WORKING PAPER / 2025.11

Briefing note on universal health coverage and social protection

Patrick **Rached**
Dimitri **Renmans**
Marc **Bourgeois**
Elisabeth **Paul**

University of Antwerp
IOB | Institute of Development Policy

SOCIAL PROTECTION & INCLUSIVE GROWTH
SPRING

The IOB Working Paper Series seeks to stimulate the timely exchange of ideas about development issues, by offering a forum to get findings out quickly, even in a less than fully polished form. The IOB Working Papers are vetted by the chair of the IOB Research Commission. The findings and views expressed in the IOB Working Papers are those of the authors. They do not necessarily represent the views of IOB.

Institute of Development Policy

Postal address:
Prinsstraat 13
B-2000 Antwerpen
Belgium

Visiting address:
Lange Sint-Annastraat 7
B-2000 Antwerpen
Belgium

Tel: +32 (0)3 265 57 70
Fax: +32 (0)3 265 57 71
e-mail: iob@uantwerp.be
http://www.uantwerp.be/iob

WORKING PAPER / 2025.11

ISSN 2294-8643

Briefing note on universal health coverage and social protection

Patrick **Rached**[1], Dimitri **Renmans**[1], Marc **Bourgeois**[2], Elisabeth **Paul**[1]

[1] Université libre de Bruxelles (ULB)
[2] Université de Liège (ULiège)

This paper is the English version of a working paper previously published in French (Working Paper 2025.02)

July 2025

University of Antwerp
IOB | Institute of Development Policy

BRIEFING NOTE ON UNIVERSAL HEALTH COVERAGE AND SOCIAL PROTECTION

Patrick Rached,[1] Dimitri Renmans,[1] Marc Bourgeois,[2] Elisabeth Paul[1]

[1]Université libre de Bruxelles (ULB)

[2]University of Liège (ULiège)

FOREWORD

This briefing note is developed as part of the Policy Supporting Programme (PSP) 'Social Protection and Inclusive Growth' (SPRING). Its purpose is to present the concept of Universal Health Coverage (UHC) and Social Protection (SP), clarify some confusing aspects, and provide brief bibliographic references useful for deepening one's knowledge of UHC and SP.

The sections of this briefing note have been designed to be read and understood independently, while maintaining an overall narrative. As a reader, you have the choice of reading the briefing note in a continuous and uninterrupted manner to grasp all the aspects concerning the CSU and the PS, or in a more targeted manner by choosing the section of interest.

SPRING is one of three PSPs funded by Belgian cooperation (DGD) and supported by the academic federations (ARES and VLIR-UOS) for the period 2024-2027. SPRING is a consortium of actors committed to contributing to the strengthening the socio-economic resilience of Central and East African economies – with a particular focus on the Democratic Republic of Congo, Rwanda and Uganda. Although the case studies focus on Central and East Africa, the work aims to feed into wider research and policy debates on social protection and inclusive growth.

For more information: https://www.springpsp.be/

CONTENTS

Foreword 2

Abbreviations 4

I- What is universal health coverage? 5

Further readings 7

II- What is social protection? 9

Further readings 11

Social health protection and universal health coverage 11

Further readings 13

Social protection and the informal economy 14

Further readings 20

III- How do you "implement" UHC? 21

Further readings 23

IV- How can UHC and SHP be financed? 24

Further readings 30

V- How do you "measure" UHC and SP? 33

Further readings 38

VI- Some complementary concepts to UHC 39

UHC and equity 39

Further readingS 41

Primary health services and UHC 42

Further readingS 45

Strengthening health systems, resilience, health security and UHC 46

Further readings 48

Main references 50

ABBREVIATIONS

ICLS	International Conference of Labour Statisticians
UHC	Universal Health Coverage
GBD	Global Burden of Disease Study
GHED	Global Health Expenditure Database
IHME	Institute for Health Metrics and Evaluation
CBHI	Community Based Health Insurance
SDG	Sustainable Development Goal
ILO	International Labour Organization
WHO	World Health Organization
OOP	Out of Pocket Payments
PPP	Purchasing Power Parity
SP	Social Protection
SHP	Social Health Protection
USP	Universal Social Protection
HSS	Health Systems Strengthening
SCI	UHC Service Coverage Index
HS	Health System
PHC	Primary Health Care
VAT	Value Added Tax
WASH	Water Sanitation And Hygiene
WHA	World Health Assembly

I- WHAT IS UNIVERSAL HEALTH COVERAGE?

According to the World Health Organisation (WHO)**, universal health coverage (UHC) means that everyone receives the health services they need – ranging from health promotion, prevention, curative, rehabilitative or palliative – of good quality, while ensuring they do not expose the user to financial hardship** (*Tracking Universal Health Coverage*, 2015). It is now included in the Sustainable Development Goal (SDG) 3.8, entitled: by 2030, "*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*" (Resolution Adoptée Par l'Assemblée Générale Le 25 Septembre 2015 N°70/1 Transformer Notre Monde : Le Programme de Développement Durable à l'horizon 2030, 2015). This right is also mentioned in the 2012 Recommendations No. 202 on Social Protection Floors of the International Labour Organization (ILO) (*Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.). UHC also contributes to the achievement of a number of SDGs, including SDG 1 (no poverty), 4 (quality education), 5 (gender equality), 8 (decent work) and 16 (peaceful and inclusive societies) (Kieny et al., 2017).

UHC is a broad concept, and is often misinterpreted – for example, when it is associated with a specific policy or programme – when in fact it is an ideal objective (no country can offer all health services free of charge to everyone) and is achieved through various reforms. It comprises two fundamental dimensions: health coverage (availability of quality health services) and financial protection associated with the use of these services.

The 'financial protection' component of UHC is similar to the concept of social health protection (SHP), defined by the ILO as "*a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health*" (International Labour Organisation, 2010).

Background: While the origins of UHC lie in primary health care policies, "Health for All 2000", and the construction of national public health services, the term UHC first appeared in the WHA58.33 Resolution adopted at the 2005 World Health Assembly (WHA) (Fifty-Eighth World Health Assembly, Geneva, 16-25 May 2005: Resolutions and Decisions: Annex, 2005). The WHO is encouraging member countries to offer accessible, high-quality services while guaranteeing financial protection for their populations. The WHO's 2008 report "Primary health care, now more than ever" (Rapport Sur La Santé Dans Le Monde 2008, 2008) highlights four sets of primary health care reforms to reorient systems towards health for all. Among these, UHC reforms ensure equity in the system. It was in this report that the "UHC cube" first appeared (Figure1).

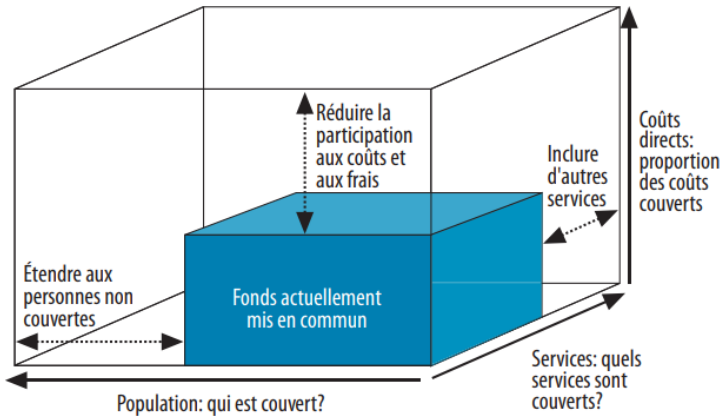

Figure1 The three dimensions of UHC (Rapport Sur La Santé Dans Le Monde 2008, 2008; The World Health Report, 2010)

We can conclude from its definition that UHC is a **multidimensional concept** (Abiiro & De Allegri, 2015). First, **population coverage** is an essential element of CSU. This notion is addressed with mentions of "anyone" and "everyone" ... in the various definitions. It is based on the principle that the entire population is entitled to health and financial protection ('Universal Health Coverage Post-2015', 2014). To guarantee this universality, various policies to extend the UHC and ensure health equity must be implemented.

Then there is the subject of **health coverage:** it is important to guarantee that the population **has access to high-quality** curative, preventive, palliative and health promotion services (Abiiro & De Allegri, 2015; International Labour Organisation, 2010; World Health Organization, 2013). Ensuring the high quality of the services offered, whether they are centred on primary healthcare (Rapport Sur La Santé Dans Le Monde 2008, 2008) or on a package of basic services(International Labour Organisation, 2010), is an important prerequisite for implementing the UHC. These services must be accessible according to the five Penchansky and Thomas criteria: availability, acceptability, affordability, acceptability and accommodation (Penchansky & Thomas, 1981) . Accessibility is also an intermediate objective of the health systems (HS).

Finally, **financial protection**: households are protected from the financial difficulties caused by illness and out of pocket payments (OOP) (International Labour Organisation, 2010; Papanicolas et al., 2022; The World Health Report, 2010). It seeks to reduce these OOPs through a system of financing (see section IV) to prevent households from incurring catastrophic and/or impoverishing expenses. This financial protection is considered to be one of the ultimate objectives of the HS (Papanicolas et al., 2022) (see their analytical framework, page 35). UHC is sometimes reduced to this financial function in national policies (Prabhakaran et al., 2017).

Moreover, UHC is a **dynamic concept** (Jimba & Fujimura, 2018) , as public finances, socio-economic context, health needs of the population... are constantly evolving. **This means that UHC** (Kutzin, 2013; McIntyre & Kutzin, 2016) **is never really achieved**, and that each country must make continuuous efforts to maintain progress as the context and people's preferences change and evolve. UHC is therefore the ideal (theoretical) situation to aim for, but it is not the final objective of either the HS (Papanicolas et al., 2022) or national health policies.

Various elements of UHC, as well as certain preconceived ideas, are summarised inTable 1**Fout! Verwijzingsbron niet gevonden.** . Some of these will be discussed in the following sections.

Table 1 Truths and misconceptions about UHC, inspired by (Alyanak, 2022)

UHC is about	UHC is not
✅ The full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care	❌ Only treatments services
✅ Addressing all components of the health system: financing, legislation, service delivery systems, workforce, facilities, communications networks, technologies, information systems, quality assurance and governance	❌ Only health financing
✅ Both individual and population-based services (e.g. public-health campaigns)	❌ Only individual services
✅ Policies that are inclusive of all individuals and groups and progress that is assessed at a population level	❌ Providing benefits to only certain groups or assessing progress among only those served by a certain programme
✅ Protecting people from the financial consequences of paying for health services out of their own pockets at the point of use	❌ Free coverage for all health interventions, regardless of cost
✅ Ensuring an equitable expansion of service coverage and financial protection as more resources become available	❌ Only ensuring a minimum package of health services
✅ Taking steps towards economic and other development priorities, poverty reduction, social inclusion and cohesion, and equity	❌ Only health

In conclusion, **UHC is a theoretical framework that provides direction for a HS to achieve its objectives** (and less so a 'destination' in itself) (Kutzin, 2013). Often reduced in the collective imagination to the **financial protection of** alone, UHC also seeks to ensure **the accessibility** (geographical, technical, cultural, etc.) and **quality** of health services. It is the "*most powerful concept that public health has to offer*" (Speech by Dr Margaret Chan at the WHO General Assembly in 2012)[1].

Some see **health equity** as an ultimate goal of UHC (Alyanak, 2022). However, policies pursued in the name of UHC do not automatically guarantee this equity (Gwatkin & Ergo, 2011). This is why its translation into health policies (see section III) is a long and complex process, and must include consideration of equity at every stage, requiring a thorough understanding of the various issues. Without this, UHC could have harmful repercussions for certain categories of the population.

FURTHER READINGS

[1] Quote available https://ehospice.com/international_posts/universal-health-coverage-the-most-powerful-concept-that-public-health-has-to-offer/

Abiiro, Gilbert Abotisem, and Manuela De Allegri. 'Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates'. *BMC International Health and Human Rights* 15, no. 1 (4 July 2015): 17. https://doi.org/10.1186/s12914-015-0056-9

Brearley, Lara, Robert Marten, and Thomas O'Connell. 'Universal Health Coverage: A Commitment to Close the Gap', 9 September 2013.

World Health Organization. The World Health Report 2008: Primary Health Care - Now More Than Ever'. Geneva: World Health Organization, 2008. https://iris.who.int/handle/10665/43951

Schiel-Adlung, Xenia. 'Universal Health Protection: Progress to Date and the Way Forward'. Geneva: International Labour Organisation, 2014. http://s2.medicina.uady.mx/observatorio/docs/eq/lg/Eq2014_Lg_ILO.pdf

Smithers, Daniel, and Howard Waitzkin. 'Universal Health Coverage as Hegemonic Health Policy in Low- and Middle-Income Countries: A Mixed-Methods Analysis'. *Social Science & Medicine* 302 (1 June 2022): 114961. https://doi.org/10.1016/j.socscimed.2022.114961

Tracking Universal Health Coverage: First Global Monitoring Report. World Health Organization, 2015. https://iris.who.int/handle/10665/174536

Watkins, David A., Gavin Yamey, Marco Schäferhoff, Olusoji Adeyi, George Alleyne, Ala Alwan, Seth Berkley, et al. 'Alma-Ata at 40 Years: Reflections from the Lancet Commission on Investing in Health'. *Lancet (London, England)* 392, no. 10156 (20 October 2018): 1434-60. https://doi.org/10.1016/S0140-6736(18)32389-4

World Health Organization, ed. *Research for Universal Health Coverage*. The World Health Report 2013. Geneva: World Health Organization, 2013.

World Health Organization. 'Fifty-Eighth World Health Assembly, Geneva, 16-25 May 2005: Resolutions and Decisions: Annex'. Geneva: World Health Organization, 25 May 2005. https://iris.who.int/handle/10665/20398

World Health Organization. The World Health Report: Health Systems Financing: The Path to Universal Coverage'. Geneva: World Health Organization, 2010. https://iris.who.int/handle/10665/44371

Xu, Ke, Agnes Soucat, Joseph Kutzin, Callum Brindley, Elina Dale, Nathalie Van de Maele, Thomas Roubal, Chandika Indikadahena, Hapsa Toure, and Veneta Cherilova. 'New Perspectives on Global Health Spending for Universal Health Coverage'. Geneva: World Health Organization, 2018. https://iris.who.int/bitstream/handle/10665/259632/WHO-HIS-HGF-HFWorkingPaper-17.10-eng.pdf

As well as the pages on the CSU and financial protection on the WHO website.

II- WHAT IS SOCIAL PROTECTION?

Decent work was first mentioned in 1999 by the ILO to include the diversity of dimensions associated with employment (Ghai, 2003). This concept is mainly taken up today by the SDG 8: "*promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all*" (*Il Est Temps d'agir Pour L'ODD 8*, 2019). This agenda has four pillars: job creation, social protection (SP), rights at work, and social dialogue (*Decent Work | International Labour Organization*, 2024; Ghai, 2003).

SP is the set of policies and programmes designed to reduce poverty and vulnerability throughout the life course. It is a "*fundamental human right, but also an economic and social necessity*" (Diop and Cichon) (World Social Protection Report 2020-22: Social Protection at the Crossroads - in Pursuit of a Better Future, 2021)**. The principles of SP are initially governed by the ratified international convention No. 102 of 1952** (*Convention C102 - Social Security (Minimum Standards) Convention, 1952 (No. 102)*, n.d.) under the aegis of the ILO (Markov & Stern Plaza, 2020). This Convention is the only international treaty with a systemic vision of SP, and proposes the financial, governance and administrative bases for implementing it. It emphasises that SP is a fundamental right defined by national law, underlining the importance of state commitment; it guarantees a minimum level of protection; advocates sustainable financing with participatory management; and includes transparency and compliance mechanisms (Markov & Stern Plaza, 2020).

It also identifies **the nine branches of SP** (Markov & Stern Plaza, 2020; *Social Protection | International Labour Organization*, 2024) :

1) **Health protection**, which guarantees effective access to quality care without financial hardships or impoverishment;
2) **Sickness benefits**, which guarantee financial security in the event of loss of income due to illness;
3) **Unemployment benefits**, which guarantee income security when an individual loses his or her pay because he or she is unable to find a job;
4) **Old-age pensions**, which guarantee a secure income for the elderly so that they can continue to live with dignity (often following a lifetime of work);
5) **Employment injury benefits** (or occupational illness), which safeguard workers' rights in the event of health problems in the workplace;
6) **Family and child benefits**, which guarantee the long-term well-being of children;
7) **Maternity benefits**, which protect pregnant and post-partum women from health problems and discrimination in the workplace;
8) **Disability benefits**, which guarantee the inclusion of people with disabilities in the society, with a particular emphasis on removing the barriers they may face;
9) **Survivors' benefits**, which guarantee financial security for families who have lost their main source of income (e.g. widow(er)s).

A few definitions:

There is a wide range of terminology used in the world in relation to SP, which can lead to confusion (SP, social security, social welfare, social assistance, etc.). It is therefore important to take stock of the different definitions.

The ILO uses the term **SP** and sometimes the term **social security** interchangeably. The term SP will therefore be used in this document.

According to the ILO, **social insurance** refers to SP schemes whose funding and entitlement to benefits is contributory (see section IV). **Social assistance**, on the other hand, refers to non-contributory schemes, where beneficiaries' contributions are not used to finance or determine entitlement to benefits(International Labour Organisation, 2010) . Social assistance is often reduced to mechanisms whose target audience is the poor.

The convention No. 102 was followed by many others, dealing with each branch individually (No. 121, 128, 130, 131, 134, 168, 176, 183 and 191, to name but a few). It was then updated by **Recommendation No. 202 of 2012** "Recommendations for Social Protection Floors" (Markov & Stern Plaza, 2020; *Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.). This introduces two new concepts: social protection floors and universal social protection (USP).

Social protection floors are guarantees of basic SP services, which must "*ensure at a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services defined as necessary at the national level*" (International Labour Organisation, 2010; *Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.). These floors must be embedded in law at the national level, as a reminder of the State's commitment. The definition of these floors must be based on the needs of the population, the basic security of income to live in dignity, and must constantly be monitored and updated (*Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.). Convention No. 202 also recommends extending SP building upon the defined floors. This extension concerns both the number of services offered by these floors as well as the number of people covered by these services. It focuses on the informal sector and disadvantaged populations or those with specific needs (*Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.). All this has evolved into what is known as **Universal Social Protection (USP)**.

Today, the USP is mainly taken up in SDG 1.3 " *Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable*". The USP also contributes to achieving goals 3.8 for UHC, 5.4 for gender equality, 8.5 for decent work, 10.4 for reducing inequalities and 16.6 for effective institutions (Stern Plaza et al., 2019)[2]. The USP is organised around three key principles (Stern Plaza et al., 2019) :

- **Universal coverage** seeks to guarantee the services of the social protection floors, and more, to the entire population. It promotes the principles of non-discrimination, gender equality, social inclusion (including the informal sector) and dignity.
- **Comprehensive protection**, which encompasses the nine areas of SP mentioned above, and which is not limited to a single aspect of SP.
- **The adequacy of protection in** relation to international standards and frameworks (including the SDGs).

[2] All the SDGs are available at https://www.un.org/sustainabledevelopment/fr/

It is based on the establishment of the SP floors at first, which define a set of services that guarantee a minimum quality of life and wellbeing for the population, and then extend it. Its implementation depends on the national context, which highlights the responsibility of the State.

However, there is no *one-size-fits-all* model for implementing the USP. Like the UHC, the concept of the USP must be understood as a conceptual framework that focuses on objectives and must be adapted to the national context (*Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.; Stern Plaza et al., 2019). On the other hand, USP is, of course, not limited to health (it concerns nine areas or branches) and, above all, and is part of a broader political agenda. It is, in fact, one of the pillars of the decent work agenda promoted by the ILO. We will be taking a closer look at the health aspects, with social protection in health, as well as the informal sector, which represents one of the major challenges of the decent work agenda.

