care)



Both the Millennium Development Goals and the inclusion of UHC as a specific target of the SDGs have given renewed impetus to efforts to integrate UHC into national plans and to strengthen national health-care sectors. Parliaments can do much to keep building this momentum – by initiating UHC, by improving its implementation, and by monitoring and reporting on progress.

The core parliamentary roles of **law-making, budgeting, oversight and representation of constituency interests** are all critical to the full implementation of UHC. These will be described in fuller detail in subsequent sections of this handbook.

What counts is taking action as soon as possible and not waiting for the perfect moment to move forward with reform. Taking advantage of political opportunities and using supportive social movements will help to advance the UHC agenda.

## 2.4 Suggested actions for MPs

- Advocate for UHC to become a national goal and promote dialogue on how to achieve UHC and overcome challenges to its successful implementation.
- Identify parliamentary and national mechanisms, both in and outside of parliament, that address different areas of UHC:
  - If no mechanism exists, explore whether one should be established and consider becoming involved in its work.
  - Identify precedents for parliamentary engagement in government task forces on health and related issues.
  - Use lessons learned from this involvement to inform and guide the work of parliament in support of UHC implementation.
- Place UHC issues on the agenda of appropriate parliamentary committees (such as health, the economy, education, social affairs, poverty reduction and international cooperation).
- Ensure progress on UHC is tracked along with other SDG targets and indicators to assess progress, and ensure progress reports are made available to parliament for scrutiny.
- Use data on access to essential quality public health-care services and the financial burden of health-care expenditures to advocate for stronger UHC implementation as part of economic investment. This data should be disaggregated by spatial units across the country, reflecting the levels of governance for decision-making, as well as by rural/urban, sex/gender, age, and a range of equity stratifiers such as income, education, occupation, migrant status and others.
- Help empower the parliamentary secretariat to systematically gather pertinent information on UHC and its implementation, ensure that the parliamentary library has the capacity and resources to provide parliamentarians with briefings and analysis on UHC issues, and include information about UHC in briefing materials for new MPs after elections.

## 3. Universal health coverage law



People belonging to the E'ñepa ethnic group look at health-care workers attending to patients at the Chaviripa shanty town in the Maniapure sector of the Bolivar state, 595 km south-east of Caracas.

© Federico Parra/AFP

### 3.1 What universal health coverage laws are for

UHC is a political commitment enshrined in both IPU and United Nations General Assembly resolutions. But it cannot be achieved without a legal foundation. For this reason, the UN political declaration of the high-level meeting on UHC recognizes “the vital importance of strengthening legislative and regulatory frameworks and institutions for the achievement of universal health coverage.”<sup>20</sup> Likewise, the IPU resolution, *Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health*, adopted by the 141st IPU Assembly, urges parliaments to “put in place a robust legal

<sup>20</sup> United Nations, *Political declaration of the high-level meeting on universal health coverage*, A/Res/74/2 (2019).

## Key messages on UHC law

- A robust legislative framework is a cornerstone of quality health care and a requirement for UHC.
- Parliaments have three major roles to play in legislating for UHC: assessing existing laws, enacting new laws, and making sure laws are properly implemented and evaluated.
- Effective laws can support UHC by:
  - creating a right to health and providing a set of legally binding measures
  - equipping health systems with the tools to plan, implement and revisit UHC measures
  - addressing the role of all actors in society in contributing to UHC.
- Some laws not specifically developed for UHC or health issues can still affect the achievement of UHC (positively or negatively).
- Health-care services should be classified by priority, with a focus on expanding coverage of high-priority services for all, and making sure that vulnerable and marginalized groups are not left behind.
- Parliaments can learn from the experiences of other countries that have had success with UHC.

framework for UHC, to ensure effective implementation of UHC legislation in reality, and to ensure that the right of everyone to public health and medical care is guaranteed for all in law and in practice, without discrimination.”<sup>21</sup>

UHC needs a robust legal framework because this framework creates a set of rights, protective mechanisms, standards and requirements, and institutional and organizational arrangements – all of which are needed to translate political commitment for UHC into action. Taken together, a variety of legal instruments including laws, regulations and case law make up the body of what is called “UHC law.”<sup>22</sup> These instruments are necessary because UHC spans such a broad range of issues, as underscored by the UHC law infographic developed by WHO (see pp. 22–23).

When developing and enacting laws for UHC, at least two dimensions should be taken into account: achieving the three UHC objectives of access, quality and affordability (the “what”), and providing enablers for implementation (the “how”). This includes, for example, laws that strengthen health systems, facilitate efficient partnerships and promote solutions appropriate to the country context. Without laws such as these, UHC commitments will remain superficial, lacking the mechanisms to translate the vision of UHC into actionable measures.

21 IPU, *Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health*, resolution adopted by the 141st IPU Assembly (2019).

22 The reference to “UHC law” should be understood as including any legally binding instruments, such as statutory laws enacted by the legislative authorities (parliament), regulatory or administrative laws enacted by the administrative authorities (government ministry) and case law by the judicial authorities (court rulings).

Effective UHC laws can:

- create a right to health and provide a set of legally binding (i.e. mandatory) measures that support universal access to health care, protect people from financial risk and ensure the quality of health care, with a particular focus on the most vulnerable and marginalized groups
- equip health systems with the tools to plan, implement and revisit UHC measures, for instance by clearly assigning roles and responsibilities, allocating resources, or providing mechanisms for coordination, participation,<sup>23</sup> transparency and accountability
- address the role of all those who contribute to UHC, including by regulating and managing partnerships with the private sector
- provide legal solutions that are adapted to each country and that take into account its needs, human-rights obligations, history, legal system, capacities and resources

In addition to laws specifically designed to support the achievement of UHC, other legislation not directly related to health matters can also have a positive (or negative) impact on UHC, such as laws on social security, housing, land use, human rights, privacy, licensing or entitlements.

## 3.2 Making laws that support universal health coverage

Parliaments are at the heart of legislation and have key roles to play across the spectrum of the law-making process: they can identify which laws are needed, help prioritize them, propose and/or enact these laws, oversee their implementation, and evaluate their impact on UHC.

Parliaments work in partnership with other authorities, but they do not always have identical roles in every context. In some countries (usually those governed by civil law), parliaments will take the lead on policymaking and implementation, while in others (typically common-law jurisdictions), governments will set policies that are then implemented through laws. Understanding a country's institutions and particular context will prove helpful in identifying the most appropriate avenues for action – for instance, determining who has the authority to propose bills, who is involved in drafting laws, or how bills are processed.

Parliaments, just like any authority involved in policymaking, have three distinct and critical roles to play in achieving UHC: assessment, enactment and implementation. Each of these requires the involvement of a broad range of stakeholders, including the private

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<sup>23</sup> WHO, *Voice, agency, empowerment – handbook on social participation for universal health coverage* (Geneva: WHO, 2021): [apps.who.int/iris/handle/10665/342704](https://apps.who.int/iris/handle/10665/342704).

sector, academia and civil society.<sup>24</sup> These stakeholders provide valuable insights into the relevance of existing laws or their success, and are crucial to understanding both a population's needs and the barriers people face in accessing good-quality health care without financial hardship.

Experience from countries that have successfully moved towards UHC, and that have similar health and socioeconomic structures and gross domestic product (GDP), can also be useful during the prioritization phase.

### 3.2.1 Assessing universal health coverage laws

#### Questions for parliamentarians to consider

- Are there legal barriers to the achievement of UHC or gaps in existing laws (all laws: statutory laws including criminal codes, administrative law and case law)? Do some groups face discrimination or legal disenfranchisement owing to their legal or social status? Are some service providers not covered by requirements for quality care? Are the costs of essential health-care services managed efficiently across all categories of providers?
- Are existing laws properly implemented and enforced? If not, why not? Is this because of a lack of resources, a lack of political will, a weak mandate or limited capacities?
- Are existing laws (when implemented) effective in ensuring universal access to health care, financial risk protection and quality of health care?
- Do existing laws, in purpose or effect, hinder access to health-care services for populations that are stigmatized or in vulnerable settings (such as migrants fleeing armed conflict)?

Countries aiming to achieve UHC must understand how the legal framework can positively or negatively influence efforts towards this goal. For this reason, the first role of parliaments is to ensure that relevant authorities – such as the ministry of health or parliament itself – take action to understand how existing laws address UHC. This involves assessing the country's legal framework to identify the legal barriers to UHC or gaps that must be addressed. This assessment should look at what the laws say and how well they are implemented, as well as examining their practical impact on access, quality and financial risk protection in relation to health-care services. Particular emphasis should be placed on how existing laws address the needs of the most vulnerable and marginalized groups, as well as on their gender impact.

