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COUNTRY	YEAR	UHC REFORM	POLITICAL TIMING / REASON
United Kingdom	1948	Tax financed National Health Service with universal entitlement to services	Welfare state reforms of new government following the Second World War
Japan	1961	Nationwide universal coverage reforms	Provide popular social benefits to the population
South Korea	1977	National health insurance launched	Flagship social policy of President Park Jung Hee
Brazil	1988	Universal (tax-financed) health services	Quick-win social policy of new democratic government
South Africa	1994	Launch of free (tax-financed) services for pregnant women and children under six	Major social policy of incoming African National Congress Government
Thailand	2001	Universal coverage scheme extends coverage to the entire informal sector	Main plank of the populist platform of incoming government
Zambia	2006	Free health care for people in rural area (extended to urban areas in 2009)	Presidential initiative in the run up to elections
Burundi	2006	Free health care for pregnant women and children	Presidential initiative in response to civil society pressure
Nepal	2008	Universal free health care up to district hospital level	Flagship social policy of incoming government
Ghana	2008	National Health Insurance coverage extended to all pregnant women	Leading up to a Presidential election
China	2009	Huge increase in public spending to increase service coverage and financial protection	Response to growing political unrest over inadequate coverage
Sierra Leone	2010	Free health care for pregnant women and children	Presidential initiative which was a major factor in recent elections
Georgia	2012	Extending health coverage to all citizens	Key component of new Government's manifesto
USA	2012	National health reforms designed to reduce number of people without health insurance	Major domestic social policy of the President

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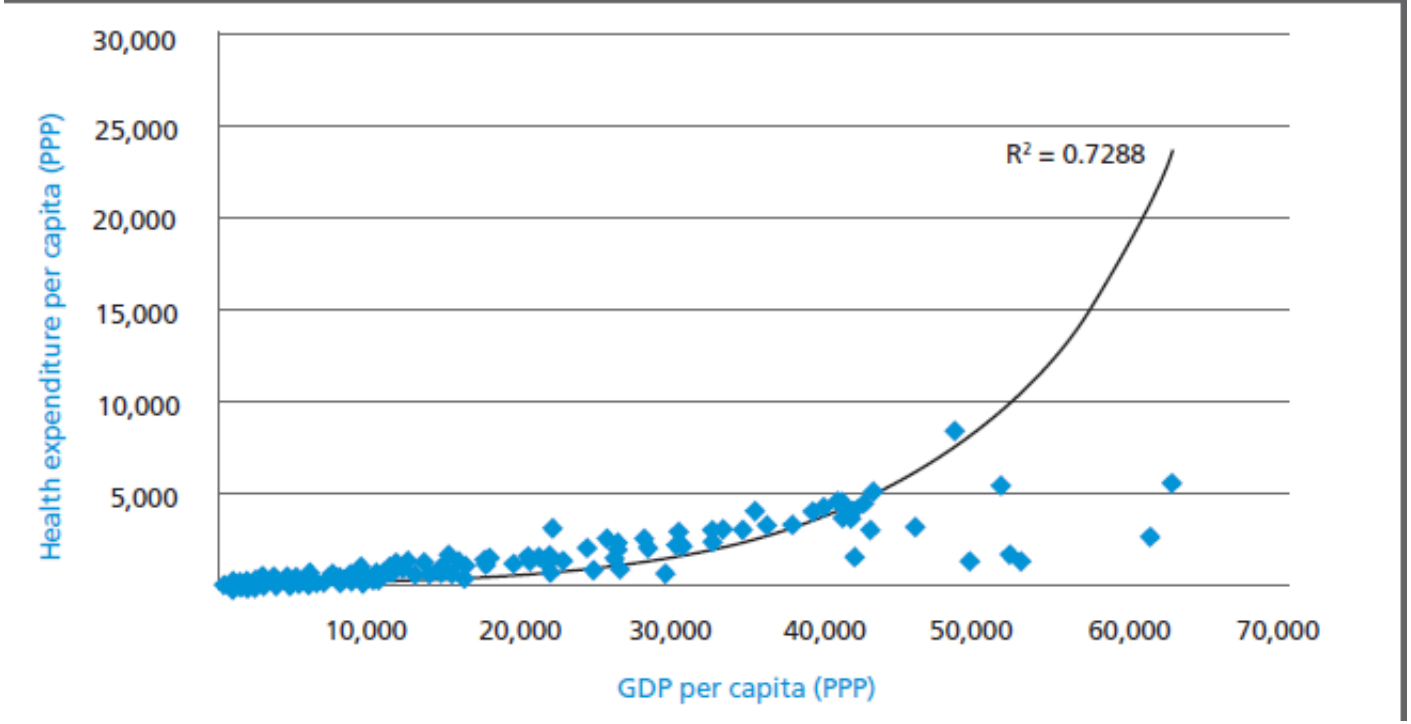
GRAPH 1: 2011 GLOBAL HEALTH EXPENDITURE DATA WHO MEMBER STATES
(excluding Monaco, Luxemburg and Qatar)



