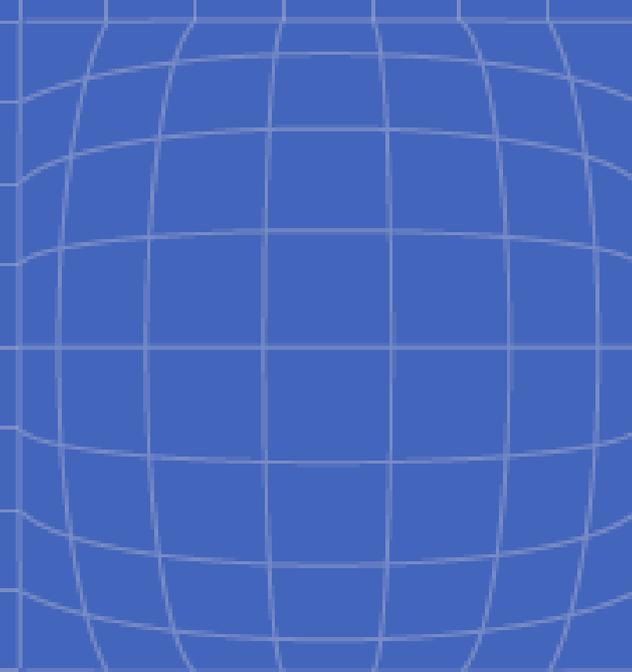


# Global Conference on Universal Health Coverage for Inclusive and Sustainable Growth

LESSONS FROM 11 COUNTRY CASE STUDIES:  
A GLOBAL SYNTHESIS



**JAPAN-WORLD BANK PARTNERSHIP PROGRAM ON UNIVERSAL HEALTH COVERAGE**  
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## LESSONS FROM 11 COUNTRY CASE STUDIES: A GLOBAL SYNTHESIS<sup>1</sup>

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### **GOALS OF UNIVERSAL HEALTH COVERAGE**

To end poverty and help to ensure shared prosperity, all countries need a sustainable, inclusive development strategy built on human capital investments in health, education, and social protection for all. Countries as diverse as Brazil, France, Japan, Thailand, and Turkey have achieved universal health coverage (UHC) and are showing how UHC programs can serve as vital mechanisms for improving the health and welfare of their citizens, while laying the foundation for economic growth and competitiveness grounded on the principles of equity and sustainability.

Two interrelated goals form the basis of the UHC agenda:

First, the global community is committed to making sure that no family is forced into poverty because of health care expenses. Countries can tackle this injustice by introducing effective models of equitable health financing with strong social protection measures for all members of society.

Second, the global community should endeavor to close the gap in access to quality health services for the poorest 40 percent of the population in every country. This requires a health system that ensures that health investments and expenditures will contribute to improving health outcomes equitably and sustainably.

### ***Opportunities***

Improving health outcomes is critical to building all citizens' capabilities and enabling them to compete for jobs that will let them share in the prosperity and opportunities generated through inclusive and sustainable development. UHC aims to provide health services equitably to all citizens to prevent the ill-effects of diseases and injuries, and to do so without exposing them to burdensome and often catastrophic medical expenses. In particular, a focus on the poor as a target group for health investments yields significant socioeconomic as well as health benefits at individual and population levels.

### ***Challenges***

While UHC offers a powerful aspirational goal for a nation, we also need to recognize the many challenges associated with adopting, achieving, and then sustaining it. Entrenched interest groups often pose significant challenges to reforms that upset existing inequitable and/or ineffective arrangements. Health services themselves are highly susceptible to market failure, owing to the difficulties in measuring and accounting for the use of resources and these resources' impact on quality, safety, and effectiveness of services. The rapid pace of technological innovation is constantly changing service standards, raising questions about both appropriate and equitable distribution, and requirements for safety, efficacy, and quality. Similarly, demographic and epidemiological transitions are continuously transforming the nature of demand for health services.

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<sup>1</sup> This paper has been prepared by the World Bank for presentation at the Global Conference on Universal Health Coverage for Inclusive and Sustainable Growth, December 5–6, 2013, Tokyo. It synthesizes findings from 11 country cases on UHC that were supported under the Japan–World Bank Partnership Program on Universal Health Coverage.

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Even in countries that have achieved UHC, effective engagement of stakeholders, equitable distribution of resources and services, and able governance of programs are still needed. These factors call for continuous monitoring and evaluation (Box 1), including quality improvement mechanisms, as well as regulation of health coverage and quality to ensure that valuable resources, both public and private, are effectively used for priority goals and are not diverted or wasted. These processes require commitment from all segments of society—elected officials, policy makers, health professionals, business leaders, and citizens themselves—to establish a robust governance structure that supports a resilient health system that is responsive to population needs and is adaptive to changing conditions.

**Box 1 What marks countries' achievement of UHC?**

According to the World Health Organization (WHO), the following are indicators of progress in achieving UHC:

Universal health coverage is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.

This definition of universal health coverage embodies three related objectives:

- equity in access to health services—those who need the services should get them, not only those who can pay for them;
- that the quality of health services is good enough to improve the health of those receiving services; and
- financial-risk protection—ensuring that the cost of using care does not put people at risk of financial hardship.

Source: WHO website, [http://www.who.int/healthsystems/universal\\_health\\_coverage/en/](http://www.who.int/healthsystems/universal_health_coverage/en/), accessed October 29, 2013.

## **OBJECTIVES OF THE STUDY**

There is a growing demand from low- and middle-income countries (LMICs) to understand the conditions and requirements for achieving UHC. Following the occasion of the 50<sup>th</sup> anniversary of Japan's own achievement of UHC (in 1961), the Japan–World Bank Partnership Program on Universal Health Coverage (the Program) was conceived as a joint effort by the government of Japan and the World Bank to respond to this growing demand from LMICs for technical advice and investment support for designing and implementing UHC policies and strategies.

The Program has undertaken detailed studies of Japan's 50-year experience with UHC, which aim to identify potential lessons from Japan for LMICs on policies that led to coverage-enhancing (alternatively, coverage-eroding) results—discussed further below. Ten other case-study countries (Table 1) were selected, largely for their commitment to UHC and readiness to explore the key policy questions included in the Program's analytical framework (see "Framework for analysis," below).

The Program covers countries at different stages of UHC, ranging from those at early stages of adoption to those with well-established UHC programs; countries from several geographic regions;

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and countries with different health financing and delivery systems (e.g. social health insurance or national health services). The countries also reflect different historical backgrounds (e.g. the post-World War II era for Japan and France or the new millennium's reforms for Bangladesh). The 11 countries are broadly placed into four groups, or stages of UHC adoption and development.

**Table 1 Profile of countries participating in the Program**

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

The studies supported under the Program complement other major initiatives by the World Bank on UHC. The Universal Health Coverage Challenge Program (UNICO—Box 2) undertook 25 country case studies that focused specifically on programs designed to extend health coverage to poor and vulnerable groups. UNICO will also develop a Universal Health Coverage Assessment Tool (UNICAT) to evaluate existing country capacity to implement UHC policies. These efforts are part of a global effort to collect evidence and develop tools that can be used by countries advancing toward UHC.

**Box 2 Tools for implementing universal health coverage—UNICO**

The World Bank is promoting the reduction of extreme poverty and increasing shared prosperity by supporting the efforts of countries to transition toward UHC. The analogous objectives of UHC are to improve health outcomes, reduce the financial risks associated with ill health, and increase equity across the population. The Bank recognizes that there are many paths toward UHC and it does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions that countries establish to implement UHC are essential to its success.

As part of its efforts to support UHC, the World Bank is implementing UNICO, which consists of two efforts to develop and share operational toolboxes for moving toward UHC.

The first involves the preparation of case studies that explore the “nuts and bolts” of programs in 25 countries, designed to expand health coverage from the bottom up (i.e. starting with the poor and vulnerable). These studies have been published under the Bank’s Universal Health Coverage Study Series and a synthesis comparing the 25 countries will be available in early 2014. The synthesis will assist countries to focus on equity, efficiency, and fiscal sustainability by using a framework that emphasizes three elements: the “nuts and bolts” of expanding the “UHC cube;” the supply and mode of health service delivery; and the use of monitoring to ensure accountability of implementation.

The second effort is in developing UNICAT to help countries and development partners assess the strengths and weaknesses of their capacity for executing UHC policies. The tool not only provides a factual capacity review, but also uniquely elicits opinions from a wide range of experts on the structural and political hurdles to achieving UHC in their country. The tool has been piloted in 15 countries and its results will be evaluated in early 2014.

## **FRAMEWORK FOR ANALYSIS**

Because of the multiplicity of actors and the complexity of interactions that influence health coverage, identifying key factors that enhance or erode coverage is daunting. For this reason, research on health systems and UHC has tended to disaggregate the system into its constituent parts and to examine isolated relationships in which the policy interventions and results can be more readily measured and evaluated. In reality, however, policy-makers have to intervene in all aspects of the health system simultaneously, in order to address difficult trade-offs and take advantage of potential synergies. For example, policies on health financing have a profound influence on, and in turn are influenced by, those related to health workforce availability, distribution, and performance. The interaction between these policy areas merits deeper examination.

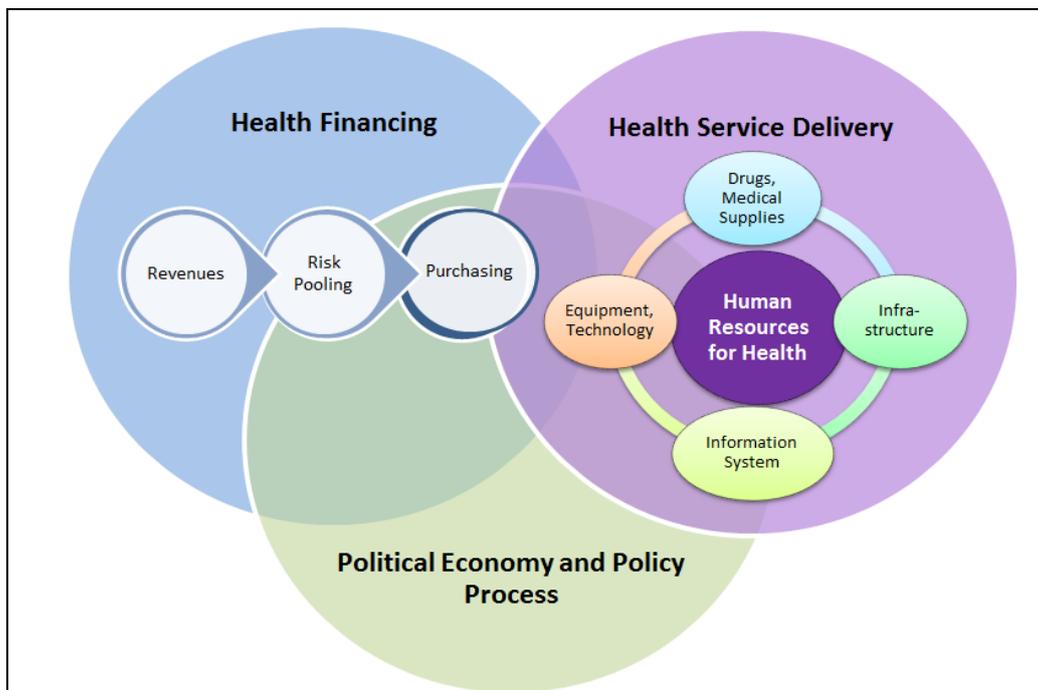
To achieve the aims of this study, a case-study method was selected to focus on *how* each country uses different policy levers simultaneously for reaching its UHC objectives. The outputs from these case studies are *not* intended to prescribe generalizable solutions, but rather to describe steps taken by countries that have enhanced (or eroded) UHC and to suggest possible lessons for further evaluation. This method is also used to identify knowledge gaps for future research.

