



G7 Universal Health Coverage (UHC)

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Question

What work is being done in G7 countries in relation to universal health coverage (including equity, access, and leave no-one behind)?

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1. Summary

Universal Health Coverage (UHC) cannot be delivered by the health sector alone. It requires the highest political support (The Global Governance Project, 2019). This rapid review focuses on what the Group of Seven (G7) countries are doing in relation to UHC. It follows on from the G7/G20 Commitments on health reported by Lucas (2019).

WHO pointed out that “moving towards UHC requires strengthening health systems in all countries” (WHO, 2019a). It means that these countries’ actions should not be limited to their own territory, but also include actions at international fora. However, this rapid review will focus in the national level policies and programmes in the G7 countries.¹

Evidence was obtained from academic and grey literature, and multi-country analyses. Key points are highlighted below:

- The University of Toronto produced detailed analyses on the extent of which each G7/G8/G20 country has met its commitments on UHC since the last summit. Although several commitments for UHC were listed in the past five G7/G8 summits, out of all the G20 Health Commitments (2008-2019), UHC was only discussed in 2018 Buenos Aires (Warren, 2019).
- The United States (US) is the only G7 country without UHC. Although it spends the most per capita on health (USD 10,271), multi-country analysis ranked it last in terms of access, affordability, and healthcare outcomes (Schneider et al., 2017). Adopting UHC could save the country trillions of dollars.
- UHC essential service coverage index scores have increased in all countries from 2017 to 2018 (IHME and WHO data). This score is an assessment of progress towards UHC. Five countries (not Italy) have fully complied with the commitment on UHC, taking actions aimed at promotion of UHC both domestically and internationally (Cicci et al., 2019). Italy acknowledges the domestic importance of UHC, but fails to propose any strategy for how to achieve it (Bergen et al., 2019: 389).
- *Funding models:* UHC in G7 countries has been achieved by a mixed model of funding. Some nations (France, Germany, Japan) employ a multi-payer system in which healthcare is funded by private and public contributions. Other countries (Canada, Italy, UK) choose to fund national health services directly from taxation alone, also known as “residence-based coverage” (Pearson et al., 2016). Increasing public spending on health in general, or reallocating spending towards primary healthcare is necessary to achieve UHC.
- *Equity of access:* Regional disparities in type of healthcare (Canada, France, Italy) and poor continuation of care (Germany, Japan) are concerns. Health insurance schemes play an important role in health expenditure, but are not as helpful for the self-employed or migrants (Germany, USA). Legislation (e.g. Canada’s Health Act, France’s Touraine’s Law on public health, Germany’s Preventive Health Care Act), bodies mandated by law (e.g. France’s National Health Authority) and government initiatives (Italy’s Regional Prevention Plans) are designed to improve the quality of patient care, and to guarantee

¹ Another report in this series is: Tull, K. (2019). *G7 Health Systems Strengthening (HSS)*. K4D Helpdesk Report 679. Brighton, UK: Institute of Development Studies. This includes official development assistance (ODA) data on health for each country, as well as international HSS actions by each country.

equity within the healthcare system. Out-of-pocket spending per total health spending in 2016 was lowest in France (9.6%) and highest in Italy (23.1%) and (Global Burden of Disease Health Financing Collaborator Network, 2019).

- *Leave no-one behind:* To achieve a UHC system that truly leave no-one behind, the G7 must adopt people-centred, rights-based, and gender-transformative approaches in implementing UHC (The Global Governance Project, 2019). Japan promotes UHC to enable women and girls to better protect their physical and mental health by accessing essential services (IPPF, 2018). Japan is fully aware that innovation is indispensable to the realisation of UHC (Kurokawa, 2017; Shaw et al., 2019; The Global Governance Project, 2019). Health promotion services are also a feature in Canadian, German and Italian UHC systems.

2. Introduction

UHC definitions

The WHO defines universal health coverage (UHC) as ensuring access to quality and affordable healthcare for all across the full spectrum of healthcare provision – prevention, promotion, treatment, rehabilitation, and palliation (WHO, n.d.; The Global Governance Project, 2019: 122). UHC is “a condition where all the people who need health services receive them without financial hardship” (USAID, 2015: 7). Therefore, UHC provides access to quality essential health services; access to safe, effective and affordable essential medicines and vaccines, and protection from financial risk (WHO, 2016a).

Moving towards UHC may refer to three main objectives pointed out by WHO (n.d.):

1. Equity in access to health services – everyone who needs services should get them, not only those who can pay for them;
2. The quality of health services should be good enough to improve the health of those receiving services; and
3. People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

UHC contributes to equity, social justice, and inclusive economic growth. There is plenty of evidence that UHC also leads to stronger economies and more resilient societies by equity, access, and leaving no-one behind (The Global Governance Project, 2019: 9):

G7/G20 and UHC

The G7 first publically used the term UHC at its 2016 Ise-Shima Summit, where several (20) commitments were made. However, at the 2017 Taormina Summit and 2018 Charlevoix Summit, the term UHC was not used by the G7 Leaders’ at all (The Global Governance Project, 2019: 123). Out of all the G20 Health Commitments 2008-2019, UHC was only discussed in 2018 Buenos Aires (Warren, 2019).²

