SOCIAL PROTECTION POLICY PAPERS

Paper 10

Universal Health Protection:

Progress to date and the way forward

Social Protection Department

International Labour Office

Copyright © International Labour Organization 2014
First published 2014

Publications of the International Labour Office enjoy copyright under Protocol 2 of the Universal Copyright Convention. Nevertheless, short excerpts from them may be reproduced without authorization, on condition that the source is indicated. For rights of reproduction or translation, application should be made to ILO Publications (Rights and Permissions), International Labour Office, CH-1211 Geneva 22, Switzerland, or by email: pubdroit@ilo.org. The International Labour Office welcomes such applications.
Libraries, institutions and other users registered with reproduction rights organizations may make copies in accordance with the licences issued to them for this purpose. Visit www.ifrro.org to find the reproduction rights organization in your country.

ILO Cataloguing in Publication Data

Scheil-Adlung, Xenia

Universal Health Protection : Progress to date and the way forward / International Labour Office, Social Protection Department. - Geneva: ILO, 2014

ISSN 1020-9581; 1020-959X (web pdf)

International Labour Office, Social Protection Dept.

social security / health insurance / scope of coverage / social security policy / institutional framework / role of ILO / ILO Convention / ILO Recommendation

02.03.1

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers.
The responsibility for opinions expressed in signed articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them.
Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval.
ILO publications and electronic products can be obtained through major booksellers or ILO local offices in many countries, or direct from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland. Catalogues or lists of new publications are available free of charge from the above address, or by email: pubvente@ilo.org
Visit our web site: www.ilo.org/publns

The editor of the series is the Director of the Social Protection Department, ILO. For more information on the series, or to submit a paper, please contact:
Isabel Ortiz, Director Social Protection Department
International Labour Organization
4 Route des Morillons
CH-1211 Geneva 22 Switzerland
Tel. +41.22.799.6226 • Fax:+41.22.799.79.62

Printed in Switzerland

Abstract

This paper proposes policy options based on ILO research and experiences that aim at universal coverage and equitable access to health care. The policy options discussed focus on ensuring the human rights to social security and health and on the rights-based approaches underpinning the need for equity and poverty alleviation. The paper also provides insights into aspects of implementation and related challenges. It includes an overview of ILO concepts, definitions and strategic approaches to achieving socially inclusive and sustainable progress and highlights recent global trends.

JEL Classification: I10, I130, I140, H5

Keywords: health, health insurance, development, inequality, policy

About this document

Although there is a wide range of options for achieving progress in health protection, when aiming at universal health coverage, no single national or regional model can serve as a blueprint. The most suitable solutions must be developed at country level, taking into account the unique historical, social and economic developments of each country.

This publication is intended to inform about available policy options for developing and improving coverage and effective access to health care for all in need. It focuses on ILO experiences and approaches that aim at universal coverage and equitable access to health care. It also provides insights into aspects of implementation and related challenges. The policy options discussed focus on ensuring the human rights to social security and health and on the rights-based approaches underpinning the need for equity and poverty alleviation.

The text has been intentionally condensed for ease of reading and practical use. The main sections include an overview of ILO concepts, current state and strategic approaches to achieving socially inclusive and sustainable progress; they also highlight recent global trends.

This document can be used as a companion piece to other publications such as the World Social Protection Report, 2014/2015: Building economic recovery, inclusive development and social justice (ILO, 2014) and successive reports.

Xenia Scheil-Adlung, Health Policy Coordinator (ILO), took the overall responsibility for the drafting of this paper. The document has benefited greatly from the valuable comments made by ILO colleagues both at headquarters and field and experts from various institutions including international organizations and universities.

Further information and frequently updated data is available on the ILO Social Protection platform at www.social-protection.org.

Contents

Page

Acronyms and abbreviations ix

1. Introduction: Social protection in health 1
   - 1.1. The ILO's mandate for health protection 2
   - 1.2. National social protection floors and health coverage 3
2. The ILO concept of health protection 4
   - 2.1. Universal coverage 4
   - 2.2. Financing mechanisms 9
3. The current state of health protection 11
   - 3.1. Global overview: Selected performance indicators 11
   - 3.2. Socio-economic impacts of gaps in health protection 20
   - 3.3. Root causes of deficits in health protection 33
4. Moving towards Equity: National Social Protection Floors as a key strategy for achieving universal coverage in health 36
   - 4.1. Objectives, scope and principles 36
   - 4.2. National strategies towards universal health protection 38
   - 4.3. Monitoring progress towards universal coverage 47

Annexes

I. Country cases 53

II. The Social Protection Floors Recommendation, 2012 (No. 202) 75

III. The multiple dimensions of health coverage 81

IV. Total (public and private) health expenditure not financed by private households' out-of-pocket payments (percentage) 96

V. Classification of countries by level of vulnerability 104

VI. Global tools and support on social protection in health 107

Bibliography 113

Databases 119

Acronyms and abbreviations

ADB	Asian Development Bank
CBHI	community-based health insurance
ECLAC	Economic Commission for Latin America and the Caribbean
EHCP	essential health care package
FAO	Food and Agriculture Organization of the United Nations
G20	Group of 20
GDP	gross domestic product
GESS	Global Extension of Social Security
HDI	Human Development Index
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HPI	Human Poverty Index
ICESCR	International Covenant on Economic Social and Cultural Rights
ILO	International Labour Office/Organization
IMF	International Monetary Fund
ISSA	International Social Security Association
ISSR	International Social Security Review
KILM	Key Indicators for the Labour Market
LE	life expectancy
LTC	long-term care
MDGs	Millennium Development Goals
MMR	maternal mortality rate
MOH	Ministry of Health
NGO	non-governmental organization
NHA	national health accounts
NHIP	National Health Insurance Programme
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development

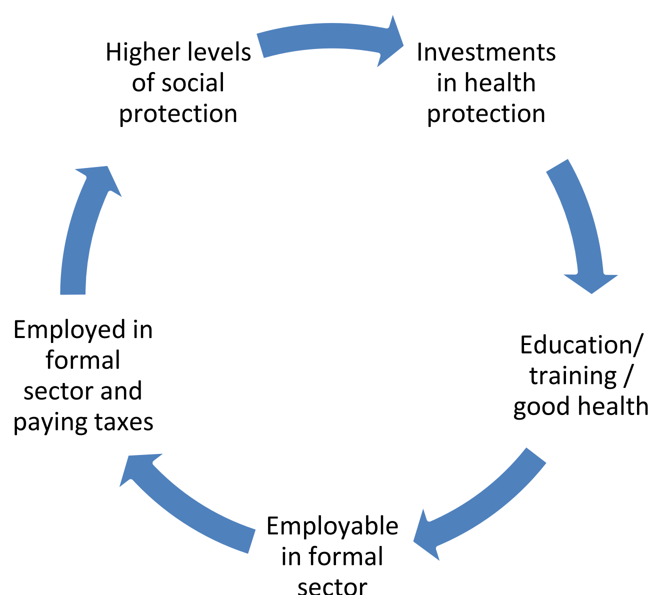
OOP	out-of-pocket payments
PLHIV	people living with HIV/AIDS
PPP	purchasing power parity
SAD	Staff Deficit Indicator
SHI	social health insurance
SPF-I	Social Protection Floor Initiative
STEP	Strategies and Tools against Exclusion and Poverty (ILO Programme)
THE	total health expenditure
TPE	total therapeutical expenditure
UHC	universal health coverage
U5MR	under-5 mortality rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNPOP	United Nations Population Division
WHO	World Health Organization

1. Introduction: Social protection in health

Economic instabilities such as the recent financial and economic crises have resulted in loss of jobs and income for millions of people around the globe. They have also led to decreasing social protection coverage and thus unaffordable access to health care and impoverishment of families and their dependents. The poor and vulnerable in developing countries have been especially hard-hit: over one quarter of residents in these countries are currently living on less than US$1.25 a day (World Bank, 2010a).

In times of crisis, social protection in health functions as a social and economic stabilizer impacting significantly on development. This can be attributed to close links between health, the labour market and income generation: increased employment in health sector, increased productivity from healthy workers and reduced morbidity and mortality rates. Conversely, the denial of access to medically necessary health care may have substantial social and economic repercussions, often driving people into poverty and out of the workforce (ILO, 2013a).

Figure 1.1. Cycle of development as a result of investments in social protection in health



Source: ILO, 2013a.

Figure 1.1 illustrates the role of health protection for sustainable development. Investments in health protection have been shown to improve the health of the population, and in combination with education and training help to reinforce formal-sector employability of individuals (European Commission, 2013). In turn, higher levels of formal-sector employment increase the potential of governments to raise taxes and generate income for social protection, which may subsequently be used for financing higher levels of coverage and benefits for social protection, including health protection (OECD, 2004). This triggers what is known as a "virtuous cycle of development".

For many years, it was believed that deficits in coverage and access to health care would decrease automatically in line with enhanced economic development. This expectation proved to be invalid: due to increasing levels of informal employment, coverage rates stagnated or even declined (ILO, 2011a).

Today, nearly one-third or the world's population lacks access to health facilities and other essential medical services. Gaps in health protection are concentrated in lower-income countries, frequently leaving those most in need without any protection. The ILO estimates that only 10 per cent of the population in the poorest countries in the world have some means of health protection, while the remaining 90 per cent are forced to pay out-of-pocket for necessary health care, or forgo them entirely (ILO, 2010a).

Globally, out-of-pocket payments (OOP) constitute the largest source of financing for health. They include direct payments to providers, such as user fees for services and goods, as well as indirect costs, such as transport to reach health-care facilities, especially in rural areas. As a consequence of their regressive nature and lack of financial solidarity through risk pooling, OOP are the most inequitable source of health financing. They place a considerable financial burden on households, especially at times of crisis with the consequent reduced incomes, often forcing households with limited resources to choose between paying for health care and paying for other basic necessities (Scheil-Adlung, 2013a).

Important issues related to gaps in coverage and lack of equitable access to essential health care can arise from problems within the health system and beyond. Issues within the health system may include: inequities in legal health coverage due to political, legislative and administrative failures, particularly for specific groups such as women, migrants and the elderly; a limited scope of benefits excluding specific needs, e.g. for medicines; and imbalances in the geographical distribution of infrastructure and the health workforce in rural and urban areas. Beyond the health system, issues frequently concern the unemployed as well as informal-sector workers, who lack sufficient income to pay for necessary health care (ibid.).

1.1. The ILO's mandate for health protection

Since its creation in 1919, the ILO has been tasked with establishing international labour standards as well as advocating for the progressive realization of the right to social protection, including for health (ILO, 2011a). Its mandate regarding social protection was incorporated into the Declaration of Philadelphia and its own constitution, as "the solemn obligation of the International Labour Organization to further among the nations of the world programmes which will achieve [...] the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care" (Art. III (f)), including maternity protection.

In order to realize this mandate, the ILO takes various actions including setting international labour standards in the form of Conventions and Recommendations, in which specific obligations and guidelines are laid down. The most notable in the area of health protection are as follows:

- the Social Security (Minimum Standards) Convention, 1952 (No. 102), which includes health in a set of nine contingencies or branches of social protection, and lays down minimum standards and principles for sustainability and good governance; and

- the Social Protection Floors Recommendation, 2012 (No. 202), which provides guidance to member States aiming at ensuring that all members of society enjoy at least a basic level of social security throughout their lives, and guaranteeing that all in need have access to at least essential health care and to basic income security.

Considering that health is a basic human right (Universal Declaration of Human Rights, 1948, Art. 25), the extension of social security should ultimately lead to universal

protection in health, ensuring that all people in need have effective access to at least adequate care.

In order to achieve universal coverage in health, gaps in coverage and related root causes at both the systemic and the individual levels must be addressed by an appropriate policy response. National social protection floors have the potential to address such issues within as well as beyond the health system.

1.2. National social protection floors and health coverage

Social protection floors (SPF) are "nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion" (Recommendation No. 202, para. I.2; see Annex I for the full text of the Recommendation). In June 2012, the International Labour Conference adopted Recommendation No. 202 in order to provide guidance to member States in establishing these sets of basic social security guarantees. They should ensure at a minimum that, over the life cycle, all in need have "access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality" (para. 5 (a)).

Recommendation No. 202 is based on new paradigms, including that:

- essential social (health) protection is feasible at any level of GDP;
- national SPFs are not just about protecting against ill health and impoverishment, but also about prevention;
- national SPFs are an investment in people rather than a tool to redistribute income; and
- social (health) protection is not simply a national issue, but has implications on a global level.

A two-tiered approach toward addressing poverty and social exclusion is suggested. SPFs aim at guaranteeing investments in human capital through:

1. universal in-kind benefits which include at least essential health care including curative care, preventive care and maternity care; and
2. basic income throughout the life cycle by providing cash benefits to children and persons in active age, as well as older persons.

Essential health care should be available to all in need. The exclusion of certain population subgroups such as women, migrants and informal workers can only be avoided when various policy measures are well coordinated and coherent. In-kind and in-cash benefits establishing access to basic goods and services and ensuring a basic income should be accompanied by measures aiming at promoting productive economic activity and enhancing formal employment. Such policies include public procurement; active labour market policies; and the promotion of education, literacy, productive skills and employability of individuals. Cooperation across social, health and economic sectors, increasing risk pooling, as well as the coordination of various health protection schemes that have resulted in fragmentation, is key for these different policies.

In addition, the root causes of discrimination and exclusion must be addressed. This requires broad policy and developmental strategies focusing on equity, social change and the alleviation of deprivation (Scheil-Adlung, 2013a).

2. The ILO concept of health protection

This chapter introduces concepts and underlying principles on social protection in health that are advocated by the ILO and which also serve to shed light on current issues.

2.1. Universal coverage

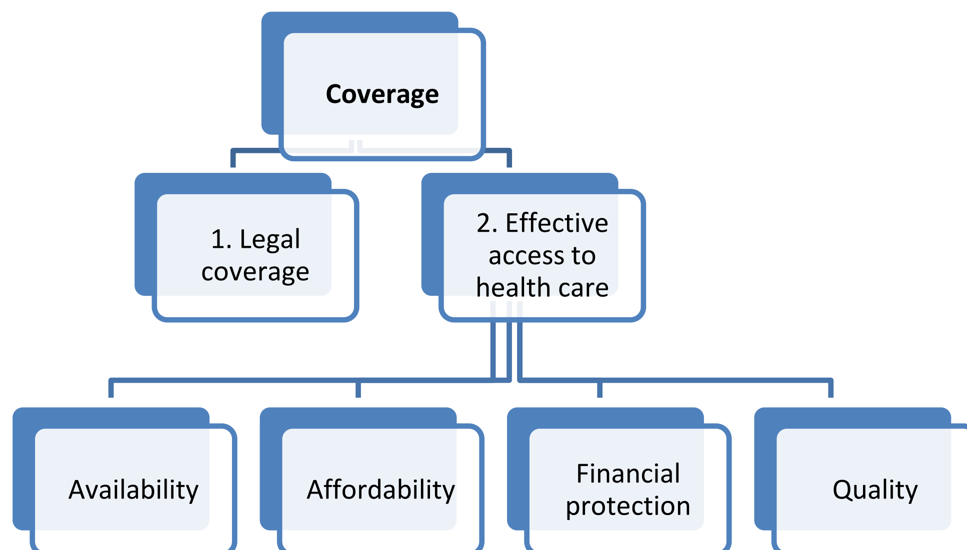
The ILO defines social protection in health as “a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health” (ILO, 2010a).

The overall objective of social protection policies in health is achieving universal coverage that leads to effective access to at least essential health care for all in need. Following ILO Conventions and Recommendations, health benefits should include in-kind health-care benefits, cash sickness benefits, preventive benefits and maternity benefits. Effective access to such benefits requires:

- a rights-based approach, i.e. coverage anchored in legislation or contracts;
- affordability of necessary health care, i.e. without financial hardship or increased risk of poverty;
- availability of necessary health services that are of adequate quality; and
- financial protection.

Health care should thus be equally attainable for all members of the population. Figure 2.1 provides an overview of the ILO concept of coverage.

Figure 2.1. The ILO concept of coverage



Source: ILO, 2013a.

2.1.1. Legal health coverage

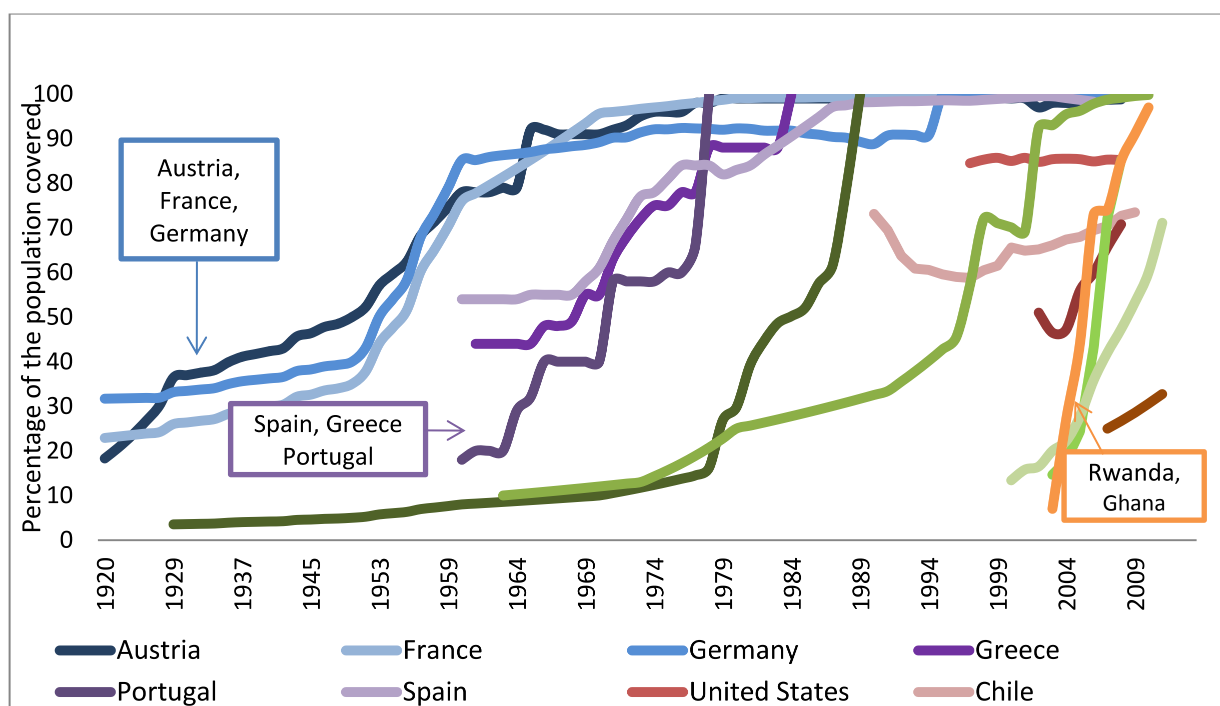
The Universal Declaration of Human Rights (1948) states that "Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality" (Art. 22).

ILO Recommendation No. 202 reaffirms the human right to social security, including health protection. It emphasizes the need to translate this right to protection into entitlements to benefits as prescribed by national law (para. I. 3(b)) as a key principle for social protection provision. The related national legislation should specify:

- the population covered;
- qualifying conditions to access health benefits; and
- complaint and appeal procedures.

Figure 2.2 shows historical developments in legal health coverage of the population in various countries. It refers to the percentage of the population covered as stipulated by law in national health systems, social health insurance or other forms of health protection. Although it appears that in a number of countries, legal health coverage has increased to reach nearly 100 per cent, no conclusions can be drawn about whether individuals can effectively access health care in case of ill health based on this graph. For effective access, the design of health schemes or systems and their implementation play an important role. Thus, even with statutory coverage of 100 per cent of the population, universal coverage in a meaningful sense may not be achieved if the legislation is not sufficiently implemented.

Figure 2.2. Legal health coverage as a percentage of total population, selected OECD countries and others (Selected countries)



Source: ILO, 2011b.

To be meaningful, legal health coverage needs to result in effective access for all residents of a country, regardless of the financing subsystem to which they belong. However, this does not preclude national health policies from focusing temporarily on priority groups such as the most vulnerable when extending social protection in health. Frequently, vulnerable population groups do not have equal access to necessary health care. This is often due to gaps in legislation, and particularly concerns the following categories:

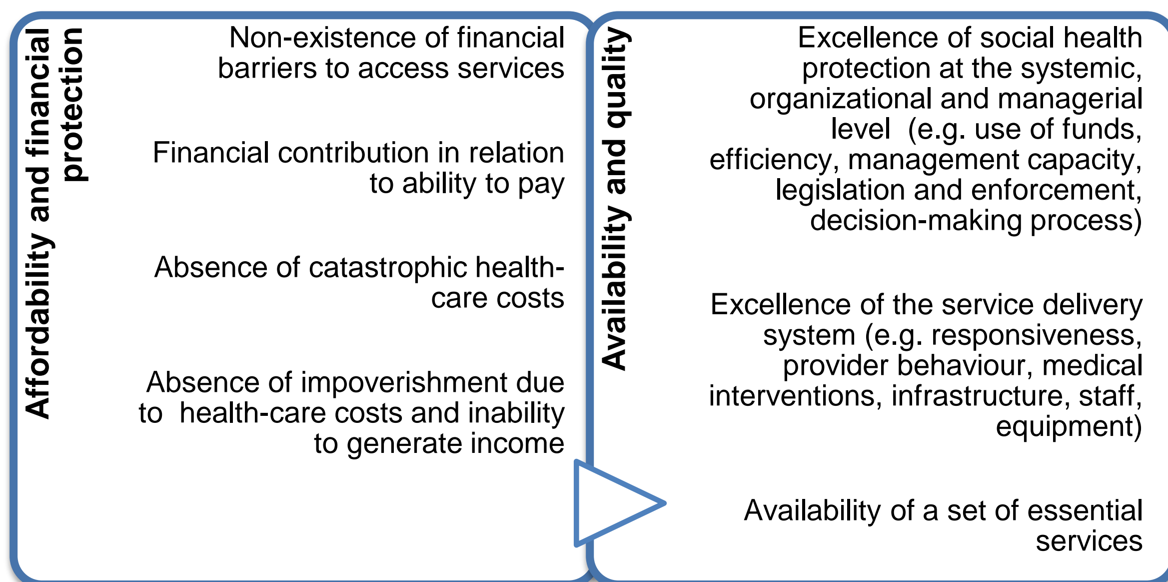
- the poor;
- workers in the informal economy and their families;
- women;
- persons with special needs, such as persons living with HIV/AIDS (PLHIV); and
- ethnic minorities and migrants.

2.1.2. Effective access to health care

Despite legal coverage, the sick are often not in a position to access necessary quality health care without risk of poverty and financial hardship. This is not solely dependent on the existence of legislation or affiliation to a scheme or system; it depends also on a range of issues such as gaps in the implementation of legislation as well as social, economic and other factors.

In order to ensure adequate protection in terms of effective and equitable access to health care, affordability and financial protection in addition to availability of quality services must be guaranteed by the removal of financial barriers such as out-of-pocket payments (OOP). Furthermore, there must be sufficient funding for quality service delivery, and excellence in governance and management of health systems and schemes. An overview of key aspects to be assessed is provided in figure 2.3.

Figure 2.3. Dimensions of effective access to health care



Source: ILO, 2013a.

Affordability and financial protection of health care

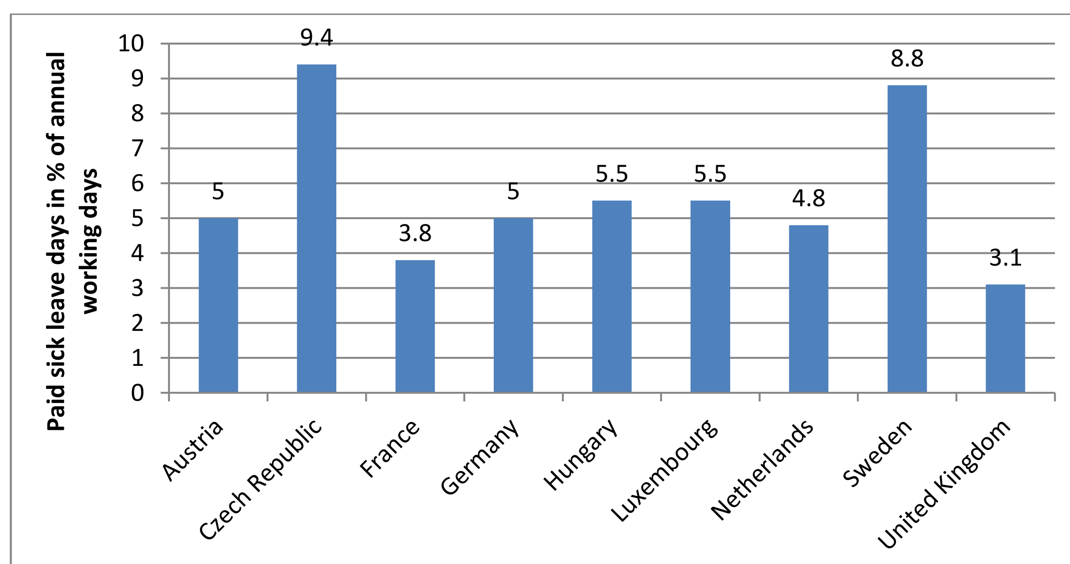
Access to health care frequently involves costs such as co-payments, other direct payments for health services and goods, and indirect costs such as transport, resulting in out-of-pocket payments (OOP). The criteria of affordability of health care relates to the non-existence of such financial barriers to access for individuals, population groups and societies as a whole.