A common framework for case-study analysis was used to examine policies and their impact on enhancing or eroding UHC. The case studies focused on three aspects of health systems: the political economy and its implications on the process of policy formulation, decision making, and implementation; the health financing system and associated policies; and the health service delivery system, with a focus on human resources (Figure 1 provides a schematic view). The health financing

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system is usually decomposed into the capacity to mobilize revenues, organize risk pools, and make payments for services. Health service delivery involves investments in a wide range of inputs, such as drugs, medical supplies, technology, and infrastructure, and most critically the health workers who play a central role in delivering services and mediating all aspects of health care. The political economy and policy process context plays a major role in shaping policy decisions and how they are implemented. The case studies examine the interactions among these three aspects. They do not address many other important aspects such as demand-side policies and programs, or an in-depth analysis of impacts and importance of technology change, although this should not imply lower priority for these issues.

**Figure 1 Components of the health system affecting coverage**



## **EMERGING LESSONS FROM COUNTRY EXPERIENCES**

As countries commit to UHC and move along the different stages toward that goal, the challenge of making trade-offs and balancing competing demands is continuous. At each point, the choices made can be either *coverage enhancing* or *coverage eroding*. If political compromises or fiscal sustainability pressures result in decisions that exclude coverage for some population groups, reduce benefits or access to services, or increase cost-sharing, coverage will be eroded along one of the different dimensions of “coverage”: population coverage, access to services, and financial protection. Policies that support strategic payment systems, or that lead to better negotiated medicines prices and well-targeted subsidies, can be coverage-enhancing policy choices, freeing up resources to provide more people with better access to high-quality services with greater financial risk protection.

The line is often blurred between policies that enhance or erode coverage. Some of the former when carried out too far can eventually put too much pressure on financial, human, and other resources and begin to erode coverage. For example, strategic cost-sharing that directs patients to more cost-effective primary care services may eventually be coverage enhancing, but could also act as a barrier to access. Turkey's price negotiations with pharmaceutical companies and global spending caps have helped to reduce the cost of medicines for UHC since 2008, thus helping to free resources to expand coverage; but this approach is now showing signs of discouraging market participation and innovation in the pharmaceutical sector by reducing the companies' profit margins, and this could eventually erode access to medicines.

Thus the stages toward UHC require a constant rebalancing that relies on regularly reassessing where the pressures on the system are having negative consequences and where new pressure can most effectively be applied to maintain fiscal balance, reallocate resources, and align incentives to ensure equitable coverage. Ultimately, the countries that have been most successful in achieving and sustaining UHC have made choices at critical junctures that are, on balance, coverage enhancing; have learned from their past mistakes; and have established a system that continuously absorbs lessons, and adapts.

The studies described—we lead off with Japan—are an attempt to capture some of the key country decisions and their consequences. It is hoped that they will provide useful lessons for other countries facing similar challenges and seeking practical solutions to achieve and sustain UHC.

## **KEY LESSONS FROM JAPAN**

Japan's political and historical context shows that the country made long-term commitments to UHC that persisted under different political conditions. Japan began its movement toward UHC before World War II as part of its preparation for war to develop a healthy workforce, and expansion continued during hostilities. After the war, UHC was picked up by the governing party as a national goal for social solidarity contributing to recovery from the devastation, and as a way to respond to challenges from opposition parties associated with socialist and communist movements.

Eventually compulsory arrangements were needed to expand coverage to the informal sector and other hard-to-reach groups, taking a variety of forms. Japan expanded health coverage to informal, self-employed, and unemployed populations through residence-based health insurance programs managed by municipalities (Citizens Health Insurance). These plans were initially introduced on a voluntary basis for the residents, and gradually expanded by increasing government subsidies to cover additional beneficiaries. The plan became mandatory for all residents once coverage exceeded 80 percent in that municipality, and those who were not covered by other health insurance plans

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were automatically enrolled in this program. Japan achieved UHC in 1961 when the last municipality reached mandatory enrollment status under its Citizens Health Insurance.

Economic growth can help provide fiscal space for UHC. Japan's "Income-Doubling Plan" helped expand and sustain UHC. In the mid-1950s, nearly half the population was living near the poverty line, but in the 1960s the country enjoyed rapid economic growth, driven by the plan, designed by the economist Osamu Shimomura and introduced by Prime Minister Hayato Ikeda in 1960. The plan aimed to double real per capita national income in 10 years by achieving annual gross domestic product growth of 11 percent. In fact, income doubled by 1967, making it easier for Japanese citizens to pay the premium contributions to the social health insurance system, and for the government to allocate more funds to health.

Redistribution mechanisms and policies to harmonize benefits and payment systems have played a key role in reducing inequities across multiple insurance programs. Japan incrementally expanded health coverage through multiple health programs covering different categories of insured groups. Over time, it harmonized entitlements to the same benefits and had the same cost-sharing for people of the same age group. However, the financial base to meet these standards varies across health insurance plans, because the age distribution and risk profiles of enrollees are highly imbalanced. To address these disparities, transfers are made from the central and local governments and other health insurance program to the most disadvantaged group under Citizens Health Insurance. Although these redistribution mechanisms have improved equity across plans and population groups, the contributions as a proportion of income still vary across groups. In recent years, changes in the employment and demographic profiles of beneficiaries have led to growing disparities in contribution rates across different groups, which the existing redistribution mechanism has been unable to address, highlighting the risk of creating multiple health plans that require complex redistribution systems to maintain equity.

Managing health spending under a single payment system has helped the government to maintain strong control over total health expenditure. Japan manages its health care expenditures through its single payment system and the fee schedule set by the government. This schedule is revised every two years, first by setting a global price revision rate on all services and drugs and cap on the level of subsidies available to the health system. Adherence to these conditions is regularly audited, which has mitigated inappropriate utilization of services. The payment system also prohibits balanced billing (charging fees to patients above the price set in the fee schedule) by providers and strictly restricts extra billing (charging services listed in the fee schedule with those that are not). These measures have helped Japan control health care expenditures: in 2011 total health spending was 9.6 percent of gross domestic product—just above the average for the Organisation for Economic Co-operation and Development—an impressive achievement, given that Japan has the oldest population in the world.

Japan's fee schedule has also been used to influence the behavior of health care providers. It not only sets prices, but also establishes an institutionalized process of negotiating resource allocation and benefits among key stakeholders, by setting conditions for reimbursements. For example, the fee schedule provides detailed conditions of payments, such as nurse staffing levels and diagnosis criteria for procedures. The biennial revision provides an important platform for reviewing and revising priorities, negotiating trade-offs, and involving all the stakeholders in a continuous process of adjustment to meet the health sector's strategic objectives and directions.

Japan has introduced multiple policies to ensure equitable access and distribution of health services and health workers. Although 80 percent of hospitals and nearly all clinics are in the private sector, they are all integrated into the delivery system because more than 90 percent of their revenues are derived from services regulated by the fee schedule. Public sector hospitals have additional revenues in the form of subsidies from national and local government general budgets. Under pressure to

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reform, the national hospitals were transferred to an independent nonprofit agency, which has improved managerial accountability and efficiency (Box 3). Although geographic disparities in distribution of physicians remains an issue, innovative approaches have been introduced, for example: prefectural governments subsidize the tuition and living expenses for the two to three entrants to the special medical school whose graduates are obligated to work in remote areas. The fee schedule has also helped to mitigate the over-concentration of physicians in large urban hospitals and in specialized care by setting higher reimbursement rates for primary care services. Hospitals in rural areas offer higher salaries for doctors than those in urban areas to attract and retain them; they offset the higher cost for physicians' salaries by offering lower salaries to nurses and other staff, who are willing to work for lower wages and are less likely to migrate to cities.

**Box 3 Japan's National Hospital Reform**

Japan introduced major reforms in the organization of its national government-run hospitals to improve efficiency. Although the fee schedule system places considerable pressures on health care providers to run their services efficiently, these hospitals had been insulated by the high subsidies from the government budget.

And so in 2004 Japan created a single independent nonprofit agency, the National Hospital Organization, to operate these hospitals. This gave greater autonomy and flexibility to hospital management, which were no longer obliged to follow the civil administration regulation of government agencies restricting the hiring of personnel and in setting wages. The new governance structure demanded higher accountability from hospital directors, and permitted flexible labor contracts with hospital staff. These reforms collectively improved managerial accountability and efficiency among the national hospitals, and government subsidies are no longer required for operating the hospitals.

## **GLOBAL LESSONS IN THE POLITICAL ECONOMY AND POLICY PROCESS**

The international development community in recent years has increasingly recognized that carefully crafted technical solutions may have little practical effect if political economy concerns are ignored. The World Bank, working with other international, regional, and bilateral development agencies, has played a lead role in raising global awareness of the importance of political economy and creating approaches to address related concerns in order to ensure that reforms in the health sector and beyond are enabled, rather than constrained (World Bank 2008; Poole 2011; Reich and Balarajan 2012).

The findings now presented synthesize themes that have emerged from consideration of the 11 country cases, and highlight the emerging lessons that are most likely to be of practical use to national policy makers.

### ***Adopting UHC***

UHC initiatives are often adopted in response to a major social, economic, or political change. For example, UHC was adopted as a national priority following the period of financial crisis in Indonesia, Thailand, and Turkey (Box 4); or at the time of re-democratization in Brazil; and as part of the postwar reconstruction effort in France and Japan. These moments of crises or major upheavals have offered opportunities for breaking through old interest group politics that may have held back

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reforms, and allowed innovative approaches to be tested and adopted. These critical events have also served to mobilize the national solidarity and support needed to embark on such major reforms.

**Box 4 Financial crisis as an impetus for reform in Turkey**

A crushing deficit, banking weakness, and capital flight led to a major economic crisis in Turkey in the early 2000s and prompted major government reform in the country, laying the basis for the 2003 Health Transformation Program. The aftermath of the financial crisis led to initiatives aimed at cleaning up government deficits and creating leaner and more efficient state bureaucracies. The disruptions caused by these reforms also created new opportunities for reform in the health sector by breaking old interest group politics. For example, they allowed the introduction of a new contracting mechanism with private providers through capitation payments that opened the way for a more sustainable approach to health care provision and helped make the goal of effective universal health coverage possible.

Turkey's response to crisis demonstrates that financial constraints—even a major financial crisis—can actually serve as an opportunity for reformers interested in expanding coverage.

Source: Tatar et al. 2011; Akyuz and Boratav 2003; Bump and Sparkes 2013.

Adoption of UHC programs has been contingent on a strong executive or political party leadership. Having health care access embedded in the Constitution as a right provided important institutional underpinning to UHC initiatives in most of the 11 countries (Bangladesh, Brazil, France, Japan, Thailand, Turkey, and Vietnam), providing reformers with a legal basis for UHC advocacy. Other countries have relied on integrating UHC strategy within a national development plan to secure support and resources. Countries have also set explicit target dates for UHC as a way to mobilize political support and keep the country focused on the goal. These include Vietnam (with a target date of 2020), Indonesia (2019), and Bangladesh (2032).

In many countries, social movements helped put UHC on the political agenda initially and subsequently held governments accountable after its implementation. Social movements and civil society have been especially important for helping to connect and engage important segments of the population with government and for protecting the interest of poor and vulnerable populations (Box 5).

Economic growth, while instrumental in supporting the subsequent expansion of coverage, does not appear to have been a necessary condition for adoption of the UHC agenda. Countries in Group 1, such as Bangladesh and Ethiopia, while facing significant macroeconomic constraints, have nevertheless made UHC a national goal to be achieved over the long term. Brazil's commitment to UHC grew out of the re-democratization movement during the period of slow economic growth. Thailand committed itself to the expansion of coverage under the Universal Coverage Scheme in 2002, after the Asian financial crisis when macroeconomic growth prospects were still fragile. However, in many countries the advent of economic growth has been one of the important enabling factors underpinning the expansion of coverage once UHC goals have been adopted. The recent expansion of health coverage in Group 2 countries of Ghana, Indonesia, Peru, and Vietnam have been aided by a relatively strong economic growth.

**Box 5 Social Movements for UHC in Brazil and Thailand**

While prime ministers and political parties often receive the bulk of the credit for the adoption of UHC reforms, social movements have also played critical roles in helping to drive and support UHC reforms in a number of countries. In Thailand and Brazil, for example, longstanding networks of doctors and public health professionals, concerned with expanding health equity and improving access to healthcare, put pressure on politicians to adopt universal coverage in moments of democratic change.