² *G20 Leaders Buenos Aires Declaration - 2018-47: We reaffirm the need for stronger health systems providing cost effective and evidence-based intervention to achieve better access to healthcare and to improve its quality and affordability to move towards UHC, in line with their national contexts and priorities.*

Although UHC fell off the G7 Leaders' agenda in 2017 and 2018, the health ministers maintained some of the momentum for 2019 (The Global Governance Project, 2019: 123). The G7 Research Group at the University of Toronto assessed 70 of the 410 leaders' health commitments for compliance and found an average of 76%. Seventeen of these assessments references an aspect of UHC, and one references UHC directly for average compliance of 70% (The Global Governance Project, 2019: 124).

Both G7 and G20 have begun linking sustainable development and health, including associating the environment, gender and digitalisation (The Global Governance Project, 2019: 126). Most recently they have introduced UHC to their agendas, although not yet as a permanent feature, and only appearing when an interested host choses to champion it (The Global Governance Project, 2019: 126).

3. Equity in access

UHC is key to promoting equity (The Global Governance Project, 2019). **UHC implies equity of access for all, including those living in poverty and unable to pay out-of-pocket costs, or make payments to prepaid or pooled health insurance arrangements** (USAID, 2015: 7).

Equal access for equal need requires conditions whereby those with equal needs have equal opportunities to access healthcare (that is, horizontal equity).³ Ensuring equitable access requires a transformation in how health services are **funded, managed and delivered** so that services are centred around the needs of people and communities (WHO, 2016a). Under-utilisation of essential services by the poor leads to an ongoing cycle of poverty, as people who are sick and vulnerable are unable to participate in the labour market (USAID, 2015: 7).

Table 1: Health spending by source (2016)

G7 Country	Health spending per capita USD / per GDP	Out of pocket spending per total spending USD
Canada	4,875 / 8.0%	14.6%
France	4,945 / 9.8%	9.6%
Germany	5,263 / 9.6%	12.4%
Italy	3,059 / 7.4%	23.1%
Japan	4,175 / 7.2%	13.3%
UK	4,113 / 8.3%	15.3%
USA	10,271 / 17.1%	11.1%
Average	5,243 / 9.6%	14.2%

Sources: Global Burden of Disease Health Financing Collaborator Network (2019), licensed under [Creative Commons Attribution \(CC BY 4.0\)](#)

³ Oliver A and Mossialos, E (2004). Equity of access to health care: outlining the foundations for action. *Journal of Epidemiology & Community Health*, 58:655-658. <https://jech.bmj.com/content/58/8/655>

WHO pointed out that “moving towards UHC requires strengthening health systems in all countries” (WHO, 2019a). It means that these countries’ actions should not be limited to their own territory, but also include actions at international fora. However, this rapid review will focus in the national level policies and programmes in the G7 countries:

Canada

Canada's universal, publicly funded health-care system - known as Medicare - is a source of national pride, and a model of UHC (Martin et al., 2018). It is a decentralised collection of provincial and territorial insurance plans covering a narrow basket of services, which are free at the point of care. Although administration and service delivery are highly decentralised, coverage is portable across the country (Martin et al., 2018).

Cost-sharing exemptions for non-insured services (such as prescription drugs) vary among provinces and territories, and there are no caps on out-of-pocket spending.⁴ **Medicare provides relatively equitable access to physician and hospital services through 13 provincial and territorial tax-funded public insurance plans** (Martin et al., 2018). Out-of-pocket spending⁵ per total health spending was calculated as 14.6% in 2016 (Global Burden of Disease Health Financing Collaborator Network, 2019) - this is above average compared with the other G7 countries (see Table 1).

The Canada Health Act of 1984 added the principle of accessibility to the previous Medicare principles of universality, comprehensiveness, portability, and public administration (Smith et al., 2019). Under the universal healthcare system, insured services are services that are deemed to be medically necessary.⁶ In addition to these insured services, those services that have not been defined as medically necessary (e.g. dental care, vision care, private or semi-private hospital rooms, ambulance services, special nursing care, podiatry, chiropractic, other alternative health services, prescription drugs, psychology services, and medical devices prescribed outside hospital walls), may all be covered through what is termed **supplementary, or private, insurance** (Smith et al., 2019). The Health Act created the potential for health professionals other than physicians to provide insured services. It also explicitly prohibited user fees by adding a penalty clause for violations by provinces in this area (Smith et al., 2019).

France

The National Health Authority (HAS) was set up in 2004 in order to bring together a number of activities designed to guarantee equity within the healthcare system, and improve the quality of patient care. It is not a government body, but is mandated by law to undertake work that ranges from the assessment of drugs, medical devices and procedures to publication of guidelines and accreditation of healthcare organisations and certification of doctors. It liaises closely with government health agencies, national health insurance (NHI, sometimes called social health insurance - SHI), research organisations, unions of healthcare professionals, and patients’ representatives (Civitas, 2013). This employment-based SHI system attained UHC in 2000 by introducing a state-funded insurance scheme for the poorest segment

⁴ <https://international.commonwealthfund.org/countries/canada/>

⁵ Out-of-pocket medical costs are in addition to the amount individuals contribute towards health insurance premiums.