FURTHER READINGS

International Labour Organisation (ILO). 'Convention C102 - Social Security (Minimum Standards) Convention, 1952 (No. 102)'. https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312247

International Labour Organisation (ILO). 'Recommendation R202 - Social Protection Floors Recommendation, 2012 (No. 202)'. https://normlex.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID,P12100_LANG_CODE:3065524,fr:NO

International Labour Organisation. *World Social Protection Report 2017-19: Universal Social Protection to Achieve the Sustainable Development Goals*. World Social Security Report. Geneva 22, 2017

Stern Plaza, Maya, Mira Bierbaum, and Christina Behrendt. Universal Social Protection: Key Concepts and International Framework'. Social Protection Spotlight. Geneva: International Labour Organisation, April 2019. https://www.social-protection.org/gimi/Media.action?id=16794

SOCIAL HEALTH PROTECTION AND UNIVERSAL HEALTH COVERAGE

Social health protection (SHP) is defined by the ILO as "*a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health"* (International Labour Organisation, 2010). It is therefore a branch of SP that applies to the health sector. **SHP is central in order to move towards UHC, of which it partially covers the "financial protection" aspect**. It is part of human rights and simultaneously contributes to SDGs 3.8 and 1.3 (Tessier, 2020; Tessier & Louis Dit Guérin, 2024).

SHP has two objectives: (i) to guarantee universal access to affordable, quality healthcare services and (ii) to guarantee financial security to compensate for loss of income in the event of illness (Tessier, 2020) . **They correspond to the first two branches of SP**.

SHP is based on ten key principles (Tessier, 2020) :

- **Universality of protection**: since SHP is a human right, and in line with the "*leave no one behind*" principle of the SDGs, it guarantees effective universal access – and therefore to everyone – to adequate services.
- **Diversity of approaches and progressive realisation**: there are many valid ways of implementing SHP (as well as UHC) as long as they respect the key principles (Tessier & Louis Dit Guérin, 2024). There is no such thing as *one-size-fits-all* policy (see section III).
- **Risk-sharing and solidarity in financing** (Tessier & Louis Dit Guérin, 2024) : The financing of accessibility to health services (and of UHC) is detailed in section IV. Regarding income security following illness, the two main mechanisms are: (i) social insurance (with a contribution from the employee and the employer) / statutory sick pay covered by employers under labour legislation, or (ii) social assistance. These two mechanisms sometimes coexist.
- **Overall and primary responsibility of the State**: as with USP, the State guarantees the implementation of the SHP (Tessier & Louis Dit Guérin, 2024)
- **Adequacy of benefits:** services must be appropriate to the population's health needs, accessible (according to the five Penchansky and Thomas criteria, see section I), and of high quality.
- **Predictability of benefits:** the benefits to which beneficiaries are entitled must be predictable and clearly defined by a legal framework. This implies a form of transparency on the part of the State.
- **Non-discrimination, gender equality and social inclusion** (see section VI).
- **Fiscal and economic sustainability with regards to social justice and equity:** financial sustainability refers to the current and future capacity of the system to bear the costs associated with the SHP. Responsible governance of SHP aims to guarantee transparency in financial management, while ensuring that equity is at the forefront of all reforms.
- **Participation, social dialogue and accountability:** social dialogue enables the various stakeholders to express themselves to co-construct solutions, avoid the exclusion of certain populations, and guarantee the system's accountability to its population.
- **Integration within a comprehensive SP system:** SHP is an integral part of the USP, so it is vital to coordinate SHP policies with those of the other branches of the USP, as well as with employment policies.

From these principles, an observation follows: **the principles governing the CSU and the PSS are very similar and partially overlap**. Both advocate effective, equitable and universal access to quality healthcare services without subjecting users to financial hardship (Bayarsaikhan et al., 2022). Both also face the same challenges: how to sustainably and equitably finance UHC/SHP, how to make processes transparent, how to ensure equity and accountability, etc.

However, each has its own distinct aspects. On the one hand**, the financial protection of UHC encompasses private and voluntary coverage mechanisms that are not included in the SHP**. On the other hand, **regarding health coverage, the two concepts agree on universalism and coverage of the entire population while guaranteeing their rights**. However, **SHP is not responsible for the service provision**. The provision, quality and accessibility of health services are the responsibility of the UHC. Finally, **the SHP includes a "financial security" component to compensate for loss of income in the event of illness, which is closely linked to employment and decent work policies and is not covered by the UHC** (Figure2).

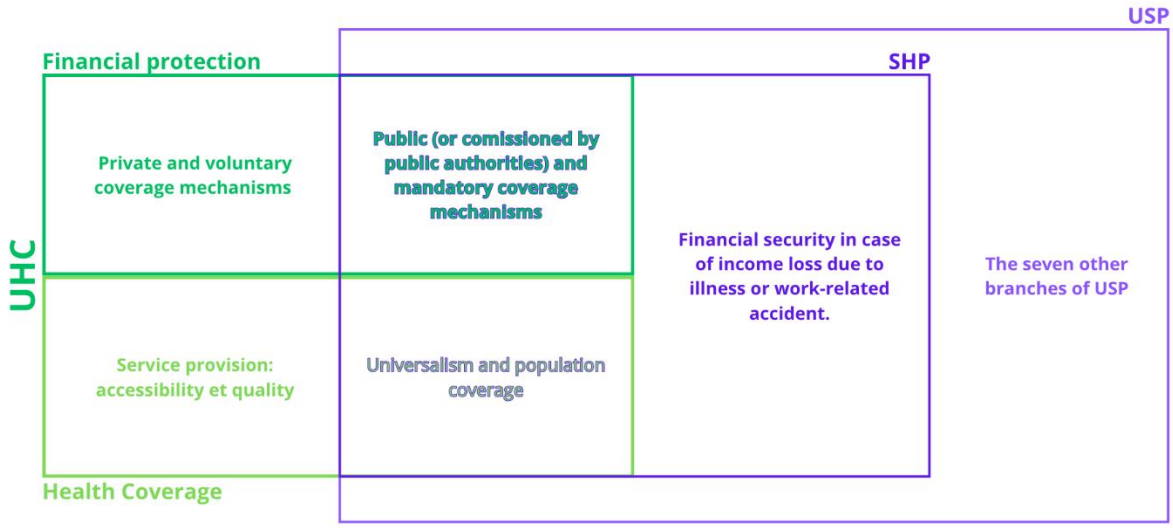

Figure2 Overlaps and differences between UHC, SHP and USP

It is important to note that, although there are conceptual differences between UHC and SHP, **these do not constitute divergences**. For example, the SHP recognises the importance of having quality services to cover the population (Bayarsaikhan et al., 2022), without this falling under the responsibility of its "sector". Finally, both concepts agree on the importance of policy coherence, especially when it comes to cross-sectoral policies (International Labour Organisation, 2010; World Social Protection Report 2020-22: Social Protection at the Crossroads - in Pursuit of a Better Future, 2021; World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024).

To go further, the tenth principle of the SHP states that it is an integral part of the USP. Given the many conceptual similarities between UHC and SHP**, it would therefore be essential to coordinate UHC policies with USP policies at national level, so that they are coherent, relevant and synergistic** (Rapport Sur La Santé Dans Le Monde 2008, 2008). Although USP covers several branches of protection, some are closely linked to the health sector: medical care (included in the SHP), but also some of the accidents at work and occupational illness, maternity and invalidity benefits. In addition, there are two major principles between the USP and the UHC**: universal coverage** and **social protection floors, which are taken up by the WHO in the formulation "minimum service package"**.

In conclusion, SHP guarantees universal access to affordable healthcare services (in this respect, it comes under the financial protection aspect of UHC) and financial security to compensate for loss of income in the event of illness. Its various principles echo those governing UHC. It is therefore appropriate to develop coordinated and coherent national policies that respect both UHC and the SP agendas.

The remainder of this document will detail several concepts for implementing the CSU. These aspects can also be used for SHP.

FURTHER READINGS

EN3S, 'Dossier Inequalities and poverty in international comparison'. Bi-annual review published by the École nationale supérieure de Sécurité sociale. EN3S, June 2024. https://www.calameo.com/read/004310504153e0590e6e7

International Labour Organisation, Tessier, Lou, 'Towards Universal Health Coverage: Social Health Protection Principles'. Social Protection Spotlight, 26 May 2020. https://www.ilo.org/publications/towards-universal-health-coverage-social-health-protection-principles

Yeates, Nicola, 1965-Holden Chris, Roosa Lambin, Carolyn Snell, Nabila Idris, and Sophie Mackinder. *A Global Fund for Social Protection: Lessons from the Diverse Experiences of Global Health, Agriculture and Climate Funds*. ILO, 2023. https://doi.org/10.54394/IBBI1570

SOCIAL PROTECTION AND THE INFORMAL ECONOMY

The informal economy is defined by ILO Convention R204 as "*all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements*" and which are not illegal (Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015). According to the ILO, they are represented by self-employed workers, workers in micro and small enterprises, domestic workers, agricultural workers, workers in the construction sector, cultural and creative workers, workers in the digital sector (*Questions Pour Secteurs et Catégories de Travailleurs Spécifiques - NOTES DE SYNTHÈSE*, n.d.) , as well as cooperatives and social and solidarity economy units (Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015). Although this definition denotes the diversity of the profiles of this economy, it remains non-exhaustive (we can still cite workers in the mining sector, tourism, or any self-employed profession...) and is confusing. In addition to this, there are many other terminologies and concepts linked to informality: the informal economy, the informal sector, employment in the informal sector, household production, etc.

The first resolution of the 21st International Conference of Labour Statisticians (ICLS) concerning statistics in the informal economy proposes statistical definitions, with the aim of standardising the definition, and subsequently statistical analyses and comparisons. It defines the informal sector statistically as: " **comprising economic units that are producers of goods and services mainly intended for the market to generate income and profit and that are not formally recognized by government authorities as distinct market producers and thus not covered by formal arrangements**" (Article 40) (Resolution I Concerning Statistics on the Informal Economy - 21st International Conference of Labour Statisticians, 2023).

In 2018, worldwide, 61.2% of workers over the age of 15 worked informally, of which 51.9% in the informal sector, 6.7% in the formal sector[3] and 2.5% at household level. The informal economy mainly concerns young workers and older workers. Informality is also strongly correlated with education: someone with a higher level of education is less likely to be an informal worker than someone with primary education or less. The agriculture sector is the most represented in the informal economy,

[3] An informal worker in the formal sector is someone who performs work for/with a formal enterprise or employer without being covered by the formal arrangements (Resolution I Concerning Statistics on the Informal Economy - 21st International Conference of Labour Statisticians, 2023)

but it is important to remember that all sectors are affected by informality (International Labour Office, 2018).

It is often assumed that all informal workers are poor, but this is an erroneous shortcut. Although there is a strong correlation between poverty and informality, there are many disparities between the socio-economic profiles of workers. Moreover, poverty also exists in the formal sector (International Labour Office, 2018). Evidence shows that workers choose informality for a variety of reasons (International Labour Office, 2018), and that most workers end up in informality not by choice, but because of a lack of opportunities in the formal sector to meet their basic needs, as a mean of last resort (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022; Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015).

In Africa, the informal economy is the main source of employment, accounting for 85.8% of jobs (89.2% on average in sub-Saharan Africa), with major variations between countries (34% in South Africa, 94.6% in Burkina Faso). A large majority work in the informal economy (76%), a share that is well above the global average. Agriculture remains the predominant sector. This region is characterised by a higher proportion of women than men in informal employment. Trends in terms of education and age are similar to those observed worldwide (International Labour Office, 2018).

The informal economy is a thorny issue because " *the high incidence of the informal economy in all its aspects is a **major challenge** for the rights of workers, including the fundamental principles and rights at work, and for social protection, decent working conditions, inclusive development and the rule of law* [...]" according to Recommendation R204 (Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015).

Without being so alarming, **the informal economy represents a challenge for extending USP**. These workers are often excluded from social insurance schemes (because of their limited ability to contribute) and social assistance schemes (which mainly target the poorest), hence the term "*missing* middle" (Anh Nguyen & Behrendt, 2021). These workers find themselves without any protection, and are therefore vulnerable to shocks (particularly during the COVID-19 crisis)[4] (Anh Nguyen & Behrendt, 2020, 2021). It is therefore important to identify the factors that stand in the way of extending SP to the informal sector, including (Anh Nguyen & Behrendt, 2021; Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022) :

- **Exclusion from legal coverage**: the legal framework can often exclude or restrict access to SP services by design, for example by setting conditions for the worker to have access to SP services. These conditions may depend on the existence of an employer/employee relationship, the place of work, the type of contract, etc.
- **Lack of information, awareness and trust,** all of which contribute to the lack of incentive to enrol in SP schemes. This includes illiteracy, language barriers and distrust of public institutions.

[4] During the COVID-19 crisis, many temporary SP measures were put in place, which may have supported some households and informal workers. However, several measures did not lead to long-term SP policies and remained temporary (Anh Nguyen & Behrendt, 2020, 2021).

- **Benefits not aligned with priorities:** given the heterogeneity of the informal economy, some workers are not convinced by the benefits provided, which do not meet their basic needs.
- **Costs and inadequate financing arrangements:** contributions may be inadequate depending on the level or irregularity of informal workers' income. Some informal workers do not see the point of contributing[5] (The various funding mechanisms are detailed in section IV).
- **Complex and burdensome administrative procedures and services:** the complexity of procedures and the inaccessibility of administrative offices can dissuade both employers and employees from enrolling in SP schemes.
- **Lack of enforcement and control, and low compliance:** the absence of mechanisms for enforcing and controlling compliance with labour regulations contributes to a low level of compliance with the national legal framework.
- **Lack of representation and organisation:** There is a correlation between the ability of workers to organise themselves and the ease of their integration into contributory schemes and into social and political dialogue. The fact that certain categories of workers are not organised naturally excludes them from political dialogue. However, the capacity of the informal sector to organise itself organically should not be underestimated.
- **Lack of integration and policy coherence:** The fragmentation of the various SP schemes and the lack of coordination with the policies of the various sectors (particularly health) often result in gaps in the coverage and services offered.

For a better understanding of the informal economy, its challenges and possible solutions, we invite you to explore the work of the other members of the SPRING consortium, under the theme of the informal economy. You will find research work that is more specific to the informal economy and to certain particular sectors of activity.

To meet these challenges, **the ILO is promoting the transition from the informal to the formal economy with the recommendations of Convention R204 of 2015 as part of the decent work agenda** (Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015). At company level, this means that they must be covered by national regulations (tax, labour, SP, etc.) and registered as a legal person/entity, with the rights and duties that this entails. For own-account workers, this depends on the formal or informal status of their own business (La transition de l'économie informelle vers l'économie formelle - Théorie du changement, 2021).

Although the UHC agenda, supported in particular by the WHO, recognises the importance of the informal economy and the difficulties of covering this population against financial risks, it has a more pragmatic vision, achievable in the shorter term, and does not take a position on formalising the economy. It advocates the use of non-contributory mechanisms to take care of the most disadvantaged.

This formalisation is not an objective in itself, but is a *sine qua non* condition for achieving the objectives of the decent work agenda: reducing poverty, increasing the productivity of enterprises, guaranteeing that they are sustainable, promoting fair competition, and above all ensuring adequate

[5] A fairly widespread special case: self-employed workers are jointly liable for contributions from the employee and the employer.

SP for the various employees (La transition de l'économie informelle vers l'économie formelle - Théorie du changement, 2021). The formalisation process follows three complementary paths: (i) the creation of decent jobs and sustainable businesses in the formal economy, (ii) the transition of workers and businesses to the formal economy, and (iii) the prevention of the informalisation of employment. This requires different strategies to be implemented, depending on the national context. All strategies must therefore begin with a diagnosis of the factors, causes, characteristics and circumstances of informality, through social dialogue (La transition de l'économie informelle vers l'économie formelle - Théorie du changement, 2021; Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015). It is a long and complex process, because, while some workers or businesses may be able to formalise in the short term, many do not have the capacity to do so realistically (La transition de l'économie informelle vers l'économie formelle - Théorie du changement, 2021).

The extension of SP is positioned in this process both as a strategy for formalisation and as one of its results: the extension of the SP facilitates the transition from the informal to the formal economy, but this transition is also a necessary condition for guaranteeing the rights of the worker, including his SP (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022; La transition de l'économie informelle vers l'économie formelle - Théorie du changement, 2021; Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015).

A diagram of the theory of change for the transition from the informal to the formal economy according to the ILO is available on "The transition from the informal to the formal economy - Theory of change", page 2 (La transition de l'économie informelle vers l'économie formelle - Théorie du changement, 2021).

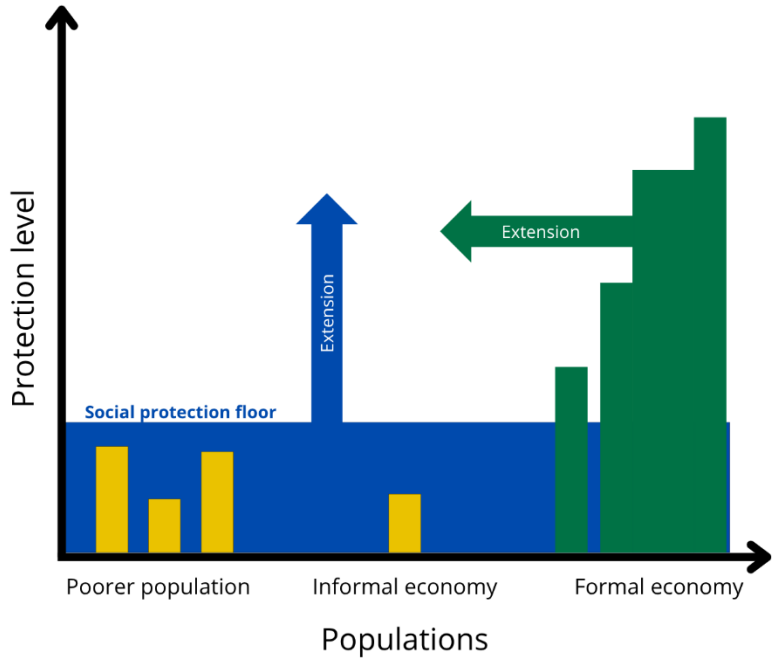

Figure3 Strategies for extending social protection coverage to workers in the informal economy[6] , inspired by (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022)

The extension of social security is then done in two ways: one through "formalisation", and the other "independently of status" (Figure3 andFigure4) (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022).

Extension through formalisation (green arrow inFigure3 **) is mainly based on** existing **social insurance mechanisms** (and therefore through contributory financing mechanisms), **and concerns workers who are already close to the formal economy** and who have a contributory capacity (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022). This social insurance facilitates the transition to the formal economy and strengthens inclusion and social cohesion (Anh Nguyen & Behrendt, 2021; Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022; Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015).

Extension independently of status (blue arrow inFigure3) **is achieved through social assistance mechanisms** (and therefore non-contributory funding mechanisms) **that enable SP to be extended to previously uncovered groups** irrespective of their employment status(Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022).

These two mechanisms are not incompatible and are, on the contrary, complementary in extending SP to the informal economy. **It is therefore important to combine the two components when developing USP policies** (Figure4)**. However, regardless of the combination adopted, the ILO still states its "preference", which is to promote the transition to the formal sector as a priority**: " *if government subsidies are provided to support the social insurance participation of workers with limited contributory capacity, particular care should be taken that these do not subsidize informality per se,*

[6] We can also see in this figure the "missing middle" effect, where the poorest have access to some targeted SP schemes, however, the informal economy is neglected.

but maintain and strengthen incentives to move from the informal to the formal economy, as to ensure sustainable and equitable social protection systems " (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022) (see box "The WHO and ILO visions", section IV).