Brazil's *sanitarista* (public health) movement had long been advocates for more equitable health reforms and played a critical role in institutionalizing principles of universalism in the 1988 constitution, following the transition to democracy in 1985, and for advocating for the 1990 Unified Health System law. In Thailand, a long-standing healthcare professionals who had worked in rural areas in the 1970s and had founded an organization called the Rural Doctors' Society, worked with grassroots partners in civil society to make expanding healthcare access an issue in the national elections in 2001. Once the ideas were adopted by an innovative new political party, this movement played an important role subsequently in the implementation and governance of the new Universal Coverage program. Without the efforts of these social movements, amid a backdrop of economic strain and competing policy priorities, the implementation of UHC reforms in both these countries would likely have remained an open question (Weyland 1995; Falletti 2010; Harris 2012).

**Expanding coverage**

While some countries have ultimately sought to cover their populations through a single program and others through a web of programs, all the 11 countries have taken an incremental approach to UHC expansion. This has been necessitated by the complexity of the process and the effort required to gain support among interest groups, and by the time it takes to develop the institutional and technical capacities to support them. Learning from past policy experiences, including mistakes, has proven to be invaluable. In particular, Group 2 countries—which have made significant progress but still face major gaps in coverage—are reaching the stage where major review and adjustments are needed.

Understanding the underlying political situation and negotiating effectively with the various interest groups is an essential strategy for ensuring expansion with equity. Professional bodies, hospital and manufacturers' associations, and other interest groups influence key decisions on allocation of key factors of inputs. Decisions on deployment of health workers, investment in infrastructure, and budgets for purchasing pharmaceuticals and supplies are often determined by interest group politics that may not always be aligned with UHC goals. Thus, technical solutions for expanding coverage will need to be accompanied by careful consideration of the political context, and strategic planning is needed to anticipate and manage these interest group politics. Ghana is celebrating its tenth anniversary of establishing the National Health Insurance Scheme (NHIS), which integrated the multiple community-based plans under the national program. The system is at a turning point with coverage hovering at 36 percent of the population and sustainability emerging as a major concern, as expenditure per beneficiary has been outpacing revenues. Efforts are being made to review the system and make adjustments to put it on a sustainable path. A similar review is under way in Vietnam, where the Ministry of Health and Vietnam Social Security have undertaken a thorough assessment of the national health insurance system to propose adjustments in an upcoming revision of the Health Insurance Law. Peru and Indonesia are also taking important steps to integrate the multiple programs under an integrated national program.

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Professional associations have an influential role in the regulation of health workers, as well as boundaries for entry and exit of health workers, with implications for system costs and access to services. Medical associations, in particular, have at times played an important role in opposing efforts to institutionalize universal coverage in a number of countries around the world, often over fears related to the way in which their professional autonomy and compensation will be affected. Professional associations have also played an important role in influencing policies that affect coverage, for example by placing limits on the number of doctors or nurses who may practice, or conditions on qualifications required to practice. In Brazil, for example, medical associations have successfully lobbied to restrict nurses' scope of practice, and by setting these conditions for entering the health labor market they influence the overall availability and distribution of health workers. Negotiating the conditions for expanding coverage will be a key element of success.

### ***Reducing inequities***

The incremental nature of UHC expansion often leads to the development of multiple risk pools, as different programs evolve to cover different population groups. This raises new challenges for ensuring equitable coverage and redistributing resources across the different pools. Once multiple programs are established, it becomes politically difficult to merge or integrate them, as this will inevitably require trade-offs with some interest groups losing their privileges. Countries that have maintained multiple insurance programs (such as Japan) have had to develop a redistribution mechanism to allocate subsidies across the multiple plans to reduce inequities. But harmonizing benefits and contribution rates across the different groups has proven challenging and requires considerable political clout and leadership to enforce. All the Group 2 countries have made (Ghana and Vietnam) or are making (Indonesia and Peru) efforts either to integrate or harmonize their multiple programs.

Expanding coverage to the informal sector is a major challenge for most LMICs, especially those doing so through contributory systems. The 11 country experiences show that countries tend to expand coverage first to civil servants or workers in the formal sector. Very frequently, this happens because those groups are often the easiest to cover and involve covering people who are politically active and live in urban areas that are near to existing health care infrastructure and who have institutionalized relationships with government through the payment of taxes. This excludes households in the informal sector, which are often the hardest groups to reach. For the four Group 2 countries, expanding coverage to the informal sector remains a major challenge. Group 1 countries such as Bangladesh and Ethiopia are considering introducing social health insurance programs, which could result in steering government resources toward workers in the formal sector and away from the less affluent farmers and informal sector workers.

Countries in groups 3 and 4 have extended access to the poor and the informal sector through tax-funded approaches to subsidize their participation in a larger risk pool. Many countries in the process of expanding coverage toward UHC have created programs to provide free or subsidized coverage to the poor. However, these programs typically exist alongside a host of other programs that compete to cover different population groups and are subject to interest group politics. Political leadership and social movements play an important role in ensuring that the resources to the poor are protected, especially in times of economic downturn. Even France only reached full UHC in 2000 when it introduced a state-subsidized program for low-income groups.

### ***Sustaining UHC through adaptive and accountable systems***

Knowledge and experience gained through implementing UHC are invaluable for building a resilient and adaptive health system. Countries that have achieved UHC have learned from the shortcomings of their earlier policies, made adjustments, built on institutional and technical capacities, and have

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been willing to try different approaches without abandoning the original principles of UHC. Given the political, socioeconomic, and technical complexities of UHC, there are no unique right or wrong policies and no absolute successes or failures. Careful attention to the many factors, including governance structure, influences of lobbying groups, demographic and other socioeconomic changes, and global economic shifts, helps ensure that the health system is both sustainable and responsive in the face of constantly changing population needs, technical innovations, and economic conditions. Adaptive leadership in the case-study countries in groups 3 and 4 has been instrumental in allowing and facilitating such dynamic change, with the hallmarks of such leadership in place at key points in the history of the UHC process, if not consistently over time. These include, for example, taking into account the iterative nature of the process and recognizing that it takes time; learning lessons from experience and building on them; and the imperative to mobilize individuals and populations to address the complex problems at hand (Heifetz, Grashow, and Linsky 2009).

## **GLOBAL LESSONS IN HEALTH FINANCING STRATEGY**

UHC requires adequate financial resources to pay for necessary health services, requiring fiscal commitment from the government, and a significant role of the state in establishing pooling and redistributive mechanisms that ensure financial protection and equitable subsidization of coverage for the poor (Table 1 in the Annex). In fact, no country has reached UHC relying on private voluntary funding sources (Kutzin 2012). Health expenditures also require careful regulation and management to ensure equity, fiscal responsibility, and value for money, i.e. covering the most people with access to quality services and with effective financial protection, particularly given the high rate of market failure in health services. The following sections describe key themes and lessons emerging from the 11 case studies.

### ***Raising revenues***

All 11 countries are facing challenges on finding the “fiscal space” to financing UHC policies and programs on a sustainable basis, but the specific nature of the problem varies. The term fiscal space is defined as the available budget determined by a combination of the country’s overall macroeconomic and fiscal context, public spending priorities, and how efficiently current expenditures are used. Countries in Group 1—those with the fewest resources—face macroeconomic constraints and limited government capacity to raise revenues. These countries rely on external assistance to finance a significant portion of health benefits. For them, a major issue has been the need to leverage external assistance in a way that complements the country’s own budget contributions and that supports their own policy priorities. Bangladesh is implementing a Sector-wide Approach<sup>2</sup> to harmonize external assistance, and Ethiopia is directing external assistance to finance investments (in infrastructure, equipment, and supplies) that complement its own budget for salaries of health workers under its Health Extension Program.

Countries in Group 2 are middle-income countries beginning to benefit from strong macroeconomic growth and naturally expanding fiscal space, although government budgets for health vary: Ghana and Peru allocate a significant share of government spending to health, while Vietnam has raised its

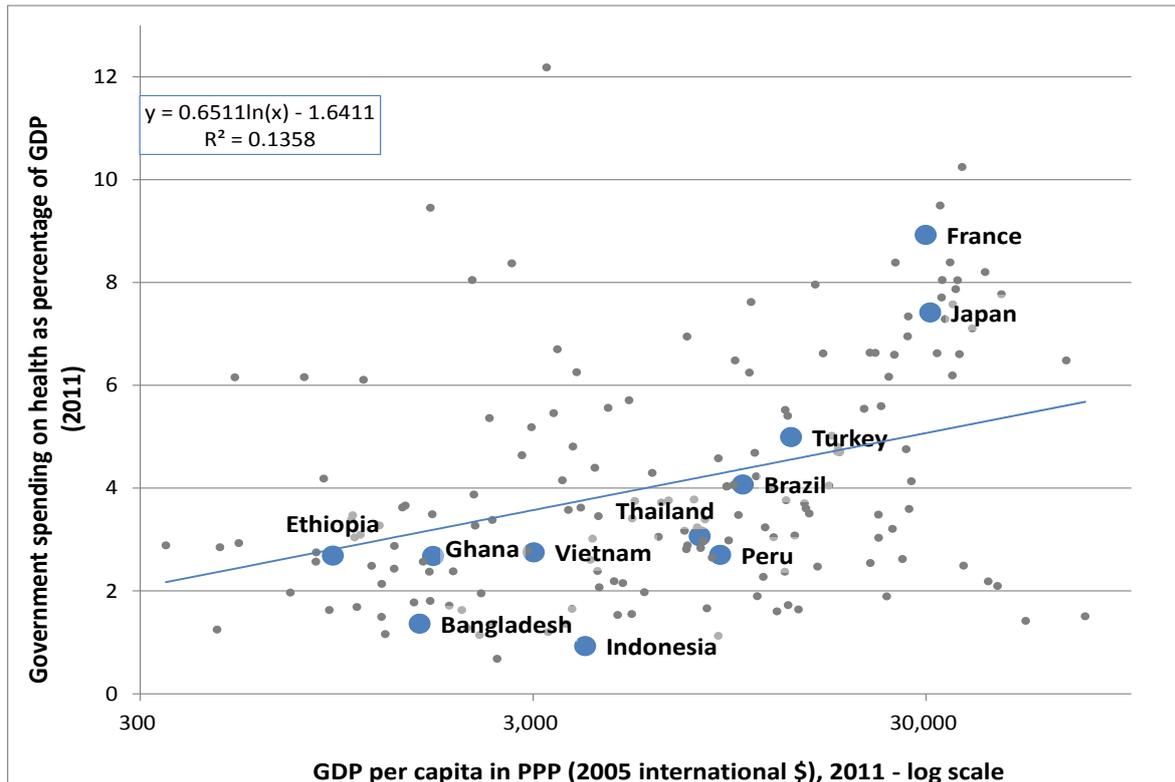
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<sup>2</sup> SWAps in health were developed in the 1990s in response to widespread dissatisfaction with fragmented donor-sponsored projects and prescriptive adjustment lending. They were intended to provide a more coherent way to articulate and manage government-led sector policies and expenditure frameworks, build local institutional capacity, and offer a platform to promote a more effective relationship between government and external partners.

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share from a low 6.3 percent in 2002 to 9.4 percent in 2011. During the same period, its real gross national income per capita nearly doubled and population coverage expanded from 16 percent to nearly 68 percent. At the same time, Vietnam’s government health spending climbed faster than economic growth, and much of this increase was to subsidize premiums for health insurance for the poor. Indonesia’s health budget, by contrast, remained relatively low. Figure 2 compares the level of government spending on health as a share of a country’s GDP.