To develop a comprehensive overview of UHC law in the country, the assessment should examine:

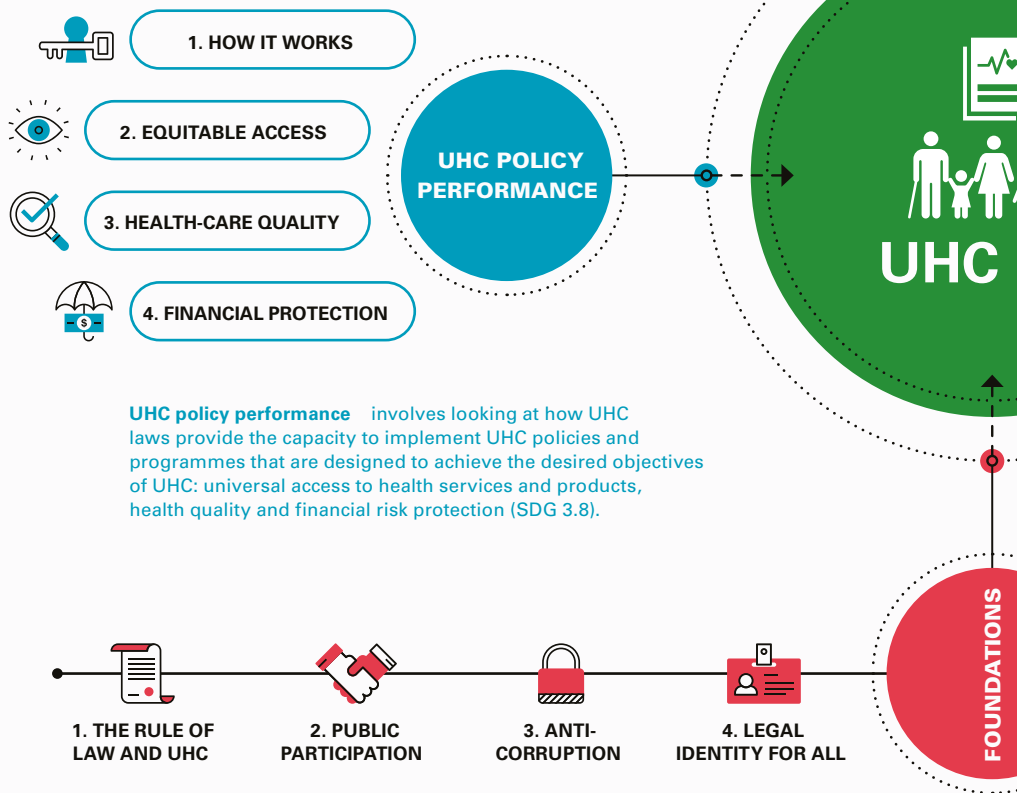
- the wording of the laws across the four areas underlined in the UHC law infographic: UHC policy performance, country context, partnerships and foundations (see Figure 3.1)
- the institutional and organizational framework surrounding these laws

24 The high-level declaration on UHC highlights the important role of stakeholders' engagement in policy process. Para. 58 states: "Improve regulatory capacities and further strengthen responsible and ethical regulatory and legislative system that promotes inclusiveness of all stakeholders, including public and private providers, supports innovation, guards against conflicts of interest and undue influence, responds to the evolving needs in a period of rapid technological change".

Figure 3.1 **UHC law infographic**

**UHC law means** any legal rule existing and applicable within a country that regulates UHC, including: formal written laws such as statutory laws (enacted by a legislative body such as a parliament), regulatory and administrative laws (passed by executive authorities of the government), contracts, case law (court rulings), and customary laws.

**UHC law works by** providing the means to create the institutional framework for UHC made up of UHC principles, the rule systems needed for UHC, legal capacity, rights and relationships, organizational frameworks and partnerships.



1. ACCEPTANCE



2. AUTHORITY



3. ABILITY



**The country context for UHC law reform** is essential to understanding work on UHC law. It includes the health-sector context, the legal and regulatory context, and the political context for reform. It is essential to understand whether UHC law reform is feasible, whether there is acceptance of (or opposition to) the proposed reform, whether there is authority to proceed (especially authority from political decision-makers) and whether the country has the ability to complete the work (does it have the capacity to make, implement and administer the planned law(s)?).

1. HOW IT WORKS



2. GOVERNANCE OF PRIVATE-SECTOR SERVICE DELIVERY



3. REGULATING THE PUBLIC-PRIVATE MIX



4. GOVERNANCE OF PUBLIC-PRIVATE PARTNERSHIPS



PARTNERSHIP

**Partnership with the private sector** for UHC depends on the capacity of governments to exercise effective governance over the private sector, including: formulating public policies about the role of the private sector, understanding the private sector in a country and the operation of a country's health markets, and implementing public policy about the private sector's contribution to health using a variety of legal instruments.

5. ACCOUNTABILITY AND TRANSPARENCY



6. ACCESS TO INFORMATION



7. LAWS TO PREVENT DISCRIMINATION



- the perspectives of key stakeholders on the relevance and effectiveness of UHC laws (such as how well they are implemented and how well they actually contribute to UHC achievement)

### 3.2.2 Enacting universal health coverage laws

#### Questions for parliamentarians to consider

- Which legal solutions can be explored to improve access to health care, provide financial risk protection and guarantee the quality of health care?
- Which of these solutions should be prioritized in your country, taking into account the needs of the population (and especially the most vulnerable and marginalized groups), political priorities, the cost-effectiveness of various health-care services and the country's capacity to implement the measures under consideration?
- Can something other than laws better achieve this outcome (such as better enforcement of existing provisions or better coordination of health-care service delivery)?

Once parliaments are equipped with a good understanding of the strengths and weaknesses of the existing legal framework, the next step is to ensure that relevant authorities – such as the ministry of health or parliament itself – make laws that support UHC. This entails building on the results of the assessment to propose, prioritize and enact legal solutions for UHC.

When considering further action, parliaments should take into account:

- the needs highlighted in the assessment (whether there are legal barriers to UHC to remove or gaps to fill, and how effectively different population groups or local areas are covered by existing UHC laws)
- appropriate legal avenues (which authorities – legislative or administrative – are best placed to take the required legal action and, where applicable, whether subnational authorities are delivering on their role in developing and implementing laws)
- data and science (what the population's health needs are and what the most cost-effective measures are to address them)
- the country context (including political priorities, the needs of the population – and especially the most vulnerable and marginalized groups – and the human, financial and technical capacity to implement the solutions identified in the assessment)

When enacting laws for UHC, relevant authorities should be guided by the following principles:<sup>25</sup>

- Improvements for vulnerable and marginalized groups should be prioritized in policy formulation: these groups should be included from the outset (including in discussions on drafting legislation) and explicit provisions should be made for them.

25 WHO, *Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage* (Geneva: WHO, 2014): [apps.who.int/iris/handle/10665/112671](https://apps.who.int/iris/handle/10665/112671).



- Health-care services should be categorized into priority classes, taking into account the population's needs. Likewise, priority should be given to legislation and related acts of parliament that clearly stipulate that high-priority health interventions must be made available to everyone.
- The more important a service, the more important it is that the service be universally covered. Instead of covering a very broad set of health-care services from the outset, all reasonable measures should be taken to include everyone as quickly as possible for the most important services.

Last but not least, when enacting new laws, relevant authorities must ensure that the legal framework remains coherent and easy to implement, while confirming that there are no loopholes or contradictions between the different sources of laws that could prevent effective implementation. This also implies identifying and removing existing laws that block UHC efforts, for example because they are not based on public-health evidence or are inconsistent with human-rights standards.

## Potential legal solutions to support progress towards UHC

### Ensure equitable access

#### Potential legal solutions:

- Legislation giving everyone in the State's jurisdiction the right to access health-care services and products (under constitutional rights or through other sources of legislation such as health law)
- Legislation protecting people from being denied access to health-care services and products on the basis of race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, disability, or behaviour/status (such as sex workers, substance users or prisoners/detainees)
- Legislation eliminating discriminatory laws that prevent vulnerable and marginalized groups from accessing health care
- Legislation ensuring that health information concerning each citizen is treated as confidential and enshrining the individual right to privacy
- Legislation establishing a mechanism that allows any individual to easily, and without cost, submit a complaint when access to health-care services and/or products is denied, and that puts the legal onus on the health-care provider to respond rapidly to every complaint it receives

#### Country examples:

- **Portugal:** Law 30/2000 of November 2000 decriminalized the consumption, acquisition and possession of drugs for personal use.<sup>26</sup> This measure has expanded access to health-care services for people who use drugs while decreasing HIV and hepatitis C virus infections and drug-related deaths, without leading to an expected increase in drug use.

26 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Portugal Country Drug Report 2019* (Lisbon: EMCDDA, 2019), 5: [www.emcdda.europa.eu/system/files/publications/11331/portugal-cdr-2019\\_0.pdf](http://www.emcdda.europa.eu/system/files/publications/11331/portugal-cdr-2019_0.pdf).