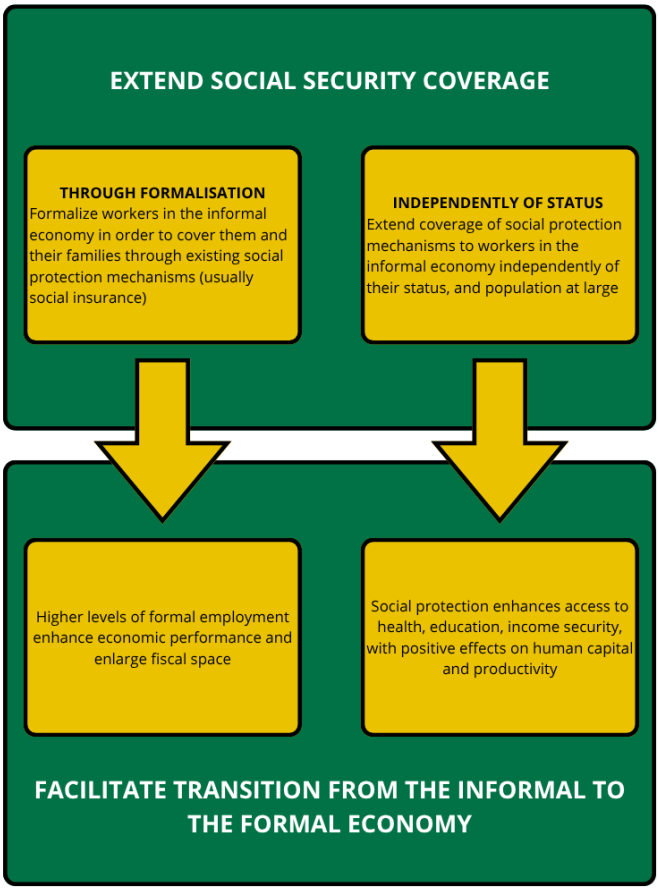

Figure4 A two-track approach to extending social security coverage and facilitating transition from the informal to the formal economy, inspired by (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022)

Whether we favour one or the other, it is essential to address the extension challenges mentioned above by providing solutions (Anh Nguyen & Behrendt, 2020; Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022) :

- **Promoting a comprehensive and integrated strategy for the extension of coverage**: extending SP must be part of a coherent national policy, and be based on fundamental principles: universal coverage, quality and accessibility of adequate services, financial sustainability, non-discrimination, and the transparency and reliability of public institutions.
- **Adapting the legal framework** so that it is adapted to the needs of workers and employers and promotes the transition to the formal economy.
- **Meeting priority needs and designing adapted solutions:** this starts with strengthening the voice and participation of the informal workers to achieve a diagnosis of the heterogeneity and needs of workers.
- **Raising awareness, sharing information and enhancing trust.**

- **Simplify administrative procedures,** including the registration of the companies or beneficiaries. For example: reduce the number of documents required, combine several administrative departments into a single point of contact...
- **Taking into account the financial capacity of workers in the informal economy**, by adapting contribution scales and/or subsidising certain contributions.
- **Complementing the extension of contributory coverage with non-contributory schemes, and building national social protection floors,** following on from the previous point.
- **Facilitating the enforcement of the law and enhancing compliance,** to ensure respect for the legal framework defined above.
- **Embed access to social protection in an integrated approach to facilitate transition from the informal to the formal economy.** SP is one of the elements, amongst other global strategies, that favour the transition from the informal to the formal economy. It is linked to the strategies of the other three pillars of the decent work agenda (labour law, job creation and social dialogue), as well as to cross-sectoral strategies (education, health, public finance, etc.).

In conclusion, the informal economy represents a major challenge for the SHP agenda, given its diversity and the fact that it is little known by the public sector. In order to extend SHP to the informal economy, the ILO recommends implementing a process of formalisation of this economy. To this end, each country is advised to identify the factors that encourage informality in its national context and to propose long-term strategies to remedy them, while guaranteeing social dialogue with those involved in the informal economy.

FURTHER READINGS

Berman, Pierre. *Extending Coverage: Social Protection and the Informal Economy - Experiences and Ideas from Researchers and Practitioners*, 2017.

Brahmachari, Rittika, Manasee Mishra, George Gotsadze, and Sabyasachi Mandal. Leveraging the Social Networks of Informal Healthcare Providers for Universal Health Coverage: Insights from the Indian Sundarbans'. *Health Policy and Planning* 39, no. Supplement_2 (18 November 2024): i105-20. https://doi.org/10.1093/heapol/czae060

International Labour Office. Extending social security to workers in the informal economy - Lessons from international experience'. Policy brief. International Labour Office, 2022. https://www.social-protection.org/gimi/Media.action?id=18963

International Labour Organisation, Anh Nguyen, Quynh, and Christina Behrendt. 'Extending Social Security to Workers in the Informal Economy - Key Lessons Learned from International Experience'. Social Protection Spotlight, March 2021. https://www.social-protection.org/gimi/Media.action?id=16991

Mahal, Ajay, Vivek Panwar, Arun Tiwari, Rahul Reddy, and Sumit Kane, 'The "Missing Middle": How to Provide 350 Million Indians with Health Coverage?' *Margin: The Journal of Applied Economic Research*, 24 October 2024, 00252921241284190. https://doi.org/10.1177/00252921241284190

Pinna Pintor, Matteo, Elena Fumagalli, and Marc Suhrcke. 'The Impact of Health on Labour Market Outcomes: A Rapid Systematic Review'. *Health Policy* 143 (1 May 2024): 105057. https://doi.org/10.1016/j.healthpol.2024.105057

III- HOW DO YOU "IMPLEMENT" UHC?

UHC encompasses various dimensions. It is therefore becoming an ambiguous term, but above all a blurred a politically convenient label, making it difficult to formulate clear and relevant health policies. It is therefore important to clarify from the outset that:

i) **A "UHC policy" is a meaningless formulation**, because it does not identify the areas on which the policy intends to act. UHC becomes a generic means of justifying any health policy whatsoever.

ii) **There is no *one size fits all* policy or model for moving towards UHC**. Each country has its own history, its own values and its own socio-eco-political and epidemiological context; these factors have and will continue to influence the way in which health systems are built and the chosen strategies to organise collective action in favour of health (Stern Plaza et al., 2019; The World Health Report, 2010). This is known as *path dependency* (Kay, 2005).

UHC policies are often set out in strategic documents produced by the health and/or social protection sectors, but to ensure that they are effective, they must first and foremost be supported by a **legal framework** (Alyanak, 2022; Prabhakaran et al., 2017). This may come under the country's Constitution or take the form of one or more laws (which are not necessarily formulated using the term "UHC") that guarantee the population's right to health, identify the role of the various actors in the HS, and provide them with the tools and skills needed to implement the policies. Other strategic or legal texts may then specify certain aspects of the UHC policy and the implementation procedures(Alyanak, 2022). As good practice, we can start by draft a relevant, coherent, realistic and sustainable **national health development plan**, in which all the health policies to be implemented at national level are specified, while ensuring that the legal framework is adapted and in line with these strategic lines.

As far as health coverage is concerned, these policies should make it possible to extend the number of covered priority services ("depth" of the UHC cube). This means setting up a system for identifying a "**minimum/essential package of services**"[7] to be covered by the collective health pre-financed mechanism. This package should be selected and updated according to the needs of the population, the available resources and a series of prioritisation criteria (equity, efficiency, etc.) with the aim of gradually expanding it (International Labour Organisation, 2010; Making Explicit Choices on the Path to UHC : The JLN Health Benefits Package Revision Guide, n.d.; *Making Fair Choices on the Path to Universal Health Coverage*, 2014). The provision of easily accessible **primary healthcare services** is a solution often put forward by international institutions (Alyanak, 2022; Rapport Sur La Santé Dans Le Monde 2008, 2008) (see section VI). This minimum package of services is very similar to the social protection floors mentioned earlier (see section II) (*Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.).

Coverage must also be extended to **the entire population** ("width" of the cube). This means including marginalised and vulnerable groups in an equitable manner in coverage policies (people living in poverty, the informal sector, pregnant women, etc.) (see section VI).

[7] We are talking here about a *benefits package*, not a **care** package. The latter formulation would exclude promotion and prevention services.

Finally, **financial protection** policies need to be developed. These should protect households from financial hardships linked to their state of health by reducing their financial barriers. This includes OOPs, meaning the share of health service costs paid directly by users ("height" of the cube), but also transport costs, income loss… (International Labour Organisation, 2010; Saksena et al., 2014). To achieve this, financial solidarity mechanisms through **fund pooling policies** must be implemented (these pooled funds represent the blue cube within the cube of all health services) (17). These policies will redistribute risks between the richest and the poorest, between healthier and sicker people... regardless of the funding mechanism chosen (Tessier, 2020). In this way, the funds collected can be used to cover (in advance in the case of third-party payment, afterwards in the case of reimbursement) the health services of the population, which will reduce their share of the payment. These policies must be carefully designed to ensure equity in the collection and redistribution of funds for UHC. They are closely linked to health financing policies (Papanicolas et al., 2022), detailed in section IV.

However, these funds pooled together to protect the population are never enough to cover all services free of charge for everyone (a solid cube that would fill the entire volume of the UHC cube) (The World Health Report, 2010). Progress towards UHC is therefore gradual and can be achieved by focusing on one or other of the three axes, or on all three at the same time. **It is advised to guarantee universal coverage first** (width of the cube), and therefore to start by offering a minimum service package **to the entire population**, before gradually extending the package covered (*Making Fair Choices on the Path to Universal Health Coverage*, 2014; The World Health Report, 2010). This is in line with ILO Recommendation No. 202 on Social Protection Floors (*Recommandation R202 - Social Protection Floors Recommendation, 2012 (No. 202)*, n.d.).

The funding policies of the HS (closely linked to financial protection) which will increase the funds available, will be detailed in section VI.

However, the implementation of UHC is not limited to financing and health risk coverage policies. It must also ensure that the services covered are **accessible and of high quality**. It is therefore a question of **ensuring perfect coherence and congruence between all health policies**. These include, but are not limited to

- Geographical accessibility policies (Prabhakaran et al., 2017; Rapport Sur La Santé Dans Le Monde 2008, 2008) (e.g. decentralisation of health services, primary health services, patient transport services, etc.)
- Human resources policies in health (Scheffler et al., 2016) (initial and continuing training, distribution across the territory, remuneration, staff retention, etc.)
- Health infrastructure and equipment policies (Strategic Health Infrastructure Investments to Support Universal Health Coverage, 2023) (WASH, construction of health centres, equipment maintenance, etc.)
- Policies on the health information systems and their digitalisation (Hussein, 2015a, 2015b)
- Pharmaceutical system policies (production, supply and distribution chain...) (Wagner et al., 2014)
- Policies to improve the quality of services (accreditation, etc.) (Yanful et al., 2023)
- The overall governance, including the monitoring, evaluation and accountability system of all these policies (Prabhakaran et al., 2017)

In conclusion, in order to "implement" UHC**, health policies must be holistic and address all aspects of the HS**. **They must not be reduced to financial protection policies**. Rather, UHC would serve as a theoretical framework for better integrating all these reforms and making them coherent.

FURTHER READINGS

Making Explicit Choices on the Path to UHC: The JLN Health Benefits Package Revision Guide'. Washington D.C.: World Bank Group, n.d. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099120924161033683/p17623510c267803319a0b1e9a556ec2472

Bertram, Katri, and Justin Koonin. 'Simplifying the Universal Health Coverage Narrative Can Help to Achieve Political Action'. *BMJ* 387 (6 November 2024): q2441. https://doi.org/10.1136/bmj.q2441

Goodman, Catherine, Sophie Witter, Mark Hellowell, Louise Allen, Shuchi Srinivasan, Swapna Nixon, Ayesha Burney, et al. 'Approaches, Enablers and Barriers to Govern the Private Sector in Health in Low- and Middle-Income Countries: A Scoping Review'. *BMJ Global Health* 8, no. Suppl 5 (1 October 2024): e015771. https://doi.org/10.1136/bmjgh-2024-015771

The WHO UHC Compendium includes tools to help countries make decisions about the minimum package of services: 'UHC Compendium'. Accessed 18 September 2024. https://www.who.int/universal-health-coverage/compendium

The "*National health planning tool*" is a WHO tool which assists political decision-makers in drawing up health plans or policies: 'National Health Planning Tools'. Accessed 18 September 2024. https://extranet.who.int/nhptool/Default.aspx

UHC2030, 'From Words to Action: The Universal Health Coverage Action Programme of the UHC Movement'. UHC2030, 2023. https://www.uhc2030.org/what-we-do/voices/action-agenda-from-the-uhc-movement/

World Health Organization, 'UHC Technical Brief: Strengthening Health Information Systems'. World Health Organization, 2017. https://iris.who.int/handle/10665/259716

World Health Organization, *Global Strategy on Human Resources for Health: Workforce 2030*. Geneva, 2016. https://iris.who.int/handle/10665/250368

IV- HOW CAN UHC AND SHP BE FINANCED?

UHC and its financing are often misinterpreted by political decision-makers and experts. In fact, **UHC cannot be directly financed (since it is an abstract concept), rather policy makers implement health system financing policies**. The financing system will collect, pool and use the funds needed to finance the HS in the broader sense, including policies and programmes that evolve towards acheiving UHC (McIntyre & Kutzin, 2016). To quote J. Kutzin, "*Unless the concept is clearly understood, UHC can be used to justify practically any health financing reform or scheme*" (Kutzin, 2013).

A first step is to **develop a coherent financing strategy for the HS** that: (i) begins with a diagnosis of the financial situation of HS (including the sources of health financing, the fiscal capacity of the system and the public finance management), (ii) focuses on the population as a whole, (iii) identifies objectives specific to the country, and (iv) includes an evaluation strategy. This strategy should not stand alone but should be incorporated into the health sector strategic plan or, ideally, into the national (cross-sector) development plan. At the very least, this strategy should be drawn up by the bodies responsible for health (e.g. the Ministry of Health) and finance, through a multisectoral working group responsible for drawing up and implementing the strategy (Kutzin et al., 2017, 2018)**.**

Health financing is based on **three functions: fundraising, *pooling* and purchasing of services** (McIntyre & Kutzin, 2016; Papanicolas et al., 2022)**.**

Firstly**, fundraising** (or revenue mobilisation) refers to the sources of health funding and the mechanisms used to raise them. These funds may come from external sources (such as development aid, international loans, etc.) or internal (or domestic) sources (Papanicolas et al., 2022). **It is important for countries to rely mainly on internal sources of revenue, and therefore to reduce the share of external funding, as these mechanisms induce dependency and are not sustainable** (Kutzin et al., 2017, 2018) . Each country must therefore expand its fiscal space[8] , in order to mobilise more funds for a desired purpose (P. S. Heller, 2006; McIntyre & Kutzin, 2016). The identify the OOPs first which finance the system directly from the users at the point of use of the services. The other sources are uncoupled from the direct use of healthcare services. These are prepaid and pooled funds (Papanicolas et al., 2022), either in a private insurance scheme or in a public scheme. These pre-paid funds fall into one of two ccategories (McIntyre & Kutzin, 2016):

- Contributions (compulsory or voluntary/optional) to national and/or private insurance programmes.
- The State's tax and non-tax revenues. These may come either from (i) general revenues (taxes, direct and indirect levies, etc.) which feed into the (national or local) State budget, and part of which will be allocated to health when the annual budget is drawn up. Or (ii) from revenues earmarked for health (for example, taxes on tobacco, part of which goes directly to the health budget) (Papanicolas et al., 2022; Schiel-Adlung, 2014).

However, in practice, several mechanisms often coexist. It is therefore **strongly recommended that a mixed funding policy be implemented, combining both contributory and non-contributory mechanisms** (Cattaneo et al., 2024; Étendre la sécurité sociale aux travailleurs dans l'économie

[8] Fiscal space refers to the availability of budgetary room that allows a government to allocate resources to a specific objective without undermining the sustainability of its financial position (P. Heller, 2005; P. S. Heller, 2006).

informelle - Leçons tirées de l'expérience internationale, 2022; McIntyre & Kutzin, 2016)**, depending on the local context**.

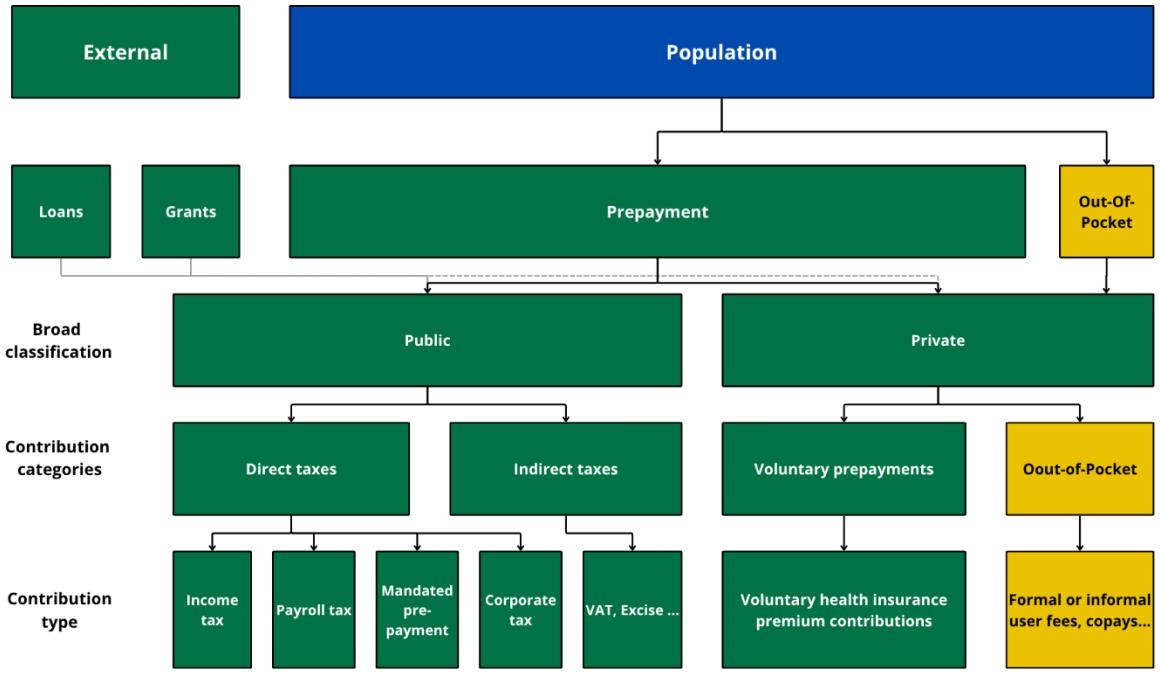

Figure5 Major revenue sources and contribution mechanisms, inspired by (Kutzin et al., 2018)

The revenue raising function is a key determinant in the redistribution of the financial burden across the population (Kutzin et al., 2017, 2018; Papanicolas et al., 2022). Regardless of the selected fundraising mechanism(s), and **in the interest of financial equity,** it is important to design fundraising mechanisms that are **progressive, i.e. the better-off households contribute proportionally more than to the funding of the system than the poorest households** (McIntyre & Kutzin, 2016)**.**

Proportional financing means that everyone contributes the same percentage of their income to financing the system, whereas a **regressive** revenue raising mechanism occurs when the poorest people spend a greater percentage of their income on health. OOPs and fixed insurance premiums, for example, are regressive "contributions".

Then, if the objectives of coverage, equity and "cross-subsidisation" (see below) are to be achieved, while reducing the risks of adverse selection inherent in insurance mechanisms, public fundraising mechanisms **should be compulsory,** i.e. the population is legally obliged to participate in the fundraising effort (Kutzin et al., 2017, 2018; McIntyre & Kutzin, 2016)**. No country has ever achieved universal health coverage with voluntary prepayment mechanisms alone** (McIntyre & Kutzin, 2016). This may be done through compulsory contributions to social health insurance services, direct taxes (e.g. income or corporate taxes) or indirect taxes (e.g. VAT). Voluntary contributions may be limited for the private insurance or for additional public services that go beyond the minimum package. As the funds allocated to health are insufficient to finance the extension of the UHC in many countries,

the WHO recommends finding **innovative financing**[9] , described as "*non-traditional applications of official development assistance, joint public-private mechanisms, and flows that either support fundraising by tapping new resources or deliver financial solutions to development problems on the ground*" (Le Gargasson & Salomé, 2010; Nabyonga Orem et al., 2022). In other words, new ways of increasing fiscal space.