**Figure 2 Government spending on health as a percentage of GDP, 2011**



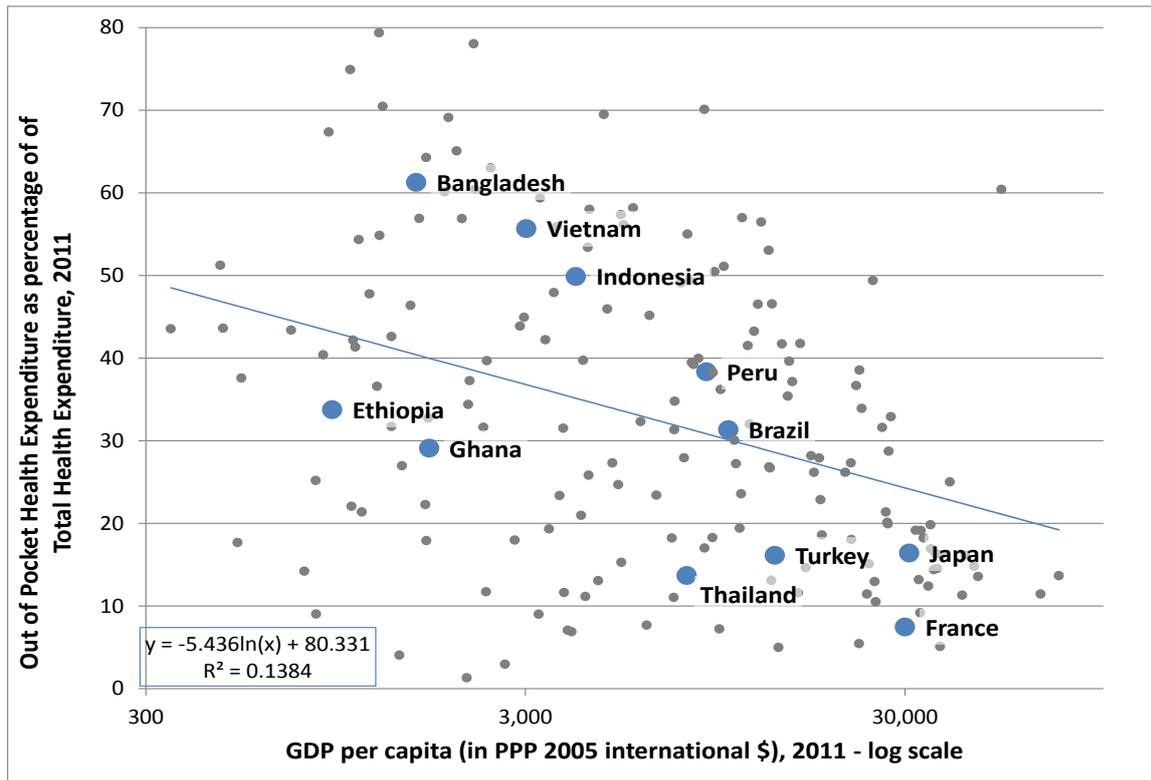
Source: World Development Indicators 2013. (Global data with 11 case countries highlighted.)

Priority in the government budget for health, with macroeconomic growth, has been important in enabling countries to expand population coverage and provide better financial protection. Governments do not often accompany their political commitment to UHC with an explicit financial pledge, such as earmarking revenue. Only three of the 11 countries (Brazil, France, and Ghana) have some form of explicit budget earmarks. Other countries that have achieved UHC have done so without such earmarks, but have consistently kept their budgetary allocation to health relatively high. In Japan, for example, the Ministry of Finance and the Ministry of Health, Labour and Welfare negotiate to set the fiscal subsidy each year, and the fee schedule and payment systems are adjusted every two years to meet the changing fiscal envelope (Table 2).

Thailand and Turkey have strong macroeconomic conditions and have placed a high priority on health in the government budget. Brazil integrated its multiple programs into a single publicly funded Unified Health System (SUS) covering the whole population and financed through general taxation. The new arrangement allowed for private health insurance, initially expected to be supplemental, although a low health budget and SUS underfunding led private health insurance programs to expand. Although the whole population is entitled to free services in the SUS delivery

system, its chronic underfunding has driven significant numbers into the private insurance market, which has increased out-of-pocket spending and eroded financial protection. Brazil has the highest share of out-of-pocket spending among group 3 and 4 countries at 30 percent (Figure 3). This private spending is concentrated among the wealthiest, with the top income quintile accounting for 58 percent of it (private insurance and out-of-pocket payments combined), but it also places a burden on low-income households, consuming up to 7 percent of their income (Uga and Santos 2007).

**Figure 3 Out-of-pocket health spending as a percentage of total health expenditure, 2011**



Source: World Development Indicators, 2013. (Global data with 11 case countries highlighted.)

In France and Japan, demographic changes (e.g. an aging population and a decline in the share of working age adults), combined with recent financial crises and a prolonged recession have been eroding fiscal space. As a result, Group 4's countries, both high income, are now seeking ways to diversify their revenue base, including expanding consumption tax (Japan) and further diversifying earmarked taxes (France). In France, wage-based contributions constituted 98 percent of the total at the inception of the social health insurance system, but now represent less than half. Unemployment was another factor in lowering wage-based contributions in that country.

Many countries are seeking to diversify sources of revenue for UHC. Various factors explain this, and so strategies vary among countries at different stages moving toward UHC. High-income countries such as France and Japan are seeking to reduce overreliance on payroll taxes, which can lead to labor market distortions and are no longer generating enough revenue given aging populations. Countries with a large informal sector such as Thailand have also found it difficult to expand coverage through payroll taxes alone and have expanded their allocation to health through general revenues. By contrast, low-income countries such as Bangladesh and Ethiopia are seeking ways to expand their narrow tax base by introducing new payroll taxes under a social insurance program.

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**Table 2 Financial earmarking and commitments to UHC in 11 countries**

<b>Political commitment to UHC accompanied by specific financial earmarking</b>	France	Earmarked taxes (initially payroll tax; since 1998 earmarked taxes on income and capital)
	Ghana	Earmarked portion of value-added tax and social security contributions
	Brazil	The minimum amount of resources to be allocated to the Ministry of Health and to state and municipal health secretariats is defined by Constitutional Amendment No. 29/2000, which defined minimum levels of health spending by sphere of government.*
<b>Political commitment without explicit earmarked commitment</b>	Japan	No explicit earmarked amounts, but high priority in the budget
	Thailand	
	Turkey	
	Bangladesh	No specific commitment, and varying levels of budget priorities
	Ethiopia	
	Indonesia	
	Peru	
Vietnam		

Source: Country summary reports on UHC, 2013.

\* Brazil's constitutional amendment earmarks the following minimum budget allocation for health care services: for the municipalities, a minimum of 15 percent of the total budget; for the states, no less than 12 percent of the total budget; and for the federal government, the equivalent of the health budget from previous fiscal year adjusted by the nominal change in GDP.

### ***Managing expenditures well and ensuring value for money***

As all countries face resource constraints in achieving or maintaining universal coverage, managing spending efficiently is critical to get the most from available funding in terms of coverage. Countries therefore need to put in place expenditure management measures that ensure that the expansion of coverage can provide benefits in a fiscally disciplined and accountable manner. Fiscal sustainability of the health system means that health expenditure growth does not exceed the available resource base, which is determined by both the overall fiscal context and policy priorities within available resources.

Countries at early stages of UHC face the challenge of mobilizing resources to expand coverage, a move that relies on increases in health expenditure. These countries have tended to focus more on mobilizing revenues to expand coverage and less on managing costs. Often, however, policies born from compromises early in the design and adoption phase plant the seeds of future cost escalation. Insufficient attention to expenditure management in early stages can potentially leave countries vulnerable to cost escalation and subsequent strong policy influence by interest groups at future stages. And so investing in the institutional capacity to use expenditure management levers during the early design phase and at key junctures of system refinement are important considerations for enabling future coverage expansion.

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How expenditure management is carried out is critical, as simply pursuing cost containment may erode coverage. Expenditure must be carefully managed to improve efficiency in a way that, on balance, leads to coverage-enhancing outcomes and avoids measures eroding coverage. Finding the right balance of policies that help to contain costs (even while overall spending may need to increase) without eroding coverage is a challenge, although experience from countries in groups 3 and 4 may offer suggestions on how to do this. France is a country that sets explicit national spending targets, with rigorous monitoring mechanisms to help curb health expenditures. Also, group 3 and 4 countries have introduced policies that focus on reducing rents accumulating to some interest groups, such as tertiary care providers and pharmaceutical companies, rather than cutting back on benefits. Other examples of implicit expenditure management include encouraging utilization of more cost-effective services, such as emphasizing primary care in the benefits package and investment in health services, or reducing cost-sharing on more cost-effective services. Examples of coverage-eroding measures include an increase in cost-sharing and shifting a greater financial burden to beneficiaries. In Brazil, for example, the chronic underfinancing of the integrated health services under SUS has resulted in limited access to quality health services for lower income groups, while the wealthier households have relied on private insurance.

Countries relying on open-ended fee-for-service payment are facing cost escalation, and efforts to contain costs are eroding coverage. A number of countries in groups 1, 2, and 4 either pay providers open-ended fee for service (Ethiopia, Ghana, Indonesia, France) or have ineffective caps (Peru and Vietnam). In Peru for instance, one of the main health funds (SIS) pays providers open-ended fee for service with, ostensibly, no budget caps, but to stay within the budget regional administrators impose implicit caps by ceasing to provide certain services, medicines, tests, and procedures (Francke 2013). Similarly in Vietnam the health purchaser, Vietnam Social Security, pays most hospitals by fee for service with a global budget cap, but there are strong incentives for hospitals to spend beyond the cap. For example, Vietnam Social Security typically reimburses hospitals up to 60 percent of their overruns, and overspending in one year leads to a higher cap the next year resulting in a more generous budget. Some cost management measures designed to counter these rising costs end up shifting the burden to the beneficiaries, thus increasing informal payments and eroding financial protection.

All countries struggle to find an appropriate balance between containing costs and protecting coverage. Japan has a unique approach to fee for service through its biennial revision of the fee schedule, which places strong downward pressure on total health spending. The country offers financial protection to households by capping copayments and subsidizing catastrophic health expenditures. These measures have helped Japan to mitigate the coverage-eroding effects of an open-ended fee-for service payment system. For its part, France has recently introduced pay-for-performance contracts for primary care (initially paid fee for service) as a means to control costs while simultaneously improving quality and coordination of care—although the outcomes of these efforts have yet to be evaluated.

Managing costs without eroding coverage can be facilitated by a strong purchasing agency that has both the leverage and capacity to negotiate prices with providers and suppliers on behalf of beneficiaries. The integration of health programs in Thailand and Turkey has helped to create such purchasing capacity. For example, Thailand's National Health Security Office is the single purchaser for three-quarters of the country's population under the Universal Coverage Scheme (or about 50 million beneficiaries), giving it substantial bargaining power. It has negotiated to bring down prices of medicines, medical products, and interventions—cutting, for example, the price of hemodialysis from \$67 to \$50 per cycle, potentially saving \$170 million a year (Health Insurance System Research Office 2012).

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In addition to leveraging provider payment systems to make health care providers accountable for providing services efficiently, some countries have explicitly focused on supply-side policies that promote more cost-effective interventions. These include investments in primary care and public health functions, and stronger regulation on the introduction of new technologies. They have also used demand-side management, including strategic copayments to discourage unnecessary services or to encourage utilization of primary care, or have offered incentives and subsidies to patients for services with public health benefits.

Countries more successful in managing costs without eroding coverage have used concerted approaches. In Thailand and Turkey, effective policies include a balanced approach to prioritizing services and medicines for benefits package expansion, strong negotiation with pharmaceutical companies, and leveraging provider payment systems so as to bring more benefits to more people. In France, 20 years of budget deficits started to decline in the past several years through a series of measures including setting national spending targets, reforming provider payments for both primary and acute care and strengthening state stewardship on health insurance spending through rigorous monitoring mechanisms established under the “Alert Committee”. The problem is far from solved, however, as the economic downturn has put further strain on budget revenues, and new cost pressures have arisen (Table 3).