⁶ How to define the term medically necessary has been an issue of great controversy, as provincial variation exists in the interpretation of this term. The result has been that services insured in some provinces may not be insured in others.

of the population (Barroy et al., 2014a, 2014b: 1). Still, under pressure to sustain UHC without compromising equity of access, the system has been fine-tuned continually since inception (Barroy et al., 2014b: iii).

Touraine's law on public health was adopted on 14 April 2015. It focuses on access to healthcare and prevention as top priorities of the national health agenda (Nay et al., 2016: 2238). **Over three-quarters of health expenditure is publicly funded, therefore complementary health insurance plays an important role** (European Commission – France, 2017: 1). Out-of-pocket spending per total health spending was calculated as 9.6% in 2016, well below the G7 average of 14.2% (Global Burden of Disease Health Financing Collaborator Network, 2019). Health spending in France is higher than in most other G7 countries, with health expenditure reaching USD 4,945 per capita in 2016. This is equivalent to 9.8% of GDP, slightly above the G7 average of 9.6%.

Access to healthcare is generally good, and unmet care needs remain low, even if disparities across income groups exist. However, one persisting challenge is to address **regional disparities** in access to care (European Commission – France, 2017: 1).

Germany

In 1993, the freedom to choose one's sickness fund was formally introduced. Reforms that encourage competition and a strengthened market orientation have gradually gained importance in the past 25 years; these reforms were designed and implemented to protect the principles of solidarity and self-governance. In 2004, self-governance was strengthened through the establishment of the Federal Joint Committee, a major payer–provider structure given the task of defining uniform rules for access to and distribution of healthcare, benefits coverage, and coordination of care across sectors, quality, and efficiency (Busse et al., 2017).

Health expenditure in Germany is high. In 2016, it spent USD 5,263 per capita on health, the second highest amount in the G7 (Global Burden of Disease Health Financing Collaborator Network, 2019). However, Germany spends the same proportion of its GDP on health (9.6%) than any other country in the G7 (G7 average: 9.6%). While the majority (84.5%) of health spending is publicly funded, out-of-pocket spending amounts to 12.4%, and is below most other G7 countries (G7 average 14.2%) (Global Burden of Disease Health Financing Collaborator Network, 2019).

Under the oversight of the Federal Joint Committee, payer and provider associations have ensured good access to high-quality healthcare without substantial shortages or waiting times (European Commission – Germany, 2017: 1). However, the German health insurance system is not as cost-effective as in some of the G7 countries, which, given present expenditure levels, indicates a need to improve efficiency and value for patients (Busse et al., 2017). Self-governance has led to an oversupply of pharmaceutical products, an excess in the number of inpatient cases and hospital stays, and problems with delivering continuity of care across sectoral boundaries.

Italy

The WHO ranks Italy's healthcare system number 2 in the world (European Portal for Action on Health Inequalities, n.d.). However, in terms of UHC, inter-regional inequity due to regional budget deficits is a long-standing concern in Italy. The less affluent southern regions suffer from a paucity in the number of beds, availability of advanced medical equipment, and less-developed

community care services than the more affluent northern regions (European Portal for Action on Health Inequalities, n.d.). **Health spending in Italy, at USD 3,059 per capita in 2016, is the second lowest of the G7 countries.** This equals 7.4% of GDP, also below the G7 average of 9.6%. Although a core set of essential services are free, out-of-pocket spending is relatively high (23% in 2016, compared to the G7 average of 14.2% in 2016) and is mainly used to pay for pharmaceuticals and dental care (European Commission - Italy, 2017: 1; Global Burden of Disease Health Financing Collaborator Network, 2019).

The healthcare system in Italy is a **regionally based national health service** known as *Servizio Sanitario Nazionale* (SSN). It provides universal coverage to citizens and residents, with public healthcare largely free of charge. Treatments which are covered by the public system and a small co-payment include tests, medications, surgeries during hospitalisation, family doctor visits, and medical assistance provided by paediatricians and other specialists. However, public healthcare facilities vary in terms of quality depending on the region (European Portal for Action on Health Inequalities, n.d.). **Access to healthcare also varies by income group** (European Commission - Italy, 2017: 1). Private hospitals in Italy boast excellent facilities. Although the comfort and the quality of service at private hospitals are generally superior, the quality of care is likely to be similar to that of public hospitals. Some treatments at private hospitals in Italy can be prohibitively expensive without the assistance of a private health insurance policy.⁷

Japan

The Prime Minister has long been a champion of UHC, at home, in partner countries, as well as through its health diplomacy efforts (The Global Governance Project, 2019: 127). In the 2017 UHC Forum, Japan set a clear, equity focused target across UHC: calling for one billion more people to enjoy access to basic health services by 2023 (The Global Governance Project, 2019: 128). **Japan achieved UHC in 1961, in the early stage of economic development through measures such as the establishment of a national health insurance programme, which has in part contributed to good health at low cost, with equity** (University of Tokyo, n.d.; IPPF, 2018: 2). **Out-of-pocket spending per total health spending was calculated as 13.3% in 2016, which is less than half that of the US, and the lowest of the G7 countries** (average of 14.2%) (Global Burden of Disease Health Financing Collaborator Network, 2019).