ILO Recommendation No. 202 stresses the importance of affordable health care by emphasizing the principle of solidarity in financing (para. I. 3(h)). This includes minimizing OOP by increasing fairness in financing through pre-payments and risk pooling, while ensuring that taxes, contributions and premiums are charged according to capacity to pay.

The Recommendation also states that "persons in need of health care should not face hardship and an increased risk of poverty due to the financial consequences of accessing essential health care" (para. II. 8(a)). High OOP on top of decreased productivity and earnings may cause such hardship and impoverish individuals and their families. Financial protection has the potential to protect against various types of expenditures incurred when accessing health care, including transport costs to reach health-care facilities and compensation for the economic loss caused by reductions in productivity and earnings due to ill health.

In order to provide protection against OOP as well as loss of earnings, social protection systems should be in place for all in need, including vulnerable groups. Particularly in times of crisis, when workers may be forced to choose between risking their health or losing income when reporting sickness, paid sick leave is an important tool of financial protection. In this context it is interesting to note that the economic costs of working while sick exceed the costs of paid sick leave, because of an increased number of persons to be treated with more severe signs of ill health. Additionally, the lower productivity of sick workers has been found to slow down growth and development (Scheil-Adlung and Sandner, 2010). Figure 2.4 illustrates the number of days of paid sick leave as a share of annual working days in selected European countries, ranging from between three and ten days per year.

Figure 2.4. Paid sick leave days as a percentage of annual working days, selected European countries, 2006



Source: Scheil-Adlung and Sandner, 2010.

Availability of quality health care

The availability of health care relates to the physical existence of a set of essential health services, a health workforce to deliver these services, infrastructure allowing individuals to reach health facilities, and medical goods and products to provide care responding to needs. In the absence of one or more of these components, effective access to adequate care will not be possible.

Globally, the availability of health care is distributed unevenly between low-, middle- and high-income countries, as well as frequently within these countries. This is mainly due to issues within health schemes and systems at the organizational and managerial levels. The unavailability of services also entails gaps in the scope of benefits that lead to exclusion from essential health care.

Service delivery and an unequal distribution of the health workforce and infrastructure are also highly relevant to this discussion. Discrepancies in the availability of health care are particularly prevalent across geographic regions – specifically between rural areas, cities and slums – within a given country.

Recent studies have shown that it is residents of urban slums in developing countries who may experience the greatest inequities in accessing essential health care at the national level. This is evident in Dhaka, Bangladesh (see table 2.1), where only about 23 per cent of urban slum dwellers visited providers with skilled health workers as compared to 35 per cent of the sick from rural areas. The source of health care most used in urban slums was pharmacies, which accounted for 42.6 per cent of visits to health-care providers (Khan, Grübner and Krämer, 2012).

Table 2.1. Dhaka: Health-care utilization by residents in urban slums and rural areas, 2008—09 (percentages)

	Urban slums		Rural areas	
Providers visited				
Pharmacy	42.6		30.1	
Government hospital/clinic	13.5		8.9	
Private hospital/clinic	2.7	22.6	16.1	35
Qualified allopathic practitioners	3.9		8.4	
Paraprofessionals	2.5		1.6	
Traditional health providers	1.4		3.1	
Others	0.0		1.6	

Source: Khan, Grübner and Krämer, 2012

Similar observations could also be made with regard to skilled attendance at births in the same areas of Bangladesh: in 2009, 19 per cent in rural areas but only 15 per cent in slums (UNICEF, 2010).

Health care that is available and affordable cannot fulfill its purpose unless it is at an adequate level of quality. Quality refers to various dimensions, including:

- compliance with medical guidelines or protocols as developed by WHO or other institutions, such as the guideline on natural ventilation for infection control in health-

care settings (WHO, 2009a), and the WHO recommendation on screening donated blood for transfusion-transmissible infections (WHO, 2009b);

- responsiveness to needs, including special needs such as those of people living with HIV/AIDS (PLHIV), the elderly or disabled;

- ethical dimensions such as dignity, confidentiality, respect of gender and culture, and issues such as choice of provider and waiting times; and

- administration and management of health protection systems and schemes, e.g. with accountability, transparency and participation.

Quality is strongly linked to the availability of sufficient financial and human resources.

2.2. Financing mechanisms

There is no single right financing model for providing universal health protection. Countries use various resources generated from various tax schemes, income-related contributions and divers forms of risk pooling, among others, to create dynamic systems that evolve over years, often resulting from historical and economic developments, social and cultural values, institutional settings and political commitment. However, financing mechanisms should be developed in such a way as to foster solidarity and generate sufficient income for the health system. Thus, no individual in need of health care should face hardship or an increased risk of poverty when accessing essential health care (Recommendation No. 202, para. II. 8(a)).

It is usually the case that different financing mechanisms are combined into a pluralistic health financing system in order to generate sufficient income for the delivery of health care. The following principles need to be taken into account during this process:

- solidarity in financing, to ensure that those in need and with limited capacity to pay (e.g. through co-payments, contributions or VAT) are supported by those who are healthy and financially better off;

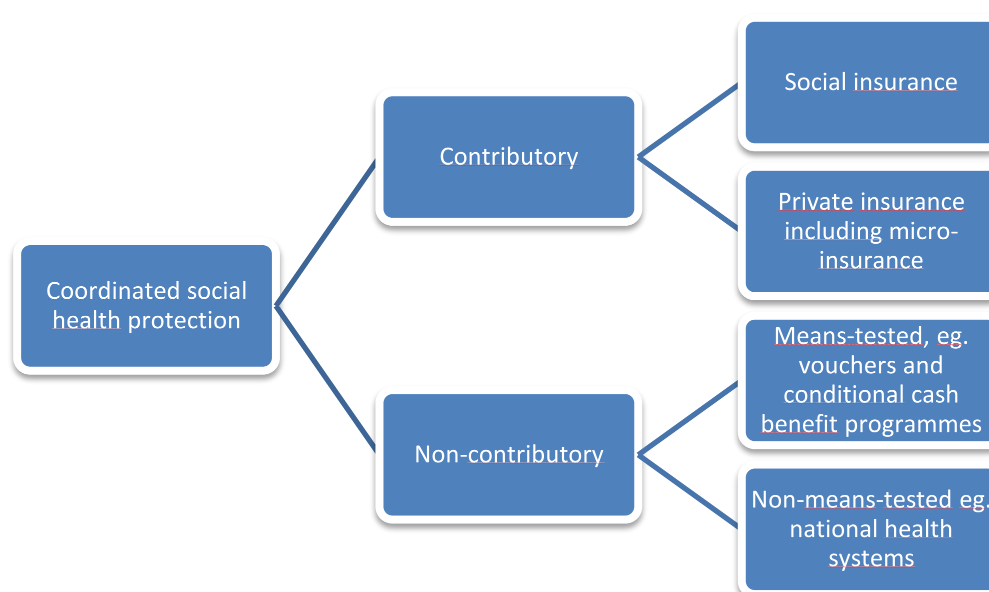
- consideration of the diversity of existing methods and approaches, including of financing mechanisms and delivery systems when aiming at universal coverage;

- transparent, accountable and sound financial management and administration; and

- financial, fiscal and economic sustainability, taking into account social justice and equity.

Figure 2.5 provides an overview of the most important financing mechanisms funding health protection systems and schemes; these mechanisms should be coordinated with a view to achieving equity in access to health care. While OOP are frequently used as a financing rather than a control mechanism, the ILO does not consider OOP to be an acceptable method of generating income for health systems, given their negative impacts on equity and household income.

Figure 2.5. Social protection in health: A typology of financing mechanisms



Source: ILO, 2013a.

Health financing mechanisms can be broadly categorized into contributory and non-contributory schemes:

1. **Contributory health protection systems and schemes** are based on income-related contributions or payroll taxes usually shared between employers and employees. They are collected by social security institutions or public bodies. For private schemes, premiums from households are collected by insurance funds.

   Social health insurance usually implies compulsory membership, creating a risk pool for the population covered. Frequently, tax subsidies are provided to cover the poor and other vulnerable groups.

   Private insurance schemes such as for-profit health insurances are funded by risk-based premiums. Not-for-profit private schemes include community-based health insurance (CBHI). CBHIs provide coverage to specific groups, such as informal-economy workers and their families. Membership in private schemes is usually voluntary. The benefits of contributory and premium-based schemes are defined and provided in kind, or the services are paid for and reimbursed in cash, and may be amended by paid sick leave schemes.

2. **Non-contributory systems** such as tax-funded health protection through national health systems (NHS) typically provide health care free at the point of delivery to residents. Non-contributory schemes are fully funded by taxes. These may be direct or indirect taxes or other state income.

   The benefits provided are usually not defined. They may be targeted and sometimes means-tested (e.g. to the poor or other vulnerable groups) and they often include vouchers for services such as maternity care, or conditional cash transfers requiring school attendance or taking up preventive services.

   In most countries, the health financing mechanisms listed above do not exist in the pure forms described but consist of a merge of all mechanisms that are best suited to the country's financial, cultural and historical context.

3. The current state of health protection

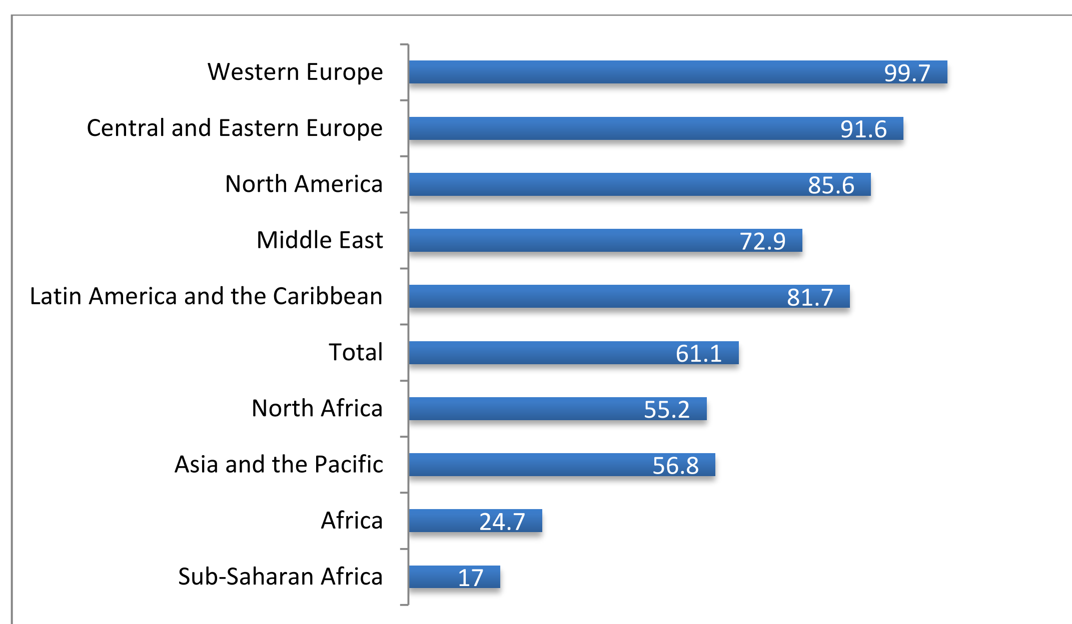
Investments in health through social protection are justified by human rights. In addition, they are essential for sustainable development by increasing the overall (future) capacity to be productive and generate income (Suhrcke, Rocco and McKee, 2007) and thus might impact on poverty alleviation and economic growth. However, in many countries the overall performance of health systems is currently facing a number of challenges. These relate particularly to gaps and deficits in rights-based approaches, funding and financing, efficiency and effectiveness — all of which can have negative impacts on households and individuals in need of health care.

3.1. Global overview: Selected performance indicators

3.1.1. Rights-based approaches

A prerequisite for universal health coverage is the translation of the rights to social protection and health into entitlements to benefits as prescribed by national law. Such legal entitlements result in legal health coverage. Legal health coverage refers to the percentage of the population that is affiliated to a health system or scheme, for example a social health insurance scheme or a national health service. Legal health coverage based on rights also includes coverage in private schemes such as micro health insurances or for-profit schemes. Figure 3.1 shows a broad overview of the percentage of the global population legally covered; current national coverage data are provided in Annexes III and IV.

Figure 3.1. Global legal health coverage, latest available year (percentage of the population covered)



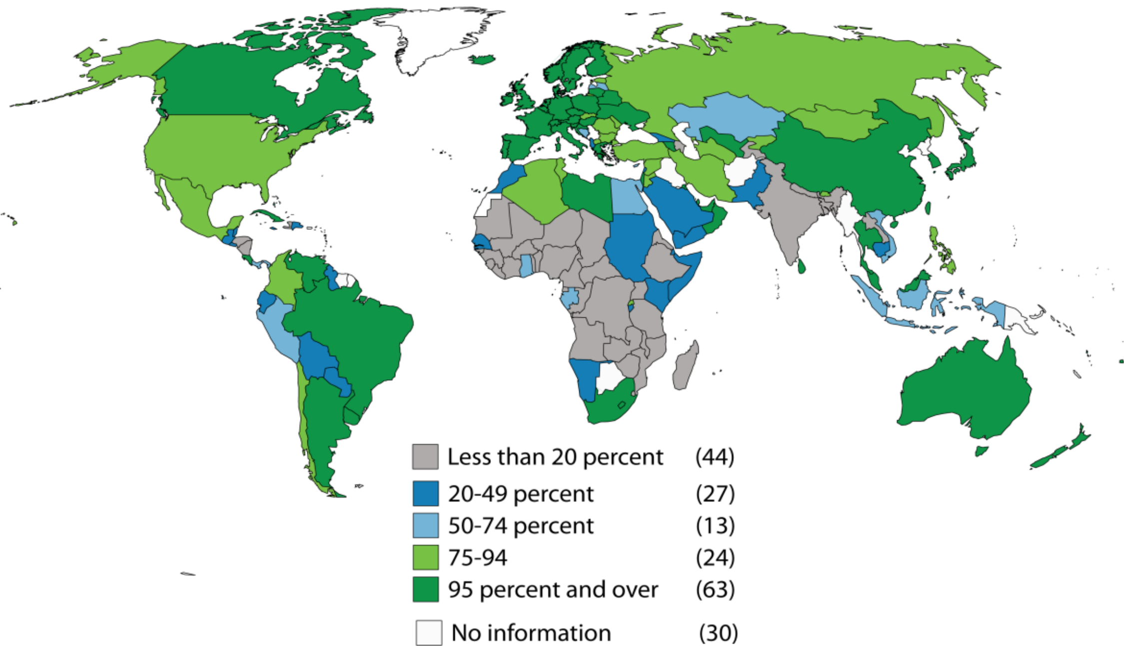
Note: Global average weighted by population.

Source: ILO, latest available data.

Legal health coverage across the world currently ranges from 100 per cent in some countries of Western Europe (figure 3.1) to less than 20 per cent of the population of selected countries in the African continent. Legal health coverage being a prerequisite for access to health care is almost negligible or non-existent in 34 countries (figure 3.2).

A recent reform example regarding legal coverage relates to the USA where the Patient Protection and Affordable Care Act (A.C.A., 2010: "Obamacare") extends existing legal coverage to some 14 percent of the population that is currently not covered and will have access to an affordable insurance policy. Another 6 percent of the population will have to buy new private insurance policies that meet the criteria of the A.C.A. (Lizza 2013).

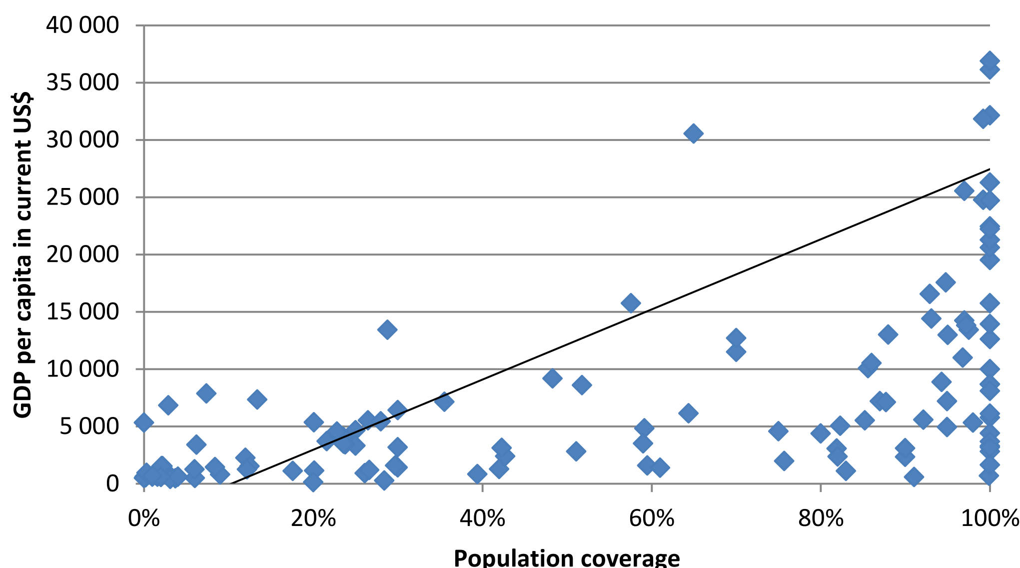
Figure 3.2. Legal health coverage from public, private or national health-care schemes and systems: Global figures, latest available year (percentages)



Source: OECD Health Statistics database; national sources for non-OECD countries

Health coverage is closely correlated with levels of wealth, as might be expected: wealthier countries reach higher average levels of coverage than less well-off countries. According to ILO estimates, in some of the poorest countries of the world no more than 10 per cent of the population are covered while the remaining 90 per cent have to pay for health care without any risk pooling through health protection, often in the form of OOP (ILO, 2010a). Generally, at the global level, GDP per capita and coverage are positively related. Figure 3.3 shows this relation: higher levels of GDP are linked to higher coverage rates.

Figure 3.3. Health coverage and per capita GDP, latest available data



Source: ILO, based on ILO, LABORSTA and UN; UNDATA, 2013.

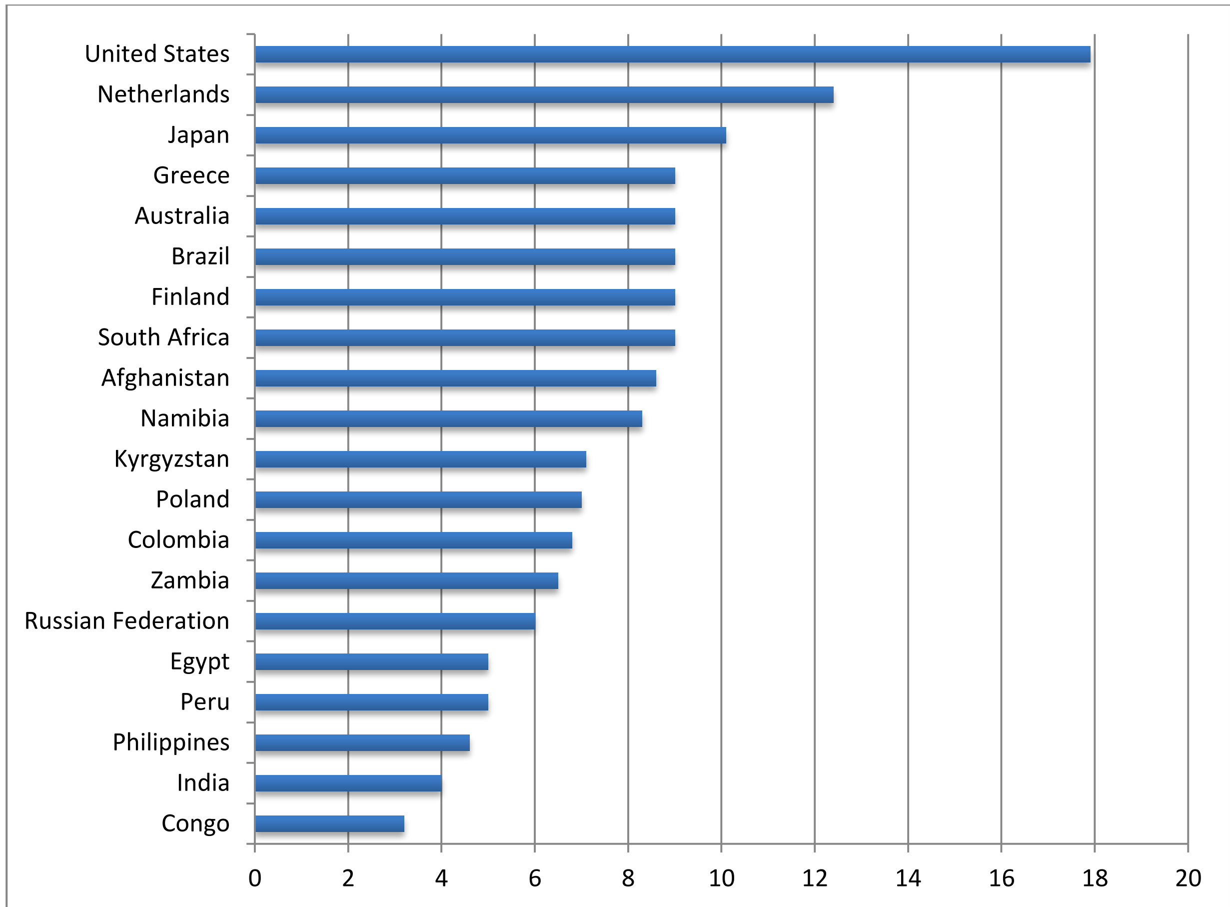
Gaps in health coverage are particularly concentrated in developing countries. In particular, they frequently affect vulnerable groups such as the poor, workers in the informal sector, migrants and women (ILO, 2012b). They are frequently an indication of fragmented legislation and rights-based approaches on health systems that are characterized by inadequate coordination of various financing mechanisms such as microinsurance, social insurance, private insurance and others.

3.1.2. Funding and financing

National levels of health expenditure define the availability of quality services, medicines, infrastructure and other elements. Health care will be delivered only at low quality (if at all) where funding is insufficient. Inadequate financing mechanisms that impose large amounts of expenditure on private households also impact negatively on the accessibility of necessary health care by creating financial barriers. Thus, minimum requirements for health funding and financing include meeting at least the key principles of providing access to at least essential health-care services, and fairness in health financing. What is the situation at the global level?

National health expenditure varies widely across countries. Those that spend the most on health care are situated in the Americas and Europe. In 2012, the United States spent more than 18 per cent of its GDP on health, while the Netherlands spent 12 per cent (figure 3.4). Those countries that spend the least on health are largely situated in sub-Saharan Africa: for instance, health expenditure in the Congo amounts to about 3 per cent of GDP.