**Table 3 Coverage-enhancing expenditure management approaches**

<b>France</b>	<ul style="list-style-type: none"> <li>• A set of expenditure controls through prospective and compulsory spending targets; enhancing primary care gatekeeping; introducing pay-for-performance for GPs and reforming Hospital payment system</li> </ul>
<b>Japan</b>	<ul style="list-style-type: none"> <li>• Nationally managed fee schedule revised every two years to keep total expenditure increases within agreed level of budget subsidies set by government</li> </ul>
<b>Thailand</b>	<ul style="list-style-type: none"> <li>• Closed-ended capitation contracting with diagnosis-related group hospital payment</li> <li>• Strong primary care gatekeeping</li> <li>• Tough negotiation with pharmaceutical companies</li> <li>• Priority-setting for expansion of the benefits package</li> <li>• System focused on primary care</li> </ul>
<b>Turkey</b>	<ul style="list-style-type: none"> <li>• Closed-ended payment systems with performance-based component (global budget for hospitals and capitation for primary care)</li> <li>• Expenditure caps at the hospital level and on pharmaceuticals</li> <li>• System focused on primary care</li> </ul>

Source: Country summary reports on UHC, 2013.

***Managing effective risk pooling and redistribution of resources***

Providing universal coverage and financial protection for the whole population requires cross-subsidization, both from rich to poor and from people at low risk of illness (e.g. the young) to people with higher risks (e.g. the elderly). The structure of UHC programs as well as the sequencing of coverage expansion is critical for effective redistribution to achieve equity.

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Cross-subsidization appears to be more effective when there is a single integrated program based on general tax revenue. Turkey has set up a single integrated program and achieved a high degree of cross-subsidization and equity in financing. Although Ghana has yet to achieve universal coverage, within the risk pool established under the NHIS, redistribution from wealthy to poorer households is made possible by the reliance of progressive general taxation for the majority of funding in the system, and the redistributive function of the NHIS pool. One Ghana study found that the poorest 20 percent of households bear less than 3 percent of the burden of funding the system, but the wealthiest 20 percent almost 60 percent (Akazili, Gyapong, and McIntyre 2011).

Effective risk pooling and cross-subsidization constitute a major challenge, however, when coverage expands through multiple programs. Thailand's Universal Coverage Scheme covers the largest number of beneficiaries and it effectively ensures cross-subsidization and equitable financial risk protection *within* this covered group. However, Thailand still maintains three separate insurance programs, and per-beneficiary expenditure across the three is highly skewed because of the lack of redistribution *across* them. In 2011, annual per-beneficiary expenditure was \$366 for the Civil Servant Scheme, \$97 for the Universal Coverage Scheme, and \$71 for the formal sector program.

Some countries have achieved effective cross-subsidization with multiple programs by standardizing key facets of the system and cross-subsidizing or consolidating pools. The Group 4 countries have achieved this across multiple programs by standardizing the benefits package and enforcing redistribution mechanisms (Japan) or consolidating into fewer programs with larger pools (France). Japan uses a combination of standardization of benefits and provider payment across plans, intergovernmental transfers of subsidies, as well as transfers between funds. For example, in 2013 the insurance plans for large corporations is expected to transfer about 46 percent of the premiums they collect directly to the elderly care risk pool managed by the government. This transfer is on top of the general revenue subsidies going to these programs. Cross-subsidization has not, however, kept pace with the changing demographic profile, and disparities in premium rates are growing among the social health insurance groups .

Consolidation of insurance schemes has been key to UHC in several countries. Among the Group 3 countries, Turkey undertook major reforms to consolidate multiple insurance programs and achieve integration and cross-subsidization. Brazil's 1988 constitution established the SUS, financed through general taxation. Thailand consolidated two programs in 2001, but still maintains three separate programs, as just seen. Among the Group 2 countries, Ghana and Vietnam have integrated multiple programs. Ghana has a single risk pool under its new health insurance law, but in Vietnam, the actual pooling of revenues and cross-subsidization of expenditures remain incomplete. Indonesia and Peru are moving toward consolidating multiple programs in a final push to UHC. Indonesia's integration into one national system is scheduled for January 1, 2014. In Peru, the 2010 Universal Health Insurance Law has created a regulatory framework to achieve UHC through a coordinated institutional integration process of the two main social insurance funds (SIS and EsSalud). Peru is working on plans for further institutional integration, to be introduced in 2014.

## **GLOBAL LESSONS IN HEALTH SERVICE DELIVERY AND HUMAN RESOURCES FOR HEALTH**

Improving access to health services—whether in the form of essential medicines and technologies to prevent health problems or to diagnose and treat patients—requires well-trained, motivated health workers. Yet all 11 countries face major challenges in health worker production, distribution, and performance for meeting changing health care demands.

***Increasing the production of qualified health workers***

The expansion of benefits and coverage under UHC requires investments in the health workforce to ensure affordable, appropriate, and effective health services. Countries that have committed to UHC need to develop strategies to increase the production of health workers to meet growing and changing demand for health services.

Shortage of health workers is a global challenge, but it is especially acute for countries in early stages of UHC adoption and implementation. Of the 11 countries, those in groups 1–3 are at various stages in their efforts to scale up the education and training of health workers. Table 4 shows the density of skilled doctors, nurses, and midwives in the countries, and summarizes the skilled health workforce gaps faced by them, as measured by the percentage increase in health workers required by 2035 to meet the minimum threshold of 2.28 workers per 10,000 population, as estimated by WHO. While criticisms have been raised over the viability of the threshold estimate, the approach has helped draw attention to the global health workforce crisis. These figures are not meant to inform decision makers about an optimal distribution of health workers in their country nor establish a normative standard, but rather offer an indication of the size of the challenges that low-income countries face. Bangladesh and Ethiopia, for example, facing a four- to 13-fold increase in the number of skilled health professionals—even when spread over two decades—have a formidable challenge. For these and other countries in the early stages of UHC adoption and implementation, the table underscores the need to revisit traditional models of education, deployment, and remuneration.

**Table 4 Health workforce estimates for the 11 countries, c. 2010 and 2035**

Country	Density of skilled health professionals (doctors, nurses and midwives) per 10,000 population, c. 2010	Percentage change in workforce required to reach 22.8 threshold* by 2035
<b>Group 1</b>		
Bangladesh	5.7	404
Ethiopia	2.7	1,354
<b>Group 2</b>		
Ghana	13.6	221
Indonesia	16.1	78
Peru	22.2	33
Vietnam	22.3	19**
<b>Group 3</b>		
Brazil	81.4	0
Thailand	17.4	32
Turkey	41.1	0
<b>Group 4</b>		
France	126.6	0
Japan	63.3	0

Source: Global Health Workforce Alliance 2013.

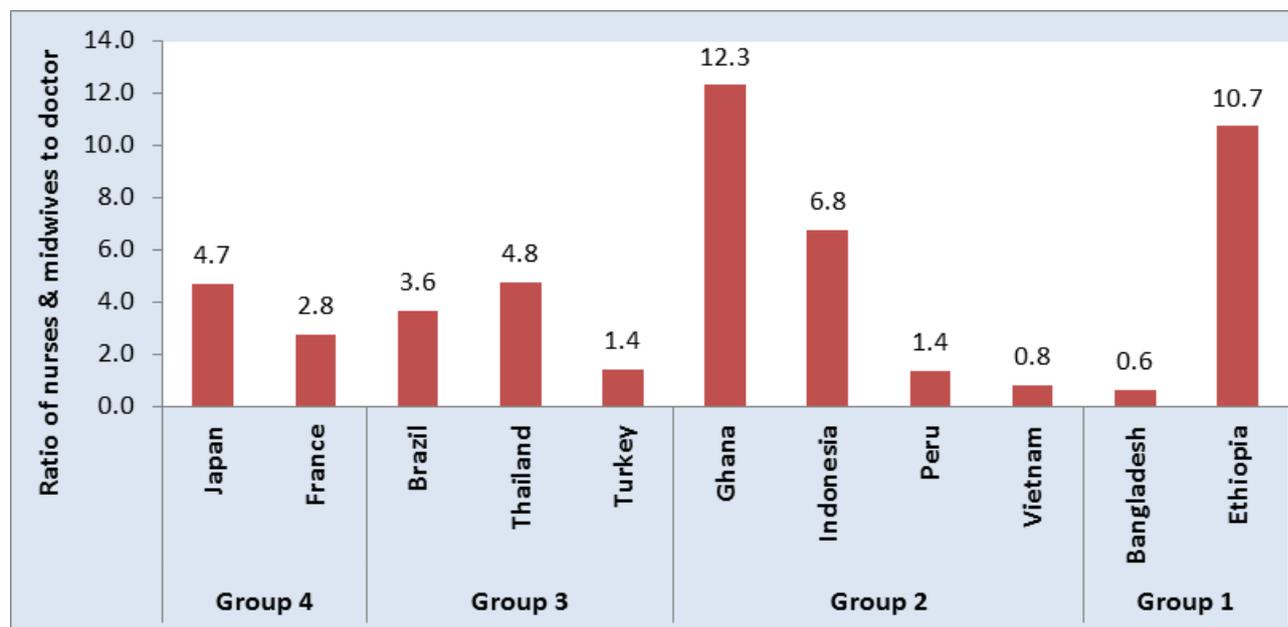
\* Health workforce density of 22.8 skilled health professionals per 10,000 population is the lower level recommended by WHO to achieve relatively high coverage for essential health interventions in countries most in need (WHO 2006).

\*\* Authors' calculation.

Scaling up health workforce production should not be considered only in terms of adding new staff, but will require consideration of the current workforce profile and skill mix of health workers that match local conditions and service requirements. The 11 countries have considerable variation in the skill mix of health workers, in categories of professionals (doctors, nurses, midwives, community health workers) and within professional groups (generalist and specialist doctors) (Figure 4). Countries have very different staff mixes, and it is evident there is no single universal optimal mix. However, a skewed mix—for example, countries with a very high ratio of doctors to nurses, as in Bangladesh—will mean that doctors are not working optimally because they may have to cover for insufficient availability of nursing care. Countries should examine their current mix, benchmark against others, and make policy decisions about the need for any adjustment to improve UHC attainment.

Understanding the underlying reasons for these skill imbalances and their implications for the health service delivery system will require further analysis. But what is not immediately evident in either Table 4 or Figure 4 is the role of other para-professionals and community health workers, who are important in health care. In some countries, community health workers are vital for delivery of preventive and primary care services, particularly in rural areas. As discussed in the next section, changes in the health care delivery model and introduction of different categories of health workers are likely to be important strategies for increasing the availability of health workers for the immediate and medium-term future.

**Figure 4 Ratio of nurses and midwives to doctors**



Source: World Development Indicators (2011 or latest year available); Ministry of Health, Labour and Welfare for Japan.

Broadening the recruitment pool and offering flexible career opportunities to health workers will be important for expanding the health workforce in a relatively short time. Many low- and middle-income countries face a limited pool of graduates while the demand for health professionals is outstripping the system’s capacity to produce them. High-income countries face similar challenges in recruiting students at a time when demand for health and long-term care continues to rise. To

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address this gap, many countries are introducing mechanisms to broaden the recruitment pool, and are examining the scope for flexible and nontraditional routes into the health workforce.

Some of the 11 countries are expanding recruitment of mid- and lower-level health workers, and in some cases creating new categories of health workers to meet the specific needs of communities facing health worker shortages. These categories have shorter periods of education and can be developed and deployed faster. Examples include Ethiopia's health extension workers (Box 6), community health workers in Brazil, and Licensed Practical Nurses in Japan. These strategies have helped significantly in expanding health services by building up the workforce capacity in underserved areas or specialties. However, they also require multiple changes in the way health care is delivered and a redefinition of the scope of practice and functions of health workers' different categories. There is usually also a need to develop the system of regulation to determine and differentiate the education content, and standards of training and practice. Regulation should clearly distinguish the scope of practice of different categories, so as to avoid role confusion or unnecessary role overlap, and to ensure safe care provision.

**Box 6 Ethiopia's Health Extension Program**

The Health Extension Program (HEP) was launched in 2003 in the four major agrarian regions and later tailored and scaled up for pastoral and urban communities. HEP was developed by the government to be the main vehicle for achieving universal coverage of primary health care. The motivations for HEP included: low coverage of high-impact interventions; low access to health services, particularly by the rural poor, as well as an overall shortage of health workers; and weak institutional synergies to expand primary health care. The HEP is now fully integrated into the broader health system and is an integral part of the Primary Health Care Unit structure. The program delivers 16 defined packages of preventive, promotive, and basic curative services. All its services are free and available to everyone.