While Japan is the second-largest market for pharmaceuticals and medical technology products globally, with an increasing demand for high-tech health services, the digitalisation of healthcare services has been slow. The penetration of electronic medical records (EMRs) is limited to large hospitals (greater than 600 beds), and there is poor information sharing outside the hospital. As a result, quality and continuity of care suffer greatly and concepts like care management and team-based care are virtually non-existent.¹⁶

UK

The National Health Service (NHS) is a healthcare system that has been providing comprehensive and high-quality UHC for over 70 years (Friebel et al., 2018). All comprehensive public services are provided for free at the point of use. **Spending per head of USD 4,113 in 2016 is well below the G7 average of USD 5,243. The share of GDP spent on health (8.3%) is also below average** (Global Burden of Disease Health Financing Collaborator Network,

⁷ <https://www.allianzcare.com/en/support/health-and-wellness/national-healthcare-systems/healthcare-in-italy.html>

2019). Public sources provide 80% of total health expenditure, which equates to 18.4% of total government spending (European Commission - UK, 2017: 1). **Out-of-pocket payments as a share of household consumption rank second highest in the G7 at 15.3%** (Global Burden of Disease Health Financing Collaborator Network, 2019).

Waiting times for operations are long: up to 78 days for a hip replacement.⁸ However, in general, unmet needs for medical care are low. **Coverage is highly equitable** with very narrow differences in access to care between high and low income groups on measures related to timeliness, financial barriers to care, and patient-centred care (European Commission - UK, 2017: 1; Scheider et al., 2017).

US

USA doesn't have UHC. It is the only high income country in the G7 that doesn't provide UHC.⁹ UHC requires a special focus on equity (USAID, 2015: 9). It is part of the Four Strategic Outcomes.¹⁰

The US spends more money per capita (USD 10,271), or as a share of GDP (17.1%) on health than any other industrialised country (The Global Governance Project, 2019: 50; Global Burden of Disease Health Financing Collaborator Network, 2019). **Despite this, it has the poorest health outcomes.** Analysis by The Commonwealth Fund shows that the US ranked 10th/11 for administrative efficiency and bottom (11th) equity and healthcare outcomes (Schneider et al., 2017). Out-of-pocket spending per total health spending was calculated as 11.1% in 2016, below the G7 average of 14.2% (Global Burden of Disease Health Financing Collaborator Network, 2019).

In some respects, the US has some of the best and most accessible healthcare, e.g. in terms of waiting times for high-tech surgery and technology (The Global Governance Project, 2019: 50-51). However, it is expensive: according to 11-country analysis by The Commonwealth Fund, the **US has the poorest performance of all countries in terms of affordability**, ranking last in terms of access (Schneider et al., 2017).

4. Leave no-one behind

The commitment to 'leave no one behind' is a cornerstone of the 2030 Agenda for Sustainable Development. UHC is at the centre of the 2030 Agenda's Sustainable Development Goal (SDG) 3 on health, to reduce poverty and inequality worldwide¹¹ (The Global Governance Project, 2019: 122). **UHC is key to reducing poverty and promoting social cohesion** (The Global Governance Project, 2019). UHC is critical for the extremely poor, who typically forgo even essential health services (USAID, 2015: 7). A strong system for monitoring and evaluation is

⁸ <https://www.verywellhealth.com/is-medicare-a-single-payer-tax-system-4068651>

⁹ <https://qz.com/1711520/the-us-just-promised-to-adopt-universal-health-care/>

¹⁰ These are: (1) financial protection, so the cost of essential health services permits people to use necessary services without impoverishing them; (2) essential services, so the package of high-quality prevention, promotion, treatment, and care services are available to all; (3) population coverage, so those who are poor and underserved have the same access to essential health services as other people; and (4) responsiveness, so quality health services are delivered in a timely and confidential manner that ensures dignity and respect for each client.

¹¹ **Goal 3:** Ensure healthy lives and promote well-being for all at all ages. **Target 3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

needed to ensure accountability and participation. The following cases show what the G7 governments are doing reach vulnerable groups in their countries:

Canada

Aboriginal health is a concern for federal as well as provincial and territorial governments.

The 2016 federal budget¹² included CAD8.4 billion (USD6.7 billion) over a five-year period earmarked for health and social services for indigenous people, including education and environment (e.g. water quality). Better integration of health and social services would also serve to address more effectively the social determinants of health. For example, push for universal pharmacare is currently under way in Canada.¹³

A mix of private for-profit (44%), private not-for-profit (30%), and public facilities (27%) provide facility-based long-term care.¹⁴ Public funding of home care is provided either through provincial or territorial government contracts with agencies that deliver services, or through government stipends to patients to purchase their own services, e.g. British Columbia's Choice in Support for Independent Living programme. Provinces and territories have introduced several initiatives to improve integration and co-ordination of care for chronically ill patients with complex needs. These include Divisions of Family Practice (British Columbia),¹⁵ the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario).