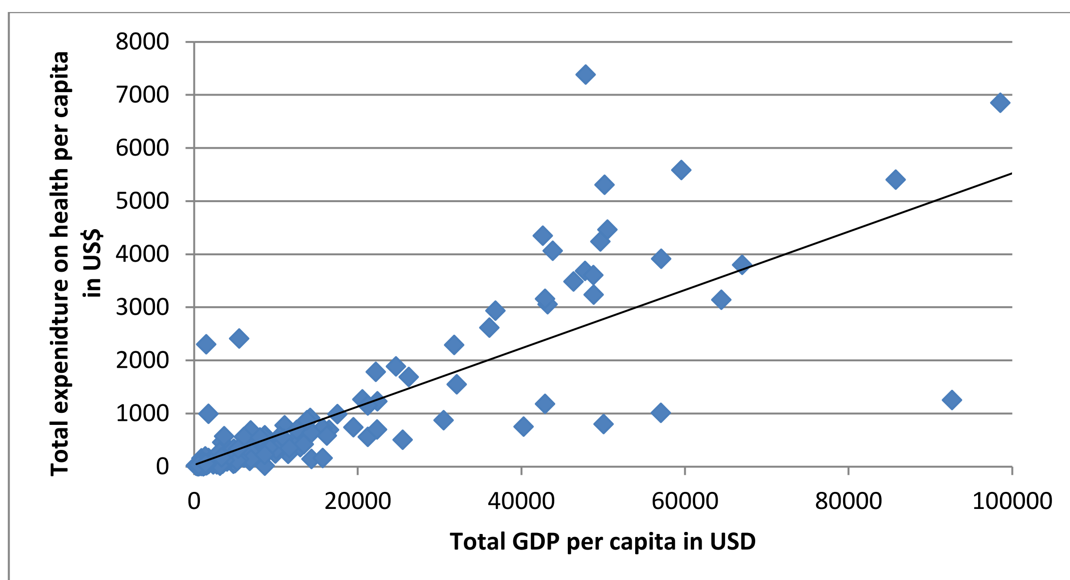
Figure 3.4. Health expenditure as a percentage of GDP, selected countries, 2012



Source: ILO, based on WHO Global Health Observatory, 2014.

The level of wealth measured through a country's GDP is closely related to its overall level of health spending. Figure 3.5 shows this positive correlation: the higher per capita GDP, the higher per capita expenditure on health. However, levels of health expenditure are not a fixed percentage of GDP levels: some countries with relatively low GDP manage to spend considerably more on health care than others with an equal level of wealth, indicating that all countries to a certain extent have the freedom to choose their own levels of health expenditure.

Figure 3.5. Correlation between wealth and health expenditure, 2013



Source: ILO, based on WHO Global Health Observatory, and UN, UNDATA, 2013.

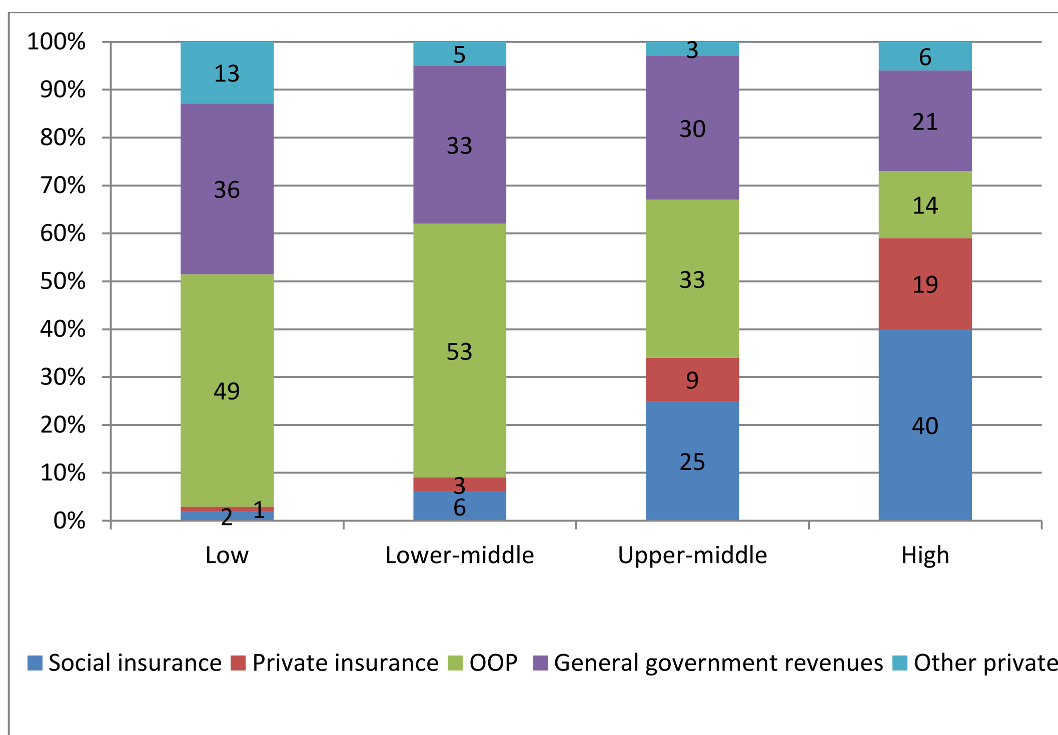
In most countries, health expenditure derives from various sources, including:

- general government revenues;
- income-related contributions to social health insurance;
- risk-based premiums to private insurance funds; and
- out-of-pocket (OOP) expenditures.

ILO Recommendation No. 202 emphasizes solidarity in financing as a basic principle for providing protection in health (para. I. 3(h)). Fair financing mechanisms ensure that persons in need of health care will not experience hardship or an increased risk of poverty due to the financial consequences of seeking care. A prerequisite for solidarity in financing is the use of pre-payment and risk-pooling mechanisms. Such mechanisms make use of pre-paid funds from a large number of individuals to cover their expenditures in case of ill health as opposed to a situation in which each individual bears his/her own health-care costs. It follows that financing mechanisms requiring excessive payments at the point of service delivery, such as OOP, do not comply with the principle of fairness. OOP include direct payments to providers, such as user fees, co-payments or other direct payments for health services and goods. They also include indirect costs such as for transport to health-care facilities. Generally, OOP are regressive in nature and frequently create a barrier to accessing health services by placing the financial burden on the individual.

Globally, however, OOP still constitute the largest source of expenditures for health care. When grouping countries by income, it is apparent that the share of OOP is highest in low-income countries (49 per cent). On the other hand, in high-income countries only 14 per cent of health expenditure originates from OOP, while 40 per cent is derived from social insurance (see figure 3.6).

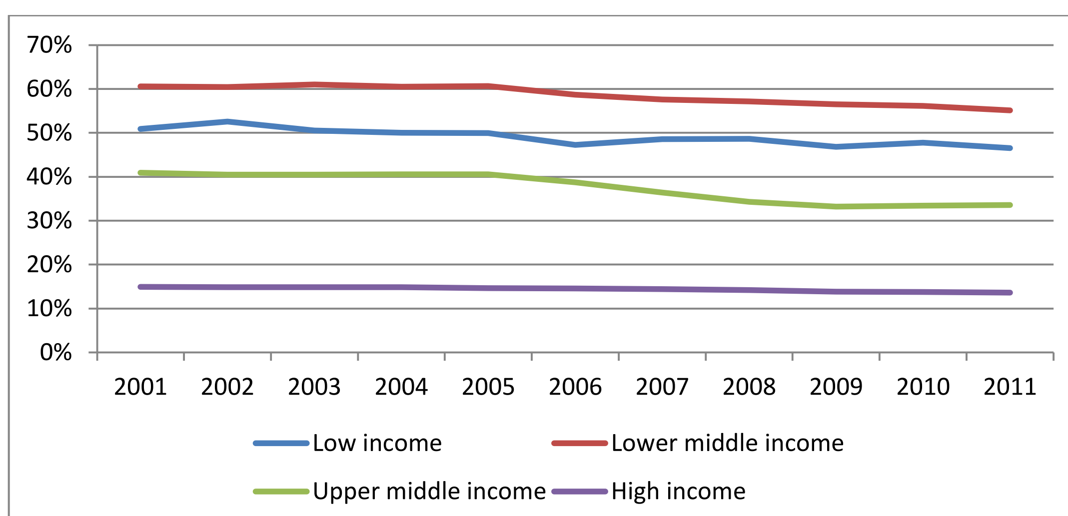
Figure 3.6. **Expenditure on health, by financing agent and income level (percentages)**



Source: WHO Global Health Observatory, 2013.

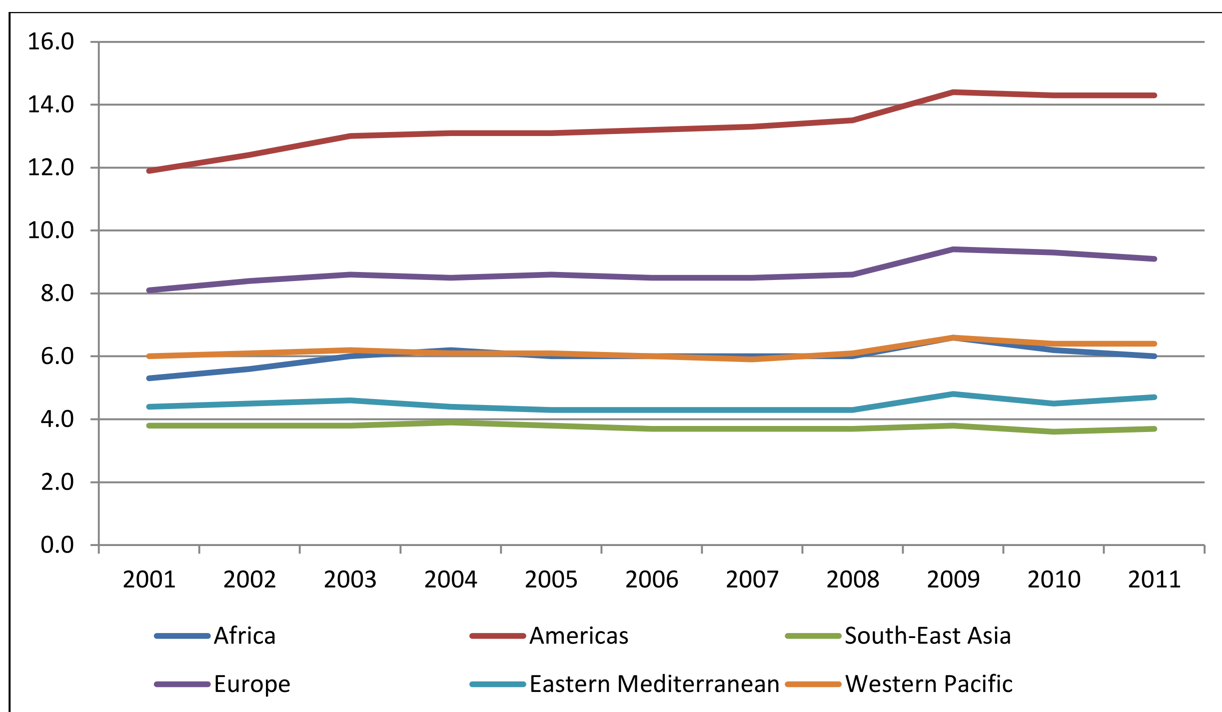
Although globally OOP remain high, some positive trends can be observed. Between 2001 and 2011, OOP as a percentage of total health expenditure decreased in all regions and country income groups (figure 3.7). At the same time, an increase in total health expenditure could be observed in all regions. Figure 3.8 demonstrates that the largest average growth – an increase from 11.9 to 14.3 per cent – occurred in the Americas.

Figure 3.7. **Development of OOP as a percentage of total health expenditure, by income level of country, 2001—11**



Source: ILO based on WHO Global Health Observatory, 2013.

Figure 3.8. Development of total health expenditure as a percentage of GDP, by region, 2001—11



Source: ILO based on WHO Global Health Observatory, 2013.

3.1.3. Governance and administration

In many countries, health systems and schemes are not sufficiently implemented with regard to governance and administration. Broad issues are concerned, including the absence of tripartite social dialogue as well as inefficiency in administrative processes such as registering members and dependents, collecting contributions, monitoring, and financial management and planning. In many countries the root causes of these issues include (Normand and Weber, 2009):

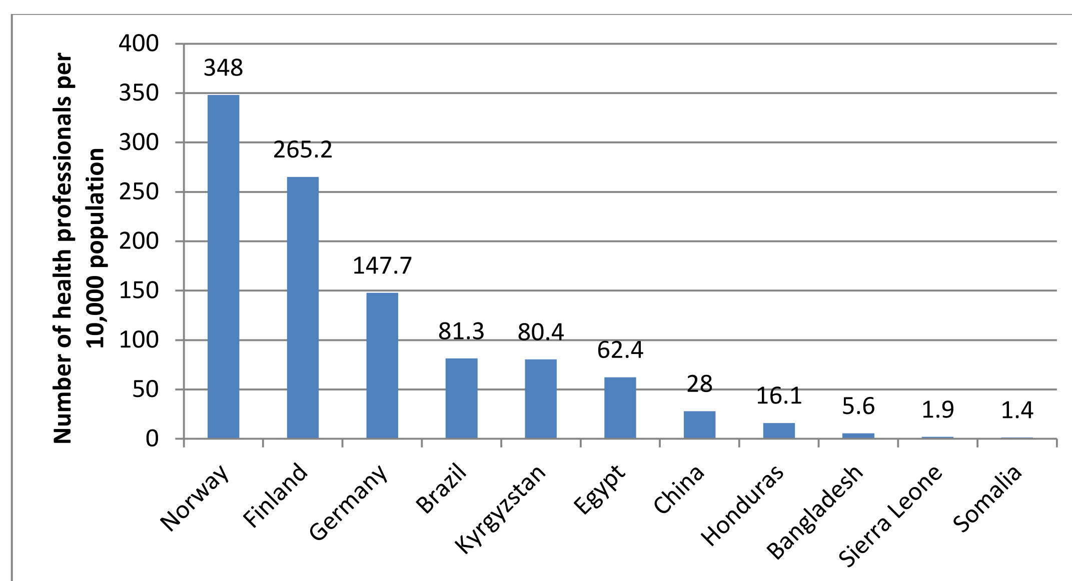
- *Inadequate staff management*. Improper recruitment procedures, inappropriate staff payment systems and lack of training and development opportunities affect the motivation and quality of workers employed by a health system.
- *Adverse financial management*. Improper management of reserves and bad investments may cause a lack of equilibrium in the health system.
- *Lack of accounting and frequent reporting*. Improper or insufficient recording of data becomes a major issue for accounting and reporting.
- *Insufficient monitoring*. In order to compare the status quo of a health system to that of others and to map progress towards universal coverage in health, monitoring is crucial.

All these inefficiencies have a severe impact on the functioning of health systems as a whole and may result in unnecessarily high expenditure levels and even deficits in health protection.

3.1.4. Skilled health workforce

The availability, acceptability, accessibility and quality of health care depends largely on the existence of a skilled health workforce that is sufficient in number and equally distributed within countries. However, the density of qualified health professionals varies widely, both between and within countries across the globe (figure 3.9).

Figure 3.9. Number of health professionals per 10,000 population, selected countries, 2013



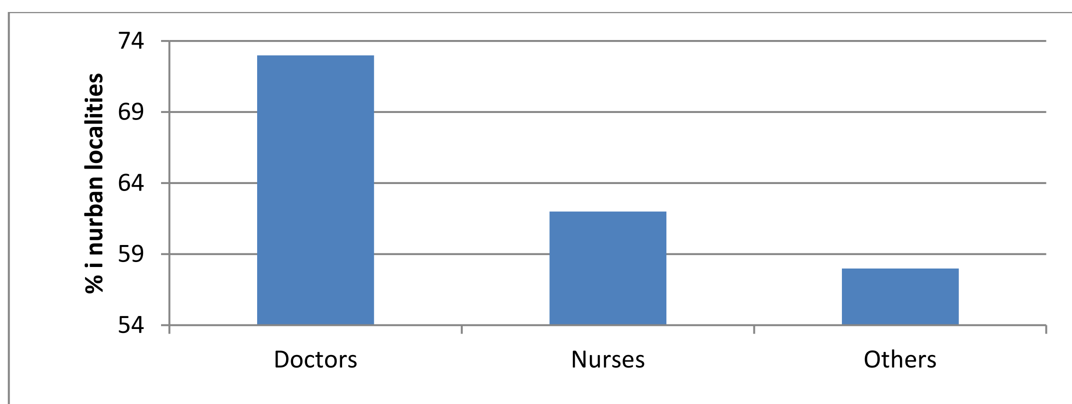
Source: ILO, LABORSTA, 2013.

While qualified health professionals in developed countries may be available in very high numbers, such as 348 and 265.2 per 10,000 population in Norway and Finland respectively, developing countries often suffer from large deficits in qualified health personnel. The countries of sub-Saharan Africa are the most heavily burdened with insufficient numbers of skilled health workers: for instance, Sierra Leone and Somalia have no more than 1.9 and 1.4 health professionals per 10,000 population respectively at their disposal. Based on recent estimations globally about 10.3 million skilled health workers are missing to provide at least essential quality services for all in need. (ILO 2014)

Within countries, also the distribution of health workers frequently poses an additional problem. Highly qualified health personnel are mostly concentrated in urban areas, while in rural areas the density is much lower (Global Health Workforce Alliance, 2012). For instance, in Bangladesh 45 per cent of childbirths in urban areas, but only 19 per cent of rural births, are assisted by skilled health personnel (Scheil-Adlung, 2013a).

Figure 3.10 illustrates the uneven global distribution of health workers between urban and rural regions. Worldwide, while 54 per cent of the world population live in urban areas, over 70 per cent of doctors, 63 per cent of nurses, and 59 per cent of other qualified health professionals are active in urban regions.

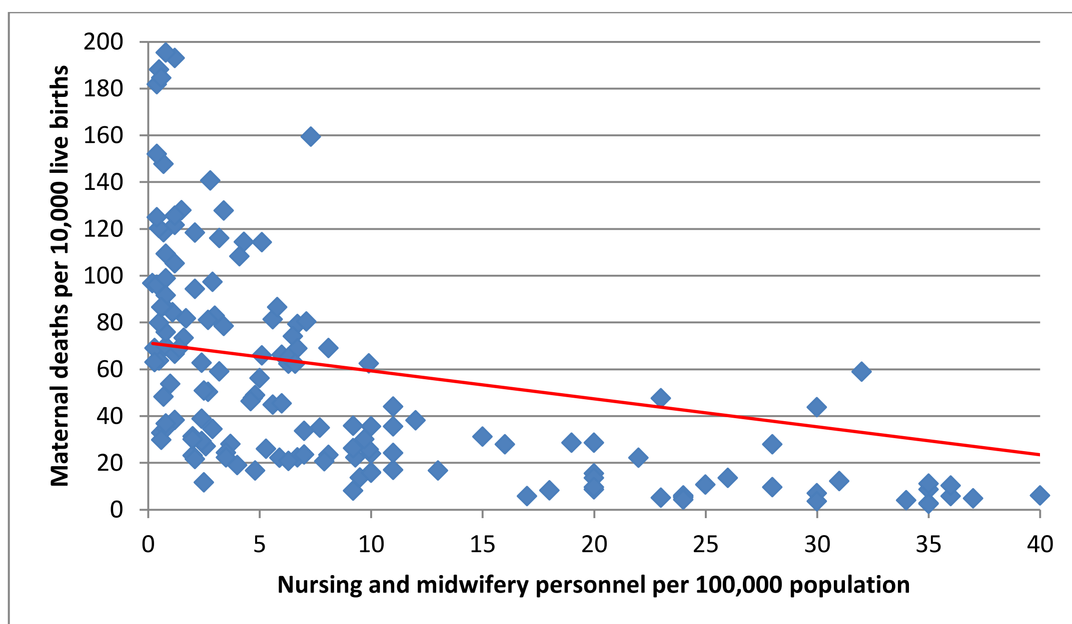
Figure 3.10. Rural–urban distribution of health service providers, 2006



Source: WHO, 2006.

The clear relationship between the health workforce density and health outcomes is reflected in the relationship between qualified nursing and midwifery personnel and the maternal mortality ratio (maternal death per 10,000 population) as shown in figure 3.11: A higher density of nurses and midwifery personnel in a country is associated with a significantly lower number of maternal deaths per 10,000 live births.

Figure 3.11. Number of nurses and midwifery personnel, and number of maternal deaths, per 100,000 population, 2013



Source: ILO, based on WHO Global Health Observatory, 2013.

In addition to the number of health workers, their wages and working conditions are an important factor having an impact on the availability, affordability and quality of services. Research carried out in several countries in Sub-Saharan Africa has demonstrated that the wages of health workers impact particularly on:

- motivation and performance, and the ability of employers to attract and retain health staff;
- the temptation to extract under-the-table payments from patients; and

- the temptation to switch to a different, better-paid job or to emigrate to another country where health workers' wages and working conditions are more favorable (McCoy et al., 2008).

Health workers' wages are very modest, especially in developing countries (ILO, LABORSTA, 2013; National Institute of Statistics, Rwanda, 2008). They are relatively low in comparison to the wages of other professions and in some cases not even sufficient to meet their basic needs. The quality of services delivered may consequently be suboptimal. In addition, low wages hinder the process of attracting and keeping sufficient staff of adequate quality.

3.2. Socio-economic impacts of gaps in health protection

3.2.1. Impacts at national level: Effects on health, poverty and employment resulting in economic costs for the society as a whole

Health protection consists of an economic sector with its own health industry and workforce, as well as unique financing mechanisms that have consequences at the national level. Thus, the population concerned by ill health (and their employers) are not the only beneficiaries of investments in health protection; the employment sector can also be considered as a stakeholder given the high shares of employment of the health workforce in total employment in many countries. On the other hand, gaps and deficits in health coverage may lead to significant costs for the society as a whole, because of:

- avoidable expenditure within health-care systems due to costs related to treatments for more severe health conditions and essential public health measures;

- increasing poverty rates due to high private health expenditure that is not shared in risk pools;

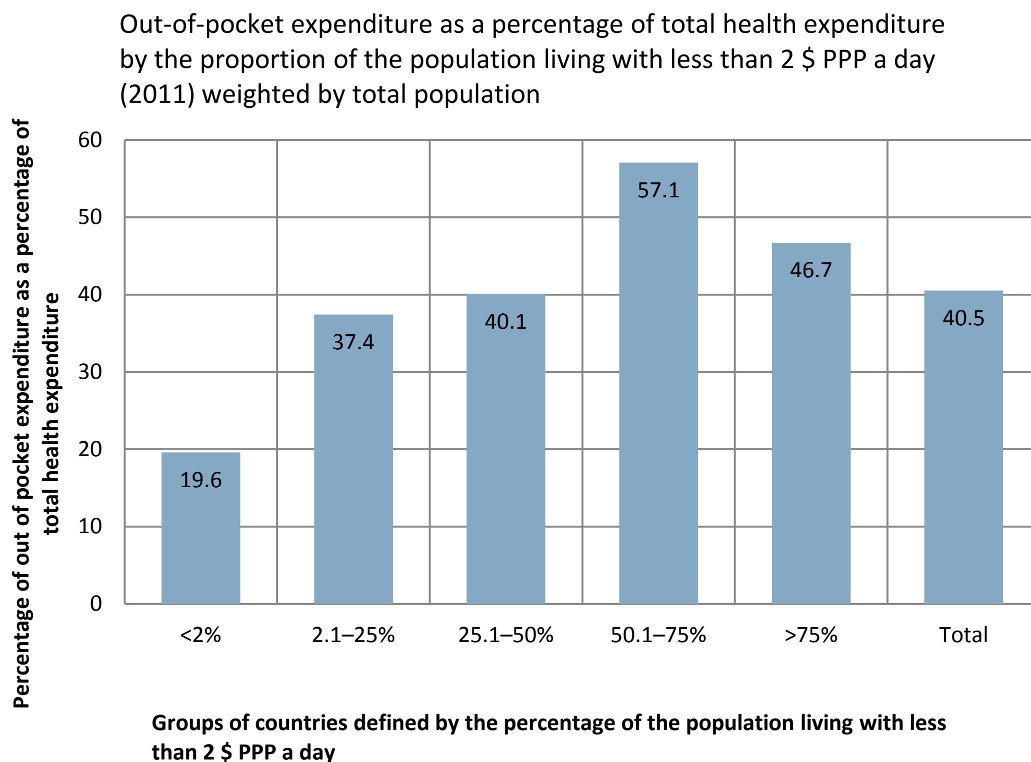
- productivity losses due to working while sick and to absenteeism;

- rising costs of social protection schemes such as disability, long-term care and social assistance/income support, due to increased risk of work accidents and development of chronic diseases, resulting in incapacity to work and impoverishment; and

- lower employment rates in the health and public sector.

The close relationship between poverty and high OOP can be observed in figure 3.12. In countries where more than 50 per cent of the population are living in poverty on less than US$2 a day, OOP reached levels of more than 50 per cent of total national health expenditure in 2010.