- **South Africa:** The National Health Act provides for a structured public-private health system that delivers equitable health-care services.
- **Thailand:** In line with Section 47 of the Constitution of Thailand, every person is granted the right to access public health-care services provided by the State, while destitute persons may access such services free of charge.<sup>27</sup>

## Ensure quality of care

### Potential legal solutions:

- Legislation putting in place requirements for licensing or certification to operate a health-care facility or to practise as a doctor or nurse
- Legislation establishing mandatory standards for health-care and related facilities as well as for the services delivered, including medicines, vaccines and other health-care products (such as standards on technical aspects of quality of care and patient safety, guidelines on service delivery and clinical practice, and rules around people-centred approaches to health-care delivery)
- Legislation governing health-care service delivery, including rules on guiding, monitoring and evaluating the contribution of the private sector to health-care service delivery and the operation of the health-care market more generally

### Country example:

- **Ghana:** Health-care professions are regulated and premises are licensed under an act of parliament, via standards supervised by the country's top medical and health bodies.

## Provide financial protection

### Potential legal solutions:<sup>28</sup>

- Legislation providing the basis for establishing a health benefits package and for creating service entitlements

### Country example:

- **Japan:** Co-payment reduction programmes have been introduced to limit potentially catastrophic OOP payments for various population and disease groups (patients suffering from specified intractable or chronic diseases pay reduced co-insurance rates using designated health-care providers). Moreover, people living below the poverty line are covered by the social welfare system (Articles 15 and 34 of the Public Assistance Act) and receive health-care services for free (100% government subsidy).<sup>29</sup>

<sup>27</sup> WHO, *UHC law in practice: Legal access rights to health care: Country profile: Thailand* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331626](https://apps.who.int/iris/handle/10665/331626).

<sup>28</sup> See Section 4 of this handbook on financing for further details.

<sup>29</sup> WHO, *UHC law in practice: Legal access rights to health care: Country profile: Japan* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331624](https://apps.who.int/iris/handle/10665/331624).

### 3.2.3 Implementing and evaluating universal health coverage laws

#### Questions for parliamentarians to consider

- Are existing laws properly implemented? Are enough resources available for their implementation?
- Are there mechanisms in place to regularly evaluate the impact of laws on UHC? Are these mechanisms implemented?
- When was the last time your country's laws were assessed for UHC?
- Are there any new health-care services to prioritize and/or additional population groups to include?

Laws are a tool, not an end in themselves. Laws designed to deliver UHC will only be effective if they are implemented and if they actually improve access to essential, quality health-care services without causing financial hardship. Parliaments' third role is therefore to ensure that relevant authorities effectively implement existing laws and to evaluate the impact of laws on progress towards UHC. Some lawmakers may think that the work is over once the laws are passed. But the parliamentarian's role goes on beyond the simple adoption of a law.

Parliaments are vital in making sure laws are properly implemented and effective in achieving UHC. Their role in monitoring and accountability is further discussed in Section 5 on oversight and accountability.

Because we live in a changing environment with emerging needs, such as the recent COVID-19 pandemic, parliaments should regularly reassess and amend their legal frameworks to ensure they continue supporting the achievement of UHC.

## 3.3 Suggested actions for MPs

- Explore past UHC efforts and determine why they were unsuccessful and whether they could be revived.
- Identify any legislative gaps that could impede UHC by examining existing laws that contain references to UHC or to key UHC-related issues.
- Advocate for relevant legislation to be accompanied by an assessment (which includes impact, gender and human rights) of how the law will likely affect the implementation of UHC.
- Prioritize legislation that clearly stipulates that high-priority health interventions must be made available to everyone.
- Supplement research and analysis by organizing parliamentary committees and hearings so that potential partners – civil society organizations (CSOs), academia, WHO, other United Nations agencies and other outside experts on UHC – can share their knowledge and experience of real-life UHC implementation issues.

- Work with vulnerable and marginalized groups to include them in the legislative process and to ensure they are provided for under the law.<sup>30</sup>
- Consider the experience of other countries with similar health and socioeconomic structures and GDP that have been successful in moving towards UHC, while consulting with WHO, other United Nations agencies, academia and other UHC experts globally.

## 3.4 Additional resources

### How laws contribute to the achievement of UHC

- WHO, “UHC law infographic,” 18 December 2019: [www.who.int/publications/m/item/uhc-law-infographic](http://www.who.int/publications/m/item/uhc-law-infographic)

### Prioritizing, enacting, monitoring and evaluating UHC laws

- WHO, *Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage* (Geneva: WHO, 2014): [apps.who.int/iris/handle/10665/112671](http://apps.who.int/iris/handle/10665/112671)
- WHO, *Anchoring universal health coverage in the right to health: What difference would it make? Policy brief* (Geneva: WHO, 2015): [apps.who.int/iris/handle/10665/199548](http://apps.who.int/iris/handle/10665/199548)
- WHO, *Strategizing national health in the 21st century: A handbook* (Geneva: WHO, 2016): [apps.who.int/iris/handle/10665/250221](http://apps.who.int/iris/handle/10665/250221) (see Chapter 10: Law, regulation and strategizing for health)
- WHO, *UHC law in practice: Legal access rights to health care: Introduction* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331623](http://apps.who.int/iris/handle/10665/331623)
  - WHO, *UHC law in practice: Legal access rights to health care: Country profile: Germany* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331622](http://apps.who.int/iris/handle/10665/331622)
  - WHO, *UHC law in practice: Legal access rights to health care: Country profile: Japan* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331624](http://apps.who.int/iris/handle/10665/331624)
  - WHO, *UHC law in practice: Legal access rights to health care: Country profile: Kenya* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331625](http://apps.who.int/iris/handle/10665/331625)
  - WHO, *UHC law in practice: Legal access rights to health care: Country profile: Thailand* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/331626](http://apps.who.int/iris/handle/10665/331626)
- WHO, *Voice, agency, empowerment – handbook on social participation for universal health coverage* (Geneva: WHO, 2021): [apps.who.int/iris/handle/10665/342704](http://apps.who.int/iris/handle/10665/342704)

<sup>30</sup> WHO, *Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage* (2014), 28 and 37–38.

## Right to health

- United Nations Committee on Economic, Social and Cultural Rights (CESCR),<sup>31</sup> *General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, E/C.12/2000/4, 11 August 2000: [daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=E/C.12/2000/4&Lang=E](https://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=E/C.12/2000/4&Lang=E)
- CESCR, *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, E/C.12/GC/22, 2 May 2016: [daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=E/C.12/GC/22&Lang=E](https://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=E/C.12/GC/22&Lang=E)

## Legal assessment

- WHO is currently developing a comprehensive legal assessment tool to help guide countries through this exercise, with indicators organized around four areas:
  - UHC Policy Performance: includes indicators to measure the country's legal capacity to deliver on the three objectives of UHC: universal access to health care, financial risk protection and quality of health care
  - UHC Foundations: includes indicators to measure whether there is a functioning legal environment in which laws directly relevant to UHC can be developed, implemented and enforced (e.g. rule of law, transparency, anti-corruption and accountability, access to justice)
  - UHC Partnerships: includes indicators to measure the extent and modalities of private-sector engagement for UHC
  - UHC Policy Development, Implementation and Enforcement: includes indicators to measure the quality of the processes used to develop, implement and evaluate laws and the actual impact of laws on UHC achievement (not limited to the quality of laws "on paper")

These indicators will be updated as new evidence emerges.

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<sup>31</sup> The CESCR is the treaty body charged with monitoring domestic implementation of the International Covenant on Economic, Social and Cultural Rights, including the right to health, and with periodically reviewing progress in its Concluding Observations at the end of a country review.

## 4. Health financing for universal health coverage



A doctor performs health checks on nomads in Türkiye. © Omer Yasin Ergin/Anadolu Agency via AFP

### 4.1 Why health financing policies are important for universal health coverage

Financing health services is essential to achieving UHC. Health financing policies directly affect both aspects of UHC – service coverage and financial protection – because they influence whether quality health services exist and whether people can afford to use them when they need them.<sup>32</sup>

<sup>32</sup> WHO, *The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO, 2010): [www.who.int/publications/i/item/9789241564021](http://www.who.int/publications/i/item/9789241564021).

## Key messages on health financing for UHC

- Health financing policies directly affect how well countries perform on financial protection and service coverage.
- Financial protection is a key component of UHC, and is achieved when:
  - i. there are no financial barriers to access, and
  - ii. direct payments required to obtain health services are not a source of financial hardship.
- In 2017, almost 1 billion people incurred catastrophic OOP payments and the total number of people experiencing financial hardship ranged from 1.4 billion to 1.9 billion.
- MPs have key roles to play in health financing for UHC (on financial protection and service coverage), by supporting policies which:
  - enhance revenue-raising for UHC (by prioritizing public/compulsory sources to finance health, i.e. “more money for health”)
  - improve financial protection in health (by prioritizing the needs of the most vulnerable groups)
  - hold government agencies to account for the efficient use of revenues in health, i.e. “more health for the money”.
- Countries at all income levels can make important progress towards UHC by raising more public funds for health, by addressing fragmentation in how these are pooled so that there is greater potential to distribute them in relation to need, and by spending these funds more efficiently.

Financial protection lies at the core of UHC. It represents one of the final coverage goals of the health system, since it enables people to access the services they need without having to change their living standards or become impoverished because of OOP payments.