Trends observed in the WHO and the ILO

Although the two international institutions advocate and argue in favour of a mixed funding model (partly contributory and partly non-contributory), the WHO and the ILO are in some ways at odds as to which fund-raising mechanisms should be favoured.

The ILO promotes SP as part of **the broader decent work agenda**. The latter advocates the **transition from the informal to the formal economy** (Recommandation R204 Sur La Transition de l'économie Informelle Vers l'économie Formelle, 2015) (see section II). The incomes of informal workers are irregular, unknown to the authorities and often low, which constitutes a challenge to the extension of SP to these populations. To overcome these difficulties, policies should (i) adapt the way contributions are determined, (ii) facilitate mechanisms for paying contributions and (iii) combine contributory and non-contributory mechanisms (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022). With this formalisation, the informal sector would no longer be on the margins of the system but would be integrated into it. It would be simpler to determine everyone's level of income, making it easier to set up a system of compulsory social contributions or income taxes (Cattaneo et al., 2024; Coltear & Rosemberg, 2018). Contributions would then be and remain the main and reliable source of funding for SP, guaranteeing a redistribution of funds and a pooling of funds between individuals, but also between generations (particularly in regard to pensions) (Calligaro & Cetrangolo, 2023; Sustainable Financing of Social Protection, 2023). These contributions, in the form of social contributions or income tax, are administratively easy to operationalise (Cattaneo et al., 2024), encourage the formalisation of employment, limit the costs of programmes, offer clarity of financial flows to politicians and the public and, in the case of social contributions alone, guarantee funds are earmarked for SP without going through the State budget allocation processes (Calligaro & Cetrangolo, 2023). This is the first track to extending SP to the informal sector, known as "formalisation". The second track, based on non-contributory funding mechanisms, is the "independently of status" track (Étendre la sécurité sociale aux travailleurs dans l'économie informelle - Leçons tirées de l'expérience internationale, 2022), which complements the formalisation promoted by the decent work agenda

On the other hand, the WHO advocates a **progressive universalism** approach (see section VI), according to which health services must, from the outset, be universal (accessible to all) and therefore, limited to the most essential services (limited at first because of financial constraints, then expanded later), with variations proportional to the needs of different populations (Francis-Oliviero et al., 2020). However, contributory mechanisms (regardless of how legally obligatory they may be) were created for a population working in the formal sector and generally better off (Coltear & Rosemberg, 2018),

[9] The term "innovative" here does not necessarily mean "new" or "cutting edge". Funding is considered innovative if (i) it meets an identified need, (ii) it complements existing mechanisms, (iii) it is effective and efficient (Nabyonga Orem et al., 2022). A simple update of funding policies can sometimes be considered innovative in this case.

excluding the informal economy, which is on the margins of the system in many contexts (McIntyre et al., 2018; Yazbeck et al., 2023). Contributory mechanisms alone are therefore inaccessible and insufficient to cover vulnerable populations. The systems that have succeeded in significantly extending healthcare coverage are those supported by revenue from general taxes (Barasa et al., 2021). Systems based on these revenues also have a greater capacity for redistribution (Luyten & Tubeuf, 2024). The WHO therefore proposes that preference be given to non-contributory mechanisms based on tax revenue. General revenues are described as being more sustainable (Yazbeck et al., 2023), progressive (McIntyre et al., 2018), and allowing the informal sector to participate in the prepayment effort (Ly et al., 2022). This trend is reflected in the introduction of "*health taxes*" or "*sin taxes*", defined as taxes levied on products or behaviours that are harmful to health (Clark et al., 2024; *Health Taxes*, n.d.), as innovative financing (Nabyonga Orem et al., 2022), while reducing taxes on basic products (Ly et al., 2022).

The second function of health financing is the **pooling of funds.** First of all, it should be noted that the funds collected can either be **allocated directly to health** (for example, a tax on tobacco which goes directly, in whole or in part, to finance the HS or certain specific activities), or **pass through the general state budget** (McIntyre & Kutzin, 2016). These unallocated funds are subject to budgetary arbitration each year before being allocated to the health budget.

The idea of pooling funds to pre-finance healthcare expenditure is inherently linked to the idea of reducing OOPs and catastrophic healthcare expenditure, reducing the financial burden to access health services. In addition to their insurance role, these pools also play the role of **maximising the redistributive capacity of prepaid funds** (McIntyre & Kutzin, 2016; Papanicolas et al., 2022), i.e. they should enable risks to be pooled and funds to be redistributed ('cross-subsidisation') between different strata of the population (the better-off supporting the poorer, the healthy the sick, etc.). This is how we operationalise financial solidarity (Alyanak, 2022). To guarantee this solidarity, the pools must meet certain criteria (McIntyre & Kutzin, 2016; Papanicolas et al., 2022):

(i) **Size**: the larger the pool, the greater its capacity to redistribute resources and guarantee services to those who need them most;
(ii) **The diversity individuals eligible for** pool funds;
(iii) **Participation and membership: it is advised to make participation compulsory**, and therefore to create a legal condition involving some or all the population. If participation is voluntary, only those in need are likely to take part, creating an "adverse selection". There is a risk that healthy or wealthy people will not take part, which limits the pool's redistributive capacity and solidarity between individuals, and jeopardises the financial sustainability of the prepayment mechanism.

Redistribution difficulties arise in particular where there is fragmentation of pools of limited size and little diversity (McIntyre & Kutzin, 2016). Depending on the national context, this fragmentation also reduces the capacity for cross-subsidisation between different pools.

OOPs represent the absence of pooling of funds: there is no possible redistribution in this case.

It is important to note that **the link between a fundraising and pooling mechanism is not one-to-one**. A pool can be funded by several collection mechanisms, and a collection mechanism can contribute to multiple pools (Kutzin et al., 2017, 2018). What is important is that the governance of the various pools is clearly identified, and that the financial flows are as clear and simple as possible.

Thirdly and lastly, **the services purchasing function can be boiled down to a few questions: who buys what, for whom, from whom and how?** (McIntyre & Kutzin, 2016). The question of "who buys" refers to the governance of the various pools and determines who the buyers of services are. Next, we focus on the "what to buy" question: **this involves determining which services these pools will buy, and under what conditions they are reimbursable** (McIntyre & Kutzin, 2016; Papanicolas et al., 2022). Ideally, the purchaser can cover **a predetermined** minimum service package (International Labour Organisation, 2010; *Making Fair Choices on the Path to Universal Health Coverage*, 2014). It is important to remember that, since resources are limited, not all health services can be covered. **A choice will have to be made about which services to cover**, which inevitably also involves a choice about what will not be covered (Kutzin et al., 2017, 2018; McIntyre & Kutzin, 2016; Norheim, 2015).

The question "for whom" refers to the beneficiaries of the services. **They are entitled to the services that the pool(s) to which they belong have to offer. These services are determined for each pool**, and therefore by population groups(Kutzin et al., 2017, 2018; McIntyre & Kutzin, 2016) . This notion refers directly to the participation and belonging mentioned above.

The question "to whom" refers to the service providers (individual, such as a doctor, or institutional, such as a health centre). **The system for purchasing services will enable certain service providers** (public or private, under contract, etc.) **to be remunerated**. The aim is to identify which providers are eligible for this remuneration through **a system of accreditation and quality monitoring** of services (Papanicolas et al., 2022). This aspect must be closely linked with health human resources and service quality policies (see section III).

Finally, the question of "how" refers to the **methods of payment and purchase of services** (McIntyre & Kutzin, 2016; Papanicolas et al., 2022). There are many different methods of payment (fee-for-service, fixed price, *per capita*, *per* budget line, etc.) which may or may not be linked to the quantity of services already performed (retrospective or prospective payment). **Each has its advantages and disadvantages, and should be chosen according to the national context** (Cashin et al., 2015; Kutzin et al., 2017, 2018). The terms and conditions must be clearly explained, chosen and contractually agreed with the providers. A passive purchasing means that payment is made independently of any information on services performed or the needs of the provider (for example, the granting of a global annual budget or the reimbursement of invoices). In contrast**, strategic purchasing is a concept that advocates an active role for buyers. It involves linking payment to information about either the needs of the population or the performance of the provider** (Cashin et al., 2015; Kutzin et al., 2017, 2018; McIntyre & Kutzin, 2016). The term "strategic purchasing" is ambiguous and often misunderstood (Paul, Brown, et al., 2020) and covers a whole range of instruments for seeking to improve the performance of the HS (McIntyre & Kutzin, 2016), mainly from the point of view of allocative or technical efficiency. This concept is closely linked to service quality and health information policies (see section III).

Health financing and UHC: Health financing is often confused with UHC and/or financial protection. **The health financing system, as described above, covers all three functions and refers to the entire**

health system and interventions. It will therefore be able to influence all the dimensions of UHC - whether financial protection, service coverage or quality of care - as well as its intermediate objectives (equity, efficiency and accountability) (Kutzin, 2013) (Figure6). Each of the sub-functions of health financing can directly or indirectly influence progress towards UHC (see section III). **It is therefore essential to first understand the overall architecture of health system financing before introducing reforms in the name of UHC, and to ensure optimisation of the financing system as a whole rather than focusing only on individual mechanisms** (Paul, Sambiéni, et al., 2020)**.**

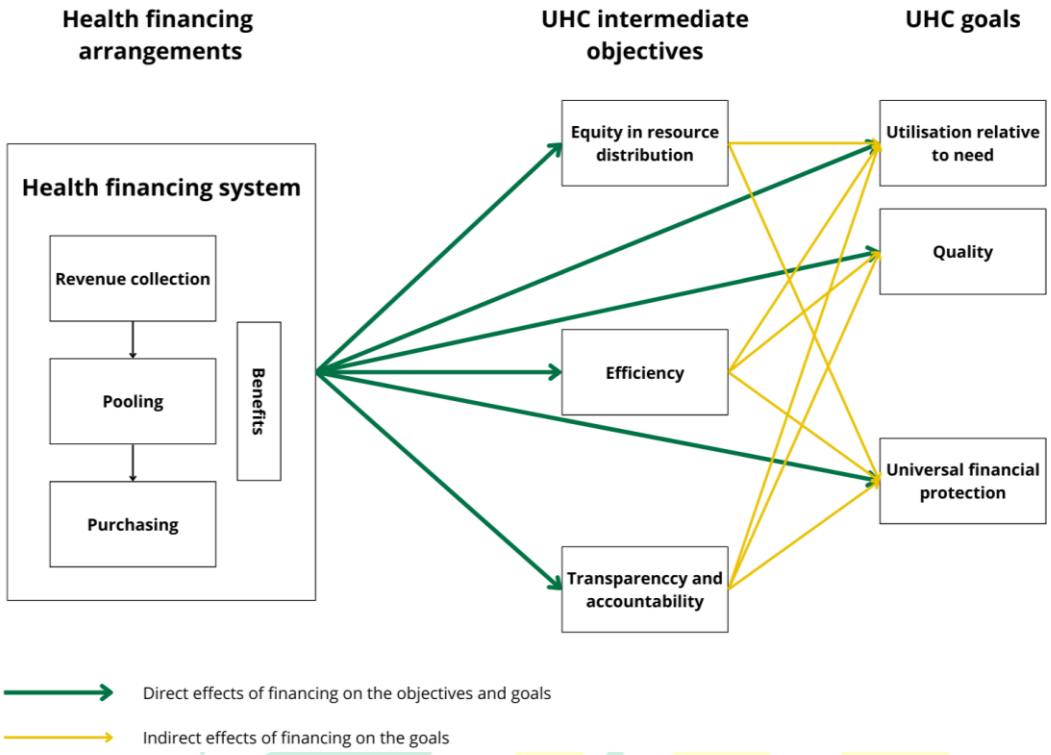

Figure6 Intermediate and final objectives of UHC that health financing can influence, inspired by(Kutzin, 2013)

<u>Special case of community based health insurance (CBHIs) (ou *mutuelles de santé communautaires)*</u>:
CBHIs are insurance organisations created and managed by communities or civil society organisations on their behalf (NGOs, religious centres, etc.). **They are characterised by their small size to preserve this community aspect, a contributory collection mechanism, and voluntary membership** (Mathauer et al., 2017; Tessier & Louis Dit Guérin, 2024). These criteria generate both advantages and disadvantages(Mathauer et al., 2017). The advantages include:

- The community aspect creates proximity with beneficiaries and is therefore a vector for **greater transparency and accountability**.
- CBHIs can reach the informal sector in contexts where compulsory national health insurance still excludes this population.
- The care packages on offer can be tailored to local needs.

The disadvantages include:

- Membership fees are often the same regardless of the member's income level, **making this funding mechanism regressive**. **This greatly reduces the number of members, especially the poorest**.

- **Enrolment is voluntary which, as mentioned above, creates adverse selection and undermines the financial sustainability of the scheme**.
- These CBHIs aim to be rooted in communities and are therefore small and numerous. **This fragmentation and lack of pooling of funds reduces their ability to pay for services and their redistributive capacity** (Tessier & Louis Dit Guérin, 2024).
- Contracts between CBHIs and service providers are drawn up on an individual basis, which reduces the scope and diversity of the offer.

CBHIs were ultimately able to increase healthcare use, but **had a limited impact on financial protection and access to care** (Mathauer et al., 2017; Tessier & Louis Dit Guérin, 2024)**. In addition, the fragmentation of funds and the small number of members mean that they have low financial viability and sustainability** (Tessier & Louis Dit Guérin, 2024). Today, health mutuals that have been successful in extending coverage are those: (i) that have been integrated into the compulsory national insurance system (Mathauer et al., 2017; Tessier & Louis Dit Guérin, 2024), (ii) that offer complementary coverage to the one provided by the state, (iii) or to which the system has delegated its management function (Tessier & Louis Dit Guérin, 2024). In these cases, they lose their community aspect in favour of financial viability and a real impact on progress towards UHC. **In conclusion, CBHIs isolated from the national coverage system have little impact and little financial viability. They need to be incorporated into a wider pool if they are to make a significant contribution to UHC**.

FURTHER READINGS

Barroy, Hélène, Pierre Yameogo, Mark Blecher, Martin Sabignoso, Moritz Piatti, and Joseph Kutzin. 'Public Financial Management: A Pathway to Universal Health Coverage in Low-and-Middle Income Countries'. *Health Systems & Reform* 10, no. 3 (18 December 2024): 2368051. https://doi.org/10.1080/23288604.2024.2368051

Cashin, Cheryl, Batbayar Ankhbayar, Hoang Thi Phuong, Gerelmaa Jamsran, Oyungerel Nanzad, Nguyen Khanh Phuong, Tran Thi Mai Oanh, Tran Van Tien, and Tsolmongerel Tsilaajav, 'Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage'. Joint Learning Network For Universal Health Coverage, 1 January 2015

Fan, Victoria, and Sanjeev Gupta. How to Heal Health Financing'. *Center For Global Development* (blog). Accessed 17 December 2024. https://www.cgdev.org/blog/how-heal-health-financing

Federspiel, Frederik, Josephine Borghi, Elhadji Mamadou Mbaye, Henning Tarp Jensen, and Melisa Martinez Alvarez. Development Partner Influence on Domestic Health Financing Contributions in Senegal: A Mixed Methods Case Study'. *Health Policy and Planning*, 21 November 2024, czae110. https://doi.org/10.1093/heapol/czae110

Heller, Peter S. 'The Prospects of Creating "Fiscal Space" for the Health Sector'. *Health Policy and Planning* 21, no. 2 (1 March 2006): 75-79. https://doi.org/10.1093/heapol/czj013

Karamagi, Humphrey Cyprian, David Njuguna, Solyana Ngusbrhan Kidane, Herve Djossou, Hillary Kipchumba Kipruto, Aminata Binetou-Wahebine Seydi, Juliet Nabyonga-Orem, Diane Karenzi Muhongerwa, Kingsley Addai Frimpong, and Benjamin Musembi Nganda. Financing Health System Elements in Africa: A Scoping Review'. *PLOS ONE* 18, no. 9 (13 September 2023): e0291371. https://doi.org/10.1371/journal.pone.0291371

Kestemont, Marie-Paule, and Elisabeth Paul. 'Le Rôle Des Mutuelles de Santé et Des Initiatives d'économie Sociale Dans l'extension Des Mécanismes de Protection Sociale Aux Travailleurs Ruraux Du Bénin'. Short-Term Policy Supporting Research (PSR). Louvain Coopération, March 2020. https://louvaincooperation.org/fr/node/707

Kutzin, Joseph. 'Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy'. *Bulletin of the World Health Organization* 91, no. 8 (1 August 2013): 602-11. https://doi.org/10.2471/BLT.12.113985

Luyten, Emilia, and Sandy Tubeuf. Equity in Healthcare Financing: A Review of Evidence'. *Health Policy*, 28 November 2024, 105218. https://doi.org/10.1016/j.healthpol.2024.105218

Ly, Mamadou Selly, Oumar Bassoum, and Adama Faye. 'Universal Health Insurance in Africa: A Narrative Review of the Literature on Institutional Models'. *BMJ Global Health* 7, no. 4 (1 April 2022): e008219. https://doi.org/10.1136/bmjgh-2021-008219

Mathauer, Inke, Benoît Mathivet, and Joseph Kutzin. 'Community-based health insurance: how can it contribute to progress towards universal health coverage?', 2017. https://iris.who.int/handle/10665/258980

Niang, Marietou, Émilie Gélinas, Oumar Mallé Samb, Lou Tessier, Mathilde Mailfert, Aurore Iradukunda, Olivier Louis dit Guérin, and Valéry Ridde. The Role of Mutuals and Community-Based Insurance in Social Health Protection Systems: International Experience on Delegated Functions'. *International Social Security Review* 76, no. 2 (1 April 2023): 3-29. https://doi.org/10.1111/issr.12323

International Labour Organisation, Tessier Lou, and Olivier Louis Dit Guérin. *What place for mutual health insurance and community-based health insurance in social health protection systems: a review of experiences*. Geneva: International Labour Organization, 2024. https://doi.org/10.54394/QUDT1352

World Health Organization, Kutzin, Joseph, Sophie Witter, Matthew Jowett, and Dorjsuren Bayarsaikhan. *Developing a national public health financing strategy: a reference guide* . Health Financing. Guidance;3. Geneva: World Health Organization, 2018. https://iris.who.int/handle/10665/275717

Paul, Elisabeth, N'koué Emmanuel Sambiéni, Jean-Pierre Wangbe, Fabienne Fecher, and Marc Bourgeois. 'Budgeting Challenges on the Path towards Universal Health Coverage: The Case of Benin'. *Health Economics Review* 10, no. 1 (5 September 2020): 28. https://doi.org/10.1186/s13561-020-00286-9

Ridde, Valéry, Mouhamadou Faly Ba, Babacar Kane, Anouk Chouaïd, and Adama Faye. 'Scaling Up Departmental Health Insurance Units in Senegal: A Mixed-Method Study'. *Health Systems & Reform* 10, no. 1 (16 December 2024): 2402084. https://doi.org/10.1080/23288604.2024.2402084

Waelkens, Maria-Pia, Soors Werner, and Criel Bart. Community Health Insurance in Low- and Middle-Income Countries'. In *International Encyclopedia of Public Health (Second Edition)*, edited by Stella R. Quah, 82-92. Oxford: Academic Press, 2017. https://doi.org/10.1016/B978-0-12-803678-5.00082-5

World Health Organisation, *The Health Financing Progress Matrix Country Assessment Guide*. Geneva: World Health Organization, 2020. https://www.who.int/publications/i/item/9789240017801

World Health Organization , 'Trends in Financial Hardship Due to Out-of-Pocket Health Spending in the WHO African Region'. World Health Organization, November 2024. https://www.afro.who.int/sites/default/files/2024-12/Regional%20brief_v5.pdf

World Health Organization, 'Global Spending on Health: Emerging from the Pandemic'. Geneva: World Health Organization, 9 December 2024. https://www.who.int/publications/i/item/9789240104495

World Health Organization, 'The World Health Report: Health Systems Financing: The Path to Universal Coverage'. Geneva: World Health Organization, 2010. https://iris.who.int/handle/10665/44371

World Health Organization, Cashin, Cheryl, Danielle Bloom, Susan Sparkes, Hélène Barroy, Joseph Kutzin, and Sheila O'Dougherty. *Aligning Public Financial Management and Health Financing: Sustaining Progress toward Universal Health Coverage*. World Health Organization, 2017. https://iris.who.int/handle/10665/254680

World Health Organization, Mathauer, Inke, Elina Dale, and Bruno Meessen. *Strategic Purchasing for Universal Health Coverage: Key Policy Issues and Questions: A Summary from Expert and Practitioners' Discussions*. World Health Organization, 2017. https://iris.who.int/handle/10665/259423

World Health Organization, McIntyre, Diane, and Joseph Kutzin. *Health Financing Country Diagnostic: A Foundation for National Strategy Development*. World Health Organization, 2016. https://iris.who.int/handle/10665/204283

World Health Organization, Nabyonga Orem, Juliet, Kingsley Addai, Kasonde Mwinga, Diane Karenzi Muhongerwa, Sylvia Namuli, and James Asamani. 'Analysis of the Nature and Contribution of Innovative Health Financing Mechanisms in the WHO African Region'. Brazzaville: World Health Organization, September 2022. https://www.afro.who.int/publications/analysis-nature-and-contribution-innovative-health-financing-mechanisms-who-african

An e-learning programme developed by the WHO on health financing and UHC: https://campus.paho.org/who/enrol/index.php?id=3.