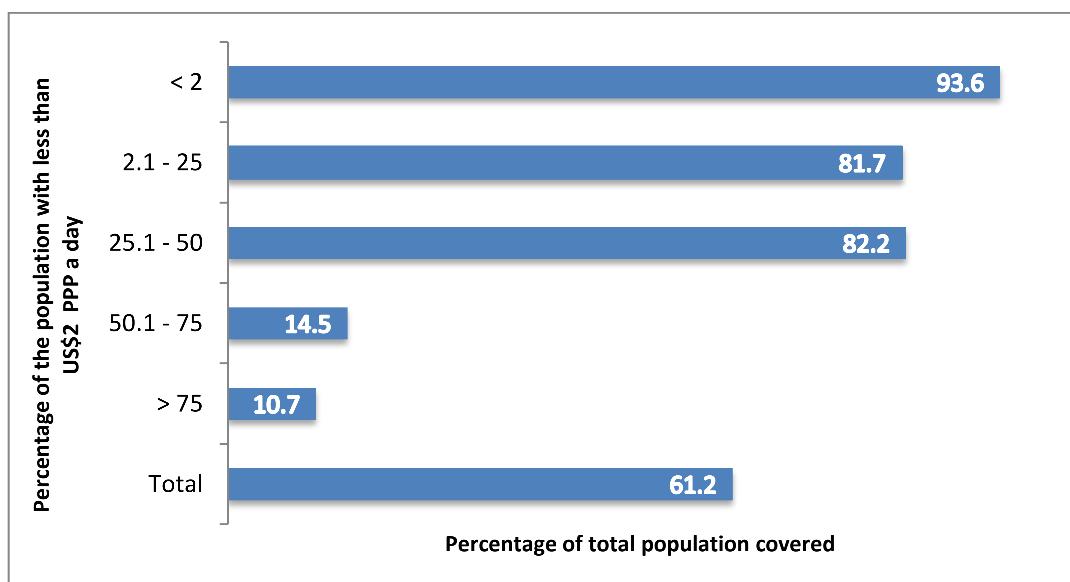
Figure 3.12. Out-of-pocket payments (OOP) by country level of poverty, 2011 (percentages)



Source: ILO, 2013a.

These developments most likely derive from gaps in legal health coverage, as we can see in figure 3.13. In countries where the majority of the population is living in poverty on less than US$2 a day, only about 10 per cent of the population have legal health coverage.

Figure 3.13. Legal health coverage to a health system or scheme, population living on less than US$2 PPP a day (percentages)

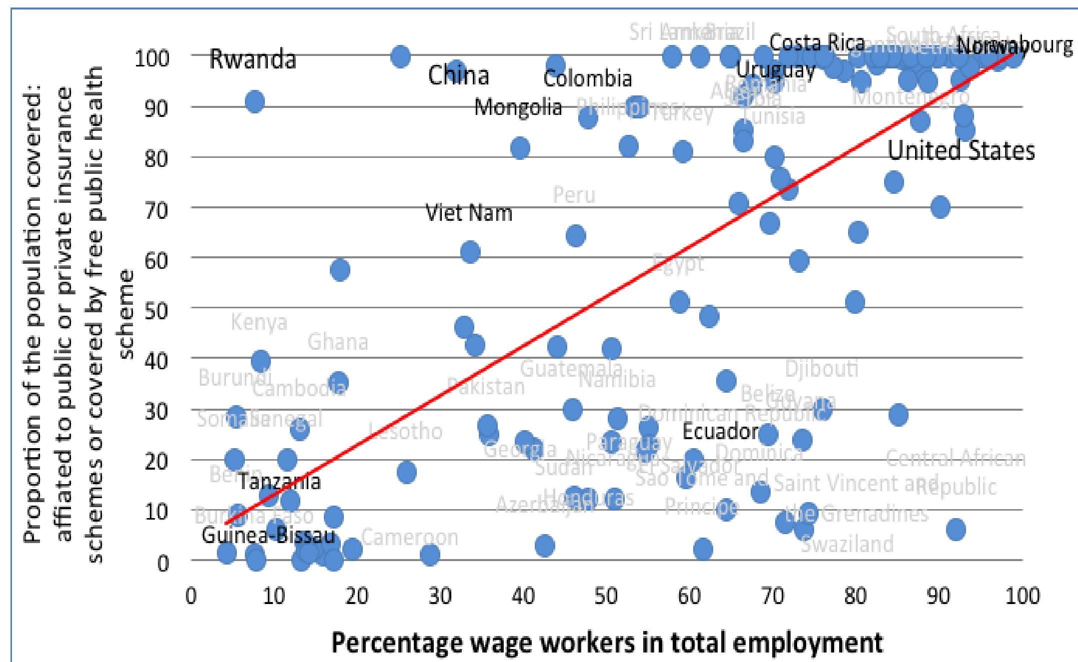


Source : ILO, 2013a

Limited levels of formal employment are also closely related to coverage and thus access to essential care. Figure 3.14 demonstrates the association between the share of workers in

formal employment, using wage workers as a proxy, and the proportion of the population with legal health coverage. Increasing shares of formal employment are correlated with higher levels of legal coverage.

Figure 3.14. Legal health coverage and proportion of wage workers in total employment



Source: ILO, latest available data.

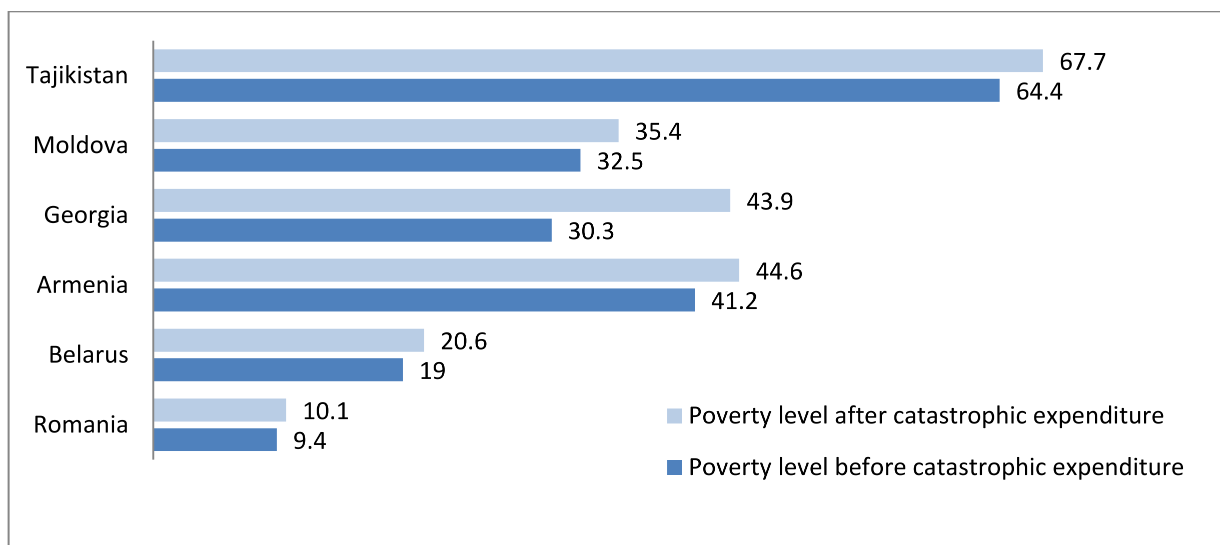
3.2.2. Impacts at individual and household level: Inequities in coverage and access to health care

Impoverishment due to OOP

OOP are often due to gaps in legal coverage and benefit constraints that exclude necessary treatments, medicines or other important health care. High OOP affect the accessibility of care by making it less affordable, deterring individuals from seeking care in spite of ill health. In addition, OOP may push households into poverty or deepen existing poverty, particularly the worst form of OOP: catastrophic health expenditure, defined as health expenditure exceeding 40 per cent of a household's income net of subsidies.

Figure 3.15 illustrates the impoverishing effects of catastrophic health expenditure. In six Eastern European and Central Asian countries, poverty levels increased significantly after catastrophic expenditure, for example by 13.6 percentage points in Georgia. Health shocks – unpredictable illnesses that diminish health status – are frequently the cause of catastrophic OOP. In combination with income loss resulting from an inability to work, OOP have the potential to bring households into financial ruin. An example is rickshaw pullers in Bangladesh: health-related shocks form the most potent trigger of downward mobility for this occupational group (Begum and Sen, 2005).

Figure 3.15. Poverty levels before and after catastrophic health expenditure, selected East European and Central Asian countries, 2010



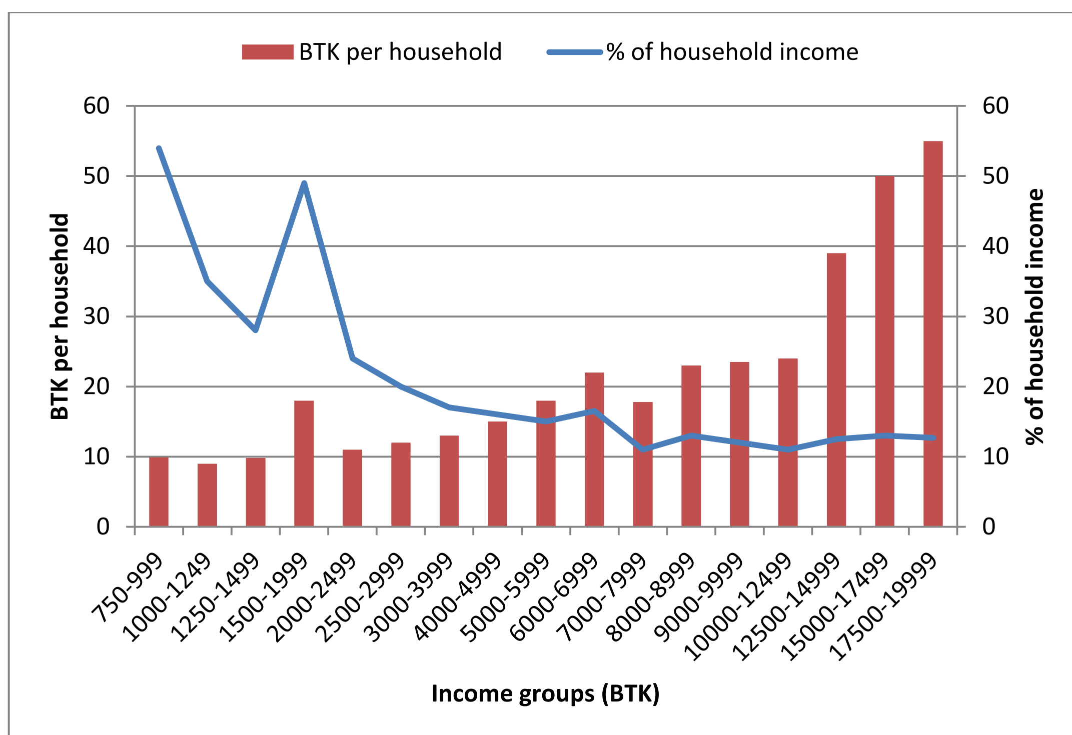
Note: Data from most recent household survey, poverty line used is US$2.15 at 2000 PPP.

Source: World Bank, 2010a.

In Asia, households in Cambodia are among those experiencing the highest OOP in the region. In any given month during 2007, medical spending pushed 4.1 per cent of households below the poverty line. Also during this year, 5.6 per cent of families were forced to spend more than 25 per cent of their household income on medical treatment costs, indicating that, in addition to its severity, the frequency of OOP was high (Anuranga et al., 2012).

Research in Bangladesh has shown that the burden of OOP is spread unevenly over different income groups (figure 3.16). In absolute terms, those households most well-off spent significantly more on OOP in 2005. However, in relative terms, the poorest 25 per cent of households spent between 20 and 55 per cent of their household income on OOP compared to 13 per cent for the top 25 per cent income groups (World Bank, 2010b).

Figure 3.16. Bangladesh: Out-of-pocket expenditure, by income group, 2005

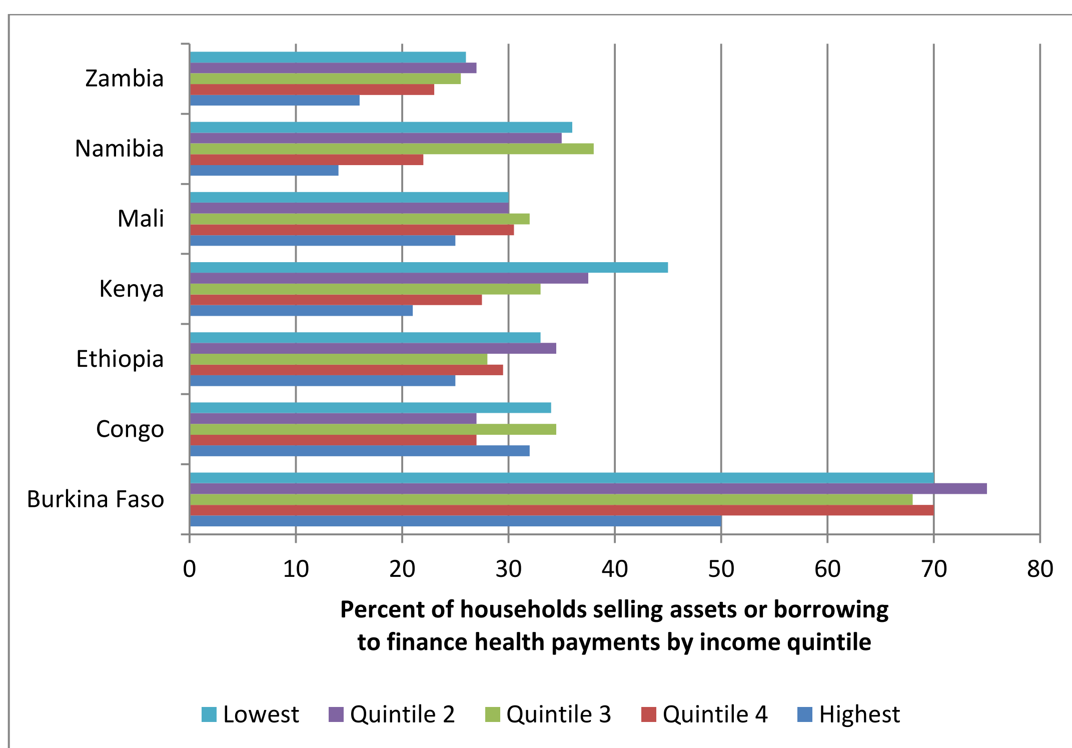


Note: TK = Bangladeshi taka (BDT).
Source: World Bank, 2010b.

When experiencing high OOP, households need to find ways of generating money. In the short run they may use savings, sell assets, borrow from friends and family or take out a loan. In seeking longer-term solutions, household members may opt for getting children into work, which may result in children being withdrawn from school (UNDP, 2013a).

Figure 3.17 shows the percentage of households in selected African countries selling assets or borrowing money to finance their health expenditures and cope with medical bills. In nearly all countries, fewer households in the richest quintile were affected compared to lower quintiles. This is in line with the previous findings in Bangladesh, indicating that poorer households carry a heavier burden of OOP (Leive and Xu, 2008).

Figure 3.17. Coping with health care expenditure through selling assets and borrowing, by household income level, selected African countries



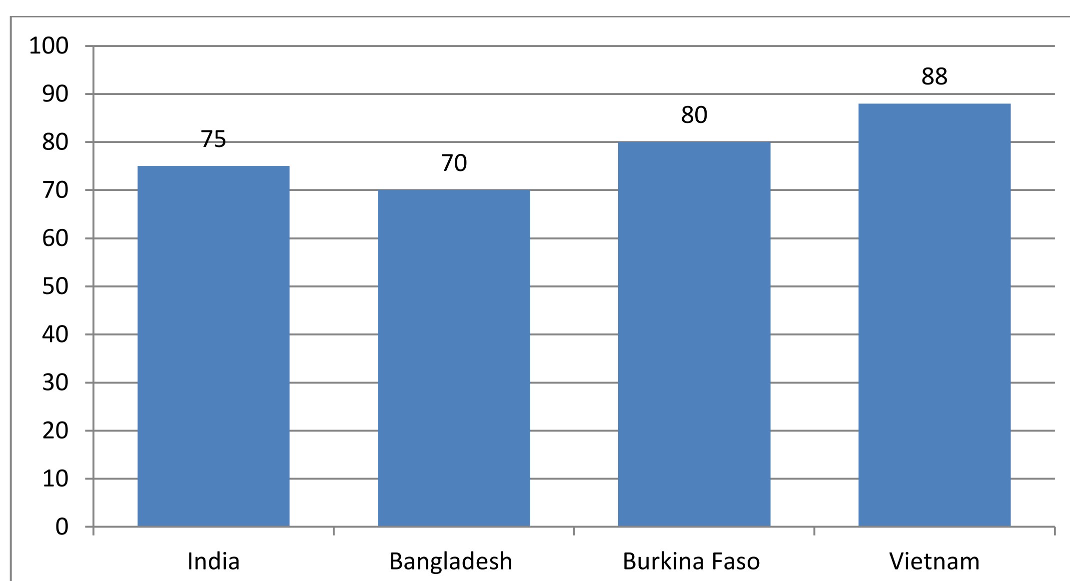
Source: Leive and Xu, 2008.

Among the most important causes of OOP are limitations of benefit packages and low quality of services covered, resulting in health services and goods that are not financially protected but instead have to be paid for directly to the service provider by the individual.

An example of limitations in benefit packages relates to pharmaceutical drugs, i.e. medicines that are only available on written prescription from a doctor, dentist or pharmacist. In low- and middle-income countries, prescription drugs represent one of the most significant components of health-related OOP, accounting for 26 to 63 per cent of the total and often caused by exclusion from benefit packages. This is one of the most important reasons for catastrophic health expenditure (see for example Wirtz et al., 2012 on Mexico).

Figure 3.18 shows the percentage of health expenditure for pharmaceutical drugs by households in four developing countries. While in Bangladesh it amounts to 70 per cent of household health expenditure, it exceeds 88 per cent of health expenditure for Vietnamese households. Poorer households not only spend proportionally more on medicaments because of their lower incomes, but are frequently also paying the highest OOP for them in absolute terms, due to the fact that the public sector in developing countries is often unable to provide affordable medicaments in a reliable way (UNDP, 2005).

Figure 3.18. Expenditures on pharmaceutical drugs as a percentage of households' health expenditures in four developing countries, 2003



Source: Wirtz et al., 2012.

The magnitude of the burden of OOP for medicaments, as well as its heavier weight on the poor in relative terms, can also be illustrated using findings from Brazil (table 3.1). On average, OOP account for 60.6 per cent of family OOP for health care in the wealthiest income decile, but up to 82.5 per cent in the poorest decile.

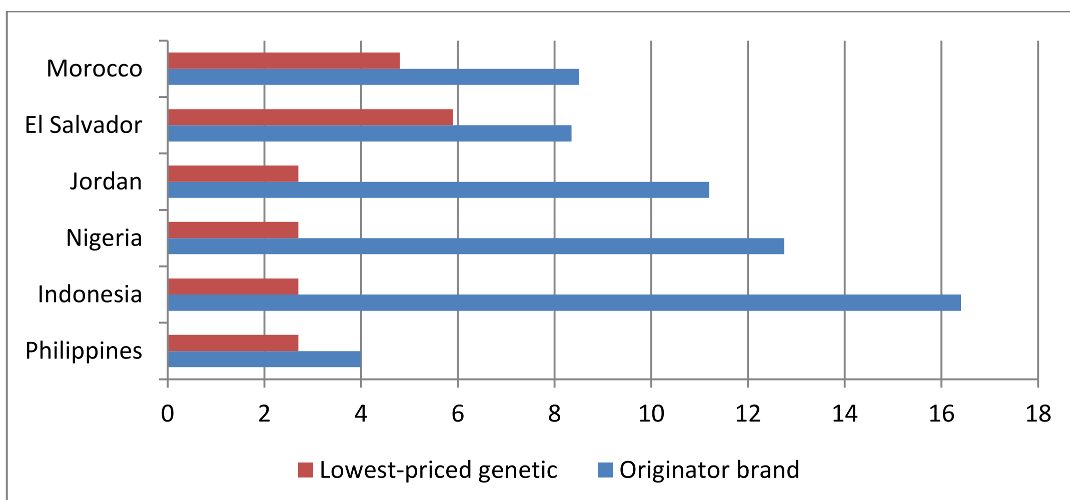
Table 3.1. Brazil: Distribution of direct family per capita OOP for health care, by income decile, 2007 (percentages)

	Family per capita income decile (from lowest to highest)							
Health spending item	1	2	3	4	5	6	7	8
Medicaments	82.5	73.4	72.4	72.1	67.6	65.8	62.9	60.6
Dental treatment	2.2	5.4	7.3	6.7	8.6	8.8	12.3	14.4
Physician appointments	5.3	6.5	6.2	6.2	7.3	8.3	7.8	8.5
Out-patient treatment	0.5	0.7	0.7	0.5	1.2	0.8	0.8	0.9
Hospitalization & surgical services	0.5	1.4	2.1	3.3	3.4	3.9	4.4	2.5
Other	9.1	12.6	11.3	11.2	12	12.3	12.1	13

Source: Dominguez Ugá and Soares Santos, 2007.

The catastrophic impact of OOP for medicaments on households is further revealed in terms of work needed to generate sufficient income to afford them. Figure 3.19 shows the number of day wages needed to purchase respiratory infection medicaments in six countries, using the average wage of the lowest-paid government officials as a reference. As such officials are not usually in the category "poor", the figure shows that medicaments – especially those of highest quality, i.e. originator brand – can become unaffordable for the lowest income groups.

Figure 3.19. Affordability of medicaments: Number of day wages needed to purchase respiratory infection medicine (Ciprofoxacin)

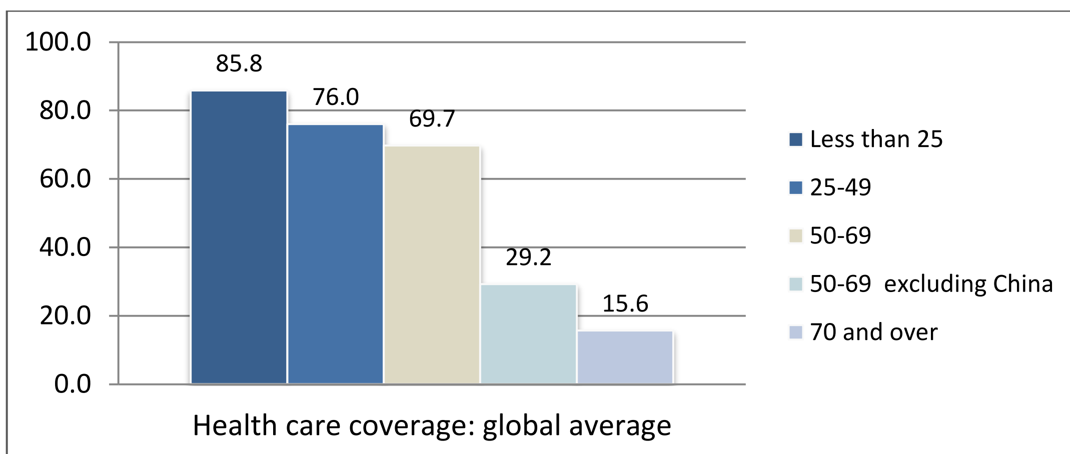


Note: Lowest-paid government worker's wage is used as reference.
Source: WHO, 2011a.

Geographic inequities

The principle of universality of social protection provisions implies that geographic location should not play a role in access to health care for those in need (ILO Recommendation No. 202, para. I. 3(a)). Nevertheless, significant geographic inequities persist in access to health care, mainly related to gaps in availability. In many countries health-care facilities tend to be concentrated in urban areas, resulting in higher barriers to access for those living in rural areas (figure 3.20).

Figure 3.20. Global rural population with legal health coverage (percentages)



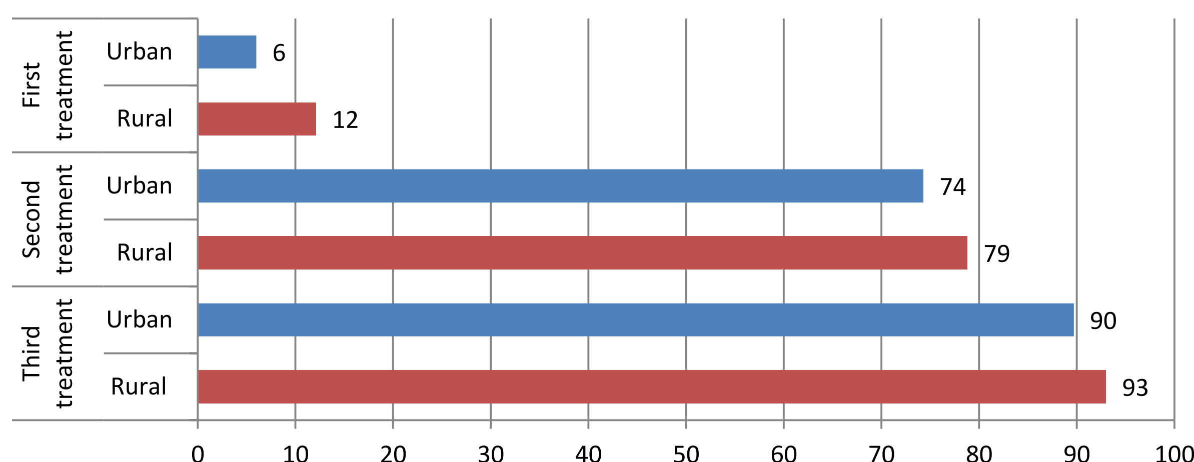
Source: Scheil-Adlung, 2013a.