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COUNTRY	NOMINAL GDP per capita take out in (in US $, UN estimates)	TOTAL HEALTH SPEND as a share of GDP	HEALTH SPEND per capita	PUBLIC HEALTH SPEND as a share of GDP	PUBLIC SPENDING as a % of total health expenditure
Cuba	6,106	10.0	610	9.5	95
Costa Rica	8,676	10.9	945	7.6	70
Mexico	10,063	6.2	624	3.0	48
Brazil	12,594	8.9	1121	4.1	46
China	5,439	5.2	283	2.9	56
Sri Lanka	2,812	3.4	96	1.5	44
Malaysia	9,977	3.6	359	1.6	44
Mongolia	3,060	5.3	162	3.0	92
Thailand	5,318	4.1	218	3.1	57
Bhutan	2,336	4.1	96	3.4	83
Rwanda	583	10.8	63	6.1	56

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= Participate in debates concerning UHC financing strategies and advocate for reducing the fragmentation of risk pools with contributions made according to ability to pay.

= Challenge strategies that create separate risk pools for more privileged groups in society (for example civil servants or people working in the formal sector) especially if these groups are to be subsidized using public funds and advocate for strategies that include the poor and vulnerable at the out-set.

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= Engage in debates concerning the purchasing of services using pooled health funds (including the allocation of the government's health budget) and ensure that allocations are efficient and equitable. In particular CSOs should be vigilant regarding allocations that disproportionately benefit tertiary hospital care at the expense of investing in local primary health care services, or that disproportionally benefit treatment at the expense of prevention and promotion.

= Conduct equity audits of health financing policies (both in raising and allocating funds) to ensure that high-need and vulnerable groups receive their fair share of benefits and are not contributing unfairly. These groups may include women, children, elderly people, disabled people, poorer members of society, marginalized ethnic groups, people with chronic illnesses and rural communities.

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	VOLUNTARY MECHANISMS	COMPULSORY MECHANISMS
No interpersonal pooling of funds	Direct out-of-pocket payment	
	Individual health savings accounts (voluntary)	Individual health savings accounts (mandatory)
Pooling of Funds	Voluntary health insurance, managed by commercial for-profit companies, not-for-profit organizations, community groups, or governments	Government agencies including health ministries and local governments; public agencies with varying degrees of autonomy, such as compulsory/social health insurance agencies, or private (for-profit or non-profit) insurance funds that manage compulsory insurance
	Philanthropic Aid	Overseas Development Assistance

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Because of adverse selection and the exclusion of the poor, no country in the world has managed to come close to UHC by using voluntary insurance as its primary financing mechanism.

BOX 4: CONCLUSION ON CBHI FROM RESYST REVIEW APRIL 2013

CBHIs have been seen as an important way of providing some protection against the user fees introduced at public sector health facilities in many African countries in the 1980s. However, the literature highlights that CBHIs generally achieve very limited population coverage if operating as voluntary schemes, tend to cover a very limited package of services and sometimes require co-payments.[28] There are also sustainability problems associated with these schemes due to the small risk pools. The ability of CBHIs to offer adequate financial risk protection is dependent on whether the schemes are part of a national financial strategy that receives government support, the design (including premium rates and timing of contribution, whether the schemes cover outpatient and inpatient services, the range of accredited health care facilities), the share of costs covered by the scheme and implementation features of the scheme. Although evidence is currently limited, CBHI contributions tend to be a highly regressive form of financing health care.

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