*The IPU resolution, [Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health](#), adopted by the 141st IPU Assembly, calls on parliaments to “ensure financial protection in order to reduce out-of-pocket payments for health services and to eliminate financial barriers that prevent access to health”.*

OOP payments can have a catastrophic financial impact on individuals and families, and deepen social inequalities. The expectation of a need to pay OOP also deters some people from using health-care services altogether. There are alternatives to OOP expenditures, such as prepayment and pooling of resources for health, which can help to protect the most vulnerable and marginalized groups. These approaches are further discussed in Section 4.2.2.

Accelerated efforts are needed in the area of health financing, specifically to improve financial protection. In fact, although coverage of essential health services is improving globally, financial protection is worsening. In 2019, coverage of essential health services stood at 68%. Yet from 2000 to 2017, the share of the world's population experiencing



catastrophic health spending increased, and by 2017, almost 1 billion people incurred catastrophic health spending and the total number of people experiencing financial hardship ranged from 1.4 billion to 1.9 billion, depending on the poverty line used to identify impoverishing health spending.<sup>33</sup>

While there is a lack of data on the number of people facing financial barriers to access (i.e. people not accessing care because of the cost), the overall share in this category is likely to be significant – especially in low-income countries (LICs), where OOP payments are the primary source of funding for health. Further details on monitoring progress on UHC can be found in Section 5 of this handbook, which deals with oversight and accountability.

A similar lack of data currently precludes a detailed and comprehensive assessment of the impact of COVID-19 on progress towards financial protection. However, the combined macroeconomic, fiscal and health impacts of the pandemic strongly suggest that financial protection has significantly worsened globally. It is reasonable to assume that growing poverty has increasingly prevented those who need it from seeking care, with a higher proportion of the population spending large amounts on health care yet facing worsening impoverishment.

## Key terms

**Financial protection** is achieved when:

- i. out-of-pocket expenditures required to obtain health services are not a source of financial hardship, and
- ii. there are no financial barriers to access.

**Out-of-pocket (OOP) expenditure** is defined as any spending incurred by a household when any member uses a health good or service, provided by any type of provider, for any type of disease, illness or health condition, in any type of setting.

**Financial hardship** is tracked with two indicators:

- i. The first measures the incidence of catastrophic health spending, which is defined as the proportion of the population with large shares of a household budget dedicated to health (SDG 3.8.2 – see Section 5.1 of this handbook).
- ii. The second measures the incidence of impoverishing health spending, recognizing the fact that, for the poor and the near poor, even small OOP payments can be a source of financial hardship.

**Financial barriers** occur when people cannot access the services they need because of the associated direct and indirect costs. Direct costs include OOP in various forms (e.g. user charges, purchase of purely private health services and medicines/supplies, and informal payments for publicly guaranteed services, either to staff or for inputs). Indirect costs, meanwhile, include transport costs, and the opportunity cost of seeking care, including the potential loss of income during the time spent seeking care.

<sup>33</sup> WHO and the International Bank for Reconstruction and Development/The World Bank, *Global monitoring report on financial protection in health 2021* (Geneva: WHO and the International Bank for Reconstruction and Development/The World Bank, 2021): [www.who.int/publications/i/item/9789240040953](http://www.who.int/publications/i/item/9789240040953).



## 4.2 How parliaments can promote health financing policies for universal health coverage

### 4.2.1 Enhance revenue-raising for universal health coverage (“more money for health”)

#### Questions for parliamentarians to consider

- Is the health system funded predominantly from public revenues?
- How much is coming directly out of people’s own pockets? Are any payments required from patients open-ended, or are there explicit limits on patient financial liability for services covered?
- Is the money allocated to the health system predictable over the medium term and does it flow in a stable, reliable manner, facilitating both medium-term investment planning and regular execution of salary and other contractual payments?
- How is the budget formulated and approved in the health sector? Does it allow sufficient flexibility to enable it to be matched with needs?
- Are approved budgets actually being released and spent effectively, on time and in full in the health sector? Are service providers able to receive, manage and account for funds?
- How is the budget approved and released in the health-care sector? Does it allow sufficient flexibility to achieve results and match revenues with health-care needs?
- How robust is the reporting system for spending in the health sector, and does it ensure transparency and accountability towards results?

Progress towards UHC can only be accelerated and sustained if sufficient resources are raised, such that essential health-care services are accessible and of appropriate quality, and that people can use them without suffering financial hardship. Smart, targeted policies are needed to ensure access and financial protection for those most in need. Many patients may still incur indirect costs, e.g. for travel to health facilities, and domestic public policies need to address or compensate for such demand-side barriers to ensure equitable progress towards UHC.

At present, there is a significant gap – ranging from US\$ 20 billion to US\$ 54 billion per year<sup>34</sup> – between countries’ current health expenditures and the estimated future funding requirements to achieve the SDG targets for UHC by 2030. This gap can be reduced by raising the necessary funds from a variety of domestic and global sources and directing these to the nationally defined set of benefits.

- **Compulsory sources** require some, or all, people to pay for health-care services, whether they use them or not. These are prepaid and, essentially, the same as taxes.

34 Karin Stenberg and others, “Financing transformative health systems towards achievement of the health Sustainable Development Goals: A model for projected resource needs in 67 low-income and middle-income countries”, *The Lancet Global Health*, 5/9 (2017), E875–E887: [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30263-2/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext).

- **Voluntary sources** are typically private, such as non-mandatory insurance and OOP payments at the time of use.<sup>35</sup> Some funds can be raised in this way, but voluntary contributions have a limited ability to cover those too poor to pay. Aside from the lack of equity associated with these sources, no country has succeeded in achieving UHC by using voluntary insurance as its primary financing mechanism.<sup>36</sup> While the difficulty of mobilizing substantial funding through voluntary health insurance varies, it has proven extremely difficult to actually direct resources raised through this mechanism to the priority service package of a country. Most countries have not been able to do so, and the result is that the spending generated through this mechanism actually widens the UHC funding gap by exacerbating inequalities in service use and protection from financial hardship, as well as adding to system inefficiencies.

It is therefore now widely accepted that compulsory sources should be prioritized, since they are crucial to establishing a funding base that is effective, efficient and equitable.<sup>37</sup>

- **Official development assistance (ODA)** remains important for LICs and lower-middle-income countries (LMICs). Between 2000 and 2015, as an average across the 31 lowest-income countries, more than 30% of health spending came from ODA.<sup>38</sup> While external aid can be used in the short term to address funding shortfalls, especially in LMICs, it lacks the longer-term ability or sustainability to achieve UHC in all countries. Still, it is important to maintain momentum for ODA, particularly for the poorest countries.

The IPU resolution, *Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health*, adopted by the 141st IPU Assembly, calls on “parliaments in developed countries providing official development assistance to work towards increasing their country’s assistance for health ... [and] ... to contribute at least 0.7 percent of their GDI [Gross Domestic Income] to official development assistance.”

## Sources of financing for UHC<sup>39</sup>

- Direct taxes levied on income, earnings or profits, and paid by households and companies directly to the government or another public agency. Examples include income tax, payroll tax (including mandatory social health insurance contributions), and taxes on corporate income or profits.
- Indirect taxes paid on what a household or company spends, not on what they earn, and paid to the government indirectly via a third party (such as a retailer or

35 Matthew Jowett and Joseph Kutzin, *Raising revenues for health in support of UHC: Strategic issues for policy makers* (Geneva: WHO, 2015): [apps.who.int/iris/handle/10665/192280](https://apps.who.int/iris/handle/10665/192280); WHO, *Arguing for universal health coverage* (Geneva: WHO, 2013): [apps.who.int/iris/handle/10665/204355](https://apps.who.int/iris/handle/10665/204355).

36 WHO, *Arguing for universal health coverage* (2013), 28.

37 WHO, *Arguing for universal health coverage* (2013), 30–31.

38 WHO, *New Perspectives on Global Health Spending for Universal Health Coverage*, (Geneva: WHO, 2018): [www.who.int/publications/i/item/WHO-HIS-HGF-HFWWorkingPaper-18.2](https://www.who.int/publications/i/item/WHO-HIS-HGF-HFWWorkingPaper-18.2).

39 Sources: Matthew Jowett and Joseph Kutzin, *Raising revenues for health in support of UHC: Strategic issues for policy makers* (Geneva: WHO, 2015): [apps.who.int/iris/handle/10665/192280](https://apps.who.int/iris/handle/10665/192280); WHO and IPU, *Saving lives and mobilizing revenue: A parliamentary action guide to health taxes* (Geneva: WHO and IPU, 2022).

supplier). Common examples include value-added tax, sales taxes, excise taxes on the consumption of products such as alcohol and tobacco, and import duties.

- Health taxes are a specific type of excise tax that are designed to reduce the consumption of products with a negative public-health impact, such as tobacco, alcohol and sugar-sweetened beverages. These taxes not only discourage consumption of products that cause non-communicable diseases, but can also generate much-needed revenue for governments, providing a societal benefit even if these resources are not earmarked for health.
- Non-tax revenues, such as those from State-owned companies, including “natural resource revenues” common in many mineral-rich countries (e.g. revenues from oil and gas).
- Financing from external (foreign) sources, which is typically categorized as public when these funds flow through recipient governments.