Barriers in access to health care for rural dwellers become obvious when analysing the urban/rural differences in coverage and utilization rates of health care. At the global level, the percentage of the population covered is negatively correlated with the extent of the rural population. While coverage rates exceed 85 per cent of the population living in countries where less than 25 per cent are living in rural areas, only 15.6 per cent are covered in countries where rural populations exceed 70 per cent (Scheil-Adlung, 2013a).

In addition to, which refers to rights and entitlements, place of residence is often an explanation for gaps in effective access to health care. In general, infrastructure and availability of health professionals act as indicators of effective access. In Ghana, for instance, 25 per cent of the population live over 60 kilometres away from a health facility attended by a doctor (Salisu and Prince, 2008). In the United Republic of Tanzania, long distances to health facilities with adequate staffing deprive those in need of care: the main reason why 44 per cent of women are unable to give birth in a health facility is that they live too far away from an adequate facility to reach it in time (Perkins et al., 2009).

A survey in Cambodia illustrated that place of residence has a significant impact on the choice of whether or not a person will seek medical treatment (figure 3.21). Of those who were ill or injured in the 30 days before they became a respondent to the Demographic and Health Survey (DHS), only 6 per cent in urban areas did not seek care, while in rural areas the number was twice as high. The number of persons not seeking a second or third treatment was also significantly higher for rural dwellers.

Figure 3.21. Cambodia: Urban and rural household members not seeking treatment, 2005 (percentages)



Note: Ill or injured in the 30 days preceding the Demographic and Health Survey.
Source: DHS Cambodia, 2005.

In turn, within urban regions certain subgroups are at least as deprived of access to adequate health-care services as their rural counterparts. This is largely due to rapid urbanization resulting in an increasing number of rural-to-urban migrants living in slums, where access to basic services such as sanitation, education and health care is very limited. These urban poor often fare worse than rural dwellers with regard to access to such services.

Table 3.2 shows that in Bangladesh, 21 per cent fewer births in urban slums are assisted by a skilled birth attendant than in rural areas, indicating lower availability and quality of health workers. As a result, the under-5 mortality rate (U5MR) is 44 per cent higher in slums (UNICEF, 2010).

Table 3.2. Bangladesh: Birth assistance and under-5 mortality rates, urban/rural/slum populations, 2010

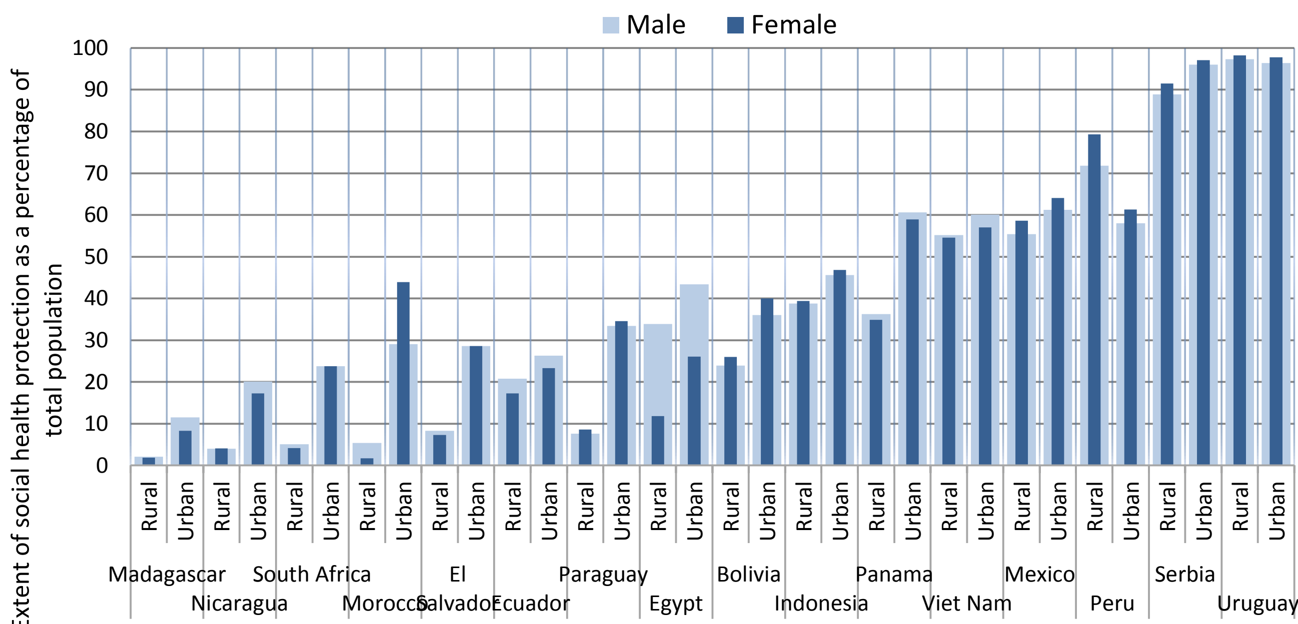
Indicator	Urban	Rural	Slums	Slum worse than rural
Skilled attendance at birth	45	19	15	-21
U5MR (per 1,000 live births)	53	66	95	44

Source: UNICEF, 2010

Gender-related inequities

In addition to geographical inequities, inequities in access for men and women can be observed in many countries, as shown in figure 3.22.

Figure 3.22. Legal health coverage as a percentage of total population, by sex and area of residence, selected countries, latest available year



Source: ILO, 2013a.

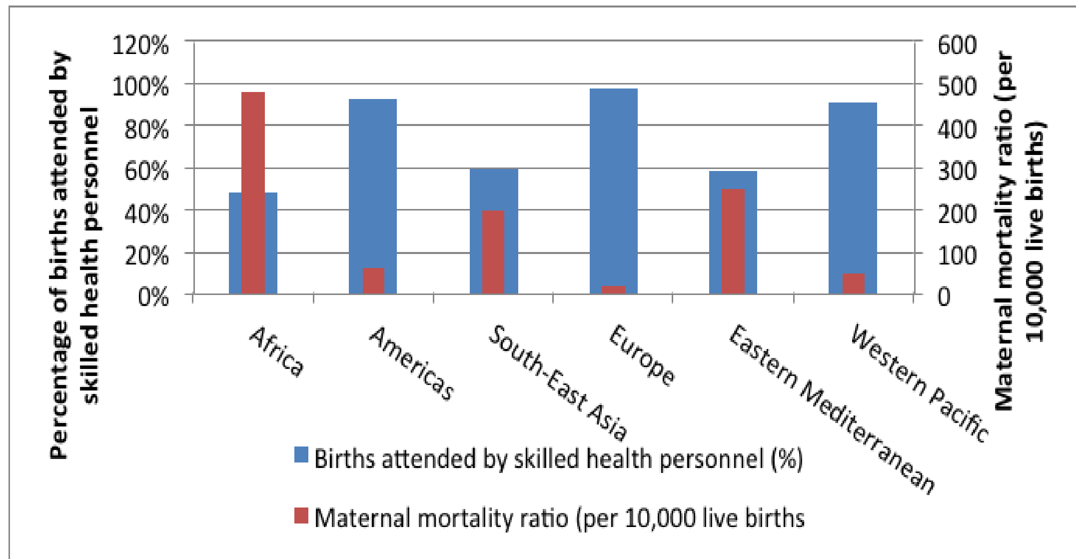
In most countries there is lower coverage for women than for men, with the most significant difference being found in Egypt.

Millennium Development Goal (MDG) No. 5, which focuses on improving maternal health, has been reported as the most off-track of all MDGs. In 2010, 287,000 maternal deaths occurred globally, corresponding to a 47 per cent decline in maternal mortality since 1990. Sub-Saharan Africa and South Asia accounted for 85 per cent of these deaths (UNFPA, 2012). Many of these countries are unlikely to reach the first target of MDG 5 of reducing maternal mortality rates by 75 per cent by 2015. The maternal mortality ratio in developing regions has decreased since 1990 from 440 maternal deaths per 100,000 live births to 240 in 2010 (UNDP, 2013b). Nevertheless, this ratio remains 15 times higher than in developed countries.

In addition to improving maternal health, MDG 5 aims at universal access to reproductive health. Globally, between 2000 and 2010 78 per cent of pregnant women received antenatal care once during pregnancy, but only 53 per cent received the minimum of four visits as recommended by the World Health Organization (WHO, 2011b). The lack of antenatal and delivery care is almost completely concentrated among the poor. A study of 65 countries demonstrated that over 85 per cent of the wealthiest quintile of the population use antenatal and delivery assistance, but only 55 and 22 per cent of the poorest population have access to antenatal and delivery care respectively (Houweling et al., 2007). Moreover, the few facilities offering these treatments tend to be concentrated in better-off urban areas, while many of the poor live in rural areas or slums.

Since 1990, the proportion of births in the world attended by a skilled health professional has increased from 55 to 78 per cent in 2011. The regions with the lowest proportion of births attended by a skilled health professional also have the highest maternal mortality, as can be seen in figure 3.23.

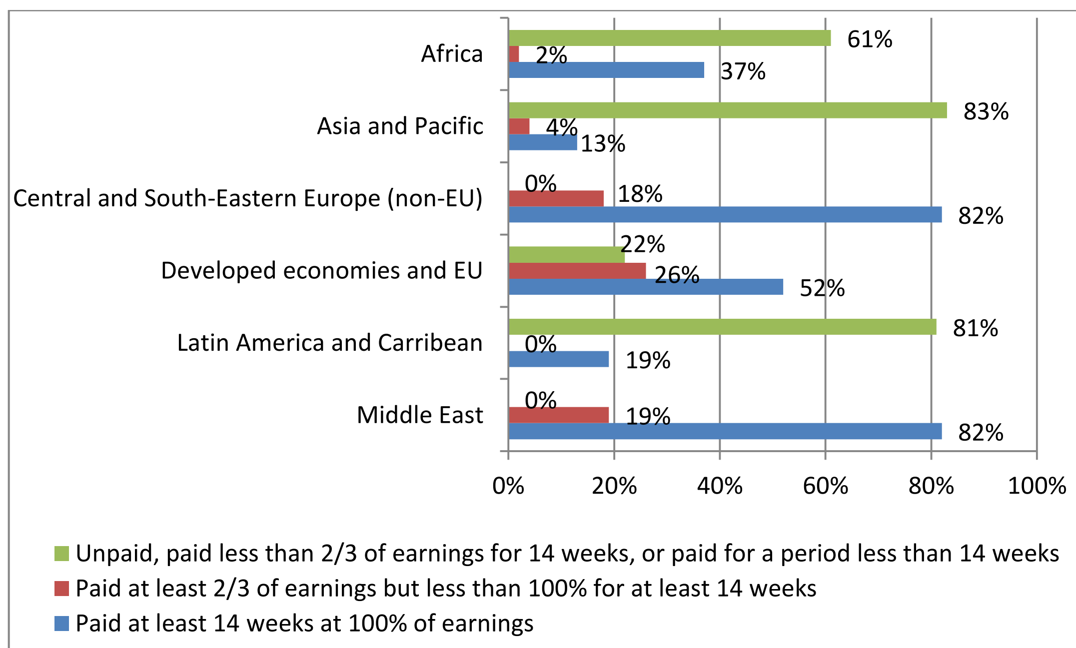
Figure 3.23. Births attended by skilled health personnel (2011) and maternal mortality ratio per 100,000 live births (2010), by region (percentages)



Source: ILO, based on WHO Global Health Observatory, 2013.

Further, access to maternity leave and related cash benefits provided to women working in the formal economy vary significantly between different regions (figure 3.24). Only 37 per cent of female workers in Africa receive paid maternity leave at 100 per cent of last earnings, as compared to 52 per cent of female workers in developed economies and 82 per cent in the Middle East.

Figure 3.24. Maternity: Cash benefits and duration of leave, by region (152 countries), 2009 (percentages)



Source: ILO, 2010b.

Moreover, the scope of maternal benefits appears to be severely limited for many women. In the Republic of Moldova, for instance, more than 50 per cent of women who received antenatal care did not receive any reimbursement for the expenses incurred; only 20 per cent received full reimbursement either by an insurance scheme or the Government (ILO, TRAVAIL database, 2011).

Age-related inequities

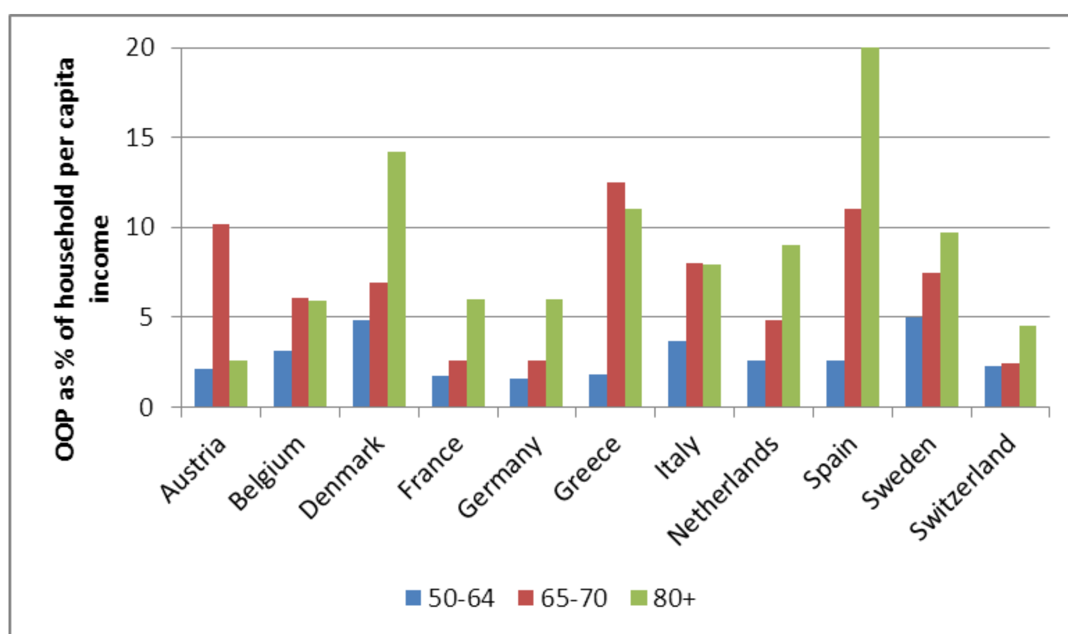
Since 1950, the number of people aged over 60 has increased rapidly in all regions of the world, resulting in a global increase in life expectancy by 2.7 years in 1950−55 to 4.5 years in 2005−10 (UNDESA, 2012). Reductions in mortality have resulted from improved agriculture that has increased food quantity; knowledge of disease transmission; and effective public health interventions that have controlled communicable diseases such as malaria (Jack and Lewis, 2009). Life expectancy is also substantially higher among females than among males.

These demographic changes are resulting in a rapid ageing of populations around the world, leading to increasing global demand for health care for the elderly – particularly women in the view of their higher life expectancy. Public expenditures on health care for the elderly are consequently growing at a rapid pace, putting public budgets increasingly under pressure. Projections forecast that life expectancy will continue to rise, accompanied by further rises in health expenditure for this age group (UNDESA, 2012).

Although the economic impacts of ageing and the related shares of total health expenditure have been analysed in depth, the socio-economic consequences of gaps in health protection of elderly households have not been in focus. The fact that older persons are more likely to experience health shocks, cost-intensive chronic illness, and frequently functional impairments compared to their younger counterparts may result in a significant monetary burden (Scheil-Adlung and Bonan, 2012).

Among the elderly, the oldest age groups are challenged by the highest OOP. Figure 3.25 shows that in many European countries individual OOP for health care increases with age. Although expenditure shares vary between different countries, persons aged 80+ spend a significantly larger share of their household per capita income on OOP for health care than younger cohorts in almost all selected countries.

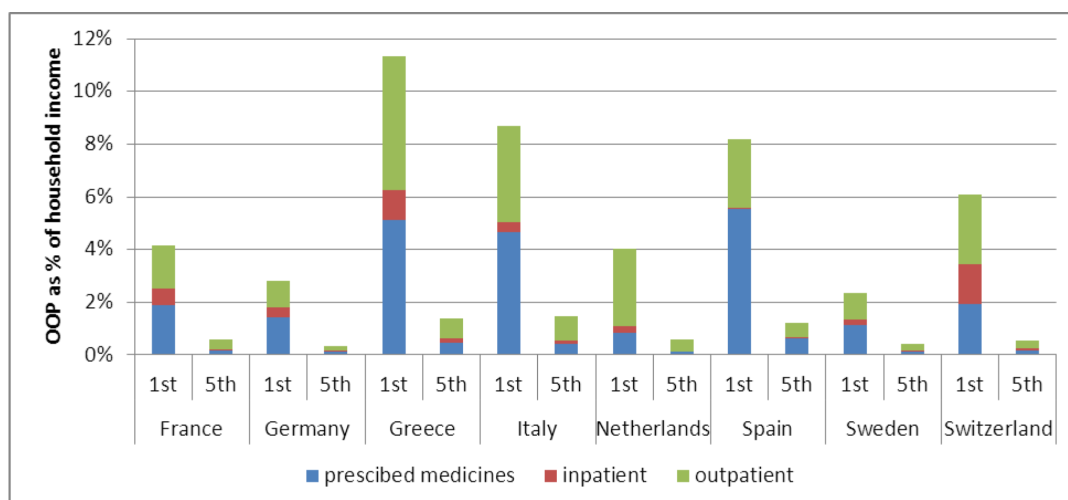
Figure 3.25. Out-of-pocket payments (OOP) as a share of household per capita income, by age cohort, selected European countries, 2004 (percentages)



Source: Scheil-Adlung and Bonan, 2012.

Poor elderly households are the most heavily affected by OOP for health care in the countries selected for figure 3.26. Although absolute OOP expenditures are often higher for higher income quintiles, they constitute a much larger part of household income for the lowest income quintiles. In most countries the main part of OOP health expenditure among the elderly is constituted of either costs for prescribed medicines or out-patient care. In Belgium and Spain, pharmaceutical drug expenses make up over 50 per cent of total OOP, whereas in Greece it is out-patient care that accounts for almost 50 per cent (ibid.).

Figure 3.26. Elderly household OOP for different health-care items as a share of household income, by household income quintile, selected European countries, 2004 (percentages)



Source: Scheil-Adlung and Bonan, 2012.

In addition to the need for health care, many of the elderly have an increasing need for long-term care (LTC). In spite of this, the scope of covered benefits for LTC is frequently limited (WHO, 2007). Constraints result from extremely high cost-sharing rates and

missing interfaces between social and medical services in countries such as Austria, Canada, Finland, Germany, Republic of Korea, Portugal and Spain (OECD, 2011).

Inequities for workers in the informal economy, migrants and ethnic minorities

Health coverage and access to care remain comparatively limited for workers in the informal economy, migrants and ethnic minorities. A variety of underlying causes are responsible for the coverage and access gaps experienced by these groups: for example, minorities such as Roma. Besides discrimination, a lack of coverage such as in health insurance, lack of documentation providing access to national health systems, geographic isolation from quality care, as well as other obstacles frequently deprive Roma from access to necessary care (Földes and Covaci, 2012).

While documented migrants are usually covered under national regulations, this is not the case for undocumented migrants or workers in the informal economy. They can hardly effectively access needed care without revealing their identity and providing official papers (Stanciole and Huber, 2009).

Figure 3.27 provides an overview of gaps in legal coverage and access of Roma and migrants in the European region:

- Eleven per cent of Roma women were denied access to treatment due to documents lacking.
- In Bulgaria and Romania 46 and 37 per cent respectively of Roma lack health insurance.

Informal-economy workers and migrants frequently experience similar barriers to necessary health care due to exclusion through financial barriers and formal rules, including the need to provide formal documentation.

Figure 3.27. Europe: Gaps in legal coverage of Roma and migrants

	Roma
European region	11% of Roma women were denied access due to lack of documents
Bulgaria	46% of Roma have no health insurance
	30% of Roma women over the age of 15 have no insurance
Romania	37% of Roma have no insurance

	Migrants
United Kingdom	47% of all migrants are without coverage in standard employment-based social health protection
Deficits in legal coverage often due to	Financial barriers
	Gaps in adequate services
	Excluded from access by formal rules
	Missing or incomplete documents

Source: EDIS SA, 2009; Krumova and Ilieva, 2008; European Roma Rights Center, 2006.

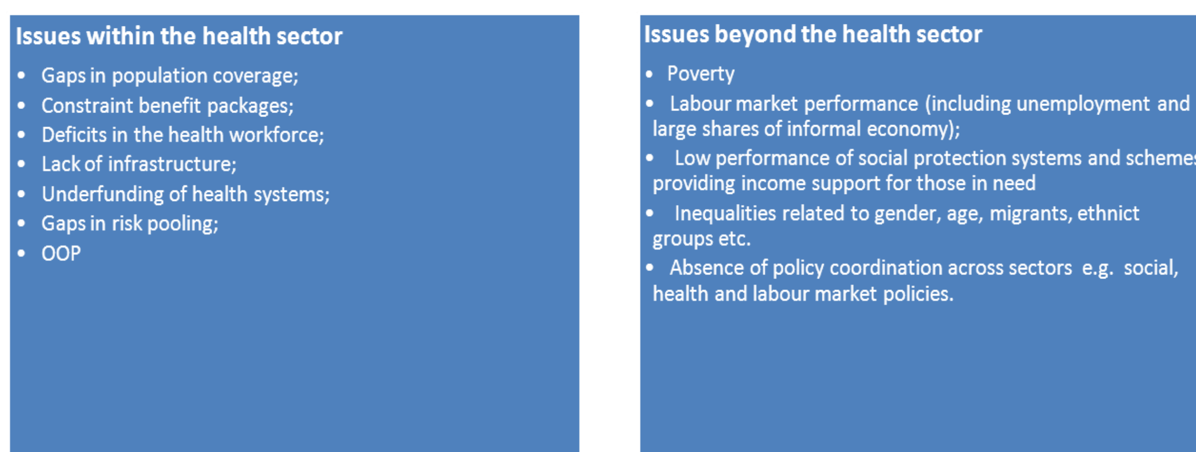
3.3. Root causes of deficits in health protection

The causes of deficits and gaps in coverage and access to essential health care are manifold. They range from issues directly related to the health system, such as gaps in availability of services, to issues far beyond the health sector, such as employment status and missing documents.

Figure 3.28 provides a broad typology of root causes of access gaps both within and beyond the health sector. Within the health sector, key issues relate to the absence of rights-based approaches, resulting in coverage gaps that force people to pay all health expenditure out-of-pocket. But even where coverage exists, many issues can be observed. In particular, gaps in availability, affordability, quality and financial protection of health care due to:

- the design of benefits packages, e.g. limitations in the scope of benefits excluding necessary treatments;
- gaps in health workforce density, uneven distribution of qualified health workers, and indecent working conditions including no or low wages;
- insufficient infrastructure impacting on the accessibility of health facilities;
- underfunding of health systems and schemes impacting on quality; and
- out-of-pocket payments (OOP), i.e. payments to be made at the point of service delivery, such as user fees, co-payments and transport costs, often exceeding a household's capacity to pay.

Figure 3.28. Root causes of coverage deficits and access gaps: A typology



Source: Scheil-Adlung, 2013a.

Issues beyond the health sector often relate to the socio-economic context in which a health care system operates, particularly:

- poverty levels;
- labour market performance: income levels, employment and status, and whether or not an individual is active in the informal sector;
- deficits in poverty alleviation due to gaps in, for example, income support aiming at addressing rural and urban poverty; and
- inequalities related to gender, age, ethnic groups and others.

Addressing these issues in a coherent way requires a level of policy coordination across sectors that is absent in many countries. Policy coherence should aim at creating sustainable progress towards universal coverage in health. This entails overcoming traditional policies that focus on solving problems within single sectors, schemes or

systems. A shift is required towards policies that simultaneously address deficits in the health sector, schemes and systems as well as the socio-economic contexts in which they are operating. Such policies should be implemented with a view to supporting vulnerable groups, such as poor women, the elderly and persons with special health-care needs. Further, developmental, health, economic and labour market policies need to be aligned so as to promote employment and the transition from informal economies. Policy coherence across sectors, particularly the health, social and economic sectors, has the potential to result in economic growth and is an important precondition for the sustainable development of countries.