Health extension workers (HEWs) are the key players in the program. They are all female, 10th grade high school graduates, recruited from the community with its participation. They are trained for a full year and then deployed back into the community to promote health and provide services at the village level. Much of their time is spent on home visits and outreach. Since HEP was launched, over 35,000 HEWs have been recruited, trained, and deployed to villages, and 15,000 health posts have been built and equipped with community participation and contributions.

Since its rollout, the HEP has shown positive results in areas related to disease prevention, family health, hygiene, and environmental sanitation. However, despite considerable achievements in the last decade, HEP faces a number of challenges. These include improving the quality of services provided under the program; enhancing skills and performance of the HEWs, particularly in the area of maternal health; and sustaining the program with an appropriate career structure for the HEWs.

Countries that wish to scale up their health workforce will need better estimates of the time required to develop and deploy different staff types, and of their costs and options for achieving optimum staffing and mix within their available labor and resource pools. Countries will also need to understand job and labor market conditions that these workers will face and the incentives influencing workers' choices and preferences and their willingness to take up employment, so that there will be a better match between job characteristics and workers' preferences. For the most effective investments, policy makers will require information on the relative costs of employing

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different types of staff, as well as the effect on care access, quality, and outcomes of these various types. Research into this aspect remains extremely limited even in high-income countries, and warrants more attention from health policy makers and researchers.

***Ensuring equitable distribution of health workers***

All the 11 countries are grappling with maldistribution of health workers, but the issue is one of the most challenging for countries in groups 1 and 2. For them, recruitment and retention in rural and remote regions often presents one of the most difficult issues in their quest to achieve UHC. Countries in Group 3 have made large improvements in reducing geographic disparities as part of their UHC efforts, and their experiences offer useful insights.

Countries that have had relative success in reducing rural–urban disparities have done so through multiple strategies that address health workers’ career aspirations via monetary and nonmonetary incentives, as well as improvements to working conditions and supportive supervision in health facilities (Araujo and Maeda 2013). These strategies include recruiting students from underserved areas, encouraging their enrollment through scholarships, setting quotas in schools, ensuring that curricula include rural service components, and offering monetary and nonmonetary support for career development. Compulsory service through bonding is another common policy for deployment in underserved areas. Countries in Group 3 have used a combination of these policies, and many of those in Group 2 are developing and implementing policies with similar, multipronged approach (Table 2 in the Annex gives details).

Another important strategic approach is to invest in primary care workers, both because investments in the hospital sector tend to skew the health workforce distribution toward urban areas and because investments in these health workers have additive benefits for health outcomes. All the Group 3 countries have followed that strategy in expanding coverage and reducing regional disparities. Brazil made major investments in its Family Health Strategy (ESF) and Community Health Agents Program (PACS), which contributed to achieving near universal coverage over the last decade. Turkey too has been successful in reducing geographic disparities, notably through its Family Medicine Program, which emphasizes primary care (and see Box 7).

**Box 7 Turkey’s strategy for reducing regional disparities in the health workforce**

The Family Medicine Program explicitly encourages doctors and health workers to serve among rural populations. When family practitioners have registered patients in rural areas, health house midwives are assigned to them. In addition, periodic mobile outreach services are provided to those who live in rural areas. The monthly base payment of family medicine physicians is adjusted for the socioeconomic level of their area of practice. Family physicians working in underserved areas receive a “service credit” on a sliding scale, also linked to the socioeconomic development index of the district. In the least advantageous areas, the service credit can be as high as 40 percent of the maximum base payment. Since the introduction of the Family Medicine Program, disparities in the distribution of health personnel across the country have declined.

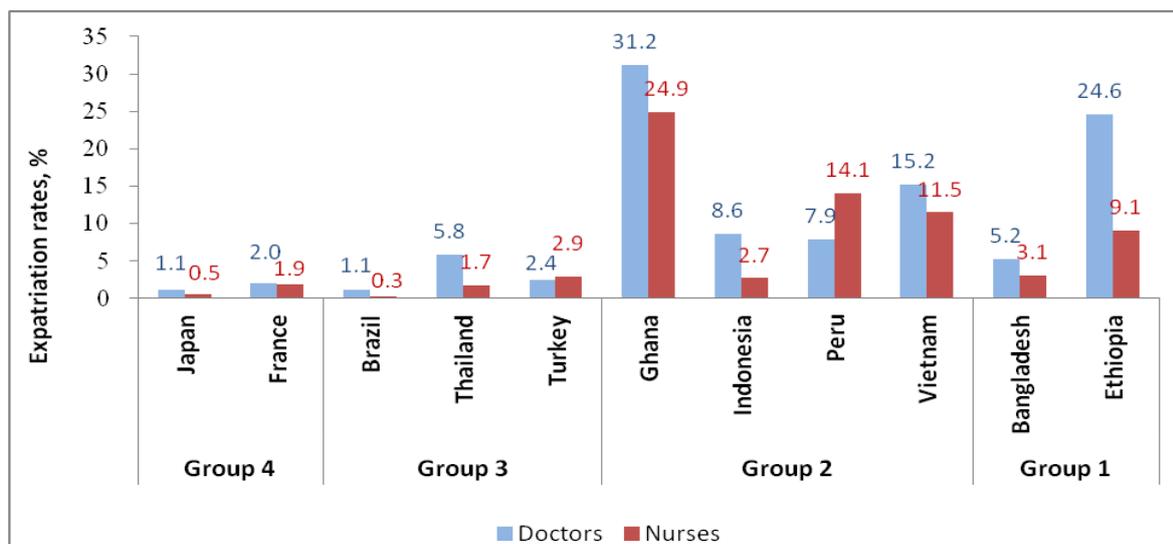
Enforcement of compulsory service for all public and private medical school graduates is another factor contributing to improving geographic distribution. Further, the Regulation on Appointment and Transfer ensures more balanced distribution of health care personnel across all MOH health care facilities. Under this regulation, specialists, general practitioners, dentists, and pharmacists are appointed through a computer-based lottery, and other personnel are appointed by a central examination conducted in accordance with general provisions.

Source: Turkey Country Summary Report 2013.

In 1979, Thailand faced a 21-fold difference in physician density between Bangkok and the rural Northeast regions. From 1975, financial incentives in the form of monthly hardship allowances were introduced for rural recruitment and retention in rural areas with a focus on primary care services, and since 1997, these allowances have been adjusted to reflect inflation and differentiated by hardship levels. By 2009 the physician density had been reduced to a five-fold difference, and the difference in the nurse density from 18-fold to three-fold.

Remuneration for workers at public facilities would need to be set high enough to attract competent students to become health workers and retain them in the priority sectors (i.e. the public sector and rural/remote areas), at the same time avoiding overpayment. Remuneration of health workers is one of the key factors affecting both recruitment (attractiveness of the profession) and job satisfaction. In many LMICs remuneration for public-sector health workers is low, leading to many problems in access to and quality of care. These include dual practice (health workers employed in government health facilities work in private clinics to maintain an acceptable standard of living); movement of health workers to private health care providers and abroad; and transfer of competent graduates to non-health occupations. The globalization of the health labor market has greatly increased mobility of health workers across national borders, requiring countries to consider this broader global health labor market when formulating their health workforce policies. Emigration of health workers abroad is substantial for countries in groups 1 and 2, but seems less of an issue for those in groups 3 and 4 (Figure 5). The 2006 wage reforms of government health workers in Ghana appear to have contributed to an increase in the number of students entering medical professionals and a decline in the number of physicians emigrating. When Thailand had to contend with a rapidly growing private sector and strong pull from abroad, the government raised remuneration for public-sector health workers (Box 8).

**Figure 5 Expatriation rates of doctors and nurses**



Source: OECD 2012.

Note: "Expatriation rate" refers to the percentage of the category of workers living outside their country at a given time. Data are for 2000, as more recent, comparable data are not yet available.

**Box 8 Raising the remuneration rate of public sector health workers in Thailand**

Thailand has made good progress in expanding the health workforce to meet growing demand. Beyond increasing the production of doctors and nurses, the government raised basic salaries and introduced incentives to attract and retain health workers to counter the strong pull from growing alternative jobs in the private sector and abroad. A nonprivate practice incentive was introduced in 1995. A long-term service allowance was introduced in 2005 for those who had worked more than three years and for those in four southern provinces suffering from unrest.

Source: Thailand Country Summary Report 2013.

***Improving health worker performance to raise productivity and quality of care***

It is essential for policy makers to understand the level and determinants of health workforce performance in order to address the shortcomings and build on its strengths. While comprehensive global evidence is lacking, partial evidence suggests that health workforce performance is far from optimal in most countries, irrespective of national income. Assessing the extent to which health workers perform well in the workplace would provide important feedback to guide education reform as well as inform changes in the system of incentives, human resources management, and broader labor market issues. Yet this is an area little studied in the health workforce literature, and there is a global lack of data and studies on measuring health worker performance, as well as a paucity of evidence on identifying what can be done to improve individual and team performance. The following summarizes some of the salient features of the 11 countries. Additional details are in Table 3 in the Annex.

The regulatory system for standards for accrediting health worker training schools, for the caliber and availability of faculty, for the examination and licensing/registering process, and for

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recertification (if any) are important in health workforce quality. Countries in group 1 and 2 countries face major constraints from education systems unable to produce enough graduates who meet minimum quality standards. These countries are seeing a rapid increase in the number of education institutions, including in the private sector, which is creating new challenges in developing capacity to assure training content and graduate quality. Without appropriate accreditation of schools by a government or independent agency, there is a risk that curriculum quality may be compromised. Countries also need to address the provision of continuing education and training to current staff so as to reorient and increase their skills.

Adequate remuneration of health workers that takes into account labor market conditions, and a system that links health worker performance to payment and is complemented by a supportive work environment, are essential for improving performance. Linking payments or other forms of incentives to health worker performance is becoming increasingly important in countries at all stages of UHC, but evidence so far is mixed on this strategy's effectiveness.

Nonmonetary incentives appear to be as important as monetary incentives, often relating to health workers' career development aspirations and working environment. Examples of nonmonetary incentives linked to job satisfaction, and so indirectly to quality of care, are individualized mentoring; periodic performance reviews with specific feedback and development plans; opportunities for continuing education (including the free time needed); career structures that offer the potential for promotion to posts with additional responsibilities and rewards; and verbal and other nonmonetary recognition of good performance.

## **CROSS-CUTTING ISSUES RELATED TO POLITICAL ECONOMY, HEALTH FINANCING, AND HEALTH SERVICE DELIVERY AND HUMAN RESOURCES FOR HEALTH**

**Key lessons that cut across these themes emerge from the country studies.**

There is a need for adaptive leadership that takes into consideration the perspectives of the different interest groups in designing and planning the UHC strategy. Adopting, expanding, and sustaining UHC programs involve interaction with multiple interest groups that influence decisions on the design and implementation of programs, including key decisions on budget allocation and investments in the health workforce. The country studies suggest that progress toward UHC involves constant adjustments to find a balance between making strategic compromises and implementing a sustainable path to equitable coverage.

Policies that reflect the perspectives of different interest groups may lead to a technically suboptimal but politically feasible solution. A recognition that political compromises may weaken the impact of some policies on UHC objectives or exacerbate potential unintended consequences can inform more flexible and inclusive monitoring and evaluation approaches to complement traditional quantitative methods.

Defining the benefits package and the depth and scope of services covered under UHC is one of the most challenging issues that policy makers face in designing and executing UHC strategy. The approach needs to go beyond defining services covered, to include levels of subsidization and copayments, choice of health care providers, and conditions for reimbursement. Moreover, these benefits need to be translated into services on the ground, with appropriately skilled workers and financing systems and adequate medicines, technology, and infrastructure.