In general, countries that spend a greater share of their GDP on health have better financing for UHC and ensure greater financial protection. Country-specific spending targets can be a useful way to encourage more investment in health. The 2019 IPU resolution specifically calls on governments to commit the equivalent of 5% of their GDP to the realization of UHC.

There is no magic figure, however: progress is possible at any given level of funding if the money is spent more efficiently. Conversely, adequate funding will not lead to progress towards UHC if the money is spent poorly.

To ensure the efficient use of money for health (“more health for the money”), countries should pay particular attention to their public financial management (PFM) rules, which govern how budgets are formed, disbursed and accounted for.<sup>40</sup> They should ensure that these rules are designed to support UHC and health-security goals, e.g. by allowing flexible budgeting approaches to enable in-year reallocations to match with changing needs.<sup>41</sup>

### **Suggested actions for MPs on revenue-raising**

- Prioritize health in government budget allocations (while approving various budgets).
- Advocate with the government for public/compulsory forms of revenue collection as the primary funding source for UHC.
- Support the implementation of programme-based budgeting in the health sector to enable flexibility and accountability in spending.

40 “This is centrally important to universal health coverage (UHC) to make sure increases in public spending translate into expanded health coverage.” [www.who.int/teams/health-systems-governance-and-financing/health-financing/policy/public-financial-management](http://www.who.int/teams/health-systems-governance-and-financing/health-financing/policy/public-financial-management).

41 [How to make budgets work for health? \(who.int\)](http://www.who.int/publications/m/item/how-to-make-budgets-work-for-health).

- Ensure sufficient financial resources are mobilized to purchase essential health services strategically<sup>42</sup> (especially PHC services).

## 4.2.2 Improve financial protection in health

### Questions for parliamentarians to consider

- What is the current situation in terms of guaranteed, legally enshrined benefits for the population?
- Is there a set of universal benefits or health-related guarantees for the population?
- Are benefits distributed according to the health needs of the population?
- Is access to health services heavily dependent on people's ability to pay?

Financial barriers deter people from using the health services they need. Simply knowing they will have to pay OOP for a health service is, in itself, a barrier for the poorest and those in precarious economic conditions, who struggle daily to meet their basic needs.

To remove these financial barriers for the most vulnerable, OOP payments should be eliminated for the poorest, and social protection assistance should be expanded and deepened for the poor, the near poor, the elderly and other groups facing economic insecurity in the country. More broadly, to avoid financial hardship for the general population, OOP payments should not absorb a large share of people's capacity to pay.

Financing strategies play a key role in determining the extent to which providers and the health system rely on OOP payments, prepayment and pooling mechanisms:

- Prepayment reduces (or eliminates) direct payments at the point of use (facility level).
- Pooling of funds (combining prepaid funds into a single fund) is critical to facilitate risk sharing across the population, e.g. between the healthy and the sick, and between richer and poorer populations, in turn helping to achieve the goal of equity.

### Country examples of mechanisms used to reduce OOP spending<sup>43</sup>

- ✓ Fee waivers or vouchers for the poor for services delivered at public health-care facilities (e.g. Bangladesh and Ethiopia)
- ✓ Contributory insurance programmes with public subsidies to cover premiums for the poor and other priority groups (e.g. Ghana, Indonesia, Peru and Vietnam)
- ✓ Non-contributory entitlement, with a defined set of services covered for people on the basis of citizenship, residence, being below the poverty line, or some other

<sup>42</sup> "Strategic purchasing means aligning funding and incentives with legal entitlements to health services and must therefore be guided by detailed information on the performance of providers and the health needs of the population served."  
WHO, *Purchasing health services for universal health coverage: how to make it more strategic?* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/311387](https://apps.who.int/iris/handle/10665/311387).

<sup>43</sup> Akiko Maeda and others, *Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies* (Washington, DC: World Bank, 2014): [elibrary.worldbank.org/doi/abs/10.1596/978-1-4648-0297-3](https://elibrary.worldbank.org/doi/abs/10.1596/978-1-4648-0297-3).

factor unrelated to a specific contribution made for health care (e.g. Thailand's Universal Health Coverage Scheme)

Not all services will cover everyone, however, and countries will have to adopt a clear package of benefits, indicating which services are covered, for whom and to what extent.<sup>44</sup> This package should be clearly defined and should consider available resources, the health needs of the population and the ability to pay of various user groups. The conditions under which people can benefit from this package – such as contribution to a mandatory health insurance scheme, or revenue level – should also be determined and clearly communicated to all population groups. It is especially important to ensure that financing policies offer financial protection to the most vulnerable groups.

### **Suggested actions for MPs on financial protection**

- Support legislation that clearly requires services to be funded predominantly through prepayment mechanisms and, when needed, by pooling compulsory funds.
- Ensure that the annual budget allows for general government revenues to be used to subsidize the contribution payments of vulnerable and marginalized people to applicable health insurance funds where relevant.
- Advocate for regular surveys comparing how much people spend OOP on health care with their household's ability to pay, and advocate for the tracking of financial barriers to accessing care.

### **4.2.3 Oversee the use of universal health coverage funds (“more health for the money”)**

#### **Questions for parliamentarians to consider**

- How are purchasing decisions made?
- Is the money allocated to UHC actually spent, and is it spent adequately?
- Does the money spent lead to progress towards UHC (in terms of increased coverage, quality services and financial protection)?

The inefficient use of limited resources can greatly hamper progress towards UHC. Estimates suggest that on average, between 20% and 40% of health funding is wasted across all countries.<sup>45</sup>

As well as adopting a more strategic approach to health-service purchasing, there are various steps that can be taken to optimize available resources:

- Ensuring health services are aligned with the health needs of the population

<sup>44</sup> WHO, *Benefit design: The perspective from health financing policy* (Geneva: WHO, 2022): [www.who.int/publications/i/item/9789240045088](http://www.who.int/publications/i/item/9789240045088).

<sup>45</sup> World Bank, *High-Performance Health Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century* (Washington, DC: World Bank, 2014): [documents1.worldbank.org/curated/en/641451561043585615/pdf/Driving-Sustainable-Inclusive-Growth-in-the-21st-Century.pdf](https://documents1.worldbank.org/curated/en/641451561043585615/pdf/Driving-Sustainable-Inclusive-Growth-in-the-21st-Century.pdf).

- Strengthening performance accountability (see Section 5 for further details)
- Reducing administrative costs, for example by giving public providers of health-care services a degree of autonomy in managing their financial resources with clear accountability (while ensuring they continue to report and are held to account)

### **Suggested actions for MPs on spending oversight**

- Use parliamentary committees or hearings to periodically review how funds are being used and whether they are promoting access to essential services, with financial protection for the entire population.
- Support legislation and regulations that align health-care spending with priority health-care services and population groups.
- Ensure that public financial management regulations align with the requirements of the health-care sector and with health-care spending needs at the provider level.
- Support legislation and regulations that govern the standards and practices of public financial management in the health sector, including periodic auditing and the release of audit recommendations to the public.
- Support and promote the introduction of programme-based budgeting in the health-care sector to ensure flexibility and accountability in spending.

## **4.3 Additional resources**

### **Overview and cross-cutting resources**

- WHO, *The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO, 2010): [www.who.int/publications/i/item/9789241564021](http://www.who.int/publications/i/item/9789241564021)
- WHO, *Financing for Universal Health Coverage: Dos and Don'ts* (Geneva: WHO, 2019): [p4h.world/en/node/8598](http://p4h.world/en/node/8598)

### **Health financing system assessment**

- WHO, *The health financing progress matrix: Country assessment guide* (Geneva: WHO, 2020): [www.who.int/publications/i/item/9789240017801](http://www.who.int/publications/i/item/9789240017801)

### **Revenue-raising**

- Matthew Jowett and Joseph Kutzin, *Raising revenues for health in support of UHC: Strategic issues for policy makers* (Geneva: WHO, 2015): [apps.who.int/iris/handle/10665/192280](http://apps.who.int/iris/handle/10665/192280)

- Matthew Jowett and others, *Spending targets for health: No magic number* (Geneva: WHO, 2016): [apps.who.int/iris/handle/10665/250048](https://apps.who.int/iris/handle/10665/250048)

## Pooling funds

- Inke Mathauer and others, “Pooling financial resources for universal health coverage: options for reform”, *Bulletin of the World Health Organization*, 98 (2020), 132–139: [www.who.int/publications/i/item/pooling-financial-resources-for-universal-health-coverage-options-for-reform](https://www.who.int/publications/i/item/pooling-financial-resources-for-universal-health-coverage-options-for-reform)

## Purchasing

- Inke Mathauer and others, *Purchasing health services for universal health coverage: How to make it more strategic?* (Geneva: WHO, 2019): [apps.who.int/iris/handle/10665/311387](https://apps.who.int/iris/handle/10665/311387)