4. Moving towards Equity: National Social Protection Floors as a key strategy for achieving universal coverage in health

The ILO Social Protection Floors Recommendation, 2012 (No. 202) can serve as a guideline for achieving sustainable universal coverage in health. It aims at:

- establishing and maintaining SPFs as a component of their national social security systems; and

- extending SPFs to progressively ensure higher levels of protection to as many people as possible (para. I. 1(a)).

It also sets out the principles underlying SPFs, outlines strategies for the extension of social protection, and describes how to monitor progress in implementing SPFs.

4.1. Objectives, scope and principles

In order to achieve universal access to essential health care a comprehensive policy concept should be applied. The most relevant aspects of such an approach are outlined in Recommendation No. 202. It refers to basic social security guarantees that should be available to all in need. These guarantees ensure that as a minimum, over the life cycle, individuals have access to essential health care and basic income, which together secure effective access to goods and services.

Basic social security guarantees consist of (1) in-kind benefits, constituting essential health care and meeting the criteria of availability, accessibility, acceptability and quality; and (2) cash benefits providing basic income security for children, persons of active age and older persons (see key aspect 4.1). Related benefits include health, maternity, sickness and disability, old-age, unemployment, employment injury, and survivors' benefits, as well as employment guarantees and any other social benefits that are in cash or in kind (para. II. 9(2)).

Key aspect 4.1

Social Protection Floors Recommendation, 2012 (No. 202), Paragraph 5

[…] social protection floors […] should comprise at least the following basic social security guarantees:

1
a. Access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;

2
b. Basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;
c. Basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
d. Basic income security, at least at a nationally defined minimum level, for older persons.

Note: Authors' emphasis.

Basic social security guarantees should be established by law. They should define the range, qualifying conditions and benefit levels. Benefits should include essential health care and basic income security, allowing for a life in dignity. This implies a monetary value of benefits corresponding to a set of necessary goods and services, or the national poverty line, or other thresholds, taking into account regional differences in the cost of

living. They should be regularly reviewed through a transparent procedure, which should equally be statutorily defined (para. II.7/8).

In addition to designing adequate benefit schemes, preventive, promotional and active measures should be taken, such as promoting productive employment in the formal economy through policies that include public procurement and promote education. Together, these measures aim at preventing or alleviating poverty and social exclusion.

When establishing national social protection floors, countries should take into account a number of policy principles (see key aspect 4.2). First, health provisions should be **universal in nature**, meaning that the whole population in a country, independent of income situation, area of residence or other criteria, should have access to essential health benefits of adequate quality. Essential health benefits are to be defined with a view to the country's contexts at the national level, taking into account both nationally and internationally agreed objectives. In addition to essential health-care benefits there should be provision for protection from income loss and impoverishment due to poor health.

Key aspect 4.2

Principles of social protection provision

- Universality of protection
- Solidarity in financing
- Non-discrimination
- Social inclusion
- Responsiveness to special needs;
- Respect for the rights and dignity of people covered

Note: The above list is not exhaustive. Further principles pursued by the ILO for the establishment of social protection floors in general and social protection provision in particular are listed in Recommendation No. 202.

Guarantees in the context of SPFs should be based on **solidarity in financing**. This implies that the individual's ability to pay is taken into account and financial hardship is avoided. This is best achieved by using risk pooling. Related financing mechanisms include tax funding, income-related contributions, risk-related premiums and a country-adjusted mix of these options.

Furthermore, **vulnerability and social exclusion** should be addressed. These act as catalysts of inequities affecting the affordability and accessibility of health care for sometimes large population groups. A number of principles provide the basis for addressing exclusionary processes such as discriminatory behaviour and for contributing to financial empowerment. They specifically include non-discrimination, social inclusion, responsiveness to special needs, and respect for the rights and dignity of people covered.

Discriminatory practices within societies lead to exclusionary behaviour and may constitute a barrier to accessing health care for certain groups, for instance through unequal employment opportunities, lack of decent work, unequal pay, etc., as well as through direct limitations in access to health care. The elimination of such practices to ensure **non-discrimination** is a long-term process, as they are often rooted in cultural values and norms engrained in society as a whole. Policies aiming at dissolving discriminatory practices should address various levels, including the legislative and regulatory. Political will and social mobility are prerequisites for progress in this respect.

An example of discriminatory practices relates to inequities for women, who continue to face barriers to entering labour markets as well as inequality of earnings (ILO, 2012b). As

a result, health care may be less affordable to them, particularly in countries where high OOP are frequent. Labour market measures should be put into place ensuring equitable treatment of women. Examples of such measures can be found in India, Latvia, Serbia and South Africa, where public works programmes have quotas for, or focus on, female participation in labour markets. Turkey has also increased the scope of subsidized labour for long-term unemployed women (ibid.).

Social inclusion should aim to ensure that the socially excluded, who are frequently poor, stigmatized by specific diseases, or active in the informal economy, are equally able to access health services when in need. This also requires providing adequate health care to **persons with special needs**. For example, people with HIV/AIDS should be in a position to access antiretroviral therapy without social or financial barriers. Further, health-care delivery should respect cultural principles and values. For instance, in countries where women traditionally do not visit male doctors, the health workforce should be comprised in such a way that women will not be deprived of care due to a lack of female doctors.

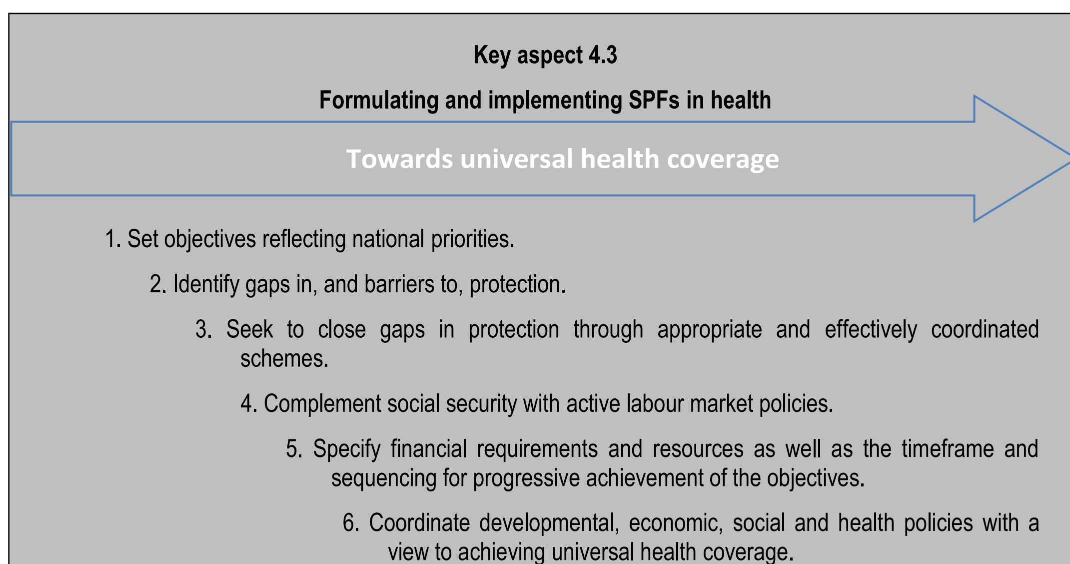
In order to improve the sustainability of progress towards universal health coverage, policies should be developed in a process of broad social and national dialogue, including government ministries, trade unions, employers, health-care providers, social insurances, civil society, patients and others. Social dialogue and consensus building are needed to ensure:

- *broad support at national level*: social partners will have to work with the newly established or extended SHP scheme and should accept and support it;
- *provision of feedback on progress*: issues cannot be known unless governments, social partners and others are informed; and
- *smooth implementation* minimizing drawbacks (Normand and Weber, 2009).

4.2. National strategies towards universal health protection

The development and extension of SPFs depends on social, economic and historical country contexts. While striving to provide at least essential health care and basic income support, countries should also seek to progressively extend the national SPF to higher levels for as many people as possible within a limited time frame.

The first step during the formulation of a national SPF is to set clear and attainable objectives within a given period (Key aspect 4.3), followed by the identification of gaps and deficits, including their origin. These should be addressed by appropriate social protection and labour market policies, focusing on the financial and related resource generation requirements. The implementation of SPFs requires coordinated policies across various sectors. Each of these steps will be discussed in this section.



4.2.1. Setting objectives and identifying gaps and barriers

National health protection policies should reflect historical and economic country contexts, social and cultural values, institutional settings, political commitment and leadership. However, there are some general principles that should be taken into account. They include universality and equity. Thus, countries should aim at improving access to health care for all citizens. In addition, objectives should be in line with globally agreed goals and objectives such as the Millennium Development Goals (MDGs) and international standards on social protection, particularly ILO Recommendation No. 202, the ILO Medical Care Recommendation, 1944 (No. 69), the ILO Medical Care and Sickness Benefits Convention, 1969 (No. 130) and the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102).

When setting objectives for SPFs, it is also important to balance potential trade-offs between different principles, such as:

- **Universality and equity**: To what extent can the principle of universality be modified to meet individual needs? Should there be a priority, e.g. for the poorest? Should high-income earners pay higher co-payments, premiums, etc.?

- **Universality, equity and essentiality of benefits**: Should the same services be provided to all, or specific needs (such as for the most vulnerable, women and the elderly) be addressed in specific benefit packages?

- **Universality, equity and quality levels** – medical and non-medical – that are acceptable in constrained financial contexts.

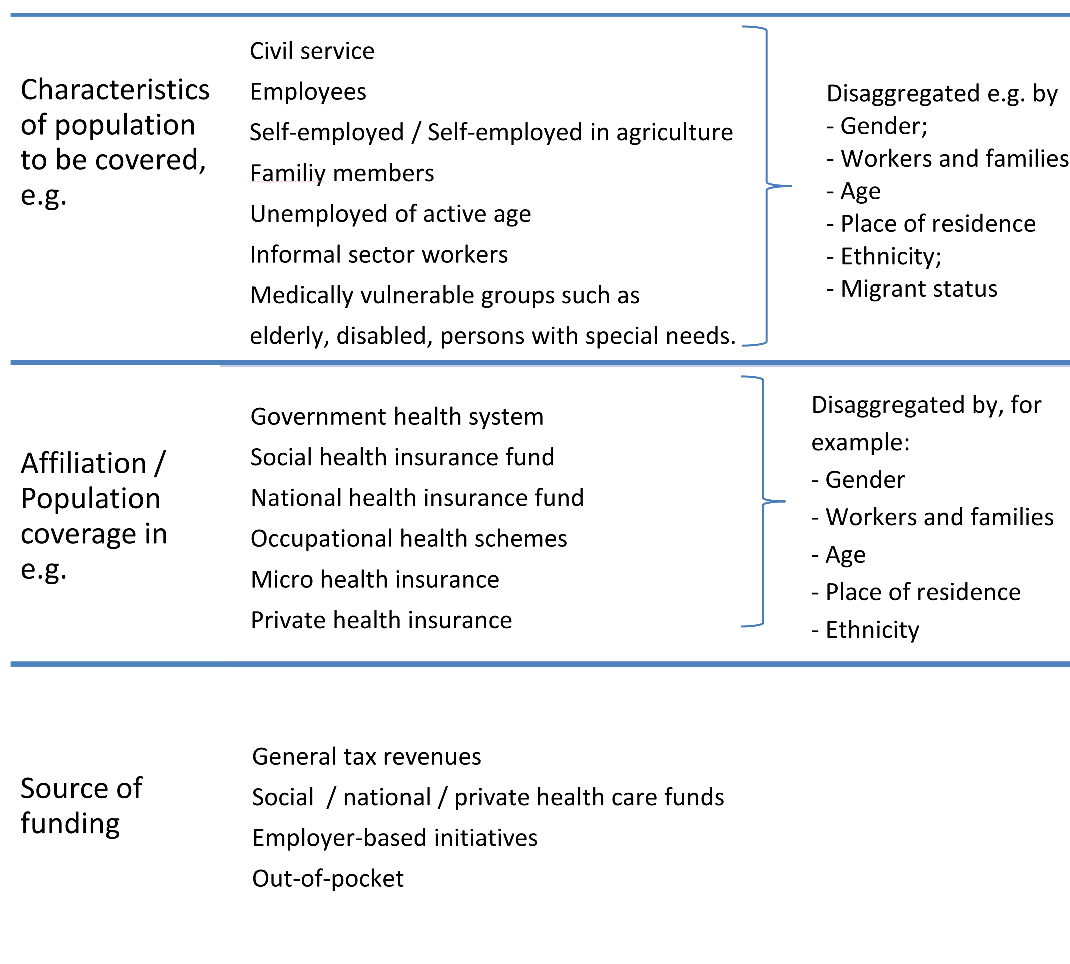
- **Universality, equity and the extent of financial protection** with a view to OOP caused by the cost of treatments, medicaments or transport, loss of income due to sickness, and others (Scheil-Adlung, ISSA, 2013a).

Following the setting of objectives, gaps in and barriers to access to health care should be identified. A comprehensive evaluation of all dimensions relevant to achieving universal and effective access to health care should be carried out. Thus, in addition to closing gaps in legislation, the availability, affordability and quality of health care, as well as financial protection, should be assessed. Special attention should be devoted to deprivation in some

or all of these dimensions for vulnerable groups such as the elderly, women, persons with special needs and ethnic minorities/migrants.

The analysis of gaps and deficits can be facilitated by developing a coverage map. A suggestion of how such a map could be structured is provided in figure 4.1. If applicable and feasible, it is recommended to include detailed information on aspects such as deficits related to gender or ethnicity. Apart from the quantitative data, qualitative information is required for a comprehensive overview.

Figure 4.1. Identifying gaps and deficits using a coverage map



4.2.2. Selecting and improving health financing mechanisms

Developing financing mechanisms that provide adequate funds is a key to progress towards universal health coverage. When selecting financing mechanisms there is no one-size-fits-all model; the criteria for selection will depend on specific national contexts.

Most countries have chosen a mix of financing mechanisms to provide social protection in health through different systems, subsystems and schemes: national health services, social health insurance, community-based insurance and mandated private health insurance. It is important that such a financing mix be coordinated to avoid fragmentation and operate within a clearly defined scope.

In order to arrive at an optimal combination of financing mechanisms for a specific country, the applicability and performance of the different mechanisms needs to be assessed on the basis of their capacity to mobilize funds and their efficiency in targeting vulnerable groups. In addition, it is important to consider the power structures impacting on both the supply and demand side in health-care delivery, accountability and quality of budgeting. Key aspect 4.4 lists important criteria for the selection of financing mechanisms.

Key aspect 4.4

Criteria for selecting financing mechanisms

- Political, economic and cultural context
- Burden of disease
- Poverty rate
- Size of the informal economy
- Number, structure and performance of existing schemes
- Size of the tax base
- Capacity to collect taxes/contributions/premiums
- Managerial capacity
- Availability of infrastructure
- Possibility of enforcing the legislation
- Regulation and related impacts on equity

The financing mechanisms selected should be based on the principle of solidarity, and thus need to reflect the individual's capacity to pay, and large risk pooling. An optimal balance of the responsibilities and interests of those who finance and benefit from health protection should be achieved, as stated in Recommendation No. 202 (para. I. 3(h)). Furthermore, financing mechanisms should be selected with regard to financial, fiscal and economic sustainability. Table 4.1 lists the pros and cons of core financing mechanisms: tax-based health protection, contribution-based social health insurance, premium-based community health insurance and private health insurance. The table does not include social assistance-type financing mechanisms in the form of vouchers or cash transfers.

Table 4.1. Pros and cons of key financing mechanisms

Tax-based health protection: National health systems

Pros	Cons
● Risks are pooled for the whole population	● Risks of unstable funding and often underfunding due to competing public expenditure
● Potential for administrative efficiency and cost control	● Inefficient due to lack of incentives and effective supervision
● Redistributes high and low risk and high- and low-income groups in the population covered	

Contribution-based social health insurance

Pros	Cons
● Generates stable revenues	● Poor are excluded unless subsidized
● Often strong support from the population	● Payroll contributions can reduce competitiveness and lead to higher unemployment
● Provides access to a broad package of services	● Complex to manage governance and accountability may be problematic
● Involvement of social partners	● Can lead to cost escalation unless effective contracting mechanisms are in place
● Redistributes between high and low risk and high- and low- income groups in the population covered	

Premium-based community-based health insurance

Pros	Cons
● Can reach out to workers in the informal economy	● Poor may be excluded unless subsidized
● Can reach the close-to-poor segments of the population	● May be financially vulnerable if not supported by national subsidies
	● Coverage usually only extended to a small percentage of the population
	● Strong incentive to adverse selection
	● May be associated with lack of professionalism in governance and administration

Premium-based private health insurance

Pros	Cons
● Preferable to out-of-pocket expenditure	● High administrative costs
● Increases financial protection and access to health services for those able to pay	● Ineffective in reducing cost pressures on public health systems
● Encourages better quality and cost- efficiency	● Inequitable without subsidized premiums or regulated insurance content and price
● Encourages better quality and cost-efficiency	● Requires administrative and financial infrastructure and capacity

Source: ILO, 2013a.

Should a mix of financing mechanisms be sought, synergies might be created to achieve redistributive effects and address disadvantages associated with private expenditure. Administrative and governance linkages between the various schemes and systems can have the potential to enhance efficiency by sharing of management functions, mutual registration support, and further coordination regarding the collection of contributions/premiums, auditing and control, contracting of providers and information processing.

Revenues that have been collected for health protection purposes should not be incorporated into general government budgets, but instead be accumulated as earmarked contributions in individual funds. This ensures that contributions are used solely for health protection coverage and access to the defined benefits.

Fiscal space and additional funds needed for extending health protection might be created and generated by increasing the efficiency of resource utilization, strengthening institutional effectiveness and efficiency, or enforcement, among others (Key aspect 4.5).

Key aspect 4.5

Options for increasing fiscal space while ensuring sustainability of funding

- Using public resources more efficiently
- Strengthening efficiency in public institutions and service delivery
- Reallocating the government budget
- Putting greater efforts into tax and contribution collection and the prevention of non-compliance
- Governing funds more effectively
- Introducing new sources of funding for the national health budget

Generally, countries should be in a position to use national resources to finance health protection. However, if national resources are insufficient to implement the basic guarantees incorporated in social protection floors, countries may seek international cooperation and support complementary to their own efforts.

4.2.3. Designing and costing essential health-care packages (EHCPs)

Designing EHCPs

The design of EHCPs cannot be identical for each country, given the differences in demographic, epidemiological, political and socio-economic characteristics. Priorities, needs and capacities define a country’s essential basket of care. Resource-poor countries might emphasize primary health-care coverage, while other countries add specific treatments for less frequent diseases. In any case, establishing an EHCP is an exercise that requires careful considerations of priorities, trade-offs, and defining what “essential” services entail for the population. By definition, an EHCP consists of a set of interventions – usually a combination of in- and out-patient services, including public health and clinical services. It guarantees a basic level of health care for every citizen in a country. However, it cannot meet all needs of the population, particularly not those with specialized diseases that are not accounted for in the EHCP.

As resources are often scarce, an emphasis on cost-effective interventions is generally found to ensure a maximum health gain with the funds, resources and personnel available. In the process of determining the composition of the benefit package, trade-offs between

cost-containment/effectiveness and risk protection are unavoidable. In addition to these objectives, reducing the burden of disease – that is, the impact on morbidity and mortality in a population – is also considered an important objective. It implies that those conditions posing a heavier burden on society could also be given priority (Obermann and Scheil-Adlung, 2013).

Recommended areas and items of health care are referred to in various ILO Conventions and Recommendations, including the Social Security Convention (Minimum Standards) (No 102), the Medical Care Recommendation, 1944 (No. 69) and the Medical Care and Sickness Benefits Convention, 1969 (No. 130). Besides curative care, such as general practitioner care and hospitalization, preventive measures and maternal care should be considered (Key aspect 4.6).

Key aspect 4.6

Health-care items referred to in ILO Conventions and Recommendations on social security and medical care

- Curative care
- Preventive care
- Maternal care
- Necessary pharmaceutical supplies on prescription
- Medical rehabilitation, including the supply, maintenance and renewal of prosthetic and orthopaedic appliances, as prescribed
- Medical aides such as eyeglasses
- Services for convalescents
- Sickness benefit in cash
- General practitioner care
- Specialist care for in-patients and out-patients
- Hospitalization where necessary
- Dental care, as prescribed

Countries may wish to define the areas to be covered as primary health care, in-patient care, prevention and maternity care rather than using an itemized approach. In all cases, services covered in EHCP should be based on a consensus derived from broad consultations with all decision-makers and others involved in health protection, taking into account a broad range of perspectives that are considered relevant in addition to the medical perspective. Key aspect 4.7 lists important aspects for consideration when defining EHCPs.

Key aspect 4.7

Aspects to be considered when defining EHCPs

- Introducing comprehensive and complementary benefit packages providing for an adequate level of services and income protection
- Ensuring availability, affordability and acceptability of health care
- Balancing the trade-off between equity and quality in broad consultations with all actors
- Addressing health-related poverty by minimizing OOP, particularly catastrophic health expenditure (>40 per cent of a household's income net of subsistence
- Ensuring adequacy through a focus on patients' needs regarding quantity, adequacy and quality of services
- Providing access to primary, secondary and tertiary care (through referral systems), including maternity care, preventive care and care in relation to HIV/AIDS
- Providing for transport costs
- Providing for financial protection against loss of income due to sickness, through paid sick leave and/or other forms of income support

In order to inform the policy dialogue in the decision-making process related to EHCPs, the ILO suggests a whole-system approach that aims to obtain indicative data for costing the implementation of an EHCP in a given country.

Costing EHCPs

In contrast to a bottom-up calculation that provides a costing of services based on a defined essential health-care package, the approach suggested by the ILO focuses on indicators for staff, medicines and infrastructure as inputs to a health-care system. By doing so, it aims to provide an initial rapid assessment of the costs of an EHCP at country level. This approach is particularly suggested for countries where relevant data for costing – such as utilization rates – are limited. For such a top-down indicative costing, the following conceptual model is proposed:

Part 1. Analysis of current macro-level spending patterns. To determine the level of care that is available three data inputs will be used: staff, infrastructure and medicines. These three inputs are key for the provision of health care. The relevant data can be found in national health accounts, and it is assumed that they indicate the level of technical efficiency in the present health-care system of a country. The three indicators are defined as follows:

- **staff**: the ratio between the total number of health-care staff (doctors, nurses, midwives, administrators and others, both self-employed and in government service) in relation to the whole population;
- **medicines**: the total per capita expenditure on medicines or total pharmaceutical expenditure (TPE) in a country, regardless of the source of payment and how they were obtained; and
- **infrastructure**: the percentage of total health expenditures spend on infrastructure, derived from the national health accounts.

Part 2. Determination of the appropriate level to be achieved. Based on the assumptions that (i) the relation of current levels of spending for staff, medicines and infrastructure is an approximation of technical efficiency; and (ii) that scaling up to some desirable level would at least provide the resource basis for some level of adequate care, a "deficiency index" can be developed that consists of the relation between current and desirable

spending. To arrive at this level of desirable spending, a peer group of three countries is formed, based on:

- GDP;
- the vulnerability of countries in terms of socio-economic characteristics (poverty rates and extent of informal economy); and
- geography.

The three aspects in Part 1 combine common experience (the tendency of countries to compare themselves with their neighbours) with economic and social indicators. Reference levels for ***staff*** will be based on the ILO Staff Deficit Indicator. For ***medicines*** the mean per capita expenditure on medicines in the three countries of the group with the best health indicators (using life expectancy (LE), under-5 mortality rates (U5MR), and maternal mortality rates (MMR)), adapted to the medicine price level of the analysed country or (if available) the cost of an essential benefit package as defined by WHO will be used. For the indicator ***infrastructure*** the model does not use any external benchmark, but would increase the spending for infrastructure on a pro-rata basis derived from the actual identified increase in spending for staff and medicines.

The result would be the calculated per capita health-care expenditure for delivering an EHCP for everyone in a country. All direct private expenditures above an OOP rate of 35 per cent of total health expenditure (this is the actual level of OOP in high-vulnerability countries as per the ILO definition) would be considered an inadequate level of financial protection. Thus, such cost would need to be borne from other sources (taxes, social health insurance funds, or if necessary international aid). Finally, the gap between the calculated requirement and the actual funding with an OOP level below 35 per cent would be called the funding gap.