France

Good health is an essential element of freedom: access to basic healthcare is recognised as a fundamental human right. **Health has been judged for a century as a public good for which the government is responsible** (Nay et al., 2016: 2248). France provides health coverage to its entire population through insurance. **Health coverage is provided through multiple schemes for the various employment-based groups.** The benefit package, which became equal across schemes only recently, is quite broad. **Financial protection, though it relies on cost sharing, is among the highest in the G7 countries.** Most of the population has complementary private insurance to cover co-payments. **Service delivery is dominated by a fee-for-service (FFS) payment system for a mix of public and private providers** (Barroy et al., 2014b: 4). Population ageing leads to an increasing proportion of people benefiting from 100% coverage for chronic diseases, thus maintaining the volume of public health spending (Nay et al., 2016: 2243).

State health regulatory institutions have gradually become leading players in regulation of health insurance and health-care provision (Nay et al., 2016: 2248). Redistribution¹⁶ does not have merely a social or moral aim: it also improves health nationally. **Nonetheless, in France, as in most high-income countries, the redistributive system still does not provide an effective response to social inequalities in health** (Nay et al., 2016: 2248).

¹² Government of Canada (2016). Budget 2016. www.budget.gc.ca/2016/home-accueil-en.html

¹³ <https://theconversation.com/how-healthy-is-the-canadian-health-care-system-82674>

¹⁴ CIHI (2012). [Residential Long-Term Care Financial Data Tables](#).

¹⁵ Divisions of Family Practice (2014). [Welcome to the Divisions of Family Practice](#).

¹⁶ The French health-care system is based on compulsory social insurance funded by social contributions, co-administered by workers' and employers' organisations under State control and driven by highly redistributive financial transfers. This system is described frequently as the French model.

Germany

The German health system is often seen at international level as an example to be followed in order to achieve UHC. **The concept of prevention, which is integral to the goal, is the priority of Germany's health policy.** The Preventive Health Care Act, adopted in mid-2015, steps-up health promotion and preventive health close to the citizens, i.e. in schools, pre-school childcare facilities and at the workplace. While the services offered by health insurance schemes in order to detect and diagnose diseases at an early stage are being further developed, interplay between health promotion in the workplace and occupational health and safety are being improved. The environmental policy of the German Government also serves to protect the population from harmful influences in the environment in the form of chemicals, contamination of air, soil or water, and noise pollution (The German Federal Government, 2016: 24). **However, the self-employed with low incomes may fall between the cracks of the Social Health Insurance system, and migrants have access only to a restricted set of benefits** (European Commission – Germany, 2017: 1).

Italy

Italy has taken actions aimed at promotion of UHC domestically (Cicci et al., 2019: 639). **Since 2007, the Italian strategy on social protection and social inclusion has been based on two main strongly interlinked programmes:** the national programme “Gaining Health: making healthy choices easier,” and the “National Prevention Plan” (European Portal for Action on Health Inequalities, n.d.). “Gaining Health,” a Government initiative led by the Ministry of Health, followed the *Health-in-All-Policies* approach. It aims to promote cross-sectoral actions, facilitate healthy behaviours, and to prevent non-communicable diseases by counteracting the main modifiable risk factors (tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity). The programme promotes health through integration between actions to encourage citizens' empowerment and actions to stimulate stakeholders' and institutions' responsibility. This aims to create supportive-to-health environments and facilitate the adoption of healthy lifestyles. The “National Prevention Plan,” which ran from 2014 to 2018, addressed many topics, including health promotion, to be tackled at regional level. All the Italian regions, in their Regional Prevention Plans (PRPs), programmed actions against unhealthy lifestyles in line with the cross-sectoral approach suggested by “Gaining Health” e.g. implementing projects in the areas of universal prevention, prevention in populations at risk, predictive medicine and prevention of complications, and recurrence of diseases.

Japan

Healthcare in Japan is, generally speaking, provided free for Japanese citizens, expatriates, and foreigners. Medical treatment in Japan is provided through UHC. Japan has contained costs and achieved policy goals in service delivery through a biennial revision of its unified fee schedule, which is a two-step approach of setting a global revision rate, then fine-tuning item-by-item revisions and setting conditions for billing. **Japan also provides financial protection to households by capping co-payments and providing coverage for catastrophic health expenditures** (Reich et al., 2016).

As the people of Japan have experienced first-hand, **UHC produces high returns on investment, especially for vulnerable communities, including women, children, adolescents and older people** (Kurokawa, 2017). For many years, the Government of Japan has responded to sexual and reproductive health challenges, together with partner organisations.

This is because Japan believes that sexual and reproductive health is important to protect and empower individuals and enable them to reach their full potential, i.e. 'human security' (IPPF, 2018: 2).