## Benefits

- WHO, *Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage* (Geneva: WHO, 2014): [apps.who.int/iris/handle/10665/112671](https://apps.who.int/iris/handle/10665/112671)
- WHO, *Benefit design: The perspective from health financing policy* (Geneva: WHO, 2022): [www.who.int/publications/i/item/9789240045088](https://www.who.int/publications/i/item/9789240045088)

## Public financial management and health financing

- Cheryl Cashin and others, *Aligning public financial management and health financing: Sustaining progress toward universal health coverage* (Geneva: WHO, 2017): [apps.who.int/iris/handle/10665/254680](https://apps.who.int/iris/handle/10665/254680)
- UHC2030, *Public financial management for universal health coverage: Why and how it matters* (Geneva: UHC2030, 2020): [www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About\\_UHC2030/UHC2030\\_Working\\_Groups/2017\\_Financial\\_Management\\_Working\\_Group/UHC\\_PFM\\_policy\\_note\\_02XII20\\_online.pdf](https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/UHC2030_Working_Groups/2017_Financial_Management_Working_Group/UHC_PFM_policy_note_02XII20_online.pdf)
- Hélène Barroy and others (eds), *How to make budgets work for health? A practical guide to designing, managing and monitoring programme budgets in the health sector* (Geneva: WHO, 2022): [www.who.int/publications/i/item/9789240049666](https://www.who.int/publications/i/item/9789240049666)

## Monitoring progress

- WHO and the International Bank for Reconstruction and Development/The World Bank, *Global monitoring report on financial protection in health 2021* (Geneva: WHO and the International Bank for Reconstruction and Development/The World Bank, 2021): [www.who.int/publications/i/item/9789240040953](https://www.who.int/publications/i/item/9789240040953)



## 5. Universal health coverage oversight and accountability



Health worker facilitates a women's conversation on family planning. © Maheder Haileselassie Tadesse/ Getty Images

### 5.1 Why parliaments should ensure that progress towards universal health coverage is tracked

Parliaments have a key role to play in holding governments to account for delivering on their commitments for UHC. As part of this role, they must ensure that there are mechanisms in place to track progress towards UHC.

The IPU resolution, *Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health*, adopted by the 141st IPU Assembly, calls on parliaments



## Key messages on UHC oversight and accountability

- Parliaments should use all their generic parliamentary functions to hold their respective national governments to account for the effective implementation of their UHC commitments.
- Two indicators are needed to track progress towards this goal: one for service coverage and another one for financial hardship. They should be jointly monitored and disaggregated, when possible, in order to understand who is being left behind, where and why.
- Parliamentarians can exercise oversight in relation to three types of accountability:
  - Financial accountability: ensuring that public resources or authority are not being abused or misused, with a particular focus on containing fraud and corruption (corruption in the health sector has a disproportionate effect on vulnerable and marginalized populations and can be a major barrier to achieving UHC)
  - Performance accountability: demonstrating and accounting for performance against previously agreed targets, with a focus on services, outputs, and the results of public and private agencies and programmes
  - Political/democratic accountability: using relevant institutions, procedures and mechanisms to ensure that the government delivers on its electoral promises, fulfils the public trust, aggregates and represents the interests of citizens, and responds to ongoing and emerging societal needs and concerns.

to “use all generic parliamentary functions to hold their respective national governments accountable for the effective implementation of their UHC commitments.”

Progress on UHC can be tracked using at least two indicators, as detailed below:

- Coverage of essential services (SDG indicator 3.8.1): A total of 14 indicators are aggregated to determine the average level of service coverage in a country. These indicators are organized into the following four categories:
  - Reproductive, maternal, newborn and child health
  - Infectious diseases
  - Non-communicable diseases
  - Service capacity and access
- Financial hardship (SDG indicator 3.8.2): This is a key consequence of a lack of financial protection and is measured by an indicator of catastrophic health spending, which is defined as the proportion of the population with household expenditures on health greater than 10% or greater than 25% (as a share of total household expenditure or income).<sup>46</sup>

At the very least, assessing progress towards UHC involves monitoring SDG indicators 3.8.1 and 3.8.2 jointly to ensure that progress on service coverage is not achieved at great

<sup>46</sup> WHO and the International Bank for Reconstruction and Development/The World Bank, *Global monitoring report on financial protection in health 2021* (2021).

cost to individuals and families (i.e. it does not cause increasing financial hardship), but is instead concurrent with a reduction in financial hardship.

Other, global indicators can also be used to track countries' progress towards UHC. One example is the existence of UHC laws, which indicates progress in amending a country's legal and institutional framework to support UHC achievement (see Section 3 for further information about UHC laws).<sup>47</sup> In addition, most countries already have an operational monitoring system that could be used to track progress on these indicators.

Unfortunately, prior to the COVID-19 pandemic, the world was off-track to achieve UHC, with improvements in service coverage delivered at the cost of significant increases in financial hardship. The latest available data shows that service coverage has been improving, with the index increasing from 64 in 2015 to 67 in 2019. However, the proportion of the population with catastrophic health spending also increased from 9.4% in 2000 to 12.7% in 2015, and to 13.2% in 2017. In addition, in 2017, 6.7% of the global population was pushed or further pushed into extreme poverty because of OOP payments for health.

This divergence in trends between SDG indicators 3.8.1 and 3.8.2 occurred across all regions between 2000 and 2017 (the period for which data is available for both indicators), although actual levels and trajectories varied substantially. Slow progress in stopping the rise in catastrophic health spending hinders countries' ability to achieve UHC.

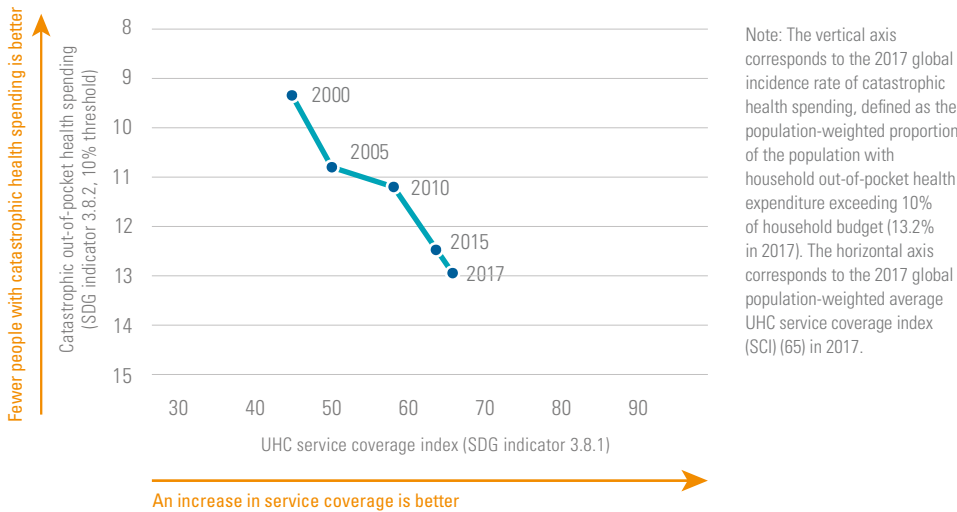
All countries need to track progress towards UHC, using the most relevant metrics to develop appropriate policy responses in addition to the SDG indicators mentioned above. Indeed, no single metric or indicator is exhaustive. For instance, SDG indicator 3.8.2 does not fully capture people facing financial barriers to accessing care, yet these emerge in the absence of adequate financial protection mechanisms. SDG 3.8.1, meanwhile, cannot be used to track inequalities, although some of its components can. Where possible, data gathered under these indicators should be disaggregated by geographical area and population group, in order to understand who is being left behind, where and why.

Now more than ever, parliamentarians should ensure that tracking of progress towards UHC is actually taking place – by advocating for adequate and comprehensive monitoring frameworks, with a focus on LNOB, and by making sure that these frameworks guide policy discussions.

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47 WHO, "Countries that have passed legislation on Universal Health Coverage (UHC)": [www.who.int/data/gho/data/indicators/indicator-details/GHO/countries-that-have-passed-legislation-on-universal-health-coverage-\(uhc\)](http://www.who.int/data/gho/data/indicators/indicator-details/GHO/countries-that-have-passed-legislation-on-universal-health-coverage-(uhc)).

Figure 5.1 Progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2, 10% threshold), 2000–2017



Source: SDG indicator 3.8.1: WHO global service coverage database, 2021 update; SDG indicator 3.8.2: WHO and World Bank global financial protection database, 2021 update.

Suggested actions for MPs on monitoring UHC progress

- Advocate for adequate and comprehensive monitoring frameworks to track progress towards UHC, with a focus on LNOB.
- Periodically request data showing progress on SDG 3.8, including using indicators 3.8.1 and 3.8.2 and other metrics included in countries’ monitoring systems.
- Encourage discussions with relevant CSOs and other stakeholders, including organizations representing vulnerable and marginalized groups, to supplement data collected for measuring progress on UHC.
- Ask relevant ministries why there are inequalities in service coverage within the country and what actions will be taken to address them, by whom and when.