Following the assessment of deficits in coverage and access and the development of a national rights-based plan aiming at closing gaps and designing and costing the EHCP, it is essential to ensure successful implementation of the planned reforms, taking into account needs for scaling up the health workforce, creating institutional and administrative efficiency, and enhancing technical capacities.

Further details and examples of calculations for costing an EHCP can be found in specific ILO publications (e.g. Obermann and Scheil-Adlung, 2013).

4.2.4. Coordination of policies within and beyond the health sector

In addition to addressing specific issues in health systems and schemes, it is important to coordinate all health financing mechanisms with a view to achieving universal coverage – for instance by using a coverage map, as mentioned above, and by creating administrative synergies if different systems and schemes are established.

Further, it is important to coordinate with policies beyond the health sector that impact, for example, on equity in access to health care. Such policy coherence and coordination across the health, economic and social sectors will also stimulate economic growth and is a key condition for sustainable progress. Of particular importance in this context are policies focusing on:

- poverty alleviation;
- labour market and decent work; and

- discrimination and exclusion.

A key tool in *poverty alleviation* is income support through social protection schemes and systems. Income support should be available for all in need throughout the life cycle, i.e. to children, persons in working age and older persons. Those most in need are the vulnerable such as the poor, sick, disabled, poor families, the unemployed and the elderly. For these groups, income support measures have the potential to contribute to social inclusion, compensate for low or lack of income, and improve housing, food and education as well as skills and assets to generate income.

However, social protection schemes and systems alone cannot correct all societal and economic developments constituting root causes of deficits in coverage. Simultaneously, economic and *labour market policies* need to be aligned with key policy objectives such as equity, enabling, for example, the employment of excluded groups and the unemployed, taking into account gender as well as other forms of discrimination. Supporting the transition from informal to formal labour markets is most relevant, so as to enhance the potential of formal employment and reduce the exclusion of vulnerable people through decent working conditions. In addition, measures that promote productive economic activity − education, vocational training, and others − could be considered. Key aspect 4.8 provides an overview of policy options promoting economic activity and formal employment.

Key aspect 4.8

Policy options for the promotion of productive economic activity and formal employment
(Recommendation No. 202, para. II.10).

- Labour market policies, including increasing formal employment, decent work and income generation
- Transforming informal into formal labour markets
- Enhancing of entrepreneurship and sustainable enterprises within a decent-work framework
- Skill-enhancing measures, such as promotion of literacy, education and vocational training

In addition, *discriminatory and exclusionary practices*, anchored in behaviours of societies, should be addressed. This requires policy and development strategies that focus on vulnerable and disadvantaged groups and people with special needs, with the aim of achieving:

- equity;
- social change;
- poverty alleviation; and
- elimination of all forms of deprivation.

4.3. Monitoring progress towards universal coverage

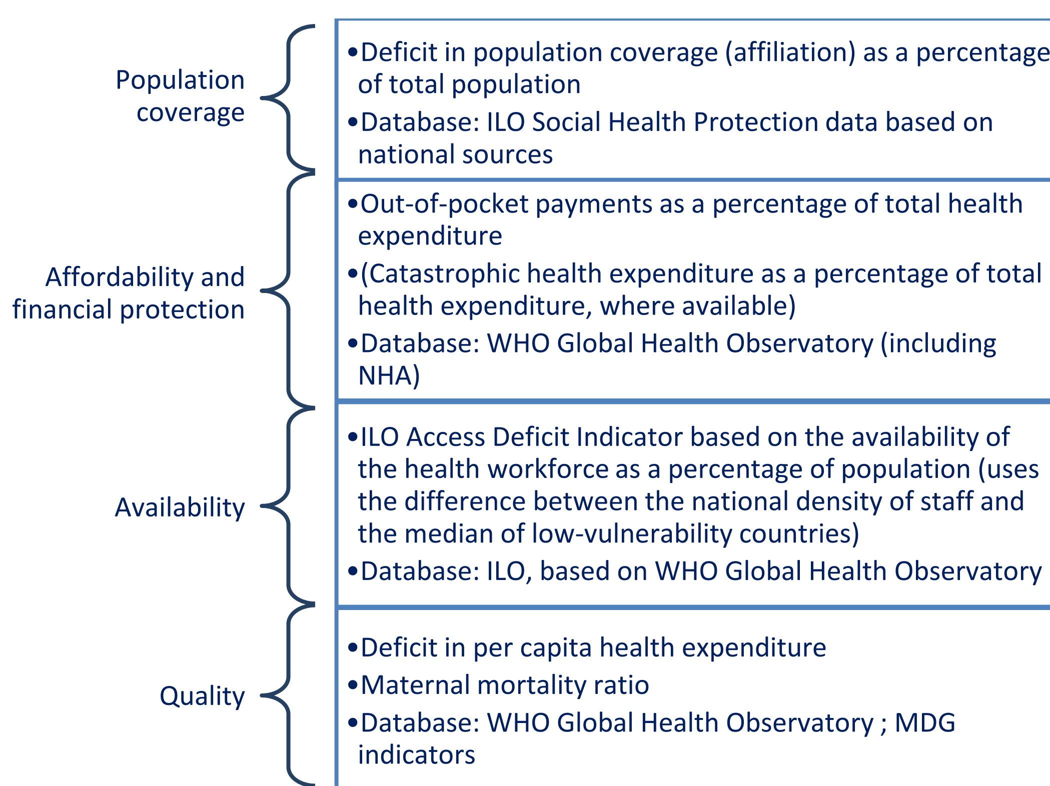
A successful SPF includes monitoring of progress to identify developments that are unintended and should be addressed. This requires appropriate evaluation mechanisms, with tripartite participation of government, worker and employer organizations, non-governmental organizations and other relevant representatives of the society at large and specific groups.

Monitoring should take into account all dimensions of coverage and access to health care that are relevant for achieving universal coverage and related effective access to services. Thus, the dimensions of availability, affordability, quality and financial protection of health care, in addition to the use of rights-based approaches, should be assessed in order to inform policy-makers on issues that might have to be addressed. In this context it is important to choose the most relevant indicators to measure access deficits, set thresholds that should be achieved and thus assess existing coverage.

4.3.1. Which indicators provide information on coverage and access to health care?

Indicators should take into account legal health coverage – a prerequisite of effective access − as well as affordability and financial protection, availability and quality of services (figure 4.2).

Figure 4.2. Indicators of effective access to health care



Source: ILO, 2013a.

In measuring the status quo and monitoring progress through these indicators, it is useful to take the following into account:

- **Deficits in legal health coverage** should be used as a proxy for the extent to which **rights-based approaches** are used for providing health care. It is calculated as the percentage of the population not covered by legislation, thus representing the share of people that have no formal entitlements to health protection.

- OOP as a percentage of total health expenditure should be used to reflect the **affordability and financial protection** of health care.

- The **quality** dimension of health care is reflected in two separate indicators: the relative deficit in per capita health spending and the maternal mortality ratio. The

relative deficit in per capita health spending can be established by calculating the relative difference between total per capita health spending (except OOP) in a specific country and the population-weighted median value of total per capita health spending (except OOP) in a group of countries. This group consists of countries where sufficient national revenues can be raised through fair health financing mechanisms to reach levels of health-care spending that would be adequate to establish equitable access to quality services for all in need.

- The **maternal mortality ratio** − the death of a woman while pregnant or within 42 days of termination of pregnancy – is expressed as maternal mortality per 10,000 live births. This indicator is suggested because it reflects access to and quality of maternal care services and the general health service, following the logic that pregnancy should not be a cause of death.

- The **availability** of health care can be measured using the **ILO Staff Access Deficit Indicator (SAD)** which reflects the share of people not having access to essential care due to lack of skilled health workers. The SAD uses a relative threshold currently amounting to 41.1 health professionals per 10,000 population. This threshold derives from the population-weighted median of a group of countries that have the potential to provide universal coverage (ILO, 2014). It provides information on the density of skilled health workers to ensure the provision of services, and indirectly it also reflects quality and accessibility of services within the health sector. In this context, decent working conditions − particularly wages − play a key role. If wages are too low, services will lack quality and health workers may be tempted to migrate or accept under-the-table payments.

In order to monitor progress based on quantitative data and using the indicators, it is suggested that countries collect, compile, analyse and publish data, statistics and indicators on social protection in health on a regular basis. Given the high costs associated with data development, it is recommended that – as far as possible – existing databases be used, including national health surveys. When information contained in national surveys is not sufficient, the databases referred to in figure 4.1 can be of use. The Resolution concerning the development of social security statistics adopted by the Ninth International Conference of Labour Statisticians can also provide some guidance in this endeavour.

4.3.2. What thresholds can be used?

Among the indicators described above, two are of relative nature: the relative deficit in per capita health spending and the Staff Access Deficit Indicator. In order to calculate the deficit between the status quo and the level striven for, it is necessary to develop thresholds that are considered adequate for achieving universal social protection in health.

As shown above, the key determinants of a country's ability to provide its inhabitants with adequate care and thus to establish universal social protection in health relate to the levels of poverty and formal employment. On the one hand, both poverty and the extent of the informal economy strongly influence a country's potential to collect taxes, premiums and contributions to finance health care to a level in which at least essential health services of adequate quality can be delivered to those in need. On the other hand, both poverty and informal economy levels represent challenges in reaching out to often vulnerable groups. Further, it is important that OOP are minimized and not used as health financing mechanism given their impoverishing impacts.

Against this background, it is suggested that in developing thresholds, countries that perform well in these respects be chosen. Countries can be grouped by levels of vulnerability, defined by their existing extent of poverty, informal economy as well as the extent of OOP used for financing health care (ILO 2014; Scheil-Adlung et al., 2010):

- Poverty levels are based on a poverty line of US$2 a day, using as a database World Development Indicators, ADB or ECLAC.

- Non-wage workers as a share of total workers is used as a proxy for informality, using as a database ILO LABORSTA, ILO KILM and national sources.

- Regarding countries with low vulnerability, health expenditure not financed by OOP to a level above 40 percent of total health expenditure.

Four levels of country vulnerability can be distinguished, ranging from very low vulnerability (e.g. Hungary) to very high vulnerability (e.g. Benin). See Annex V for complete list of countries categorized according to vulnerability.

The thresholds suggested by the ILO refer to those countries that are characterized by low poverty levels, relatively small informal economies and acceptable financing mechanisms. Thus it is the group of low-vulnerability countries that is used for calculating both the relative deficit in per capita health spending and the SAD.

Threshold for calculating the relative deficit in per capita health spending: The population-weighted median value of per capita health spending in low-vulnerable countries serves as this threshold. Subsequently, the relative difference between this value and the per capita health spending in a given country is calculated, resulting in the country's relative deficit in per capita health spending.

Threshold for calculating the Staff Access Deficit Indicator (SAD): This threshold is based on deficits in the density of health workers per population and is calculated as the population-weighted median value of qualified health staff, i.e. nurses, midwifery personnel and physicians per 10,000 population. Currently this threshold amounts to 41.1 qualified health workers per 10,000 population. The SAD uses the relative difference between the national density of health professionals in a given country and the population-weighted median value in low-vulnerability countries amounting to 41.1 health workers per 10,000 population. The advantage of using such a *relative* threshold relates to its regular adjustment to changes in the workforce density, whereas absolute values might become outdated.

4.3.3. Assessing the multiple dimensions of coverage and access

The above indicators of the multiple dimensions of effective access to health care can be applied to assess deficits in health protection. A spider diagram is used to visualize the coverage and access gaps and facilitate comparison with other countries, regions, income groups or country groups.

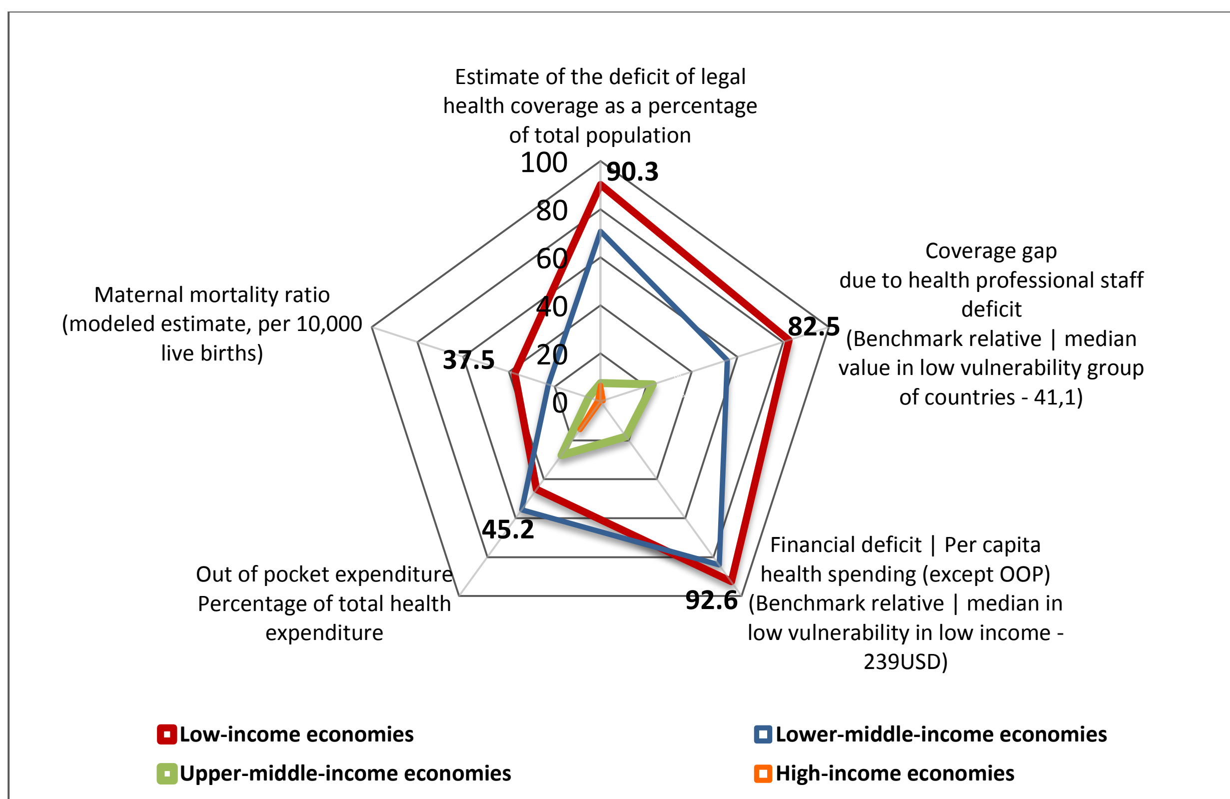
Figure 4.3 provides an overview of the global deficits in health protection by country vulnerability. It visualizes gaps in effective access to health care by using the following proxy indicators for rights-based approaches, affordability, availability and financial protection of quality care: Legal health coverage, deficits in the density of the health workforce, health expenditure deficits, OOP and maternal mortality ratios.

It reveals that:

- Coverage gaps are largest in low income countries and smallest in the least vulnerable, high income countries.

- In low income countries, deficits in legal health coverage reach unprecedented dimensions: More than 90 per cent of the population in these countries is legally not covered.
- The relative deficit in per capita health spending in this country group amounts to 92.6 per cent in high-vulnerability countries.
- The quality of health services is mirrored in the maternal mortality ratio, which reaches 37.5 per 10,000 live births in low income countries.
- In these countries, 82.5 per cent of the population cannot access health services, due to lack of qualified health personnel.
- Out-of-pocket expenditure as a percentage of total expenditure amounts to 45.2 per cent in low income countries.

Figure 4.3. The global deficit of effective health coverage (2011/2012)



Source: ILO, 2014

ANNEX I: Country cases

A.I.1 Africa

Ghana

Table A.1

Ghana: Selected development and social health protection indicators

- Total population: 24.26 million[1]
- GDP per capita: US$1,570[2]
- HDI: 0.558 [Rank: 135][3]
- Per capita total expenditures on health as a % of GDP: 4.8[4]
- Deficit of legal coverage as % of population: 26.1[5]
- OOP in per cent of THE: 29.1[5]
- Per cent of population not covered due to financial resources deficit: 77.7[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 74.1[5]
- Maternal mortality rate (per 10,000 live births): 35.0[5,4]

Sources: 1 UNDESA: World Population Prospects, 2012. 2 UNDATA, 2011. 3 UNDP: Human Development Indicators, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Calculation based on data of Annex III

In recent years Ghana has seen significant progress in economic and social development: over the past decade its GDP per capita more than tripled and poverty fell from 39.5 per cent in 1998 to 28.5 per cent in 2006 (UNDATA, 2012; Ghana Statistical Service, 2008). Redistributive factors such as land ownership, and increased access to education and health care played an important role in the process of economic growth and poverty reduction (ILO, 2013b).

The National Health Service in Ghana came into existence in 1957, offering entitlement to free public health care to all members of the population. Lack of financial sustainability forced Ghana to revise the system and introduce co-payments in 1985. In 1992, a new reform followed, introducing the "cash-and-carry" system, in which care was provided only after an initial payment. The result of the reforms was that health services became less affordable and thus less accessible, especially for the poorest members of the population (ILO, 2008).

In order to make health care more accessible for all members of its population, Ghana implemented a National Health Insurance Scheme (NHIS) in 2005. Ever since, it has made significant progress towards achieving universal coverage. The greatest virtue of the NHIS is its risk-pooling mechanism and the resulting reduction of the individual burden of health-care costs. Since the introduction of the NHIS, health financing has been evolving from community-based health insurance plans to a system of district mutual health insurance schemes (mutuelles de santé) (Schieber et al., 2012).

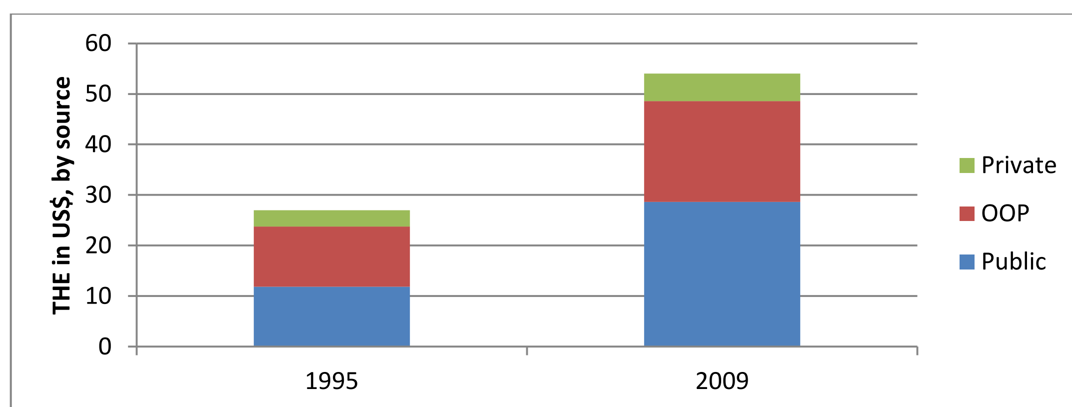
The current system is coordinated by the National Health Insurance Council. Its Health Insurance Fund receives funding from contributions paid to the Social Security and National Insurance Trust, the health insurance levy, grants, donations and other sources as

well as voluntary contributions from informal-economy workers (ILO, 2008). Funds are allocated to district mutual health insurance schemes offering essential health-care benefits as defined in the National Health Insurance Act (NHIA). The NHIA stipulates coverage for all persons residing in Ghana, including vulnerable groups such as children, pensioners, the elderly and others, many of whom were not covered previously. The number of beneficiaries has thus increased significantly in the past few years, contributing considerably to decreasing health-related impoverishment. During the process of the extending coverage in health protection, the ILO provided support in monitoring the performance of health insurance and health system budgeting aimed at effective financial governance (ILO, 2013b).

With regard to changes in Ghana's health-care financing between 1995 and 2009, the following observations can be made:

- total health expenditure increased;
- the composition of total health expenditure (THE) changed, with the share of public expenditure increasing significantly (figure A.1); and
- OOP has been at or slightly above the average for countries with comparable levels of development, indicating flaws in financial protection (Schieber et al., 2012).

Figure A.1. Ghana: Changes in composition of health expenditure, 1995 and 2009



Source: Schieber at al., 2012.

Ghana is one of the few countries in sub-Saharan Africa to earmark financing for universal health coverage, provide coverage for its vulnerable population groups and extend coverage by transitioning its existing community health insurance schemes into a national health insurance programme. Ghana is thus viewed as an example for other countries in the region. Nevertheless, criticism – for instance, regarding the system's financial sustainability – has also been voiced (Schieber et al., 2012).

When analysing access deficits using ILO indicators and related thresholds, there is still significant scope for improvement:

- The deficit in legal coverage amounts to 26.1 per cent. This implies that the implementation of the National Health Insurance Act, in spite of its efforts to increase coverage to all in need including vulnerable groups, has not resulted in extending coverage to the entire population. Ghana needs to scale up its efforts in taking a rights-based approach towards social protection in health.

- Ghana faces considerable shortages in the health workforce: 74.1 per cent of the population has no access to health services, due to the country's limited density of qualified health workers.
- The relative deficit in per capita health spending is almost 18.4 per cent, indicating that the quality of health care may be insufficient.
- OOP expenditure as a percentage of THE is at 29.1 per cent.
- In spite of progress with regard to maternal mortality over the past two decades, which has decreased from 580 to 350 deaths per 100,000 live births since 1990, Ghana will not be able to meet the MDG target of reducing maternal mortality by three-quarters by 2015.

Additional challenges faced by Ghana relate above all to extending social protection in health to the informal economy and persons living in rural areas.

Rwanda

Table A.2

Rwanda: Selected development and social health protection indicators

- Total population: 10.84 million[1]
- GDP per capita: US$583[2]
- HDI: 0.434 [Rank: 167][3]
- Total expenditures on health as a % of GDP: 10.8[4]
- Deficit of legal health coverage as % of population: 9.0[5]
- OOP in per cent of THE: 21.4[5]
- Per cent of population not covered due to financial resources deficit: 79.4[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 84[5]
- Maternal mortality ratio: 34.0[5]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Calculations based on data of Annex III

Since its civil war ended in 1994, Rwanda has achieved significant development progress. Its economic growth in the past decades has resulted in significant poverty reduction and progress towards the MDGs. Its development strategy focuses on equitable, efficient and effective pro-poor service delivery. Currently, Rwanda's GDP growth is 7.9 per cent and it is among the most stable countries in the African continent (World Bank, 2013).

From 1995 to 2011 total health expenditure as a percentage of GDP increased from 4.5 to 10.8 per cent. Total expenditure multiplied by five during this period, while OOP as a share of it decreased from 26.3 to 22.2 per cent (WHO Global Health Observatory, 2011). The ILO estimates that in 2011 approximately 91 per cent of the population was covered by some form of health insurance.

Formal-sector employees are covered by different health insurance schemes dependent on their status. The Rwanda Health Insurance Scheme (La Rwandaise d'assurance de maladie, RAMA) covers civil servants and other public-sector employees. RAMA was founded in

2001 and provides access to all public health centres, district hospitals and referral hospitals and private facilities contracted by RAMA. About 2.5 per cent of the population is covered under this scheme. Contributions are shared between the employer and the employee, amounting to 15 per cent of the base salary. Members of the armed forces are covered under their own scheme: Military Medical Insurance (MMI). Other formal-sector workers usually insure themselves through private insurances, which are regulated by Rwandese law. Contributions amount to 22.5 per cent of the base salary, of which only 5 per cent is paid by the member; the rest is covered by the Government (UNDP, 2011).

Informal-sector workers – the overall majority of workers in Rwanda – are covered under community-based health insurance schemes (CHIS) or mutuelles de santé. The CHIS specifically target informal-sector workers and the rural population.

The rapid expansion of legal coverage by CHIS from an enrolment rate of 7 per cent of the population in 2003 to 91 per cent in 2010 and low premium contribution (US$2 per member per year) led to a financially unsustainable situation. A new health insurance policy was implemented from July 2011, which shifted the financing system from a fixed rate premium to stratified premiums − ranging from US$4 to US$14 per member per year – based on wealth category, the poorest households being subsidized by the Government's budget. This resulted, during the first six months of the new policy, in decreasing coverage rates and slow registration of CHIS members, the enrolment rate falling back to less than 80 per cent. The new health insurance policy, aimed at ensuring the financial sustainability of the CHIS system in Rwanda, improving the accessibility of populations to health care, protecting households against the financial risks associated with diseases, addressing the challenges of insufficient numbers of qualified staff and of limited management capabilities, is being better understood and owned by the population thanks to sensitization campaigns in all 30 districts of the country and training sessions for CHIS staff. After an initial slow uptake of CHIS membership and some birthing pains upon introduction of the policy, coverage by CHIS increased to 91 per cent by mid-2012, bringing the national health insurance coverage to 96 per cent, according to the Ministry of Health.