It is important to lead with a strong commitment to primary health care in tandem with careful cost management. The effective rollout of universal coverage in Group 3 countries has been enabled by a

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strong tradition of primary care at local level. Brazil's Family Health Strategy gave high priority to providing quality primary care coverage to families where access had been lacking. This has helped to avoid situations which contribute to cost escalation, for example when patients sidestep clinics that provide primary care and go directly to secondary and tertiary hospitals designed to treat more advanced, complex, and severe cases, where care is more costly. Thus focusing the UHC strategy on primary health care accomplishes multiple objectives: health service access and financial protection are improved at the initial point of contact with beneficiaries; resources are directed to more cost-effective services; and overall costs in the system can be more easily managed.

Provider payment policies and systems are crucial in directing resources and creating incentives for quality, equity, and efficiency, and countries are increasingly moving away from supply-side budgeting (financing of inputs) toward demand-based payments and output-based payments that link expenditures not to inputs but to results (outputs and outcomes). These payment systems require parallel investments in institutional and technical capacity to conduct independent audits and service reviews, and are necessary to mitigate supplier-induced demand (use of unnecessary procedures) and to promote safety and adherence to quality standards in health care.

Reforms to payment systems also require concurrent reforms in governance of the health care delivery system to address some of the structural constraints, such as a rigid civil service structures and public finance systems, which can constrain providers from responding to the incentives created by the reformed payment systems. Examples include governance reforms in government-run hospitals (as in France and Japan) and contracting-out of services when internal reforms are hard to achieve (such as primary health care contracting in Brazil).

Public health programs that are designed to reduce public health risks for the population as a whole are often excluded from the discussion of health service coverage for UHC. For example, Japan's public health programs administered through local governments played a key role in reducing public health risks and improving population health outcomes, such as reducing tuberculosis in the 1950s and cutting salt intake (and so health risks from hypertension) in more recent years. These programs address issues that are not always definable in terms of individual benefits, are often not managed by the health funds that purchase or administer services for personal health care, and are funded from different budget sources.

## **LESSONS FOR COUNTRIES IN THE FOUR UHC GROUPS**

### ***Group 1 countries***

These countries are struggling with expanding very basic health prevention and promotion services, and face major constraints of acute health workforce shortages and restricted financial resources. Their initial challenge is to find innovative approaches to expanding the health care workforce in a short time, at a relatively low cost and directed at reaching underserved areas. Ethiopia's effort to scale up training and deployment of Health Extension Workers and to concentrate attention on primary care services is exemplary from this perspective. The decisions initiated at this early stage of UHC can have long-term repercussions on the development of the health system. It may be instructive for these countries to examine the experiences faced by the Group 2 countries currently tackling the problems created by their earlier decisions that have led to highly fragmented health systems. For example, Bangladesh and Ethiopia are both considering the introduction for social health insurance as the financing vehicle for expanding coverage; this would result in preferential coverage for formal sector workers and exclusion of households in the informal sector.

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***Group 2 countries***

These countries have made substantial progress toward expanding coverage and building institutional capacities, but they often end up with multiple health programs with different benefits and delivery systems. They face uncovered population groups, mostly in the informal sector, which existing programs find hard to reach. These countries are taking steps to integrate or harmonize their different systems, and are looking for approaches to reach the remaining uncovered groups. Learning from the experiences of group 3 and 4 countries may be helpful, notably in how those two groups extended coverage to the informal sector and other hard-to-reach population groups, and how they managed to integrate or harmonize multiple programs. Ghana has already taken steps toward integration through its NHIS; similarly, Indonesia and Peru are preparing to integrate health funds in one national health insurance system, both in 2014. Vietnam is reviewing its fragmented payment system and considering options to take a more coordinated approach to aligning payment incentives at all levels of the health system.

***Group 3 countries***

These have achieved UHC in terms of population coverage, but struggle to contain costs and meet the demand for more comprehensive coverage and higher quality care. They face accelerating cost pressures, rising demand for quality services from a growing middle class, and the consequences of aging populations with a higher burden of chronic diseases. Another key issue is regulating the role of the private sector in UHC, both as payer (private insurance) and provider. Thailand and Turkey have restricted the role of private insurance by ensuring substantial funding through public resources to cover health care. Brazil has allowed the private insurance market to expand rapidly, while the public sector struggles to provide quality services, as reflected in continuing high out-of-pocket spending by Brazilian households. The emergence of a two-tiered system could also undermine equitable coverage. Recent efforts by some Brazilian states to expand contracts with nongovernmental providers to expand primary care services in underserved areas present an important step to stop the erosion of coverage due to lack of access to quality primary health care.

***Group 4 countries***

This group's two countries have a long history with UHC and well-established institutions. Rapid advances in technology combined with aging populations and ever-tightening budget resources are putting new pressures on their systems. These pressures are forcing these countries to seek new ways to improve the performance of the health system, manage costs, and maintain equitable UHC. France is struggling with fiscal constraints and cost-containment issues. Japan is facing a small but growing number of people who are not covered as well as growing disparities in contribution rates among households, and is considering reform measures.

## **NEXT STEPS**

UHC offers great opportunities for reducing poverty and securing the health care needs of a country's lower-income groups. To exploit this potential, each country will need to develop an adaptive health system with solid institutional foundations and governance, leaders with the vision to take advantage of these opportunities and the will to support them, and an engaged civil society that demands accountability and transparency as a check against institutional weakness and interest-group politics. Technocratic solutions to these policy issues will need to be matched by careful strategic planning that takes account of these and other political economy issues.

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The World Bank, with support from the government of Japan and other partner governments and agencies, is committed to helping countries make informed decisions and investments in achieving their UHC goals. A number of initiatives and actions are proposed to take this agenda forward. WHO and the World Bank are collaborating to develop a framework for measuring progress toward UHC. Training and capacity building programs for policy makers and policy analysts will be provided through courses such as the World Bank Institute's Flagship Course on UHC. There will be support for joint learning platforms and practices, such as the Joint Learning Network, to help countries articulate their demand for technical assistance and information, and encourage systematic exchange of knowledge and experiences among countries.

The ultimate objective of these programs will be to assist countries set their own priorities and assess progress toward UHC, and to offer a knowledge platform that promotes effective learning across countries. The experiences of countries examined as part of the Japan–World Bank Partnership make clear that attaining UHC is a complex process, fraught with challenges, many possible paths, and multiple possible pitfalls—but one that is feasible. There is no single solution, but countries can be better prepared, and therefore have a better chance of succeeding, if they start with political commitment and a clear understanding of the political economy challenges, enabling them to undertake coverage-enhancing reform that remains sustainable over the long run.

## **COUNTRY SUMMARY REPORTS**

The information in this report is a synthesis of the following country summary reports prepared under the Japan–World Bank Partnership Program on Universal Health Coverage for the Global Conference on Universal Health Coverage for Inclusive and Sustainable Growth, Tokyo, December 2013.

1. Country Summary Report for Bangladesh
2. Country Summary Report for Brazil
3. Country Summary Report for Ethiopia
4. Country Summary Report for France
5. Country Summary Report for Ghana
6. Country Summary Report for Indonesia
7. Country Summary Report for Peru
8. Country Summary Report for Thailand
9. Country Summary Report for Turkey
10. Country Summary Report for Vietnam
11. Country Summary Report for Japan

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**ANNEX**

**Table 1 Subsidies for targeting the poor**

Country	Targeting of subsidies and exemptions
<b>Group 1</b>	
<b>Bangladesh</b>	A voucher program entitles women to access free antenatal care, delivery care, emergency referral, postpartum care services, and cash stipends to cover transportation costs and purchases of nutritious foods and medicines.
<b>Ethiopia</b>	A new fee waiver system is being introduced for poor households, selected through community participation.
<b>Group 2</b>	
<b>Ghana</b>	Poor and vulnerable groups are exempt from paying National Health Insurance Scheme premiums, which are subsidized through the value-added tax's earmarked portion. Exempt groups include all seniors aged 70 and above, retirees who contributed to the social security program, children under 18, pregnant women, and indigents. Overall 65–68 percent of members fall into one of the exempt groups. A high degree of leakage of the subsidy to nonpoor individuals in the exempt groups is suspected, while on the other hand many exempt individuals are not enrolled.
<b>Indonesia</b>	Coverage for the poor and near-poor by <i>Jamkesmas</i> is subsidized by general revenues. The poor and near-poor are identified by a combination of means testing and local government eligibility criteria. High levels of poor targeting and leakages (>50 percent) to the nonpoor stem from variable eligibility criteria and lack of validated targeting. The <i>Jampersal</i> program provides free maternity services (prenatal, delivery, and postnatal) to all pregnant women, regardless of income.
<b>Peru</b>	Enrollment in SIS is subsidized for the poor and near-poor with general revenue funds. However, leakage is significant to nonpoor individuals.
<b>Vietnam</b>	The government fully subsidizes health insurance premiums for children under 6, the elderly, and the poor, and partially subsidizes premiums for the near-poor and students. The poor are identified through local targeting that includes an economic survey and voting among community leaders.
<b>Group 3</b>	
<b>Brazil</b>	A subsidized health care system is available to all citizens, but some implicit targeting occurs as wealthier individuals choose additional private coverage.
<b>Thailand</b>	With a noncontributory system, all coverage is financed through general tax revenues (except the formal sector program).
<b>Turkey</b>	Individuals are classified into one of four income groups. Premiums are fully subsidized for the lowest income group, and on a sliding scale for the remaining three.
<b>Group 4</b>	
<b>France</b>	A state-subsidized program, with no copayments, operates for low-income groups, providing the standard insured benefit package. In addition, an extended benefit package (including complementary coverage as a substitute to private insurance) covers the poorest. A series of targeted subsidies applies for chronic diseases and financial incentives (subsidized vouchers) for accessing private voluntary health insurance.
<b>Japan</b>	Premiums of the elderly, self-employed, and unemployed enrolled in municipality-managed programs are highly subsidized through transfers from central and local government, as well as transfers from the other risk pools with more affluent population groups.

Source: Country summary reports on UHC, 2013.

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**Table 2 Health worker imbalances in distribution, and policies and interventions to address them**

<i>Country</i>	<i>Distributional imbalances</i>	<i>Policies and interventions</i>
<b>Group 1</b>		
Bangladesh	<p>Health professionals, paraprofessionals, and medical technologists are highly concentrated in urban areas, with severe shortages in rural and remote communities. Vacancy rates in rural public facilities are high, but lower among health field workers.</p> <p>There are more primary health care centers in rural areas, and more hospitals in urban areas. This leads to more demand for physicians and nurses in urban areas, and more demand for community health workers and paramedics in rural areas.</p> <p>Almost all training institutions are in urban areas. Most trainees are from urban areas because the required science classes are unavailable in rural schools.</p>	<p>Overall distribution of health workers is the responsibility of the Ministry of Health and Family Welfare, but deployment and appointments are administered by multiple units and at different governmental levels. The allocations are often subject to political influence, and do not necessarily follow policy directives.</p> <p>Many interventions are showing some impact in addressing shortages of health workers in rural areas, including training by nongovernmental organizations of community health workers and increases in the number of skilled birth attendants. However, scaling up these interventions would help to address these challenges, which should be done in a coordinated manner across the many entities involved in the policy design and implementation process.</p>
Ethiopia	<p>There is substantial regional variation in health worker density between regions. The density per 1,000 population is in the range of 0.01–0.33 for physicians, 0.003–0.06 for health officers, 0.07–1.18 for nurses, 0.01–0.08 for midwives, and 0.23–0.70 for health extension workers.</p>	<p>Health extension workers and health officers are recruited from rural communities, and trained in rural contexts. This has helped in deploying and retaining them. There is no specific financial incentive scheme to attract health workers to rural areas.</p>
<b>Group 2</b>		
Ghana	<p>Access to health workers has generally improved in recent years. However, distribution still favors urban areas, and hospitals rather than clinics. Health worker density is highest in the Greater Accra and Ashanti and Volta regions, and lowest in the North.</p> <p>Preservice training for physicians remains concentrated in a few urban areas, but nurse and midwife training institutions are more widely distributed.</p>	<p>Government measures to reduce disparities in health workforce distribution include investing in setting up training institutions for physicians in regions and districts, and offering incentive packages such as housing support, additional allowances, and career opportunities. A five-year bonding program with service commitments to high-priority areas, in exchange for preservice support, has been launched.</p>