As well as the page on health financing on the WHO website.

V- HOW DO YOU "MEASURE" UHC AND SP?

UHC and SP are broad and complex concepts, encompassing many aspects. **It is therefore impossible, even with complex and composite indices, to 'measure' UHC or SP in their entirety.** Progress of the population's coverage or protection is assessed by crossing and analysing numerous indicators measuring different aspects and adapted to the national context.

That being said, some indicators can be used to monitor the progress of each of the SDGs in a standardised way and at international level. For UHC, indicators for SDG 3.8.1 and 3.8.2 reflect the two components of the UHC: health coverage and financial protection respectively (*Tracking Universal Health Coverage*, 2023)).

The SDG indicators are established based international standards, which guarantees their reproducibility and standardisation. However, the collected data comes from national surveys, which undermines their credibility and quality. This comment applies to all SDG indicators.

SDG 3.8.1 reflects the national capacity to provide and guarantee effective, quality access to the services that the population needs. It is measured by a composite indicator called the UHC Service Coverage Index (*SCI*). This index is calculated based of fourteen indicators grouped into four service categories: reproductive health, maternal and child health, infectious diseases, non-communicable diseases, and the capacity to access services (*Tracking Universal Health Coverage*, 2023)). It can be measured at national level as well as local level (Mukherji et al., 2024), which makes it possible to make comparisons and identify inequalities in health coverage at local, national or international level (*Tracking Universal Health Coverage*, 2023). However, it does not identify the causes of inaccessibility to services.

Various definitions:

There are two concepts for estimating the financial hardships households face in accessing healthcare (2018 Global Reference List of 100 Core Health Indicators (plus Health-Related SDGs), 2018; *Tracking Universal Health Coverage*, 2023).

Catastrophic health expenditure, which is found in the numerator of the SDG indicator 3.8.2. This is the ratio of a household's health OOPs to the household's total expenditure. If the ratio exceeds a certain defined threshold (in the case of indicator 3.8.2, 10% or 25%), then the expenditure is considered catastrophic. The benchmark used is income or expenditure, representing the household's ability to pay.

Impoverishing health expenditure is not included in the SDG indicator 3.8.2, but it is often included in UHC monitoring reports. This is the absolute OOP expenditure on health that pushes the household below the poverty line. If the household was already below the poverty line, we speak of further impoverishment. Here, the reference point is an absolute poverty line (such as the SDG 1.1 line of $2.15 per day PPP[10] in 2017) or a relative poverty line (often set at 60% of the median income at national or local level).

[10] Definition: Purchasing Power Parity (PPP): a currency conversion rate designed to equalise the purchasing power of different currencies by eliminating differences in price levels between countries (*Parités de pouvoir d'achat (PPA)*, n.d.)

The two concepts are not mutually exclusive, and we can observe one, the other or both types of expenditure at the same time. InFigure7 , several hypothetical situations have been illustrated:
- For household 1, there is no catastrophic or impoverishing expenditure.
- Household 2's spending is catastrophic, as its healthcare OOPs account for 25% of its total expenditure, but this spending does not impoverish the household, as it remains above the poverty line (estimated at 40 in this case).
- For Household 3, we see impoverishing expenditure, as the household falls below the poverty line, but no catastrophic expenditure, as health OOPs represent less than 10% of its total expenditure.
- For households 4 and 5, we see both impoverishing and catastrophic expenditures.
- Household 6 is further impoverished.

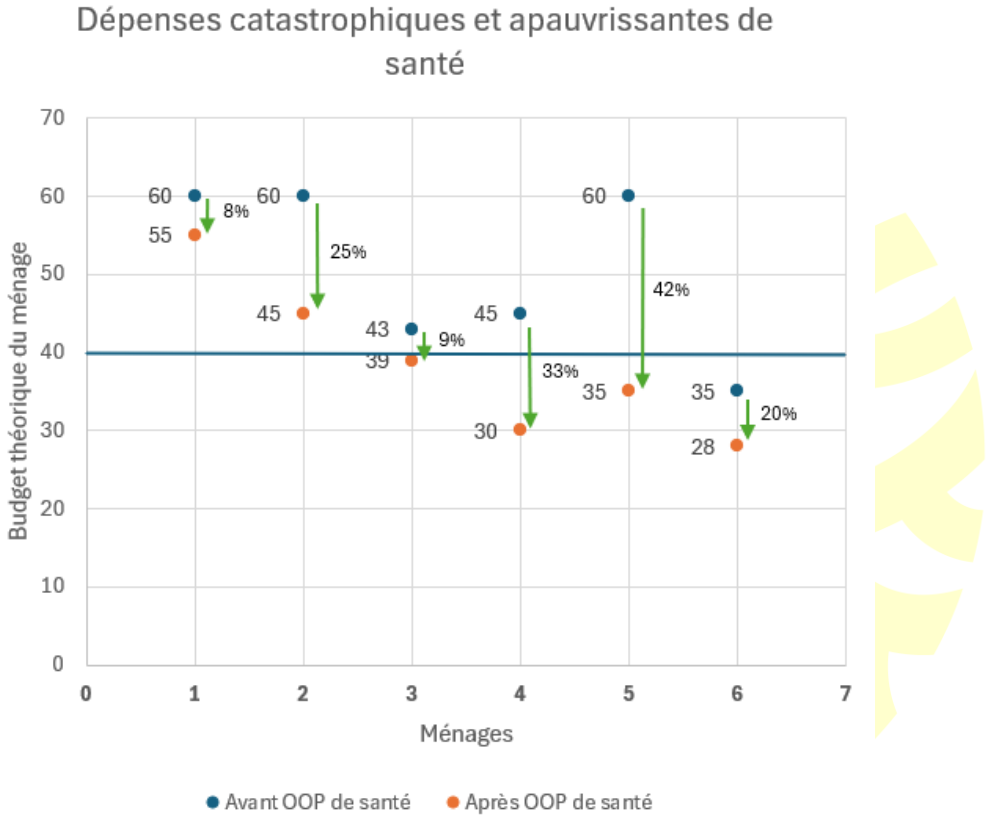

Figure7 Hypothetical situations of six different households

SDG 3.8.2 is defined as the proportion of the population whose household spends a catastrophic proportion of its total expenditure or income on health (i.e. health expenditure exceeding the threshold of 10% or 25% of expenditure or income)**. It measures the financial protection component of UHC** (2018 Global Reference List of 100 Core Health Indicators (plus Health-Related SDGs), 2018; *Tracking Universal Health Coverage*, 2023). It is often accompanied by another indicator, which is the proportion of the population experiencing impoverishing health expenditure. Like its counterpart, it can be measured at different levels, which allows comparisons to be made, but does not give any insight of the causes of the financial difficulties faced by the population.

These two indicators are regularly updated and published in the UHC "*Global monitoring report*", produced annually and jointly by the WHO and the World Bank, the latest version being in 2023 (*Tracking Universal Health Coverage*, 2023)). Their databases are also publicly accessible.[11]

In 2024 and 2025, the UN and external expert group on Sustainable Development Goal indicators will conduct an appraisal to refine, revise or replace some of the SDG indicators (*IAEG-SDGs — 2025 Comprehensive Review Process*, n.d.; *Tracking Universal Health Coverage*, 2023). Indicators 3.8.1 and 3.8.2 are among them. The main criticism of indicator 3.8.1 is that it is not aligned with the wording of SDG 3.8, and that it does not take into account the questions of whether accessible services are of sufficient quality and quantity to achieve the health goals (*Séance d'information à l'intention Des États Membres Sur Le Suivi de La Couverture Sanitaire Universelle (Cible 3.8 Des Objectifs de Développement Durable) : Révision Des Indicateurs 3.8.1 et 3.8.2 Des ODD Relatifs à La CSU*, 2024; *Tracking Universal Health Coverage*, 2023). Indicator 3.8.2 has also been criticised (Grépin et al., 2020), particularly in view of the confusion between catastrophic and impoverishing expenditure, coupled with opposing observations depending on the threshold chosen (10% or 25%, relative or absolute poverty line) (Saksena et al., 2014). One option is to consider using the discretionary budget[12] instead of the total household budget as a comparison with health expenditure (*Séance d'information à l'intention Des États Membres Sur Le Suivi de La Couverture Sanitaire Universelle (Cible 3.8 Des Objectifs de Développement Durable) : Révision Des Indicateurs 3.8.1 et 3.8.2 Des ODD Relatifs à La CSU*, 2024). The final changes are scheduled to be published on 12/12/2025, World UHC Day.

As far as SP is concerned, SDG indicator 1.3.1 is defined as the proportion of the population benefiting from social protection floors or systems, by gender and by population group (children, the unemployed, the elderly, the disabled, pregnant women and newborns, victims of accidents at work, the poor and the vulnerable). We can already see that the indicator is already disaggregated, enabling it to take equity into account. The various indicators are distributed around the nine branches of the USP [13](World Social Protection Report 2020-22: Social Protection at the Crossroads - in Pursuit of a Better Future, 2021; World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024) :

- The proportion of the population protected in at least one area [of USP], and therefore receiving cash benefits or contributing to at least one social security scheme;
- The proportion of children covered by cash benefits for children or families ;
- The proportion of women who have given birth and are receiving maternity benefits ;
- The proportion of people receiving disability benefits;
- The proportion of unemployed people receiving unemployment benefit;
- The proportion of employees covered in the event of occupational illness or accident;

---

[11] SDG 3.8.1: https://www.who.int/data/gho/data/themes/topics/service-coverage
SDG 3.8.2: https://www.who.int/data/gho/data/themes/topics/financial-protection
World Bank data: https://datacatalog.worldbank.org/search/dataset/0064780

[12] The discretionary budget of a household is defined as " s household total consumption expenditure or income net of the societal poverty line ". This is the budget remaining after deducting expenditure on rent, food and other bills (*Séance d'information à l'intention Des États Membres Sur Le Suivi de La Couverture Sanitaire Universelle (Cible 3.8 Des Objectifs de Développement Durable) : Révision Des Indicateurs 3.8.1 et 3.8.2 Des ODD Relatifs à La CSU*, 2024)

[13] Health coverage is covered by SDG 3.8, and is therefore not included here, even though it is one of the nine branches of USP.

- The proportion of elderly people receiving an old-age pension ;
- The proportion of vulnerable people receiving social assistance benefits in cash.

The composite indicator recognises the complexity of measuring SDG 1.3.1 and therefore takes into account other dimensions such as the scope (number and branches of social protection mechanisms), coverage (proportion of the target population covered) and level (adequacy) of coverage (World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024).

The data is collected using the "*Social Security Inquiry*", a publicly available online questionnaire which has become the main and exhaustive data collection tool for measuring SP in all sectors (*Social Security Inquiry*, n.d.; World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024)**. This indicator is updated and published every three years in the ILO's *World Social Protection Report***. The last two were published in 2021 (World Social Protection Report 2020-22: Social Protection at the Crossroads - in Pursuit of a Better Future, 2021) and 2024 (World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024). The ILO also provides several online databases.[14]

Health financing is one of the HS building blocks and is inseparable from UHC. **It is therefore important to know and understand the indicators of health expenditure and sources of funding**. The main indicators and their explanations are set out in table 1 of the report "Diagnosing health financing: the basis for developing a national strategy" by Kutzin and McIntyre (McIntyre & Kutzin, 2016). There is also a Health Financing Progress Matrix, developed by the WHO, which provides a standardised qualitative approach to assessing a country's health financing system (*The Health Financing Progress Matrix Country Assessment Guide*, 2020).

Data on health financing is available at national level and is collected through **national health accounts**. These accounts make it possible to track monetary flows from their sources to their use (expenditure), and therefore enable an in-depth analysis of health financing (*Guide to Producing National Health Accounts*, 2003; Quality Control of SHA-Based Health Accounts Data, 2024) . These national data are collected and centralised by the WHO in **the Global Health Expenditure Database[15]**, which is updated jointly with the various member countries (*Global Health Expenditure Database*, n.d.). This standardised database enables international comparisons to be made.

Regarding the financing of the (U)SP, data is collected from several national and international sources. The main sources and databases are listed in table A2.2 of the 2024 *World Social Protection Report*. Each of these databases has its own specificities and therefore does not provide an overall picture of SP funding. They have different definitions of the term “expenditure” on SP while some focus on a few USP branches (or not), and others on a specific region (World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024)**. It is therefore absolutely essential to cross-reference the different sources of data in order to get a comprehensive picture of the situation**. The data is always presented both including and excluding general public spending on

[14] ILOSTAT data explorer: https://rshiny.ilo.org/dataexplorer41/?lang=en&id=SDG_0131_SEX_SOC_RT_A
World social protection data dashboard: https://www.social-protection.org/gimi/WSPDB.action?id=19
Social protection monitor: https://www.social-protection.org/gimi/ShowWiki.action?id=3426
Labour statistics for the SDGs: https://ilostat.ilo.org/topics/sdg/#

[15] Global Health Expenditure Database: https://apps.who.int/nha/database/Home/Index/en/

health, in order to separate the benefits derived from the use of public health services from the cash benefits of financial protection in the event of illness (World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition, 2024) (Figure2 , see section II).

There are alternative sources of data, notably the *Global Burden of Disease* (GBD) programme run by the *Institute for Health Metrics and Evaluation* (IHME), which regularly publishes its analyses in the medical journal *The Lancet*. **The GBD programme gathers data on global health trends, including funding, and produces in-depth analyses**. The GBD has carried out a number of studies directly related to UHC. Based on their systematically analysed data since 1990, they:

- Developed an **index of effective coverage of health services**, which differs from SDG 3.8.1 in that it measures the **effective** coverage of services, taking into account the use of services (rather than accessibility alone), the health needs of different sections of the population and the quality of services (*outcomes*) (Lozano et al., 2020);
- Develop and evaluate the performance of **an index of accessibility and quality of services** (a concept missing from SDG 3.8.1)(Haakenstad, Yearwood, et al., 2022);
- Measured the **availability of human resources for health and its direct relationship with UHC** (Haakenstad, Irvine, et al., 2022)**.**

The GBD programme also carries out numerous other studies on the health status of populations, risk factors, health human resources, etc., as well as predictive models based on current trends (Global Burden of Disease 2021, 2024). These data are available online at with practical visualisation tools (*Data Sources | Institute for Health Metrics and Evaluation*, n.d.; *Global Burden of Disease Study 2019 (GBD 2019) Data Resources | GHDx*, n.d.).

Finally, there are other useful documents for monitoring UHC. The annual World Health Statistics report [16] (World Health Statistics 2024: Monitoring Health for the SDGs, Sustainable Development Goals, 2024) is an annual compilation of health data for achieving the SDGs. It includes information related to service delivery, health financing, or trends towards achieving "one billion more people with access to UHC" in 2023 (*UHC billion*) [17](Thirteenth General Programme of Work, 2019–2023: Promote Health, Keep the World Safe, Serve the Vulnerable, 2019). The WHO also provides a detailed description of 100 key indicators (non-exhaustive list), including the definition, measurement and estimation methods, preferred databases, etc. for each. The list includes many indicators relating to service delivery, service quality and health financing (2018 Global Reference List of 100 Core Health Indicators (plus Health-Related SDGs), 2018).

In conclusion, 'measuring' UHC and SP is not an easy task. It is important to cross-reference numerous indicators (however complex they may be) and data sources, and to analyse, interpret and contextualise this information, in order to make a detailed assessment of progress towards UHC and USP. Several international databases and analyses exist for this purpose. However, it is also

[16] World Health Statistics Annual Report: https://www.who.int/data/gho/publications/world-health-statistics

[17] The *UHC billion* is one of the WHO's *three billion* goals. The aim is to reach one billion more people covered by a UHC mechanism by 2023. The reasoning suggests that it will be impossible to achieve SDG 3.8 by 2030 if this intermediate target is not met.

essential to refer to the data collected at national level, whether from national surveys, routine data (statistical bulletin, national health information system) or from academic research, etc.

FURTHER READINGS

A System of Health Accounts 2011: Revised Edition. OECD, 2017. https://doi.org/10.1787/9789264270985-en

Fischer, Torben, Martin Atela, Emma Kimani, Simon Otieno Josiah, and Winfred Kananu Ntonjira. 'Financial and Non-Financial Information Flows in the Kenya Health Sector: A Pathway to Health System Accountability'. IDinsight, 11 October 2024. https://www.idinsight.org/publication/financial-and-non-financial-information-flows-in-the-kenya-health-sector-a-pathway-to-health-system-accountability/

Haakenstad, Annie, Caleb Mackay Salpeter Irvine, Megan Knight, Corinne Bintz, Aleksandr Y. Aravkin, Peng Zheng, Vin Gupta, et al. Aravkin, Peng Zheng, Vin Gupta, et al. 'Measuring the Availability of Human Resources for Health and Its Relationship to Universal Health Coverage for 204 Countries and Territories from 1990 to 2019: A Systematic Analysis for the Global Burden of Disease Study 2019'. *The Lancet* 399, no. 10341 (4 June 2022): 2129-54. https://doi.org/10.1016/S0140-6736(22)00532-3.

World Health Organization, ed. *Research for Universal Health Coverage*. The World Health Report 2013. Geneva: World Health Organization, 2013.

VI- SOME COMPLEMENTARY CONCEPTS TO UHC

UHC AND EQUITY

We have discussed in previous sections how to implement policies to move towards UHC, and we have mentioned health equity many times. However, it is important to note that **health equity is not an inherent principle of UHC**, although it is implicitly addressed by the principle of 'universality' of financial protection coverage (Alyanak, 2022; Gwatkin & Ergo, 2011; Rapport Sur La Santé Dans Le Monde 2008, 2008) , they are conceptually distinct(McIntyre & Kutzin, 2016).