To help with UHC, the Ministry of Health, Labour and Welfare has worked with prefectures, universities, and hospitals to encourage more doctors to work in remote regions via scholarship models in return for work commitments (WHO, 2016b; Yeoh et al., 2018). In his January 2019 Policy Speech for the 198th Ordinary Session of the Diet, Prime Minister Shinzo Abe reported that Japan is already promoting measures to reduce the burdens borne by caregivers, such as making use of robotics, Big data, Internet of Things, as well as research and development (Shaw et al., 2019; The Global Governance Project, 2019: 27).

UK

In the early 2000s, the UK made a major investment in the NHS, reforming primary care and cancer care in addition to increasing healthcare spending from 6.2% of GDP in 2000 to 9.9% of GDP in 2014 (Doran and Roland, 2010). The **reforms and increased spending** may have contributed to the rapid decline in mortality amenable to healthcare in the UK.

US

Although the US does not have UHC, there has been recent questioning of its use in the US.¹⁷

There has been much focus on trying to reduce spending on *Medicare* and *Medicaid*¹⁸ lately (The Global Governance Project, 2019: 51). Research from Rice et al. (2018) found that President Trump's administration is undoing some of the *Affordable Care Act's* provisions. The individual mandate to purchase coverage has been repealed. Medicaid remains, but premiums in insurance exchanges rose considerably in 2018. This means that the prospects are that the number of uninsured will grow. Adopting a UHC system could therefore save the country trillions of dollars, as well as help millions of poor citizens.¹⁹

5. Lessons learned

What UHC is not

The concept of universal healthcare is often incorrectly equated to a single-payer healthcare system, where all medical expenses are paid by one entity, usually the government. However, "single payer" and "universal" are not the same.²⁰

There are many things that are not included in the scope of UHC (WHO, 2019a; Cicci et al., 2019: 618-619):

- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.

¹⁷ Senator Bernie Sanders and 14 of his Democratic colleagues introduced the *Medicare for All Act* of 2019 in April 2019. <https://www.sanders.senate.gov/newsroom/press-releases/sanders-14-senators-introduce-medicare-for-all>.

¹⁸ A summary of current healthcare systems can be found on: <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>

¹⁹ <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>

²⁰ <https://www.verywellhealth.com/what-is-universal-healthcare-coverage-2615254>

- UHC is not just about health financing. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation.
- UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.
- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, etc.

Funding models

Sustained increases in the quantity, equity, and efficiency of health financing are essential to achieving UHC and improving health outcomes (Global Burden of Disease Health Financing Collaborator Network, 2019). Over-reliance on out-of-pocket spending diminishes access to care for those who are uninsured or underinsured, and risks exacerbating the burden of ill health and increasing poverty due to the high cost of care (Global Burden of Disease Health Financing Collaborator Network, 2019).

Experts generally group universal coverage systems into three categories: Beveridge systems (UK)²¹, single-payer systems (Canada²², Germany) and multi-payer systems (France, Japan, US) (Ridic et al., 2012; Schneider et al., 2017). These three systems are represented among the highest performers in multi-country analysis, and list of G7 countries implementing them are shown below:

1. Residence-based health coverage: Canada, Italy and UK
2. Contributory health Coverage:
 - a. Single Payer: Canada and UK*
 - b. Multiple insurers, with automatic affiliation: France and Japan
 - c. Multiple insurers, with choice of insurer: Germany and USA

Source: Pearson et al. (2016: 23)

UHC in most countries has been achieved by a mixed model of funding.²³ Some nations, such as Germany, France, and Japan, employ a multi-payer system in which healthcare is funded by private and public contributions. Single-payer healthcare* is a system in which the government, rather than private insurers, pays for all healthcare costs.²⁴ Single-payer systems may contract for healthcare services from private organisations (as is the case in Canada) or own and employ healthcare resources and personnel (as was the case in England before the introduction of the Health and Social Care Act 2012).

²¹ Also a single-payer national health service.

²² Although it is reported that many feel that it is inaccurate to characterise the Canadian system as “single – payer” because the provincial plans vary considerably (Ridic et al., 2012).

²³ http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php

²⁴ “Single-payer” thus describes only the funding mechanism and refers to healthcare financed by a single public body from a single fund and does not specify the type of delivery or for whom doctors work. Although the fund holder is usually the state, some forms of single-payer use a mixed public-private system.

In tax-based financing, individuals contribute to the provision of health services through various taxes. These are typically pooled across the whole population, unless local governments raise and retain tax revenues. Some countries (notably the UK, Canada, and Italy) choose to fund healthcare directly from taxation alone. This is also known as “residence-based coverage” (Pearson et al., 2016: 23).

In a social health insurance system, contributions from workers, the self-employed, enterprises, and governments are pooled into a single or multiple funds on a compulsory basis. It is based on risk pooling. This model is also referred to as the 'Bismarck Model,' after Prussian Chancellor Otto von Bismarck, who introduced the first UHC system in Germany in the 19th century. Social health insurance is also used in Japan.

In private health insurance, premiums are paid directly from employers, associations, individuals, and families to insurance companies, which pool risks across their membership base. Private insurance includes policies sold by commercial for profit firms, non-profit companies, and community health insurers. Generally, private insurance is voluntary in contrast to social insurance programmes, which tend to be compulsory.