Key resources

- A list of subindicators within the four categories for SDG indicator 3.8.1 can be found in the following WHO metadata document: [unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf](https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf)
- For more technical information about SDG indicator 3.8.2, see: [unstats.un.org/sdgs/metadata/files/Metadata-03-08-02.pdf](https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-02.pdf)
- The most up-to-date data on each indicator and subindicator by country can be found at: [www.who.int/data/gho/data/major-themes/universal-health-coverage-major](https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major)

# 5.2 How parliament can provide universal health coverage oversight and accountability

Parliamentary oversight is how parliament holds the government to account on behalf of the people. This includes, for example, mitigating corruption risk, promoting UHC objectives, checking the quality and acceptability of health-care provision, improving the communication of health-related decisions, and building trust and buy-in for public-health decisions and measures. This oversight role takes place through a rigorous, constructive and evidence-based process.

Table 5.1 outlines the three broad types of oversight and accountability mechanisms MPs can use in promoting health-care services in general and UHC in particular.

Table 5.1 Health-care service delivery issues and the need for financial, performance and political/democratic accountability<sup>48</sup>

Type of accountability	Illustrative health service delivery issues	Dominant purposes of accountability
Financial	<ul style="list-style-type: none"> <li>• Cost accounting/budgeting for:               <ul style="list-style-type: none"> <li>– personnel</li> <li>– operations</li> <li>– pharmaceuticals/supplies</li> <li>– definition of basic benefits packages</li> <li>– contract oversight</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Dominant purposes: control and assurance</li> <li>• Focus is on:               <ul style="list-style-type: none"> <li>– containment of waste, fraud, misuse and corruption</li> <li>– compliance with prescribed input and procedural standards</li> <li>– cost control</li> <li>– resource efficiency measures</li> </ul> </li> </ul>
Performance	<ul style="list-style-type: none"> <li>• Patient involvement in medical decision-making</li> <li>• Quality of care</li> <li>• Service provider behaviour</li> <li>• Regulation by professional bodies</li> <li>• Contracting out</li> </ul>	<ul style="list-style-type: none"> <li>• Primary purposes: assurance and improvement/learning</li> <li>• Assurance relates to:               <ul style="list-style-type: none"> <li>– adherence to the legal, regulatory and policy framework</li> <li>– professional service delivery procedures, norms and values</li> <li>– quality of care standards and audits</li> </ul> </li> <li>• Improvement/learning focuses on:               <ul style="list-style-type: none"> <li>– benchmarking</li> <li>– standard-setting</li> <li>– quality management</li> <li>– operations research</li> <li>– monitoring and evaluation</li> </ul> </li> </ul>

48 Based on: Derick Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies* (Bethesda, MD: Partners for Health Reform/plus, 2003).

## Political/ democratic

- Service delivery equity/fairness
- Transparency
- Responsiveness to citizens
- Service user trust
- Dispute resolution
- Primary purposes: control and assurance
- Control relates to:
  - citizen/voter satisfaction
  - use of taxpayer funds
  - addressing market failure
  - distribution of services (disadvantaged populations)
- Assurance focuses on:
  - principal-agent dynamics for oversight
  - availability and dissemination of relevant information
  - adherence to quality standards
  - professional norms and societal values

The ministry of health plays a key role in UHC oversight, but holding it to account is not a simple matter, for several reasons:

- It is easier to monitor service delivery than a government ministry, whose outputs are policy-related and, therefore, less tangible.
- The process is even more complex when responsibility is shared, such as when activities cut across multiple government agencies or involve public-private partnerships.
- Health-care service providers often act as gatekeepers and control the information needed for monitoring and accountability, determining who receives what care and whether this aligns with official procedures.
- There is a lack of willingness to improve accountability by learning from past mistakes.<sup>49</sup>

Despite these challenges, the ministry of health and the government in power must be held to account. MPs can play a crucial role in this process by requiring them to:

- provide answers to specific questions
- give an account of ministry of health resource utilization, activities and achievements
- explain administrative decisions
- investigate and remedy deficiencies and problems

### Key resource

- **The WHO policy brief, *Anchoring universal health coverage in the right to health: What difference would it make?***, includes a list of key questions for MPs to ask about the current status of UHC in their country. The list can be found on pp.19–20: [apps.who.int/iris/handle/10665/199548](https://apps.who.int/iris/handle/10665/199548)

MPs can apply pressure to force a resignation, if deemed appropriate.

<sup>49</sup> Derick Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies*, 23 (Bethesda, MD: Partners for Health Reformplus, 2003).

Permanent health and finance committees are of particular importance in examining complex UHC issues and providing external stakeholders – the public, CSOs, experts, academics and the private sector – with opportunities to share their views on UHC for the public record.

## 5.2.1 Parliaments and financial accountability

**Financial accountability** refers to controlling the misuse or abuse of public resources or authority by containing fraud, misuse and corruption (such as bribery, embezzlement, political influence, nepotism and informal payments).<sup>50,51</sup>

No health system is immune to abuse and fraud, and all four main health financing functions – revenue-raising, pooling (viewed within the wider context of public-sector management), purchasing and benefit design – may experience misuse of power.<sup>52</sup>

In the conclusion to its *Global Corruption Report 2006*, Transparency International made the following observation:

Health systems are prone to corruption because uncertainty, asymmetric information and large numbers of actors create systematic opportunities for corruption. These three factors combine to divide information among different actors – regulators, payers, providers, patients and suppliers – in ways that make the system vulnerable to corruption and that hinder transparency and accountability.<sup>53</sup>

Corruption in the health-care sector has a disproportionate effect on vulnerable and marginalized populations and can be a major barrier to achieving UHC. For this reason, effectively addressing corruption is a critical role for MPs. But they must first acknowledge that it occurs in their country. They must then help to build the necessary institutional capacity and ensure that measures are in place to prevent corruption. This can be done through regulation, oversight, monitoring and reporting requirements, as part of wider reforms towards UHC.<sup>54</sup> It is also important to ensure that oversight mechanisms differentiate between waste and corruption.

## Country examples of good practice on financial accountability

**Chile:** Oversight of the Central Nacional de Abastecimiento (the national pharmaceutical supply centre, which operates as a central medical store) has led to a series of reforms, including the transition to an electronic bidding system and the active use of the internet

50 Derick Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies*, 23 (Bethesda, MD: Partners for Health Reformplus, 2003).

51 Taryn Vian, "Anti-corruption, transparency and accountability in health: concepts, frameworks, and approaches", *Global Health Action*, 13:sup1 (2020): [www.tandfonline.com/doi/full/10.1080/16549716.2019.1694744](http://www.tandfonline.com/doi/full/10.1080/16549716.2019.1694744).

52 WHO, *Potential corruption risks in health financing arrangements: Report of a rapid review of the literature* (Geneva: WHO, 2020): [apps.who.int/iris/rest/bitstreams/1275307/retrieve](https://apps.who.int/iris/rest/bitstreams/1275307/retrieve).

53 William D. Savedoff and Karen Hussmann, "Why are health systems prone to corruption?", in Jana Kotalik and Diana Rodriguez D (eds), *Global Corruption Report 2006*. (London: Transparency International, 2006): [images.transparencycdn.org/images/2006\\_GCR\\_HealthSector\\_EN.pdf](https://images.transparencycdn.org/images/2006_GCR_HealthSector_EN.pdf).

54 Theadora Koller and others, "Promoting anti-corruption, transparency and accountability to achieve universal health coverage", *Global Health Action*, 13:sup1 (2020): [www.tandfonline.com/doi/full/10.1080/16549716.2019.1700660](http://www.tandfonline.com/doi/full/10.1080/16549716.2019.1700660).

to disseminate information about the procurement process. This increased transparency has resulted in price competition and served as an anti-corruption tool. In 2013, these efforts had reportedly increased transparency in 180 hospitals.<sup>55</sup>

**Pakistan:** The Family Health Project has set up village health committees in the province of Sindh. In several villages, the committees have created “accountability/vigilance committees” to oversee the finances and operations of rural health-care facilities and to report on problems.<sup>56</sup>

**Peru:** Medicines Transparency Alliance has created an observatory with government-mandated reporting of medicine prices.<sup>57</sup>

**United States:** Coordinated interventions by the Department of Health and Human Services, the Department of Justice and other agencies have helped to recover billions of dollars and resulted in hundreds of new cases and convictions each year. Examples of these interventions have included increased computer analytic capacity to review payment trends and identify improper billing, stricter health-care fraud and abuse control laws, prepayment claim checking, manual reviews, and education and enrolment screening for providers.<sup>58</sup>

### **Suggested actions for MPs on financial accountability**

- Use budget oversight functions and work with governments, health-care service providers and civil society to jointly identify corrupt practices, to design strategies to address these practices, and to hold public-sector leadership to account.
- Question ministries of health and finance about innovative approaches to prevention and risk management, addressing the underlying factors that increase the likelihood of health-system corruption.<sup>59</sup>
- Periodically review internal oversight mechanisms through independent management and financial audits, and publish the findings.
- Develop legislation and registries for asset declaration.
- Ensure public procurement accountability measures are applied to contract procedures, user fees and personnel management, as well as to the purchasing, distribution and prescription of pharmaceuticals.
- Align with the Global Network on Anti-Corruption, Transparency and Accountability (ACTA) in Health Systems (which is supported by WHO, the Global Fund and the United

55 Edgardo Díaz Navarrete, *Cuenta Pública 2013: Central de Abastecimiento S.N.S.S.* (Santiago: Ministerio de Salud, 2014). [www.cenabast.cl/wp-content/uploads/2017/09/Cuenta\\_publica\\_Cenabast\\_01\\_08\\_2014.pdf](http://www.cenabast.cl/wp-content/uploads/2017/09/Cuenta_publica_Cenabast_01_08_2014.pdf).