Health equity is defined by the WHO as "*the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality*" (*Health Equity*, n.d.). These differences are systemic and are closely linked to the social determinants of health (Braveman & Gruskin, 2003). However, like any definition based on a negative, it creates confusion regarding this concept (Paul et al., 2021). Equity is confused with (in)equality (or disparities), or justice in particular (*Making Fair Choices on the Path to Universal Health Coverage*, 2014; *What Are Health Disparities and Health Equity? We Need to Be Clear - Paula Braveman, 2014*, n.d.; Norheim, 2015; Paul et al., 2019). It is also presented as much as an outcome of the HS as a process (Braveman et al., 2018; Papanicolas et al., 2022). However, in the UHC terminology, the aim to provide services for 'all' refers more to equality but underestimates the specific needs of vulnerable populations. Equity is also absent from the fundamental frameworks governing UHC, notably in the UHC cube (Roberts et al., 2015). These amalgams mean that the term is used rather rhetorically in national strategic plans (Paul et al., 2019, 2021). Braveman et al (2018) have developed an alternative definition which considers that "*Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles to health—such as poverty and discrimination and their consequences, which include powerlessness and lack of access to good jobs with fair pay*[18]*; quality education, housing, and health care; and safe environments*" (Braveman et al., 2018).

Vulnerable populations are those with a higher risk of health issues due to physical, psychological, socio-economic or environmental factors (Ernstmeyer & Christman, 2022; Ohno et al., 2019; *Vulnerability and Vulnerable Populations*, n.d.). Often reduced to the poorest populations or those with a particular medical profile (maternal health, extremes of age), these vulnerable populations encompass a wider range of profiles, resulting in health inequalities: gender, ethnic and sexual minorities, the carceral population, veterans, migrants, certain workers exposed to health risks, (Ernstmeyer & Christman, 2022)**. Neither should we overlook the so-called hard-to-reach populations** (sometimes even those excluded from the HS), who may or may not be vulnerable. The confusion arises from the fact that vulnerable populations are often on the margins of the HS, but there are better-off populations who may nevertheless remain on the margins: **the informal sector** (often referred to as the "missing middle", and which is not always poor) (World Social Protection Report 2020-22: Social Protection at the Crossroads - in Pursuit of a Better Future, 2021) (see section II), or simply people who are unaware of their rights.

[18] This can be seen as a link with the ILO's Decent Work Agenda.

If policies are put in place that respect the UHC conceptual framework(s) without paying particular attention to equity, these policies could widen inequalities (The World Health Report, 2010) : "*When left to its own devices, a health system does not tend to promote equity*" (Rapport Sur La Santé Dans Le Monde 2008, 2008). For example, even in a theoretical scenario where the entire population is covered for the same service package, inequitable distribution of funds across different pools could lead to inequitable access to services (Papanicolas et al., 2022). Or conversely, a country that achieves universal financial protection could have difficulty achieving effective coverage of its population (Kutzin, 2013). Or a country that makes certain services free in the name of equity may find that these services are more used by the rich than by the poor, widening inequalities (Parmar & Banerjee, 2019).

Roberts et al (2015) propose a new vision of the UHC cube. Indeed, the cube as we know it describes the coverage situation based on national averages and does not show the disparities between different sections of the population which are covered by different mechanisms. They propose to disaggregate the cube (i) first by income bracket or coverage mechanism (in the "population" axis), (ii) then by service category (primary, secondary and tertiary according to their recommendations, in the "services" axis), and finally (iii) to determine, for each service category, the proportion covered by pooled resources. The resulting cube reveals the disparities in coverage (and even access to certain services in some cases) between different sections of the population (Roberts et al., 2015). This disaggregation can be based on other criteria depending on the context (by type of economy – formal or informal, or by coverage mechanism, rather than by income bracket, for example). This situation is even more typical if there are multiple coverage mechanisms, as each will pool its own funds (multiple pooling), covering a specific population with a different service package, and at different costs.

These inequities may be due to the natural evolution of policy, as in the "inverse care law" (Gwatkin & Ergo, 2011; Hart, 1971; The World Health Report, 2010), or by design (Fisher et al., 2022; Rodney & Hill, 2014)**. It is therefore necessary, right from the design stage of reforms, to think about how to include, reach and cover the most vulnerable and hard-to-reach populations according to their needs and capacities.** With limited funds to extend coverage, choices must be made (Kutzin et al., 2017, 2018; McIntyre & Kutzin, 2016), but certain trade-offs that undermine the equity of these reforms must be avoided (Norheim, 2015).

However, this does not mean that we should set up vertical health programmes, targeted solely at different vulnerable populations[19]. These are incompatible with universality, are not sustainable over the life cycle of the individual, and exacerbate inequalities (Frohlich & Potvin, 2008)**. The recommended approach is that of 'progressive universalism'** (Francis-Oliviero et al., 2020; Gwatkin & Ergo, 2011; Rodney & Hill, 2014) whereby health interventions should be universal (and therefore accessible to all) with variations proportionate to the needs of different populations (Francis-Oliviero et al., 2020)[20]. Another way of making these policies more equitable is **to include, in the covered**

[19] For example: a policy of free healthcare for children under the age of 5. Although this is a vulnerable population, these children will not benefit from care from their 5th birthday onward if there is no more universal and extended health and coverage policy. It should also be noted that such a policy is not equitable in the sense that children from wealthy families are exempted in the same way as children from poor families.

[20] Building on the previous example: a policy can make paediatric services accessible and partially (not fully) reimbursed to all, with a reduction in direct payment for households with young children or large families.

services, health promotion and prevention interventions as well as palliative care, which are often neglected in favour of curative care (Jimba & Fujimura, 2018; Peeler et al., 2024).

This progressive universalism must be reflected in all policies directly or indirectly linked to UHC (see section III). For example, flexible policies and health service packages can be developed (International Labour Organisation, 2010; The World Health Report, 2010), and therefore be adaptable to the needs of vulnerable populations. The most advanced, equitable and efficient form of these policies is based on primary health care (Alyanak, 2022; Ohno et al., 2019; Rapport Sur La Santé Dans Le Monde 2008, 2008). It can also take the form of a progressive financing mechanism (see section IV) (McIntyre & Kutzin, 2016) or a high-performance health information system to obtain the necessary information on these populations (Ohno et al., 2019), to name a few.

Equity in UHC is closely linked to the monitoring and evaluation mechanisms, and therefore to the progress monitoring towards UHC (see section V). As health equity is difficult to demonstrate, it is necessary to have the right tools and a clear detailed monitoring plan to identify the sources of inequity in the HS.

In conclusion, it is essential that when any health policy is developed, the designers actively include a health equity component, guaranteeing services for all while meeting the specific needs of vulnerable or hard-to-reach populations.

FURTHER READINGS

Carey, Gemma, Brad Crammond, and Evelyne De Leeuw. 'Towards Health Equity: A Framework for the Application of Proportionate Universalism'. *International Journal for Equity in Health* 14, no. 1 (15 September 2015): 81. https://doi.org/10.1186/s12939-015-0207-6

Jimba, Masamine, and Maya Sophia Fujimura. 'Shrink the Universal Health Coverage Cube'. *The Lancet* 392, no. 10164 (15 December 2018): 2551. https://doi.org/10.1016/S0140-6736(18)32518-2.

Norheim, Ole Frithjof. 'Ethical Perspective: Five Unacceptable Trade-Offs on the Path to Universal Health Coverage'. *International Journal of Health Policy and Management* 4, no. 11 (11 October 2015): 711-14. https://doi.org/10.15171/ijhpm.2015.184

Ohno, Izumi, John W. McArthur, and Homi Kharas. Vulnerable Populations and Universal Health Coverage'. In *Leave No One Behind: Time for Specifics on the Sustainable Development Goals*, 129-48. Brookings Institution Press, 2019. https://muse.jhu.edu/pub/11/edited_volume/chapter/2427753

Paul, Elisabeth, Marc Bourgeois, and Valéry Ridde. 'La Place de l'équité Dans La Couverture de Santé Universelle Au Niveau Mondial, Au Bénin et Au Sénégal'. In *Vers Une Couverture Sanitaire Universelle En 2030?: Réformes En Afrique Subsaharienne*, Editions sciences et bien commun, 2021. https://www.documentation.ird.fr/hor/fdi:010082997

Samba, Mouhamed, Ibrahima Thiam, and Elisabeth Paul. Which Socio-Economic Groups Benefit Most from Public Health Expenditure in Senegal? A Dynamic Benefit Incidence Analysis'. *SSM - Population Health* 28 (1 December 2024): 101714. https://doi.org/10.1016/j.ssmph.2024.101714

Social Protection at the Crossroads - in Pursuit of a Better Future. World Social Protection Report 2020/2022. Geneva: International Labour Office, 2021.

PRIMARY HEALTH SERVICES AND UHC

Primary health care (PHC) is defined as *"essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination* " in the Alma Ata Declaration (Déclaration d'Alma-Ata, 1978). PHC is also recognised as the cornerstone of "health for all" (Déclaration d'Alma-Ata, 1978; Rajan et al., 2024). The Astana Declaration in 2018, which commemorated the fortieth anniversary of the Alma-Ata Declaration, reaffirms the principles of the latter (Allen, 2022; Declaration of Astana, 208 C.E.; Rajan et al., 2024). In short, the PHC approach **offers essential services as close as possible to the population, while guaranteeing community participation in the policy dialogue[21] and the identification of their health needs**.

UHC and PHC are fundamentally linked. Indeed, UHC has its origins in the WHO reports on primary health care: "Health for All by the year 2000" and "Primary health care, now more than ever" of 2008(Rapport Sur La Santé Dans Le Monde 2008, 2008)**. It is now unanimously agreed that PHC contributes directly to progress towards UHC** (Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008; Sacks et al., 2020; The Lancet Regional Health Europe, 2024).

With regard to the first aspect of the UHC, PHC plays a vital role in health coverage. **An approach centred on PHC makes it possible to guarantee the accessibility of services to the population according to the five criteria of accessibility** (Penchansky & Thomas, 1981) (Table 2), particularly for vulnerable populations or geographically isolated or dispersed communities(Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008).

PHC also guarantees a higher quality of care (a dimension that is often neglected when we talk about health coverage, see section V). Indeed, providers who offer services according to the four Cs - First **C**ontact, **C**ontinuous, **C**omprehensive and **C**oordinated - improve the health outcomes of the population, and **are therefore more effective** (Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008). PHC is not limited to front-line curative care, but **is also responsible for implementing public health, prevention and health promotion services** (a dimension also neglected by UHC policies (Jimba & Fujimura, 2018)). These services play a vital role in preventing disease, at a lower cost than the curative approach. Front-line curative care is also less costly than specialist and hospital care. **What's more, implementing an approach based on PHC allows the medical scope to be defragmented:** programmes are no longer vertical, and services are no longer focused on one disease. However, they offer a wide range of integrated and continuous services. **PHC are therefore more efficient** (Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008; The Lancet Regional

[21] There are many definitions of the term "policy dialogue", which means different things for different people (Nabyonga-Orem et al., 2016; Rajan et al., 2015). However, they all agree that its ultimate objective is to guide policies. Policy dialogue is therefore part of the policy-making process, contributing to policy development and/or implementation through evidence-based discussion and exchange. This also implies the participation of a wide range of societal actors in policy dialogue (Rajan et al., 2015).

Health Europe, 2024)**. PHC is also safer**, as long as it is provided by well-trained staff and with the necessary equipment (Rajan et al., 2024).

Table 2 Examples of PHC interventions by accessibility criterion (supply and demand side), inspired by (Rajan et al., 2024)

Supply-side access determinants		Examples of supply-side PHC interventions	Demand-side access determinants		Examples of demand-side PHC interventions
Approachability	*"People facing health needs can actually identify that some form of services exists, can be reached, and have an impact on the health of the individual."*	Outreach programmes, educational sessions in communities on prevention and screening, home visits, navigation	**Ability to perceive**	*"Ability to perceive need for care [...] determined by [...] health literacy, knowledge about health, and beliefs related to health and sickness".*	Health and service literacy
Acceptability	*"Cultural and social factors determining the possibility for people to accept the aspects of the service [...] and the judged appropriateness for the persons to seek care."*	Indigenous nurses, information customized to literacy, gender-diversity sensitive practices, use of interpreters, dedicated funding to provide service to vulnerable groups, cultural competency of providers	**Ability to seek**	*"Personal autonomy and capacity to choose to seek care, knowledge about healthcare options and individual rights that would determine expressing the intention to obtain healthcare."*	Education, self-management coaching, peer support workers

Availability	*"Health services (either the physical space or those working in healthcare roles) can be reached both physically and in a timely manner."*	After-hour services, walk-in GP appointments, telehealth, mobile technology, patient navigator, expanded scope of practice	**Ability to reach**	*"Personal mobility and availability of transportation, occupational flexibility, and knowledge about health services."*	Transportation options to access services (e.g., public transportation)
Affordability	*"The economic capacity for people to spend resources and time to use appropriate services.*	Carefully designed packages with coverage of essential medicines, low or no co-payments, universal entitlement with automatic enrolment in coverage schemes, suitable and affordable transport	**Ability to pay**	*"Out-of-pocket payments do not create a financial barrier to access or result in financial hardship (impoverishing or catastrophic health spending)".*	No out-of-pocket costs for patients
Appropriateness	*"The fit between services and [the] client's need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided."*	Good range and co-location of providers with different skills (specialists and allied health professionals), patient navigators, primary care network	**Ability to engage**	*"Participation and involvement in decision-making and treatment decisions, determined by capacity and motivation to participate in care."*	Proactive role and participation of patients and carers

In addition, UHC policies must define a minimum package of services based on the needs of the population, which will be covered by one or more financial protection mechanisms. **PHC are therefore an integral part of this package**, as they are essential services, ideally defined by and for communities[22] (Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008).

With regard to the second aspect of UHC, namely financial protection, **PHC has great potential to reduce the financial difficulties faced by populations.** Generally, PHC is less expensive than hospital services (Watkins et al., 2018), which significantly reduces the amount to be paid by the patient (Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008). However, the contribution of PHC to financial protection is not guaranteed and is highly dependent on how policies are designed. Underfunded or poorly resourced PHC services are inaccessible and would therefore have the opposite effect (Rajan et al., 2024). They could, for example, lead to the creation of a parallel market in services (the sale of over-the-counter medicines at high prices). This would lead to an increase in household OOPs. It is therefore important to coordinate PHC and UHC policies with those on human resources, infrastructure and equipment, and the pharmaceutical system (Watkins et al., 2018) ... (see section III).

In terms of funding, PHC is, as mentioned above, more efficient than curative hospital services or vertical programmes. PHC can save money by reducing spending on inefficient interventions (P. S. Heller, 2006)**. PHC is therefore a way of expanding the fiscal space for health by reducing unnecessary expenditure and, in doing so, freeing up resources to fund financial protection or other health policies**.

Finally, **because of the way they are organised, PHC make a major contribution to reducing health inequalities** through a number of mechanisms (Rajan et al., 2024; Rapport Sur La Santé Dans Le Monde 2008, 2008). They provide health prevention and promotion services (Jimba & Fujimura, 2018), guarantee continuity of care and improve access to services for the most vulnerable and excluded populations (Rajan et al., 2024). In addition, a patient allocation system (*empanelment)* empowers providers who will proactively deliver services to different populations (Bearden et al., 2019; Rajan et al., 2024).

In conclusion, PHC provide essential services as close as possible to the population, and are a cornerstone of the implementation of the UHC. They make it possible to extend health coverage by offering more accessible, high-quality services, and are an efficient solution for expanding the fiscal space devoted to HS.

However, PHC should not be reduced solely to a means of achieving UHC. PHC addresses other aspects of health that are often neglected by UHC, such as community dialogue and social participation, or the social determinants of health (Sacks et al., 2020; Sanders et al., 2019).

FURTHER READINGS

[22] It is important to note that the minimum package of services does not ONLY include PHC. Certain secondary or tertiary services (including certain types of hospital care) must be included. For example, it is difficult to exclude appendectomy surgery from the minimum package.

Khatri, Resham B., Aklilu Endalamaw, Daniel Erku, Eskinder Wolka, Frehiwot Nigatu, Anteneh Zewdie, and Yibeltal Assefa. 'Enablers and Barriers of Community Health Programs for Improved Equity and Universal Coverage of Primary Health Care Services: A Scoping Review'. *BMC Primary Care* 25, no. 1 (29 October 2024): 385. https://doi.org/10.1186/s12875-024-02629-5

Rajan, Dheepa, Katherine Rouleau, Juliane Winkelmann, Dionne Kringos, Melitta Jakab, and Faraz Khalid, eds. *Implementing the Primary Health Care Approach: A Primer*. Global Report on Primary Health Care. Geneva: World Health Organization, 2024.

STRENGTHENING HEALTH SYSTEMS, RESILIENCE, HEALTH SECURITY AND UHC

While UHC is an ideal objective to be achieved, there are also other closely related concepts. Firstly, if we are to make progress towards UHC, we need to take the whole of HS into account. As a reminder, financial protection is an ultimate objective of HS. It is therefore essential to improve the performance of the HS as a whole, by strengthening the HS.

Health system strengthening (HSS) has been promoted by the WHO since the early 2000s (*The World Health Report. 2000*, 2000)**, and is defined as "the development of capacity in each of its six key components[23] to achieve sustainable and equitable improvements in health services and population health"**(*The World Health Report. 2000*, 2000; Travis, 2006). The preoccupation with HSS arose in response to the observation that many global health agencies favour a vertical approach (Witter et al., 2019). These programmes are limited in scope to a specific disease or intervention, neither considering the context in which they are implemented nor their impact(s) on the HS. HSS, on the other hand, goes beyond vertical, disease-specific interventions and seeks to strengthen HS in a cross-cutting and far-reaching way. It is no longer limited to simply increasing inputs (defined as "supporting HS"), but also acts on many other political and technical factors (Chee et al., 2012). This cross-cutting and systemic vision also helps to reduce fragmentation and improve the efficiency of the system.

Therefore, HSS encompasses the necessary means (instruments and health policies) to achieve UHC (which is a framework for these policies) (Kutzin & Sparkes, 2016). HSS requires alignment and consensus on HS objectives and policy entry points. The various possible entry points for initiating HSS policies are superimposed on the six building blocks of HS: governance and leadership, human resources for health, infrastructure and materials, health financing, the information system and service delivery (Jaca et al., 2022; Paul, Ndiaye, et al., 2020; UHC2030, 2018).

There is no single model for implementing HSS policies. The choice of entry point therefore depends on the national context and needs (Bertone et al., 2023; HSS Evaluation - Conceptual Model and Monitoring & Learning Tool, 2022; UHC2030, 2018). However, these policies must respect basic principles (UHC2030, 2018) such as equity and non-discrimination, transparency and accountability for results (Kieny et al., 2017)*, evidence-based* support, involvement of the population (communities, civil society, private sector, etc.), cooperation and international partnerships. According to the WHO, the performance dimensions of health policies on which HSS should focus are the **quality of services, equity, efficiency, responsiveness and resilience** (UHC2030, 2018). However, these performance criteria are contested. They would have the unexpected effect of "verticalising" the assessment of HSS interventions by building block, instead of looking at the whole of the HS. The *Health System*

[23] Better known today as the six building blocks of the healthcare system.

Strengthening Evaluation Collaborative proposes instead to evaluate HSS on the basis **of process goals Fout! Verwijzingsbron niet gevonden.**(Bertone et al., 2023; HSS Evaluation - Conceptual Model and Monitoring & Learning Tool, 2022). These goals are formulated in the form of complete, prescriptive sentences in order to provide a better understanding of "how HSS is being strengthened" and whether it is moving in the right direction. Therefore, they are not, targets to be achieved. They provide a better understanding of the reinforcement process and look beyond the fragmentation by building block (HSS Evaluation - Conceptual Model and Monitoring & Learning Tool, 2022).

This HSS approach has been respected and applied throughout this briefing note (see section III), taking health financing as the main point of entry (see section IV).