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<b>Country</b>	<b>Distributional imbalances</b>	<b>Policies and interventions</b>
Indonesia	<p>Significant geographic disparities remain in the density of health workers, with concentration in Java (except North Java), and low densities in remote provinces of Nussa Tenggara Timur, Maluku, and Papua.</p> <p>Large, urban hospitals attract specialists and doctors, and the high density of doctors coincides with hospital distribution.</p> <p>Local governments hold strong powers to regulate and influence hiring and deployment of health workers, but provincial wealth and availability of fiscal capacity is not always correlated with availability of doctors.</p>	<p>The central government has tried a range of policies to improve distribution, including the Health Act, which gives government the responsibility for national distribution of health workers based on standards on inputs, processes, and outputs; the Medical Act, which restricts medical doctors from working at more than three sites; and the Hospital Act, which sets standards for hospitals, including human resources.</p> <p>Central and local governments offer financial incentives to health workers to deploy in remote areas, but have yet to develop strategies on nonmonetary incentives.</p>
Peru	<p>Geographic maldistribution of health workers is significant. The density of doctors per 1,000 habitants in Lima is 0.77 but below 0.4 in most Andean and Amazon jungle regions. The disparity also holds for nurses and midwives.</p>	<p>The fragmentation of the governance of health workforce deployment policies and the lack of accurate information on the number and distribution of providers present major challenges in coordinating allocation of health workers.</p>
Vietnam	<p>There is significant maldistribution of health workers, especially in remote and mountainous areas, which worsened in 2005–10: 59 percent of medical doctors practice in urban areas, but only 27 percent of the total population is urban.</p> <p>Each province also has imbalances, with the lowest availability of health workers at commune level: only one-third of communes have medical doctors.</p>	<p>The government has issued a series of decrees to address maldistribution, including: provision of financial incentives to workers in rural areas; continuing education (24 hours/year); access to four-year medical training for assistant doctors from rural areas; incentives for access to medical training for minority groups; and short-term rotation system from higher to lower facilities. Still in early implementation, these initiatives have yet to be evaluated.</p>
<b>Group 3</b>		
Brazil	<p>Disparities in health worker densities have narrowed greatly through expansion of Family Medicine coverage, but recruitment and retention remains a problem, especially in the rural Northern and Northeastern states.</p>	<p>The Enhancement Program for Professionals in Primary Health Care (PROVAB, 2011) offers various incentives for a minimum of one year working in primary health care in areas designated as underserved by the federal government. (These incentives are monetary as well as bonus points in the examinations for admission into medical residency programs and specialization courses in family health.) Recently, given the persistence of vacant posts in remote and underserved areas, the government decided to recruit doctors trained abroad through the “Mais Medicos” (More Doctors) program. Alongside these federal initiatives, at municipal level administrators adopt different types of incentives to recruit health workers, most often by raising salaries and introducing flexible working hours.</p>

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<b>Country</b>	<b>Distributional imbalances</b>	<b>Policies and interventions</b>
Thailand	In 1979, there was a 21-fold difference in physician density between Bangkok and the rural Northeast regions. This was reduced to a five-fold difference by 2009. Over the same period, the gap in nurse density was cut from an 18-fold to three-fold difference.	After 1975, financial incentives (a monthly hardship allowance) were introduced for rural recruitment and retention.  In 1997, rates were adjusted to reflect inflation and differentiated by levels of hardship; efforts are continuing to further reduce density disparities.
Turkey	Between 2002 and 2011, the personnel gap between the highest and lowest provinces fell: for specialists from 1:14 to 1:2.7; for general practitioners from 1:9 to 1:2.3; and for nurses and midwives from 1:8 to 1:4.  In 2011, Western Anatolia had 2.6 physicians per 1,000 population; Southeastern Anatolia had the lowest density, with 1.16 physicians per 1,000 population.  The Eastern Black Sea region had 1.84 times the density of nurses and midwives of Southeastern Anatolia.	Government policies narrowed the distributional imbalances. The Family Medicine Program encourages doctors and health workers to serve among rural populations; when family practitioners have registered patients in rural areas, health house midwives are assigned to them; the monthly base payment of family medicine physicians is adjusted for the area of practice; and family physicians who work in underserved areas receive a “service credit” on a sliding scale, linked to the socioeconomic development index of the district (this can be as high as 40 percent of the maximum base payment). Compulsory service is required from all public and private medical school graduates.
<b>Group 4</b>		
France	The geographic distribution of health workers is skewed to well-off regions, with a 1.55 times difference in physician density between the highest (Provence-Alpes-Côte d'Azur in the southeast) and lowest regions.	Government measures to reduce geographic disparities include increasing quotas for entrance to medical schools; offering financial incentives (taxes, allowances) for group practice in medically deprived areas; and offering Public Service Involvement Contracts to medical students with financial provision to set up practice in underserved areas.  To improve effective use of human resources, particularly in areas of shortage, the government has also introduced measures to enhance multidisciplinary cooperation between MDs and paramedics at local level through skill mix and task shifting.

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<b>Country</b>	<b><i>Distributional imbalances</i></b>	<b><i>Policies and interventions</i></b>
Japan	As measured by the ratio of physician density between the prefectures with the highest and lowest densities, from 1990 to 2010 geographic disparity in physician availability declined from 2.24 to 2.00. In 2010, the same ratio for nurses was 2.10 and for midwives, 2.00.	<p>To reduce geographic disparities in distribution of physicians, prefectural governments pay for the tuition and living expenses for the two to three entrants to the special medical school whose graduates are obligated to work in remote areas, and award scholarships to a few entrants in their contracted medical school under similar conditions.</p> <p>Physicians earn higher wages in rural hospitals than in urban cities, while the wage differential is reversed for nurses. Fee schedule conditions set the same price for health services regardless of location, which allows hospitals to set wages based on labor market conditions: since physicians prefer working in urban areas, they have to be offered more. Nurses in rural settings are more willing to work at lower wages in rural areas because they tend to have closer ties with their home communities.</p>

Source: Country summary reports on UHC, 2013.

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**Table 3 Improving health worker performance**

Country	Approaches to improving health worker performance
<b>Group 1</b>	
<b>Bangladesh</b>	The number of health workers at training institutions in public and private sectors grew quickly in 2011, in some cases with enrollment doubling or even tripling (Bangladesh Directorate General of Health Services, 2012). This rapid pace is raising concerns over the capacity of these institutions to adequately train students and for the health system to then absorb them. Although the number of training institutes has increased, commensurate increases in the number of faculty and learning materials have not occurred. Careful monitoring of these increases is required to ensure that the quality of trainees is not diminished.
<b>Ethiopia</b>	A recently completed evaluation showed that most health extension workers are constrained by low compensation, high workloads, and lack of supervision. The government is reviewing options to improve the performance of the health workers within its budgetary limitations. Secondary data simulations under different scenarios of increasing the number of health extension workers are being conducted to evaluate the cost of different options.
<b>Group 2</b>	
<b>Ghana</b>	Under the National Health Insurance Scheme the government increased salaries to improve worker productivity but its impact remains uncertain. The National Health Insurance Authority is piloting capitation payments for primary care and hospital outpatient services in an attempt to manage costs better while improving efficiency and effectiveness.
<b>Indonesia</b>	<p>The increase in unregulated private schools in recent years is leading to low quality of health workers. Public and private health workers show low scores for clinical quality practice in maternal and child care, despite increases in the number and intensity of training in these areas. Health workers receive very limited training on primary care and patient communication—important elements for frontline workers. The government is giving high priority to strengthening accreditation, examination standards, and quality assurance system for schools.</p> <p>More attention to the longer-term career development of health workers, including continuing education programs and support from professional associations, would provide important nonmonetary incentives. There is significant fragmentation of income sources for most health workers, with income from private sources being the largest share, reflecting the dual practice for most public sector health workers. This makes it hard to develop a coordinated incentive system for improving performance. Better integration among the payment, education, and service-delivery systems under the integrated national health insurance system may help align better the incentives for health workers via performance goals and help provide more effective tools for raising productivity and quality of services.</p>
<b>Peru</b>	In rural areas' health units, absenteeism of health workers reached 80 percent in night shifts, and in cities such as Cuzco, only 14 percent of professionals were performing at their competence level (Peru Country Summary Report, 2013). Low salaries and limited career options discourage health workers from performing well in their jobs and functions.
<b>Vietnam</b>	The quality of education delivered in the 24 medical schools is reported to be uneven. There is a lack both of a continuing education system for professionals to maintain quality along their career and of an accreditation system. The government is giving high priority to enhancing the accreditation system and raising examination standards for health professional educational institutions in public and private sectors.

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Country	Approaches to improving health worker performance
<b>Group 3</b>	
<b>Brazil</b>	One of the main factors contributing to service inefficiency is providers' lack of autonomy at health facility level and inadequate training of health workers. This is evident in the poor performance of staff: in a recent study, 32 percent of hospitals and 20 percent of outpatient units reported problems with low-qualified personnel, particularly in administrative and managerial areas (Gragnotati, Couttolenc, and Lindelow 2012). To overcome the rigidities in the government health services that have created difficulties in recruitment of qualified staff, especially in primary care settings, a number of municipalities are taking initiatives to contract out primary care services to nonprofit nongovernmental agencies.
<b>Thailand</b>	Multiple approaches have been taken to promote service health worker productivity and responsiveness to patient needs. They include enhancing professional ethos among the government health workforce, assuring an adequate basic salary, offering financial incentives (e.g. overtime rates, hardship allowances, nonprivate practice incentives, and long-service allowances) and nonfinancial incentives (e.g. social prestige and recognition, such as an annual prize for the best rural doctor or nurse), supporting career advancement, and permitting dual practice (where off-hour private practice is permitted). The government is currently testing pay-for-performance pilots in selected hospitals.
<b>Turkey</b>	<p>Before 2010 there were variable practices for certified trainings conducted in professional fields of health by public and private institutions. In 2010, the Ministry of Health introduced the Ministry of Health's Implementing Regulation on Certified Trainings to regulate the principles and procedures on certified training to be delivered by all public and private institutions and individuals.</p> <p>There are signs of improvement in workforce productivity over recent years. Consultations per physician per year—a crude measure of productivity—increased from 2,272 in 2002 to 3,176 in 2006 and to 4,850 in 2011. The Ministry introduced the Distance Health Education System in 2006 to provide education to all health care personnel but particularly managers, management trainees, and specialists, and to ensure orientation training to family physicians to be assigned in primary health care and other health care personnel to be assigned in family medicine. Several complementary reforms contributed to increased productivity including performance-based payment, activation of dormant health centers, and greater availability of examination rooms for each physician in health centers.</p>

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Country	Approaches to improving health worker performance
<b>Group 4</b>	
<b>France</b>	<p>Even in a high-income country such as France, the efficiency and quality of care have been a continuous priority concern, especially with rising health care costs and tighter budget constraints and the need to protect equity. Recent reforms have focused on improving the performance of health workers through multiple approaches to incentivize them and reforming the governance structure to enhance accountability. The performance challenges were particularly high in the relatively unregulated primary care system and in public hospitals, the latter due to inefficiencies.</p> <p>The government has launched pilot initiatives, including CAPI, which contracts primary care physicians on a performance-based payment system. Other initiatives include the introduction of an enhanced multidisciplinary group practice to promote greater collaboration between physicians and paramedics, including task-shifting across professional groups. However, most general practitioners work in solo practices. Finding an effective way of funding group practices with an emphasis on prevention and care coordination in primary care has long been a policy objective, but despite several initiatives, their uptake has been very slow: fewer than 40 percent of generalists work in group practice, and the size of practices and their distribution vary widely by region.</p>
<b>Japan</b>	<p>Japan relies primarily on legal statutes and departments within government ministries to establish standards for medical education, while certification of post-basic training is provided by several organizations, such as the specialty professional organizations and the Japanese Nurses Association. There is no autonomous umbrella professional medical council or “stand-alone” body for standards.</p>

Source: Country summary reports on UHC, 2013.