56 Derick Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies* (2003), 22.

57 Taryn Vian and others, “Promoting transparency, accountability, and access through a multi-stakeholder initiative: lessons from the medicines transparency alliance”, *Journal of Pharmaceutical Policy and Practice* 10/18 (2017): [jopp.biomedcentral.com/articles/10.1186/s40545-017-0106-x](http://jopp.biomedcentral.com/articles/10.1186/s40545-017-0106-x).

58 WHO, *Potential corruption risks in health financing arrangements: Report of a rapid review of the literature* (2020), 28.

59 Theadora Koller and others, “Promoting anti-corruption, transparency and accountability to achieve universal health coverage”, *Global Health Action* (2020).

Nations Development Programme) to ensure internal control/assurance, monitoring/evaluation and capacity development, and establish guidance on ACTA in the health-care sector by:<sup>60</sup>

- joining the network
- advocating for a shift from reactive approaches (prohibition, criminalization and punishment) towards innovative approaches (prevention and risk management).

- Request that hospitals and insurance fund agencies report regularly to the ministry of health on what public funds they receive and disburse.

## 5.2.2 Parliaments and performance accountability

**Performance accountability** measures performance against previously agreed targets. It focuses on the services, outputs and results of public and private agencies and programmes.<sup>61</sup>

There is a direct link between performance accountability and financial accountability. Both performance and financial resources require oversight on issues such as intended production of goods, delivery of services and benefits for citizens (e.g. provider payment schemes that enhance efficiency, quality of care, equity and consumer satisfaction). Corruption can undermine a country's efforts to achieve and maintain quality standards and to increase accountability for service delivery performance.<sup>62</sup> Strong financial and management information systems are also required to produce information that can be used to monitor financial and performance accountability.

The criteria for performance accountability are also linked to political/democratic accountability (see Section 5.2.3 below). They include responsiveness to citizens and the achievement of service delivery targets that meet their needs and demands.

### Country examples of good practices on performance accountability

**Egypt:** The contracting procedures for the Family Health Fund include incentives and penalties (through capital payments and performance-based reimbursements) that reward providers for reducing patient waiting times and delivering preventive care.<sup>63</sup>

**South Africa:** A reporting system has been introduced to help compare statistics, indicators and budgets across facilities and to identify problems of user fee collection and related service delivery.

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60 WHO, *Potential corruption risks in health financing arrangements: Report of a rapid review of the literature* (2020); see also: WHO, "Reducing health system corruption": [www.who.int/activities/reducing-health-system-corruption](http://www.who.int/activities/reducing-health-system-corruption).

61 Derick Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies* (2003), 7.

62 Ibid, 21.

63 Ibid, 22.



## **Suggested actions for MPs on performance accountability**

- Work with key stakeholders in the health-care sector (health councils, hospital boards, professional associations, unions, and public and private health-care providers) to advocate for specific policies, approaches or actions.
- Institutionalize participatory mechanisms as a way to support citizen mobilization at all levels, in order to ensure that public officials are held to account, and champion mechanisms that encourage citizen feedback.
- Request periodic performance audits from the ministry of health or any other relevant ministries, as appropriate and based on the country's context.
- Ensure that periodic progress reports are provided to the relevant parliamentary committee, to improve compliance with laws and regulations, professional service delivery standards, and quality of care standards.
- Effectively monitor performance-based financing systems, so that those abusing the system to meet criteria for further funding are held to account.

### **5.2.3 Parliaments and political/democratic accountability**

**Political/democratic accountability** refers to the institutions, procedures and mechanisms that ensure the government delivers on its electoral promises, fulfils the public trust, aggregates and represents the interests of citizens, and responds to ongoing and emerging societal needs and concerns.<sup>64</sup>

Elections are a key avenue for political/democratic accountability, and health-care access, costs and quality often play a role in national and local political campaigns and in campaign promises. This, in turn, raises the expectations of citizens as to how public officials will act to formulate and implement health-related policies, and deliver public goods and services. Beyond elections, political/democratic accountability therefore relates to responding to people's existing and emerging needs and concerns, and building public trust.<sup>65</sup> Parliamentarians can use their representative function, and parliaments can harness their institutional public engagement mechanisms, to gather feedback from citizens and communities, which can then be channelled into decision-making processes.<sup>66</sup>

Political/democratic accountability is linked to performance accountability (see Section 5.2.2). One key responsibility of governments is to address health-care market failures through regulation and the allocation of resources, thereby achieving equity for all citizens.

### **Country examples of good practices on political/democratic accountability**

**Albania:** The online portal set up by the government to collect and investigate citizen grievances regarding health-care service delivery received 1,605 such complaints between 2013 and 2017.<sup>67</sup>

64 Derick Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies* (2003), 7–8.

65 Ibid.

66 For further information on public engagement, see: IPU and United Nations Development Programme (UNDP), *Global Parliamentary Report 2022: Public engagement in the work of parliament* (Geneva: IPU and UNDP, 2022): [www.ipu.org/resources/publications/reports/2022-03/global-parliamentary-report-2022](http://www.ipu.org/resources/publications/reports/2022-03/global-parliamentary-report-2022).

67 Taryn Vian, "Anti-corruption, transparency and accountability in health: concepts, frameworks, and approaches", *Global Health Action* (2020).

**Karnataka, India:** A Health Vigilance Officer visited 202 administrative units between 2001 and 2006, handling 100–200 complaints per visit. In total, more than 800 of these complaints were serious enough to refer to the police.<sup>68</sup>

### **Suggested actions for MPs on political/democratic accountability**

- Help to specify health-care providers' responsibilities and performance expectations (such as through a patient bill of rights or agency charters).
- Address voters' priority concerns and determine the most cost-effective way of including them in UHC.
- Promote UHC as a medium-to-long-term objective and highlight actions of particular benefit to marginalized and vulnerable communities.
- Build trust with constituents and act in accordance with agreed-upon standards of probity, ethics, integrity and professional responsibility.<sup>69</sup>
- Involve the most vulnerable and marginalized groups in setting standards and in assigning priorities to local health-care services.
- Support citizens in seeking appropriate sanctions from health-care providers.
- Advocate for legislation that investigates complaints by citizens about health-care service delivery within the constituency.
- Broaden public engagement opportunities and use different channels to inform and consult with communities.

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68 Reinhard Huss and others, "Good governance and corruption in the health sector: lessons from the Karnataka experience", *Health Policy and Planning*, 26/6 (2011), 471–484: [doi.org/10.1093/heapol/czq080](https://doi.org/10.1093/heapol/czq080).

69 Lucy Gilson, "Trust and the development of health care as a social institution", *Social Science & Medicine*, 56/7 (2003), 1453–1468: [doi.org/10.1016/S0277-9536\(02\)00142-9](https://doi.org/10.1016/S0277-9536(02)00142-9).

## 6. Conclusion



A health-care professional serving patients. © Mustafa Ciftci/Anadolu Agency via AFP

UHC can transform societies by enabling everyone to access the health-care services they need and by eliminating the drastic inequalities that exist today, especially in the aftermath of the COVID-19 pandemic. Aside from its benefits to both population health and health security, UHC is also the foundation for realizing many of the ambitions articulated by countries in the 2030 Development Agenda, such as reducing poverty and inequalities, and building peaceful, just and strong societies.

There is no single pathway to achieving UHC. Likewise, not every country will progress at the same pace. But all countries can make progress.

MPs have an essential role to play in this process. Their core roles of law-making, budgeting and oversight place parliamentarians in a unique position to respond to the needs of populations in general, and of their constituents in particular.

This role is both complex and challenging. There are, however, a number of tools and approaches that MPs can use to flex their parliamentary muscle and ensure that UHC becomes both a priority and a reality in every country. These tools are described in detail in this handbook, along with successful approaches adopted by other countries – examples from which everyone can learn.

The key takeaway from this handbook is that parliaments should not wait for the perfect moment to move forward with reform. Political opportunities and supportive social movements are avenues for action that should not be neglected. Engaging all actors in society in the design and implementation of solutions for UHC – with a specific focus on the most vulnerable and marginalized groups – will help MPs to identify approaches that are fit for their country's context. Parliamentarians should continuously work towards UHC, by periodically assessing the appropriateness of legal frameworks and financing policies against the essential health needs of the population, and by reviewing the actual barriers people face in accessing the health-care services they need.



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