In some countries with universal coverage, private insurance often excludes many health conditions that are expensive and the state healthcare system can provide. For example, one of the largest private healthcare providers is BUPA in the UK. It has a long list of general exclusions even in its highest coverage policy, most of which are routinely provided by the NHS. In the US, dialysis treatment for end stage renal failure is generally paid for by government, not by the insurance industry. Those with privatised Medicare (Medicare Advantage) are the exception and must get their dialysis paid through their insurance company, but those with end-stage renal failure generally cannot buy Medicare Advantage plans.

Monitoring progress

The world will need to double health coverage between now and 2030, according to the *Universal Health Coverage Monitoring Report* (WHO, 2019c). It warns that if current trends continue, up to 5 billion people will still be unable to access healthcare in 2030 – the deadline world leaders have set for achieving UHC.

Countries must renew efforts to scale-up service coverage countrywide. Although coverage has increased steadily since 2000, progress has slowed down in recent years (WHO, 2019b). Monitoring progress towards UHC should focus on 2 things (WHO, 2019a):

- The proportion of a population that can access essential quality health services.
- The proportion of the population that spends a large amount of household income on health.

Most of that funding would come from countries themselves. The report says that most countries can scale-up primary healthcare using domestic resources – either by increasing public spending on health in general, or by reallocating spending towards primary healthcare – or by doing both (WHO, 2019c).

Financial protection is a core principle of UHC. On average, about 32% of each country's health expenditure comes from out-of-pocket payments (WHO, 2016a). However, there are disparities in per-capita health spending between the G7 countries. Projections suggest that

some countries are not on track to adequately cover their populations (Global Burden of Disease Health Financing Collaborator Network, 2019).

The WHO reports that global total health spending is growing faster than GDP (The Global Governance Project, 2019: 17). Governments' increased prioritisation of the health sector and economic development are the strongest factors associated with increases in government health spending globally. Future government health spending scenarios suggest that, with greater prioritisation of the health sector and increased government spending, health spending per capita could more than double, with greater impacts in countries that currently have the lowest levels of government health spending (Global Burden of Disease Health Financing Collaborator Network, 2019).

At present, most countries are underinvesting in primary healthcare (WHO, 2019b). However, Table 3 shows that **UHC essential service coverage index value has increased in all G7 countries** from 2017 to 2018. This is an assessment of progress towards UHC.

The United States stands out as the country with the highest expenditures on healthcare (Ridic et al., 2012). It would appear that systems that ration their care by government provision or government insurance incur lower per capita costs. On the other hand, in the largely private system in the United States, waiting times tend to be shorter than in rationed systems, a conclusion that follows simply from theory as well as from observation. Americans have been

Table 3: Indicator 3.8.1: Coverage of essential health services, as defined by a UHC service coverage index²⁵

G7 Country	UHC Service Coverage Index value	
	2017	2018
Canada	79	89
France	70	78
Germany	75	83
Italy	70	82
Japan	79	83
UK	80	87
USA	74	84
Average	75	84

Sources: Adapted from Vizhub (2017: <https://vizhub.healthdata.org/sdg/>) licensed under Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.; and WHO (2019c: 108-112) licensed under Attribution-NonCommercial 3.0 IGO.

²⁵ **Indicator 3.8.1:** Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

more dissatisfied with their health system than Canadians or Germans have been with theirs. Many characterise the main gap in the American system as the problem of the uninsured – more than 40 million people. **While this does not mean that they go entirely without care, the uninsured consume only half as much healthcare on average as the insured.**

Compared to the US system, the Canadian system has lower costs, more services, universal access to healthcare without financial barriers, and superior health status (Ridic et al., 2012). Part of the gap between US and Canadian healthcare costs may be explained by a failure to account for Canadian hospital capital costs, larger proportion of elderly in the United States and higher level of spending on research and development in the US. Because of the abundance of advanced medical technology, people 80 years and older in the US tend to live longer than their counterparts in most other countries (Ridic et al., 2012).

Germany achieves a high rank (2/11)²⁶ only on measures of access (Scheider et al., 2017). Germany manages to provide a health system that delivers universal health insurance while avoiding queues that often trouble government systems. However, costs per capita have been increasing faster than the incomes per capita, a problem leading to strenuous reforms in the 1990s (Ridic et al., 2012). **The German healthcare system also faces additional cost pressures from having a much older population than the US does.**

Italy acknowledges the domestic importance of UHC, but fails to propose any strategy for how to achieve it (Bergen et al., 2019: 389).

France has one of the widest socio-economic inequalities in health outcomes and in access to health services in Western Europe (Barroy et al., 2014b: 2). France's experience presents several potentially useful lessons for other countries aiming for UHC. **The mix of mandatory and voluntary insurance to cover co-payments of basic health services seems to have been effective in covering the entire population for a comprehensive set of goods and services and against costs of illness.** However, the introduction of a state-funded insurance scheme for the poorest was necessary to ensure that individuals with variable incomes actually benefit from the same health coverage. Moreover, a series of complementary schemes and measures are necessary to deal with negative effects of cost sharing for basic health services for low socio-economic groups and improve equitable access to care over time. Investing in primary care by strengthening the role of GPs in delivery and co-ordination of care has been a key strategy in recent years. **Still, inequalities in health and access to specialist services persist.** Thus, France's experience with private complementary insurance suggests that reliance on voluntary insurance for financing basic health services is problematic for equity and redistribution (Barroy et al., 2014b: 35).