Secondly, one of the qualities of the HS, which is necessary for sustained progress towards UHC, is found in the concept of resilience.

HS resilience is its ability to anticipate, prevent, prepare for, absorb, adapt in response to and recover from a variety of shocks and stressors, while providing quality services, all the while learning from internal or external experiences to continuously improve their core capabilities and performance in all contexts (Building Health System Resilience to Public Health Challenges: Guidance for Implementation in Countries, 2024; Kutzin & Sparkes, 2016)**. Resilience is a fundamental element in making sustainable progress towards UHC** through specific mechanisms. The pursuit of resilience requires increasing investment in HS and directing it towards essential public health services and PHC (and subsequently helping to reduce health inequities), engaging society and communities politically, and building the capacity of human resources for health (Building Health System Resilience to Public Health Challenges: Guidance for Implementation in Countries, 2024; Renforcer La Résilience Du Système de Santé Pour Instaurer La Couverture Sanitaire Universelle et La Sécurité Sanitaire Pendant et Après La COVID-19, 2021; Tumusiime et al., 2019)**. Resilience is an intermediate objective of the HS and, like UHC, stems from HSS** (Kieny et al., 2017; Renforcer La Résilience Du Système de Santé Pour Instaurer La Couverture Sanitaire Universelle et La Sécurité Sanitaire Pendant et Après La COVID-19, 2021)**.**

Finally, there is another concept that is sometimes presented as a 'competing' political agenda, but which is, in fact, also complementary to that of UHC: health security.

Health security **covers "all activities, both preventive and corrective, implemented to minimise vulnerability to serious health events threatening the collective populations' state of health, regardless of geographical regions or borders"**. It therefore deals with the health consequences of war, climate change, natural disasters, chemical or radio nuclear accidents, pandemics, etc. with a global impact (*Rapport Sur La Santé Dans Le Monde 2007*, 2007). As far as communicable diseases are concerned, the health security agenda focuses on the implementation of the 2005 revised International Health Regulations (IHR 2005) (*Rapport Sur La Santé Dans Le Monde 2007*, 2007). The health security and UHC agendas are often in competition at national level (Agyepong et al., 2023; Assefa et al., 2020). This competition manifests itself in fragmented and siloed policies and results in antagonism between these two agendas. However, health security and UHC are interrelated, and progress towards one will have a positive effect on the other (Agyepong et al., 2023; Assefa et al., 2020)**. Achieving UHC is essential for implementing a first line of protection and defence against health security threats**, particularly in terms of preventing and controlling the emergence of infectious diseases. In addition, disparities in coverage between several countries (or regions) encourage the

movement of sick populations to gain better access to services, which increases the risk of spread (Assefa et al., 2020)**. More horizontal and coherent interventions and policies could strengthen the synergies between the two agendas**. These interventions require a paradigm shift from a vertical vision to HSS interventions, adapted governance and improved accountability (Agyepong et al., 2023).

There is an interesting link between health safety and the SP/Decent Work agenda. Health security is not just about controlling and reducing the vulnerability of the population to infectious diseases. It also includes protection against the consequences of exposure to radiation, chemical accidents and so on. These events are closely linked to certain high-risk professions (mining, nuclear energy, laboratories, etc.). Prevention and protection against these events are closely linked to the working conditions of these workers. USP responds to these difficulties, in particular with the branches of income replacement in the event of illness and accident, invalidity benefits and survivors' benefits.

In conclusion (Kutzin & Sparkes, 2016)**, UHC** and **health security** are two ideal and interconnected objectives that an efficient HS should be able to achieve. It is therefore necessary to increase the **performance** and **resilience** of the HS through **HSS** interventions. It is only through cross-cutting policies based on a diagnosis of the performance of the various HS functions and their interrelationships that the HS will be strengthened to achieve its intermediate quality (effectiveness, accessibility, safety, user experience) and final objectives (efficiency, equity, financial protection, improved population health outcomes, patient-centred HS) (Papanicolas et al., 2022).

FURTHER READINGS

Jaca, Anelisa, Thobile Malinga, Chinwe Juliana Iwu-Jaja, Chukwudi Arnest Nnaji, Joseph Chukwudi Okeibunor, Dorcas Kamuya, and Charles Shey Wiysonge. 'Strengthening the Health System as a Strategy to Achieving a Universal Health Coverage in Underprivileged Communities in Africa: A Scoping Review'. *International Journal of Environmental Research and Public Health* 19, no. 1 (January 2022): 587. https://doi.org/10.3390/ijerph19010587

Kutzin, Joseph, Susan P. Sparkes, Alexandra J. Earle, Agnes Gatome-Munyua, and Nirmala Ravishankar. Objective-Oriented Health Systems Reform'. *Health Systems & Reform* 10, no. 3 (18 December 2024): 2428415. https://doi.org/10.1080/23288604.2024.2428415

Lal, Arush, Justin Parkhurst, and Clare Wenham. '(Re)Constructing Global Health Security and Universal Health Coverage: Norm Contestation and Interaction'. *International Affairs*, 21 October 2024, iiae238. https://doi.org/10.1093/ia/iiae238

Paul, Elisabeth, Youssoupha Ndiaye, Farba L. Sall, Fabienne Fecher, and Denis Porignon. 'An Assessment of the Core Capacities of the Senegalese Health System to Deliver Universal Health Coverage'. *Health Policy OPEN* 1 (December 2020): 100012. https://doi.org/10.1016/j.hpopen.2020.100012

Roura, Maria, Eva Capa, Bernd Appelt, Michel Lecomte, Maria Fernandez, Gerard Schmets, and Denis Porignon. 'Use of Results-Oriented Monitoring Tools to Enhance Global Health Accountability: Lessons from the European Commission/WHO "Health Systems Strengthening for Universal Health Coverage" Programme'. *BMJ Global Health* 9, no. 12 (7 December 2024). https://doi.org/10.1136/bmjgh-2024-015536

Salisbury, Nicole, Saira Nawaz, Justine Abenaitwe, Audrey Batzel, Emily Grapa, Francisco Rios Casas, Virginia Cerezo, et al. 'Ambitions and Realities: Are Global Fund Investments Designed to Achieve Resilient and Sustainable Systems for Health? Findings from the Global Fund Prospective Country Evaluation'. *PLOS Global Public Health* 4, no. 11 (14 November 2024): e0003914. https://doi.org/10.1371/journal.pgph.0003914

World Health Organization, 'Universal Health Coverage/Life Course Cluster Biennial Report 2022-2023: Advancing Health for All'. Brazzaville: World Health Organization, 5 December 2024. https://reliefweb.int/report/world/universal-health-coveragelife-course-cluster-biennial-report-2022-2023-advancing-health-all

World Health Organization, *Health Systems for Health Security: A Framework for Developing Capacities for International Health Regulations, and Components in Health Systems and Other Sectors That Work in Synergy to Meet the Demands Imposed by Health Emergencies*. 1st ed. Geneva: World Health Organization, 2021

MAIN REFERENCES

2018 Global reference list of 100 core health indicators (plus health-related SDGs). (2018). World Health Organization. https://www.who.int/publications/i/item/2018-global-reference-list-of-100-core-health-indicators-(-plus-health-related-sdgs)

Abiiro, G. A., & De Allegri, M. (2015). Universal health coverage from multiple perspectives: A synthesis of conceptual literature and global debates. *BMC International Health and Human Rights*, *15*(1), 17. https://doi.org/10.1186/s12914-015-0056-9

Agyepong, I., Spicer, N., Ooms, G., Jahn, A., Bärnighausen, T., Beiersmann, C., Amoakoh, H. B., Fink, G., Guo, Y., Hennig, L., Habtemariam, M. K., Kouyaté, B. A., Loewenson, R., Micah, A., Moon, S., Moshabela, M., Myhre, S. L., Ottersen, T., Patcharanarumol, W., … Heymann, D. (2023). Lancet Commission on synergies between universal health coverage, health security, and health promotion. *The Lancet*, *401*(10392), 1964–2012. https://doi.org/10.1016/S0140-6736(22)01930-4

Allen, L. N. (2022). The philosophical foundations of 'health for all' and Universal Health Coverage. *International Journal for Equity in Health*, *21*(1), 155. https://doi.org/10.1186/s12939-022-01780-8

Alyanak, L. (2022). *The path towards universal health coverage*. World Health Organization. https://www.who.int/publications/i/item/9789240060388

Anh Nguyen, Q., & Behrendt, C. (2020). *Extending social protection to informal workers in the COVID-19 crisis: Country responses and policy considerations* (Social Protection Spotlight). International Labour Organisation. https://www.social-protection.org/gimi/Media.action?id=18017

Anh Nguyen, Q., & Behrendt, C. (2021). *Extending social security to workers in the informal economy—Key lessons learned from international experience* (Social Protection Spotlight).

International Labour Organisation. https://www.social-protection.org/gimi/Media.action?id=16991

Assefa, Y., Hill, P. S., Gilks, C. F., Damme, W. V., van de Pas, R., Woldeyohannes, S., & Reid, S. (2020). Global health security and universal health coverage: Understanding convergences and divergences for a synergistic response. *PLoS ONE*, *15*(12), e0244555. https://doi.org/10.1371/journal.pone.0244555

Barasa, E., Kazungu, J., Nguhiu, P., & Ravishankar, N. (2021). Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries. *BMJ Global Health*, *6*(4), e004712. https://doi.org/10.1136/bmjgh-2020-004712

Bayarsaikhan, D., Tessier, L., & Ron, A. (2022). Universal Health Coverage and Social Health Protection: Policy relevance to health system financing reforms. *International Social Security Review*, *75*(2), 75–95. https://doi.org/10.1111/issr.12295

Bearden, T., Ratcliffe, H. L., Sugarman, J. R., Bitton, A., Anaman, L. A., Buckle, G., Cham, M., Quan, D. C. W., Ismail, F., Jargalsaikhan, B., Lim, W., Mohammad, N. M., Morrison, I. C., Norov, B., Oh, J., Riimaadai, G., Sararaks, S., & Hirschhorn, L. R. (2019). Empanelment: A foundational component of primary health care. *Gates Open Research*, *3*, 1654. https://doi.org/10.12688/gatesopenres.13059.1

Bertone, M. P., Palmer, N., Kruja, K., Witter, S., & HSSEC Working Group 1. (2023). How do we design and evaluate health system strengthening? Collaborative development of a set of health system process goals. *The International Journal of Health Planning and Management*, *38*(2), 279–288. https://doi.org/10.1002/hpm.3607

Braveman, P., Arkin, E., Orleans, T., Proctor, D., Acker, J., & Plough, A. (2018). What is Health Equity? *Behavioral Science & Policy*, *4*(1), 1–14. https://doi.org/10.1177/237946151800400102

Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, *57*(4), 254–258. https://doi.org/10.1136/jech.57.4.254

Building health system resilience to public health challenges: Guidance for implementation in countries. (2024). World Health Organization. https://www.who.int/publications/i/item/9789240094321

Calligaro, F., & Cetrangolo, O. (2023). *Financing Universal Social Protection: The Relevance and Labour Market Impacts of Social Security Contributions.* (WIEGO Working Paper N°47). International Labour Organisation. https://www.wiego.org/publications/financing-universal-social-protection-relevance-and-labour-market-impacts-social

Cashin, C., Ankhbayar, B., Thi Phuong, H., Jamsran, G., Nanzad, O., Khanh Phuong, N., Thi Mai Oanh, T., Van Tien, T., & Tsilaajav, T. (2015). *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage*. Joint Learning Network For Universal Health Coverage.

Cattaneo, U., Schwarzer, H., Razavi, S., & Visentin, A. (2024). *Financing gap for universal social protection: Global, regional and national estimates and strategies for creating fiscal space* (ILO Working Paper 113). International Labour Organisation. https://www.ilo.org/publications/financing-gap-universal-social-protection-global-regional-and-national

Chee, G., Pielemeier, N., Lion, A., & Connor, C. (2012). Why differentiating between health system support and health system strengthening is needed. *The International Journal of Health Planning and Management*, *28*(1), 85. https://doi.org/10.1002/hpm.2122

Clark, H., Lofthus, C., Marten, R., & Rasanathan, K. (2024). Health taxes: Missed opportunities for health and health-care financing. *The Lancet*, *404*(10466), 1905–1907. https://doi.org/10.1016/S0140-6736(24)02427-9

Coltear, D., & Rosemberg, N. (2018). *Going universal in Africa: How 46 African countries reformed user fees and implemented health care priorities*. World Bank Group. https://documents.worldbank.org/en/publication/documents-

reports/documentdetail/712041516179885313/going-universal-in-africa-how-46-african-countries-reformed-user-fees-and-implemented-health-care-priorities

Convention C102—Social Security (Minimum Standards) Convention, 1952 (No. 102). (n.d.). Retrieved 14 October 2024, from https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312247

Data sources | Institute for Health Metrics and Evaluation. (n.d.). Retrieved 5 November 2024, from https://www.healthdata.org/data-tools-practices/data-sources

Decent work | International Labour Organization. (2024, January 28). https://www.ilo.org/topics/decent-work

Déclaration d'Alma-Ata. (1978). Organisation Mondiale de la Santé. https://www.who.int/fr/publications/i/item/WHO-EURO-1978-3938-43697-61471

Declaration of Astana. (208 C.E.). World Health Organization. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.61

Ernstmeyer, K., & Christman, E. (2022). Chapter 17 Vulnerable Populations. In *Nursing: Mental Health and Community Concepts*. Chippewa Valley Technical College. https://www.ncbi.nlm.nih.gov/books/NBK590046/

Étendre la sécurité sociale aux travailleurs dans l'économie informelle—Leçons tirées de l'expérience internationale. (2022). [Note de synthèse]. Bureau international du travail. https://www.social-protection.org/gimi/Media.action?id=18963

Fifty-eighth World Health Assembly, Geneva, 16-25 May 2005: Resolutions and decisions: Annex. (2005). World Health Organization. https://iris.who.int/handle/10665/20398

Fisher, M., Freeman, T., Mackean, T., Friel, S., & Baum, F. (2022). Universal Health Coverage for Health Equity: From Principle to Practice; A Response to the Recent Commentaries.

International Journal of Health Policy and Management, *11*(8), 1601–1603. https://doi.org/10.34172/ijhpm.2022.7218

Francis-Oliviero, F., Cambon, L., Wittwer, J., Marmot, M., & Alla, F. (2020). Theoretical and practical challenges of proportionate universalism: A review. *Revista Panamericana de Salud Pública*, *44*, e110. https://doi.org/10.26633/RPSP.2020.110

Frohlich, K. L., & Potvin, L. (2008). Transcending the known in public health practice: The inequality paradox: the population approach and vulnerable populations. *American Journal of Public Health*, *98*(2), 216–221. https://doi.org/10.2105/AJPH.2007.114777

Ghai, D. (2003). Decent Work: Concept and Indicators. *International Labour Review*, *142*, 113.

Global Burden of Disease 2021 (p. 24). (2024). Institute for Health Metrics and Evaluation. https://www.healthdata.org/research-analysis/library/global-burden-disease-2021-findings-gbd-2021-study

Global Burden of Disease Study 2019 (GBD 2019) Data Resources | GHDx. (n.d.). Retrieved 5 November 2024, from https://ghdx.healthdata.org/gbd-2019

Global Health Expenditure Database. (n.d.). [Dataset]. Retrieved 28 October 2024, from https://apps.who.int/nha/database

Grépin, K. A., Irwin, B. R., & Sas Trakinsky, B. (2020). On the Measurement of Financial Protection: An Assessment of the Usefulness of the Catastrophic Health Expenditure Indicator to Monitor Progress Towards Universal Health Coverage. *Health Systems & Reform*, *6*(1), e1744988. https://doi.org/10.1080/23288604.2020.1744988

Guide to Producing National Health Accounts: With Special Applications for Low-income and Middle-income Countries. (2003). World Bank Group.

Gwatkin, D. R., & Ergo, A. (2011). Universal health coverage: Friend or foe of health equity? *The Lancet*, *377*(9784), 2160–2161. https://doi.org/10.1016/S0140-6736(10)62058-2

Haakenstad, A., Irvine, C. M. S., Knight, M., Bintz, C., Aravkin, A. Y., Zheng, P., Gupta, V., Abrigo, M. R. M., Abushouk, A. I., Adebayo, O. M., Agarwal, G., Alahdab, F., Al-Aly, Z., Alam, K., Alanzi, T. M., Alcalde-Rabanal, J. E., Alipour, V., Alvis-Guzman, N., Amit, A. M. L., … Lozano, R. (2022). Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, *399*(10341), 2129–2154. https://doi.org/10.1016/S0140-6736(22)00532-3

Haakenstad, A., Yearwood, J. A., Fullman, N., Bintz, C., Bienhoff, K., Weaver, M. R., Nandakumar, V., LeGrand, K. E., Knight, M., Abbafati, C., Abbasi-Kangevari, M., Abdoli, A., Zuñiga, R. A. A., Adedeji, I. A., Adekanmbi, V., Adetokunboh, O. O., Afzal, M. S., Afzal, S., Agudelo-Botero, M., … Lozano, R. (2022). Assessing performance of the Healthcare Access and Quality Index, overall and by select age groups, for 204 countries and territories, 1990–2019: A systematic analysis from the Global Burden of Disease Study 2019. *The Lancet Global Health*, *10*(12), e1715–e1743. https://doi.org/10.1016/S2214-109X(22)00429-6

Hart, J. T. (1971). The Inverse Care Law. *The Lancet*, *297*(7696), 405–412. https://doi.org/10.1016/S0140-6736(71)92410-X

Health equity. (n.d.). Retrieved 9 October 2024, from https://www.who.int/health-topics/health-equity

Health taxes. (n.d.). Retrieved 9 October 2024, from https://www.who.int/health-topics/health-taxes

Heller, P. (2005). Understanding Fiscal Space. *IMF Policy Discussion Papers*, *2005*, 1. https://doi.org/10.5089/9781451975635.003

Heller, P. S. (2006). The prospects of creating 'fiscal space' for the health sector. *Health Policy and Planning*, *21*(2), 75–79. https://doi.org/10.1093/heapol/czj013

HSS evaluation—Conceptual model and monitoring & learning tool. (2022). Health System Strengthening Evaluation Collaborative Itad. https://www.itad.com/wp-content/uploads/2022/07/HSSEC-WG1-FA3-Conceptual-model-and-monitoring-learning-tool.pdf

Hussein, R. (2015a). A Review of Realizing the Universal Health Coverage (UHC) Goals by 2030: Part 1- Status quo, Requirements, and Challenges. *Journal of Medical Systems*, *39*(7), 71. https://doi.org/10.1007/s10916-015-0254-y

Hussein, R. (2015b). A Review of Realizing the Universal Health Coverage (UHC) Goals by 2030: Part 2- What is the Role of eHealth and Technology? *Journal of Medical Systems*, *39*(7), 72. https://doi.org/10.1007/s10916-015-0255-x

IAEG-SDGs—2025 Comprehensive Review Process. (n.d.). Retrieved 4 November 2024, from https://unstats.un.org/sdgs/iaeg-sdgs/2025-comprehensive-review

Il Est Temps d'agir Pour L'ODD 8: Intégrer le Travail décent, la Croissance Soutenue et l'intégrité Environnementale. (2019). Organisation Internationale du Travail.

International Labour Office (Ed.). (2018). *Women and men in the informal economy: A statistical picture* (Third edition). International Labour Office.

International Labour Organisation (Ed.). (2010). *Providing coverage in times of crisis and beyond* (1. ed). International Labour Organisation.

Jaca, A., Malinga, T., Iwu-Jaja, C. J., Nnaji, C. A., Okeibunor, J. C., Kamuya, D., & Wiysonge, C. S. (2022). Strengthening the Health System as a Strategy to Achieving a Universal Health Coverage in Underprivileged Communities in Africa: A Scoping Review. *International Journal of Environmental Research and Public Health*, *19*(1), Article 1. https://doi.org/10.3390/ijerph19010587

Jimba, M., & Fujimura, M. S. (2018). Shrink the universal health coverage cube. *The Lancet*, *392*(10164), 2551. https://doi.org/10.1016/S0140-6736(18)32518-2

Kay, A. (2005). A Critique of the Use of Path Dependency in Policy Studies. *Public Administration*, *83*(3), 553–571. https://doi.org/10.1111/j.0033-3298.2005.00462.x

Kieny, M. P., Bekedam, H., Dovlo, D., Fitzgerald, J., Habicht, J., Harrison, G., Kluge, H., Lin, V., Menabde, N., Mirza, Z., Siddiqi, S., & Travis, P. (2017). Strengthening health systems for universal health coverage and sustainable development. *Bulletin of the World Health Organization*, *95*(7), 537–539. https://doi.org/10.2471/BLT.16.187476

Kutzin, J. (2013). Health financing for universal coverage and health system performance: Concepts and implications for policy. *Bulletin of the World Health Organization*, *91*(8), 602–611. https://doi.org/10.2471/BLT.12.113985

Kutzin, J., & Sparkes, S. P. (2016). Health systems strengthening, universal health coverage, health security and resilience. *Bulletin of the World Health Organization*, *94*(1), 2. https://doi.org/10.2471/BLT.15.165050

Kutzin, J., Witter, S., Jowett, M., & Bayarsaikhan, D. (2017). *Developing a national health financing strategy: A reference guide*. World Health Organization. https://iris.who.int/handle/10665/254757

Kutzin, J., Witter, S., Jowett, M., & Bayarsaikhan, D. (2018). *Développer une stratégie nationale de financement de la santé publique: Guide de référence*. Organisation mondiale de la Santé. https://iris.who.int/handle/10665/275717

La transition de l'économie informelle vers l'économie formelle—Théorie du changement (Théorie du changement). (2021). Organisation Internationale du Travail. https://www.ilo.org/fr/media/388421/download

Le Gargasson, J.-B., & Salomé, B. (2010). The role of innovative financing mechanisms for health. *World Health Report (2010) Background Paper, No12*.

Lozano, R., Fullman, N., Mumford, J. E., Knight, M., Barthelemy, C. M., Abbafati, C., Abbastabar, H., Abd-Allah, F., Abdollahi, M., Abedi, A., Abolhassani, H., Abosetugn, A. E., Abreu, L. G., Abrigo, M. R. M., Haimed, A. K. A., Abushouk, A. I., Adabi, M., Adebayo, O. M., Adekanmbi, V., … Murray, C. J. L. (2020). Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, *396*(10258), 1250–1284. https://doi.org/10.1016/S0140-6736(20)30750-9

Luyten, E., & Tubeuf, S. (2024). Equity in healthcare financing: A review of evidence. *Health Policy*, 105218. https://doi.org/10.1016/j.healthpol.2024.105218

Ly, M. S., Bassoum, O., & Faye, A. (2022). Universal health insurance in Africa: A narrative review of the literature on institutional models. *BMJ Global Health*, *7*(4), e008219. https://doi.org/10.1136/bmjgh-2021-008219

Making Explicit Choices on the Path to UHC : The JLN Health Benefits Package Revision Guide. (n.d.). World Bank Group. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099120924161033683/p17623510c267803319a0b1e9a556ec2472

Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage. (2014). World Health Organization. https://iris.who.int/handle/10665/112671

Markov, K., & Stern Plaza, M. (2020). *ILO Social Security Standards: Learn, Ratify and Apply* (Social Protection Spotlight). International Labour Organisation. https://www.social-protection.org/gimi/Media.action?id=16565

Mathauer, I., Mathivet, B., & Kutzin, J. (2017). *L'assurance maladie à base communautaire: Comment peut-elle contribuer au progrès vers la couverture universelle en santé?* (No.

WHO/HIS/HGF/PolicyBrief/17.3). Article WHO/HIS/HGF/PolicyBrief/17.3. https://iris.who.int/handle/10665/258980

McIntyre, D., & Kutzin, J. (2016). *Health financing country diagnostic: A foundation for national strategy development* (No. WHO/HIS/HGF/HFDiagnostics/16.1). World Health Organization. https://iris.who.int/handle/10665/204283

McIntyre, D., Obse, A. G., Barasa, E. W., & Ataguba, J. E. (2018). Challenges in Financing Universal Health Coverage in Sub-Saharan Africa. In *Oxford Research Encyclopedia of Economics and Finance*. https://doi.org/10.1093/acrefore/9780190625979.013.28

Mukherji, A., Rao, M., Desai, S., Subramanian, S. V., Kang, G., & Patel, V. (2024). District-level monitoring of universal health coverage, India. *Bulletin of the World Health Organization*, *102*(9), 630. https://doi.org/10.2471/BLT.23.290854

Nabyonga Orem, J., Addai, K., Mwinga, K., Karenzi Muhongerwa, D., Namuli, S., & Asamani, J. (2022). *Analysis of the nature and contribution of innovative health financing mechanisms in the WHO African Region*. World Health Organization. https://www.afro.who.int/publications/analysis-nature-and-contribution-innovative-health-financing-mechanisms-who-african

Nabyonga-Orem, J., Ousman, K., Estrelli, Y., Rene, A. K. M., Yakouba, Z., Gebrikidane, M., Mamoud, D., & Kwamie, A. (2016). Perspectives on health policy dialogue: Definition, perceived importance and coordination. *BMC Health Services Research*, *16*(4), 218. https://doi.org/10.1186/s12913-016-1451-1

Norheim, O. F. (2015). Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage. *International Journal of Health Policy and Management*, *4*(11), 711–714. https://doi.org/10.15171/ijhpm.2015.184

Ohno, I., McArthur, J. W., & Kharas, H. (2019). Vulnerable Populations and Universal Health Coverage. In *Leave No One Behind: Time for Specifics on the Sustainable Development Goals*

(pp. 129–148). Brookings Institution Press. https://muse.jhu.edu/pub/11/edited_volume/chapter/2427753

Papanicolas, I., Rajan, D., Karanikolos, M., Soucat, A., & Figueras, J. (Eds.). (2022). *Health system performance assessment: A framework for policy analysis*. European Observatory on Health Systems and Policies. http://www.ncbi.nlm.nih.gov/books/NBK590192/

Parités de pouvoir d'achat (PPA). (n.d.). OCDE. Retrieved 4 November 2024, from https://www.oecd.org/fr/data/indicators/purchasing-power-parities-ppp.html

Parmar, D., & Banerjee, A. (2019). How do supply- and demand-side interventions influence equity in healthcare utilisation? Evidence from maternal healthcare in Senegal. *Social Science & Medicine (1982)*, *241*, 112582. https://doi.org/10.1016/j.socscimed.2019.112582

Paul, E., Bourgeois, M., & Ridde, V. (2021). La place de l'équité dans la couverture de santé universelle au niveau mondial, au Bénin et au Sénégal. In *Vers une couverture sanitaire universelle en 2030? : Réformes en Afrique subsaharienne* (Editions sciences et bien commun). https://www.documentation.ird.fr/hor/fdi:010082997

Paul, E., Brown, G. W., & Ridde, V. (2020). Misunderstandings and ambiguities in strategic purchasing in low- and middle-income countries. *The International Journal of Health Planning and Management*, *35*(5), 1001–1008. https://doi.org/10.1002/hpm.3019

Paul, E., Deville, C., Bodson, O., Sambiéni, N. E., Thiam, I., Bourgeois, M., Ridde, V., & Fecher, F. (2019). How is equity approached in universal health coverage? An analysis of global and country policy documents in Benin and Senegal. *International Journal for Equity in Health*, *18*(1), 195. https://doi.org/10.1186/s12939-019-1089-9

Paul, E., Ndiaye, Y., Sall, F. L., Fecher, F., & Porignon, D. (2020). An assessment of the core capacities of the Senegalese health system to deliver Universal Health Coverage. *Health Policy OPEN*, *1*, 100012. https://doi.org/10.1016/j.hpopen.2020.100012

Paul, E., Sambiéni, N. E., Wangbe, J.-P., Fecher, F., & Bourgeois, M. (2020). Budgeting challenges on the path towards universal health coverage: The case of Benin. *Health Economics Review*, *10*(1), 28. https://doi.org/10.1186/s13561-020-00286-9

Peeler, A., Afolabi, O., & Harding, R. (2024). Palliative care is an overlooked global health priority. *BMJ*, *387*, q2387. https://doi.org/10.1136/bmj.q2387

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, *19*(2), 127–140. https://doi.org/10.1097/00005650-198102000-00001

Prabhakaran, S., Dutta, A., Saxena, A., Stromberg, K., Clarke, D., & Sharma, S. (2017). *Do Better Laws and Regulations Promote Universal Health Coverage? A Review of the Evidence*. USAID. https://www.hfgproject.org/better-laws-regulations-promote-universal-health-coverage-review-evidence/

Quality control of SHA-based health accounts data. (2024). World Health Organization. https://www.who.int/publications/i/item/9789240072534

Questions pour secteurs et catégories de travailleurs spécifiques—NOTES DE SYNTHÈSE. (n.d.). Social Protection ILO. Retrieved 17 October 2024, from https://www.social-protection.org/gimi/Emodule.action?id=106

Rajan, D., El Husseiny, D., Porignon, D., Ghaffar, A., Schmets, G., & Adam, T. (2015). Policy dialogue: What it is and how it can contribute to evidence-informed decision-making. *<a Href="https://Www.Uhcpartnership.Net">https://Www.Uhcpartnership.Net</A>*. https://orbi.uliege.be/handle/2268/179431

Rajan, D., Rouleau, K., Winkelmann, J., Kringos, D., Jakab, M., & Khalid, F. (Eds.). (2024). *Implementing the primary health care approach: A primer*. World Health Organization.

Rapport sur la santé dans le monde 2007: Un avenir plus sûr : la sécurité sanitaire mondiale au XXIè siècle. (2007). Organisation mondiale de la Santé. https://iris.who.int/handle/10665/43726

Rapport sur la santé dans le monde 2008: Les soins de santé primaires - maintenant plus que jamais (p. 125). (2008). Organisation Mondiale de la Santé. https://iris.who.int/handle/10665/43951

Recommandation R202—Social Protection Floors Recommendation, 2012 (No. 202). (n.d.). Retrieved 23 September 2024, from https://normlex.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID,P12100_LANG_CODE:3065524,fr:NO

Recommandation R204 sur la transition de l'économie informelle vers l'économie formelle (No. Recommendation R204). (2015). Organisation Internationale du Travail. https://normlex.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID,P12100_LANG_CODE:3243110,fr:NO

Renforcer la résilience du système de santé pour instaurer la couverture sanitaire universelle et la sécurité sanitaire pendant et après la COVID-19. (2021). Organisation Mondiale de la Santé. https://www.who.int/publications/i/item/WHO-UHL-PHC-SP-2021.01

Resolution adoptée par l'Assemblée générale le 25 septembre 2015 N°70/1 Transformer notre monde: Le Programme de développement durable à l'horizon 2030. (2015). Nations Unies. https://sdgs.un.org/2030agenda

Resolution I concerning statistics on the informal economy—21st International Conference of Labour Statisticians. (2023). International Labour Organisation. https://ilostat.ilo.org/fr/about/standards/icls/icls-documents/

Roberts, M. J., Hsiao, W. C., & Reich, M. R. (2015). Disaggregating the Universal Coverage Cube: Putting Equity in the Picture. *Health Systems & Reform*, *1*(1), 22–27. https://doi.org/10.1080/23288604.2014.995981

Rodney, A. M., & Hill, P. S. (2014). Achieving equity within universal health coverage: A narrative review of progress and resources for measuring success. *International Journal for Equity in Health*, *13*(1), 72. https://doi.org/10.1186/s12939-014-0072-8

Sacks, E., Schleiff, M., Were, M., Chowdhury, A. M., & Perry, H. B. (2020). Communities, universal health coverage and primary health care. *Bulletin of the World Health Organization*, *98*(11), 773. https://doi.org/10.2471/BLT.20.252445

Saksena, P., Hsu, J., & Evans, D. B. (2014). Financial Risk Protection and Universal Health Coverage: Evidence and Measurement Challenges. *PLoS Medicine*, *11*(9), e1001701. https://doi.org/10.1371/journal.pmed.1001701

Sanders, D., Nandi, S., Labonté, R., Vance, C., & Van Damme, W. (2019). From primary health care to universal health coverage—One step forward and two steps back. *The Lancet*, *394*(10199), 619–621. https://doi.org/10.1016/S0140-6736(19)31831-8

Scheffler, R., Cometto, G., Tulenko, K., Bruckner, T., Liu, J., Keuffel, E. L., Preker, A., Stilwell, B., Brasileiro, J., & Campbell, J. (2016). *Health workforce requirements for universal health coverage and the Sustainable Development Goals*. World Health Organization. https://iris.who.int/handle/10665/250330

Schiel-Adlung, X. (2014). *Universal health protection: Progress to date and the way forward*. International Labour Organisation. http://s2.medicina.uady.mx/observatorio/docs/eq/lg/Eq2014_Lg_ILO.pdf

Séance d'information à l'intention des États Membres sur le suivi de la couverture sanitaire universelle (cible 3.8 des objectifs de développement durable): Révision des indicateurs 3.8.1 et 3.8.2 des ODD relatifs à la CSU. (2024, December 8). https://cdn.who.int/media/docs/default-source/health-system-governance/202408120_whomsbriefingsession_uhcindicatorsrevision_french.pdf?sfvrsn=f6b72183_2

Social protection | International Labour Organization. (2024, January 28). https://www.ilo.org/topics-and-sectors/social-protection

Social Security Inquiry. (n.d.). ILO | Social Protection Platform. Retrieved 4 November 2024, from https://www.social-protection.org/gimi/WSPDB.action?id=41

Stern Plaza, M., Bierbaum, M., & Behrendt, C. (2019). *Universal Social Protection: Key concepts and international framework* (Social Protection Spotlight). International Labour Organisation. https://www.social-protection.org/gimi/Media.action?id=16794

Strategic health infrastructure investments to support universal health coverage. (2023). World Health Organization. https://www.who.int/publications/m/item/strategic-health-infrastructure-investments-to-support-universal-health-coverage

Sustainable financing of social protection. (2023). International Labour Organisation. https://www.ilo.org/publications/sustainable-financing-social-protection

Tessier, L. (2020). *Towards Universal Health Coverage: Social Health Protection Principles* (Social Protection Spotlight). International Labour Organisation. https://www.ilo.org/publications/towards-universal-health-coverage-social-health-protection-principles

Tessier, L., & Louis Dit Guérin, O. (2024). *Quelle place pour les mutuelles de santé et assurances-maladie à base communautaire dans les systèmes de protection sociale en santé?: Revue d'expériences*. Organisation Internationale du Travail. https://doi.org/10.54394/QUDT1352

The Health Financing Progress Matrix Country Assessment Guide. (2020). World Health Organization. https://www.who.int/publications/i/item/9789240017801

The Lancet Regional Health Europe. (2024). Strengthening primary health care to achieve universal health coverage. *The Lancet Regional Health – Europe*, *39*. https://doi.org/10.1016/j.lanepe.2024.100897

The world health report. 2000: Health systems: improving performance. (2000). World Health Organization.

The world health report: Health systems financing: the path to universal coverage. (2010). World Health Organization. https://iris.who.int/handle/10665/44371

Thirteenth general programme of work, 2019–2023: Promote health, keep the world safe, serve the vulnerable. (2019). World Health Organization. https://www.who.int/publications/i/item/thirteenth-general-programme-of-work-2019-2023

Tracking Universal Health Coverage: 2023 Global Monitoring Report (1st ed). (2023). World Health Organization.

Tracking universal health coverage: First global monitoring report. (2015). World Health Organization. https://iris.who.int/handle/10665/174536

Travis, P. (2006). *Renforcement des systèmes de santé: Quelles perspectives pour les initiatives mondiales pour la santé ?* (No. WHO/EIP/healthsystems/2006.1). Organisation Mondiale de la Santé. https://iris.who.int/handle/10665/70019

Tumusiime, P., Nabyonga-Orem, J., Karamagi, H., Lehmann, U., Elongo, T., Nikiema, J.-B., Kabaniha, G., & Okeibunor, J. (2019). Resilient health systems for attaining universal health coverage. *BMJ Global Health*, *4*(Suppl 9), e002006. https://doi.org/10.1136/bmjgh-2019-002006

UHC2030. (2018). *Healthy Systems for Universal Health Coverage: A Joint Vision for Healthy Lives*. World Health Organization and the World Bank.

Universal health coverage post-2015: Putting people first, Editorial. (2014). *Lancet (London, England)*, *384*(9960), 2083. https://doi.org/10.1016/S0140-6736(14)62355-2

Vulnerability and Vulnerable Populations. (n.d.). Retrieved 30 September 2024, from https://wkc.who.int/our-work/health-emergencies/knowledge-hub/community-disaster-risk-management/vulnerability-and-vulnerable-populations

Wagner, A. K., Quick, J. D., & Ross-Degnan, D. (2014). Quality use of medicines within universal health coverage: Challenges and opportunities. *BMC Health Services Research*, *14*(1), 357. https://doi.org/10.1186/1472-6963-14-357

Watkins, D. A., Yamey, G., Schäferhoff, M., Adeyi, O., Alleyne, G., Alwan, A., Berkley, S., Feachem, R., Frenk, J., Ghosh, G., Goldie, S. J., Guo, Y., Gupta, S., Knaul, F., Kruk, M., Nugent, R., Ogbuoji, O., Qi, J., Reddy, S., … Summers, L. H. (2018). Alma-Ata at 40 years: Reflections from the Lancet Commission on Investing in Health. *Lancet (London, England)*, *392*(10156), 1434–1460. https://doi.org/10.1016/S0140-6736(18)32389-4

What are Health Disparities and Health Equity? We Need to Be Clear—Paula Braveman, 2014. (n.d.). Retrieved 9 October 2024, from https://journals.sagepub.com/doi/10.1177/00333549141291S203

Witter, S., Palmer, N., Balabanova, D., Mounier-Jack, S., Martineau, T., Klicpera, A., Jensen, C., Pugliese-Garcia, M., & Gilson, L. (2019). Health system strengthening—Reflections on its meaning, assessment, and our state of knowledge. *The International Journal of Health Planning and Management*, *34*(4), e1980–e1989. https://doi.org/10.1002/hpm.2882

World Health Organization (Ed.). (2013). *Research for universal health coverage*. World Health Organization.

World health statistics 2024: Monitoring health for the SDGs, Sustainable Development Goals (World Health Statistics). (2024). World Health Organization. https://www.who.int/publications/i/item/9789240094703

World Social Protection Report 2020-22: Social protection at the crossroads—In pursuit of a better future. (2021). International Labour Office. https://www.ilo.org/publications/flagship-reports/world-social-protection-report-2020-22-social-protection-crossroads-pursuit

World Social Protection Report 2024–26: Universal social protection for climate action and a just transition. (2024). International Labour Organisation. https://www.social-protection.org/gimi/ShowWiki.action?id=52

Yanful, B., Kirubarajan, A., Bhatia, D., Mishra, S., Allin, S., & Di Ruggiero, E. (2023). Quality of care in the context of universal health coverage: A scoping review. *Health Research Policy and Systems*, *21*(1), 21. https://doi.org/10.1186/s12961-022-00957-5

Yazbeck, A. S., Soucat, A. L., Tandon, A., Cashin, C., Kutzin, J., Watson, J., Thomson, S., Nguyen, S. N., & Evetovits, T. (2023). Addiction to a bad idea, especially in low- and middle-income countries: Contributory health insurance. *Social Science & Medicine*, *320*, 115168. https://doi.org/10.1016/j.socscimed.2022.115168

University of Antwerp
IOB | Institute of
Development Policy