France earmarks taxes (initially payroll tax; since 1998 earmarked taxes on income and capital) (Reich et al., 2016). **Funding sources have been broadened in the past 10 years, generating additional resources through different taxes applied to a broader range of incomes, including that from financial assets.** On the expenditure side, a series of measures, including national targets, to curb escalating trends have helped monitor health expenditure more closely and demonstrated some promising results in curbing health spending in very recent years. Like many other countries, efficiency and quality of care have been a continuous concern for France's health system (Barroy et al., 2014b: 35). The experience with pay-for-performance contracts for

²⁶ The 11 countries analysed and compared with the US healthcare system were: Australia, Canada, France, Germany, New Zealand, Norway, Sweden, Switzerland, The Netherlands, and the UK.

GPs (formerly CAPI) has shown advantages over traditional FFS for improving the efficiency and accountability of providers. **However, the French experience with gatekeeping has also suggested that payment reforms built on FFS are, on their own, unable to radically change provider behaviour.** France has also been exploring alternative payment models incentivising collaborative work in multi-disciplinary group practices that emphasise prevention and care co-ordination.

At hospital level, a tailored DRG system²⁷ introduced in the mid-2000s has reached half its goals by boosting productivity, but challenges remain for ensuring quality and pertinence of care and improving performance overall. **Therefore, to deal with adverse effects of a DRG payment system, a strong information system monitoring costs and quality of hospital services is essential,** as is flexible and transparent governance supporting continual fine-tuning of the incentive structure. **To improve equity of access to care, as well as quality and efficiency, the authorities also had to modify the traditional centralised and fragmented governance model.** Health governance has been thoroughly reformed over the past decade, through the creation of regional entities overseeing all healthcare providers (hospital, ambulatory, and social care) to meet the needs of the local population, and by remodelling hospital corporate governance, leading to a new deal between hospital administration and the medical community. The conflicting pressures to curb rising health expenditures while ensuring equity of access and quality of care characterise France's experience with UHC - highlighting the crucial role of complex, perpetual reforms to sustain UHC (Barroy et al., 2014b: 35).

Both France and Japan are seeking to reduce their reliance on payroll premium contributions (because payroll premium contributions are no longer generating sufficient revenue as a consequence of ageing populations), and they are turning to other forms of tax revenues.

Health expenditure can be controlled while expanding coverage and improving equity. Incremental adjustments can appear rational but create future pressures. **Political will and stability, strategic investment, trained personnel and a well-designed health system that includes health insurance are all critical to UHC.** Another element that is often overlooked, but is a key pillar to successful UHC, is innovation - the creation of new and/or improved drugs, vaccines, diagnostics and systems. **Innovation is indispensable to the realisation of UHC:** it is no coincidence that Japan has also long been the No. 3 global leader in drug development (Kurokawa, 2017).

In the UK, introduction of key policies, such as a notion of clinical governance, NICE, and the predecessor of the CQC, were introduced with a focus on improving quality and reducing variation, in order to provide high-quality UHC (Friebel et al., 2018). **The UK ranks highly on measures related to the equity of health systems with respect to access and care process (Schneider et al., 2017). In contrast, the US, France, and Canada have larger disparities between lower and higher-income adults,** hence their low equity rankings. These were especially large on measures related to financial barriers, such as skipping needed doctor visits or dental care, forgoing treatments or tests, and not filling prescriptions because of the cost (Schneider et al., 2017). The UK stands out as a top performer in most categories except for healthcare outcomes, where it ranks with the US near the bottom.

²⁷ A diagnosis-related group (DRG) is a patient classification system that standardises prospective payment to hospitals and encourages cost containment initiatives. In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge.

To achieve a UHC system that truly leaves no-one behind, **the G7 must adopt people-centred, rights-based, and gender-transformative approaches in implementing UHC**. This can be done by (The Global Governance Project, 2019: 128):

1. **Supporting new models of community service delivery** to strengthen the capacity and professionalisation of community health workers, and promotion of gender equality and decent paid work²⁸;
2. **Inclusive multi-stakeholder governance** with meaningful engagement of communities and CSOs, clinicians and policymakers, and
3. **Do more to foster legal and policy environments** (with human rights and gender equality at the heart), so that health facilities are free from stigma and discrimination.

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²⁸ Countries must invest better, especially in gender (The Global Governance Project, 2019: 16-17). Unless societies invest in education and workforce participation of their girls and women, they will not be able to resolve the challenges they face in expanding UHC, which in turn relies on being able to meet other demands for economic growth.

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Key websites

- Institute for Health Metrics and Evaluation (IHME) Health-related SDGs Viz Hub tool to check country progress towards achieving SDGs by 2030: <https://vizhub.healthdata.org/sdg/>
- G7 Information Centre: <http://www.g7.utoronto.ca/>

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