Nevertheless, the health system in the country still faces a number of challenges, one of them being lack of financial sustainability of the CHIS resulting from their low contribution rates (Makaka, Breen and Binagwaho, 2012). Although population coverage is high in Rwanda, ILO estimates indicate that lack of financial resources as well as lack of qualified health workers result in significant barriers in access to needed care, affecting above all vulnerable population groups such as the poor and those living in rural areas. An estimated 84 per cent of the population is deprived of access to health services due to lack of qualified health workers.

Mozambique

Table A.3

Mozambique: Selected development and social health protection indicators

- Total population: 23.97 million[1]
- GDP per capita: US$536[2]
- HDI: 0.327 [Rank: 185][3]
- Total expenditures on health as a % of GDP: 6.6[4]
- Deficit of social health protection coverage as % of population: 96[5]
- OOP as a % of THE: 9[5]
- % of population not covered due to financial resources deficit: 86.6[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 92.6[5]
- Maternal mortality ratio: 49.0[5]0[4]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

After a sixteen-year armed conflict that ended in 1992, Mozambique has made progress in political stability, economic growth and poverty reduction. Nevertheless, the country still faces high poverty rates, low literacy rates and weak health outcomes. Its HDI is low: of a total of 187 countries it is number 185 (UNDP Data & Statistics, 2012). The overall majority of its workforce is employed in agriculture, in spite of the fact that this sector is relatively unproductive and remains subsistence-based. In order to facilitate inclusive growth, the country needs to invest in the provision of public goods, such as education and social security, including social protection in health (World Bank, 2013).

Mozambique has a three-level social security system: non-contributory basic, compulsory and complementary social security. Basic social protection involves non-contributory transfers and other welfare services for the poorest households, the elderly, the disabled and those who are chronically ill, as well as for households with orphans and vulnerable children. Compulsory or contributory social security includes social insurance for formal workers and public servants, and comprises old-age pensions, cash sickness and maternity benefits, hospitalization, cash death grants and allowances for burial expenses. Complementary social security offers upgrades to benefits at the compulsory level (ILO, 2013b).

The health system in Mozambique − the National Health Service (NHS) − is public. Formally, its Regulation for Basic Social Security specifies legal health coverage for primary care to all in need, including to the most vulnerable populations. In addition, income guarantees in the form of cash transfers are offered in order to ensure income security for older people, persons with disabilities, the chronically ill, households with vulnerable children, etc.

There is considerable scope for improvement in the field of health protection, as the NHS reaches only 60 per cent of the population. Deprived population groups are above all rural dwellers, which due to geographic barriers and large deficits in qualified health staff do not receive the care they need. Private-sector facilities are developing slowly and are concentrated above all in urban areas. With only 3.3 qualified health workers per 10,000 population, the ILO estimates that 92.6 per cent of the population experiences barriers to needed care due to lack of qualified health personnel. In addition, although it has increased

over the last decade and in spite of significant amounts of donor funds, funding for health is inadequate. The ILO estimates that 86.6 per cent of the population cannot access health services due to the deficit in financial resources faced by the country (ILO, 2013a).

In May 2008, the Mozambican Minister of Social Affairs requested assistance from the ILO in designing a social protection floor. ILO responded through the Strategies and Tools against Social Exclusion and Poverty (STEP) Portugal project, a technical cooperation project that aims to improve public policies and strengthen institutional capacity for the extension of social protection in Portuguese-speaking African countries. The country recently approved the National Strategy for Basic Social Security (April 2010) and the Regulation for Basic Social Security (December 2009), which forms another step in the direction of a comprehensive social security system aligning with the SPF concept (ILO, 2013b).

A.I.2 Americas

Brazil

Table A.4

Brazil: Selected development and social health protection indicators

- Total population: 195.21 million1
- GDP per capita: US$12,5942
- HDI: 0.730 [Rank: 85]3
- Total expenditures on health as a % of GDP: 8.94
- Deficit of social health protection coverage as % of population: 0.05
- OOP as a % of THE: 31.3[5]
- % of population not covered due to financial resources deficit: 0.05
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 0.05
- Maternal mortality ratio: 5.6[5]64

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

Brazil has experienced an economic, social and demographic transition over the last few decades. Between 1995 and 2009 extreme poverty (at US$1.25 a day) fell from 16.4 to 4.7 per cent and inequality decreased significantly. In line with an increase of well-being in the country, the share of elderly of the population almost doubled: in 2010, 10.3 per cent of the population was above 60 years old (World Bank, 2013). All these developments had impacts on the social security system in Brazil, including protection in health.

The Brazilian social protection system is based on three pillars: (1) social insurance policy; (2) social assistance policy; and (3) health policy. The Unified Health System (Sistema Único de Saúde, SUS) was introduced in 1988 and has ever since extended coverage from only formal-sector workers to the entire population. The SUS is based on three key principles:

- universal access to health services anchored in national legislation;
- equity in access to health care; and
- integrality and continuity of care (World Bank, 2013).

The SUS provides coverage to approximately 75 per cent of the Brazilian population. The remaining 25 per cent are covered under the Supplementary Scheme, which grants the right to access the same services provided by the SUS. The SUS is governed at the federal level by the Ministry of Health, and at the lower levels – states and municipalities – by their respective Secretaries of Health. Within the SUS public and private financing mechanisms are mixed, with private schemes covering basically the same services as the public system. Private-sector services are mainly used by the wealthier part of the population.

The Family Health Programme (PSF), which was created in 1994, covers 50 per cent of the population and is thus the largest programme within the SUS. Services provided through this programme can be divided into three groups: (1) basic health care, i.e. promotion, prevention, basic specialties and disease control; (2) specialized medium-complexity health care; and (3) high-complexity health care. Coverage varies widely between different regions.

The SUS faces a number of issues, amongst others those relating to organization and management of the health sector and its funding. Funding problems are reflected in the large share of THE financed from OOP: 31.3 per cent. With regard to other indicators, Brazil – a low-vulnerability country – is performing well. It has no staff access deficit, the MMR is at an acceptable level, and population coverage reaches 100 per cent, indicating that the right health protection is rooted in Brazilian legislation. Nevertheless, a number of challenges beyond the health sector, such as demographic development and political and leadership issues, put pressure on the Brazilian health system. The double burden of disease in this country poses another challenge to its health system: both infectious diseases as well as diseases that are emerging, along with population ageing, are currently prevalent.

Mexico

Table A.5

Mexico: Selected development and social health protection indicators

- Total population: 117.89 million[1]
- GDP per capita: US$10,063[2]
- HDI: 0.775 [Rank: 61][3]
- Total expenditures on health as a % of GDP: 6.2[4]
- Deficit of social health protection coverage as % of population: 14.4[5]
- OOP as a % of THE: 47.8[5]
- % of population not covered due to financial resources deficit: 0.0[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 0.0[5]
- Maternal mortality ratio: 5.0[5]0[4]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

Mexico is the largest economy in Latin America, with much of its population living in poverty: the National Council on Evaluation of Social Development Policy estimated that 46.2 per cent of the country’s population was poor in 2010 (World Bank, 2013).

When Mexico installed a system of national health accounts (NHAs) in the mid-1990s, over half the population was lacking health insurance. Over 50 per cent of health expenditures came from OOP, with the result that every year many households were experiencing catastrophic expenditures. According to WHO estimates, in 2000 three to four million households were affected by such expenditures (Frenk, Gómez-Dantés and Knaul, 2009).

In 2003, Mexico started the reform process of its health-care system by approving the General Health Law (Ley General de Salud). This law brought into existence the System of Social Protection in Health (Sistema de Protección Social en Salud), aiming at achieving

universal health protection coverage. Many formerly excluded subgroups of the population, such as the poor and vulnerable, were now legally covered (ibid.).

A new social insurance scheme, called Seguro Popular, provides access to a benefit package covering 284 essential health services and 522 drugs (Bonilla-Chacín 2013). This programme targets those who are not covered by any other scheme, i.e. informal workers, the unemployed and the self-employed (UNDP, 2011). The General Health Law specifies that health facilities have to be accredited to become integrated into Seguro Popular. Accreditation is conditional upon required resources being present to provide the essential health services specified by the scheme. Seguro Popular is financed through (1) a contribution from the Government; (2) solidarity contributions shared between federal and state governments; and (3) families. For the latter, contributions are tied to income and range from US$0 for the poorest to US$950 for families in the upper income decile (ibid.). This, however, has not been implemented and so far only 1 % of households has actually contributed to the Seguro Popular (Bonilla-Chacín 2013).

The Fund for Protection against Catastrophic Expenditures (Fondo de Protección contra Gastos Catastróficos, FPGC) works alongside Seguro Popular, covering 18 high-cost interventions including neonatal intensive care, breast cancer and HIV/AIDS. The General Health Law includes provisions for the annual extension of both essential and high-cost interventions, taking epidemiological developments as a basis (ibid.).

From 1995 to 2011 health expenditure as a share of GDP increased from 5.1 to 6.2 per cent, while during this same period absolute per capita health expenditure increased by 142 per cent. OOP as a percentage of THE decreased from 56.16 per cent in 1995 to 47.1 per cent in 2011 (UNDP, 2011).

The results of the reform have been positive, which is indicated by the fact that many of the key goals of the reform process, such as increasing financial protection to avoid catastrophic health expenditures, are being met. Since 2003, more than 41 per cent of the population were insured under the Seguro Popular (Knaul et al., 2012).

A.I.3 Asia

India

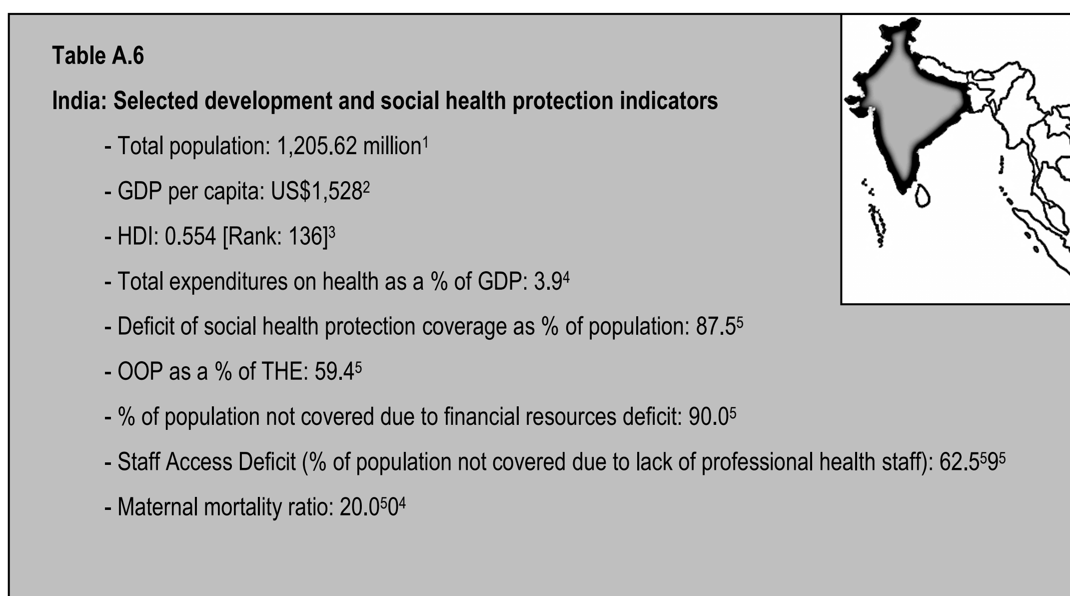


Table A.6

India: Selected development and social health protection indicators

- Total population: 1,205.62 million[1]
- GDP per capita: US$1,528[2]
- HDI: 0.554 [Rank: 136][3]
- Total expenditures on health as a % of GDP: 3.9[4]
- Deficit of social health protection coverage as % of population: 87.5[5]
- OOP as a % of THE: 59.4[5]
- % of population not covered due to financial resources deficit: 90.0[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 62.5[5]9[5]
- Maternal mortality ratio: 20.0[5]0[4]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

India is the world's fourth largest economy, and is in a process of rapid socio-economic change and development. Since independence in 1947 it has seen significant progress in the fields of agriculture, health and education, with literacy rates increasing by 300 per cent and life expectancy doubling during that period. Nevertheless, poverty rates are still high: 68.8 per cent of the population lives on US$2 a day, amounting to approximately one-third of the world's poor (World Bank, 2013). In addition to this widespread and deep-rooted poverty, India is characterized by strong inequities in all dimensions of society. Improving health care is a key priority for reducing poverty rates and moving towards a more equitable society. The ILO estimates that statutory coverage currently extends to only 12.5 per cent or the population (Govinda Rao and Choudhury, 2012).

Health provision in India is split between three tiers. The first tier is constituted by the sub-centres, which employ only paramedical staff; community health services are the second tier; sub-divisional and district-level hospitals constitute the third tier. Although India's health sector is rapidly growing, its level of health spending is among the lowest in the world. In 1995 it allocated 4.0 per cent of its GDP to health, which decreased slightly to 3.9 per cent by 2011. OOP – the main source of health financing in the country – decreased from 67.7 per cent of total health expenditure to 61.2 per cent over the same period, while absolute per capita health expenditure more than tripled. The level and composition of health expenditure differs between states. For instance, in Kerala and Tamil Nadu public health expenditures are twice as high as in Bihar; public expenditure is positively correlated with income (ibid.).

A large part of health expenditure is allocated to secondary and tertiary care, while the share allocated to primary and preventive health services is relatively small. In addition, the majority of expenditure in all three branches is used for the wages and salaries of health personnel. For example, in Madhya Pradesh and Orissa – two of the poorest states in the country – 83 and 85 per cent of health expenditure respectively is allocated to wages and salaries (ibid.). Another problem relating to health personnel is the staff density: the

ILO estimates that approximately 62.5 per cent of the population are deprived of access to services due to the lack of qualified health staff.

As a consequence of the poor quality of care offered by providers, as well as shortfalls in provision and high co-payments and contributions, microinsurance schemes are growing in rural areas as well as in India’s largest cities. These schemes target primarily persons in informal employment, which constitutes 83.6 per cent of non-agricultural employment (ibid.).

An example of a micro insurance scheme in India is Rashtriya Swasthya Bima Yojana (RSBY), launched by the central Ministry of Labour and Employment in 2008. The goal of RSBY is to provide financial security to the poor. It aims to cover their expenses related to hospitalization, in addition to increasing the quality of care. A rural household survey delivers the data based on which families are classified as poor or non-poor. On top of expenses related to hospitalization, the scheme covers transport charges of up to US$1,000 per annum for all age categories. The scheme is funded jointly by the central and state governments (UNDP, 2011).

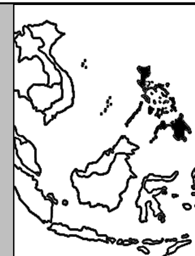
In short, the Indian health system is characterized by significant underfunding, resulting in insufficient and poor quality health services having adverse effects of the population’s health outcomes. Considerable attention must be dedicated to:

- increase public spending on health care;
- increase the focus on preventive care;
- increase access to care for the poor;
- ensure a more efficient allocation of resources; and
- expand health infrastructure in both rural and urban areas.

Philippines

Table A.7

Philippines: Selected development and social health protection indicators



- Total population: 93.44 million[1]
- GDP per capita: US$2,370[2]
- HDI: 0.654 [Rank: 114][3]
- Total expenditures on health as a % of GDP: 4.1[4]
- Deficit of social health protection coverage as % of population: 18[5]
- OOP as a % of THE: 55.9[5]1[4]
- % of population not covered due to financial resources deficit: 82.2[5]0[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 0.0[5]
- Maternal mortality ratio: 9.9[4]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

The Philippines have been experiencing many years of robust economic growth, averaging 5 per cent since 2002. In 2012 – in spite of global economic and financial insecurity – its mainly export-driven GDP growth reached 6.6 per cent. One of the strongest components of its economy is its highly skilled labour force, which is in high demand all over the world. With regard to progress in the health MDGs, the Philippines are on track in reducing infant and child mortality, but have to scale up efforts in improving child and maternal health (World Bank, 2013).

The Department of Health (DoH) serves as the governing agency of the Philippine health system, and was established as a separate entity out of the Department of Health and Public Welfare in 1941. From that point onwards, the Philippines – along with many other developing countries in the region − steadily improved patient care, medical care provision and public health. Health-care provision is currently split between three administrative levels: the central level, the provincial level and the municipalities. Furthermore, it is split between the public and the private sector: the former provides care to around 70 per cent of the population, while the latter provides care to around 30 per cent. Sources of health financing are (1) OOP from private households; (2) premium contributions or prepayment from households and enterprises; (3) budget appropriations from the Government; and (4) taxes paid by households and firms to fund budget appropriations (Romualdez et al., 2011).

Over the past 30 years several reforms have been implemented aiming at improving access to health care for the poor. A major effort was the establishment of the National Health Insurance Programme (NHIP) through the National Health Insurance Act of 1995, which is the largest insurance programme in the Philippines in terms of coverage and benefit packages. To administer the NHIP the Philippine Health Insurance Corporation (PHIC) was created, commonly known as PhilHealth. Its goal was to ensure universal health coverage by 2010, through providing affordable access to quality health care for all in need. From 2000 to 2008 coverage rates under PhilHealth almost doubled (DoH of the Republic of the Philippines, 2013). The ILO estimates that in 2009 population coverage stood at 82 per cent of the population (ILO, 2013a).

In 2010 the Government launched an effort to increase coverage among poor families. So far, progress has been promising: by April 2011 almost 4.4 million new poor families became members of PhilHealth. From that point onwards, families within the poorest 20 per cent of the population were entitled to a full government subsidy, and the second poorest 20 per cent on premiums (Romualdez et al., 2011).

PhilHealth offers coverage for basic in-patient benefits, with ceilings for each type of service, e.g. drugs and medicines, supplies and radiology, laboratory and ancillary procedures. In addition, it offers coverage for specific out-patient services such as chemotherapy and surgery. In addition, it offers benefit packages for specific services or conditions, such as a package especially designed for tuberculosis-direct observed therapy (TB-DOTS) (ibid.).

In spite of progress, important challenges remain within the Philippine health system. These are particularly related to:

- underspending in health: from 1995 to 2011 THE as a percentage of GDP increased from 3.4 to 4.1 per cent;
- fragmentation of the health financing system: government health spending is controlled by many different actors who all have direct control over resources and simultaneously different mandates and responsibilities;

- weak social protection, equity and solidarity: protection against health-related impoverishment is insufficient; and
- insufficient impact of past reforms (DoH of the Republic of the Philippines, 2013).

In addition, the Philippine health system faces issues related to retention of health workers and the availability of affordable medicines at an adequate quality.

In order to overcome these challenges, the DoH has adopted the 2010–2020 Health Care Financing Strategy aiming, amongst others, at (1) increasing resources for health; (2) increasing the sustainability of membership in social health insurance; and (3) improving allocation of resources. In order to ensure sufficient progress, an extensive monitoring and evaluation strategy has been designed (ibid.).

China

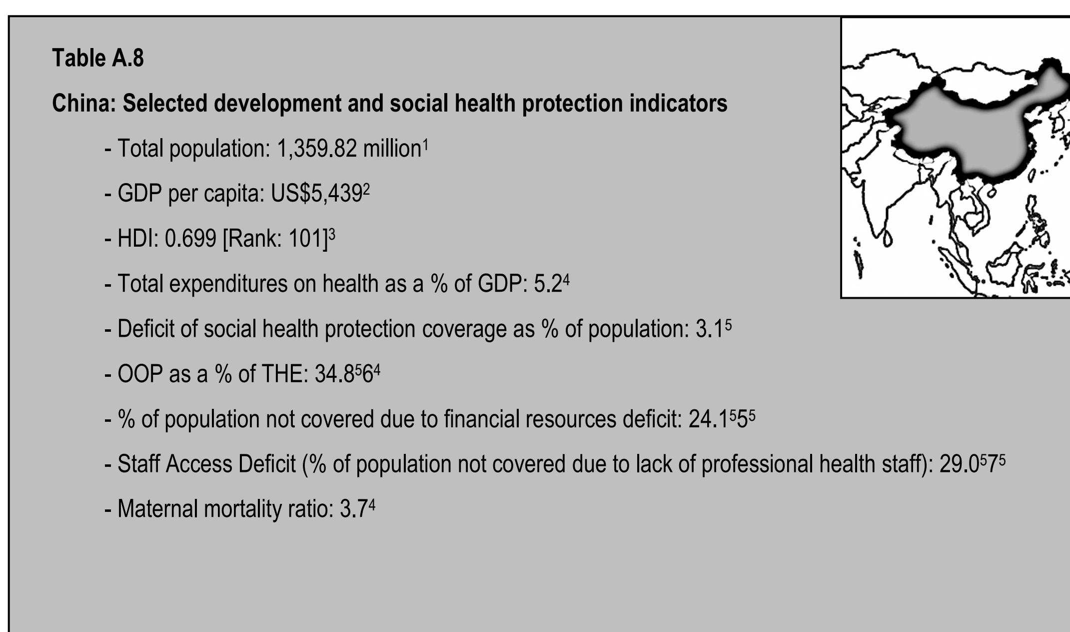


Table A.8

China: Selected development and social health protection indicators

- Total population: 1,359.82 million[1]
- GDP per capita: US$5,439[2]
- HDI: 0.699 [Rank: 101][3]
- Total expenditures on health as a % of GDP: 5.2[4]
- Deficit of social health protection coverage as % of population: 3.1[5]
- OOP as a % of THE: 34.8[5]6[4]
- % of population not covered due to financial resources deficit: 24.1[5]5[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 29.0[5]7[5]
- Maternal mortality ratio: 3.7[4]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

China is experiencing rapid social and economic changes. As the second largest economy in the world, China is becoming an increasingly important player on the world stage. Its GDP is growing fast and this growth is not only beneficial for the upper income quintiles: China's middle class is growing quickly. The country is close to reaching all the MDGs, including those in health (World Bank, 2013). Nevertheless, in spite of these positive socio-economic developments, it still faces high poverty rates and inequality.

One of today's challenges consists of China's social agenda, in which inequity in health is an important component. Until the 1980s the entire health system was run by the State and performed a social welfare function. At that point the system was strong, providing a relatively high level of services for its level of income. During China's transition from a planned to a market economy, government funding for health care decreased, leaving many – especially the poor – exposed to catastrophic health expenditures and resulting health-related impoverishment. In addition, a large and increasing gap between rural and urban access to health care emerged (Alcorn and Beibei, 2011). The growing inequities in health care were mainly caused by financing issues related to decentralization and fragmentation of the health system, and the marketization of medical establishments. In

2000, when China was ranked 188 of 191 countries with regard to fairness of financial contributions to health care, OOP amounted to almost 60 per cent of total health expenditure. Government expenditure as a share of total health expenditure reached a historic low of 15.5 per cent in the same year (WHO Global Health Observatory, 2011).

In response, in the course of the 21st century China has put increasingly more emphasis on the goal of achieving universal social protection in health coverage (Chen, Chen and Zhao, 2012); it has made this goal one of the principal requirements for improving the well-being of its population (ILO, 2008). As a result of its aim of "Basic health services for all", progress in population coverage has been significant: while in 2003 coverage rates were 55 and 21 per cent in urban and rural areas respectively, population coverage had increased to 90 per cent by 2009 (Alcorn and Beibei, 2011). Today, OOP stand at 34.8 per cent of THE, and government expenditure as a percentage of THE has increased to 55.9 per cent (Table in Annex III; WHO Global Health Observatory, 2011).

The Chinese public health insurance system currently consists of four schemes. One provides health insurance to civil servants and those with a similar status. The working urban population is covered under another scheme. The third scheme targets economically inactive residents, while the fourth targets the rural population through the New Rural Cooperative Medical Schemes (NCMS). Of these schemes, the first two date from before the transition period and have undergone a series of reforms, while the latter two are more recent initiatives. In addition to improving health insurance mechanisms, social assistance programmes are playing in increasingly important role with a view to achieving universal social protection coverage (Hipgrave, 2011).

In spite of the past reforms a number of major issues remain. Amongst others:

- Total and government expenditure are still heavily focusing on urban areas.
- Issues related to demographic ageing have not been addressed (ibid.).

The Government, aware of the many health system-related issues still to be addressed, is moving its health system reform forward and expanding its ambitions and the resources allocated to it. It has reserved additional funds to be added to the US$200 billion already provided in the past, including new funds to improve primary health care delivery and public health in order to directly address persisting inequities for the most disadvantaged (ibid.).

A.I.4 Arab States

Egypt

Table A.9

Egypt: Selected development and social health protection indicators

- Total population: 78.08 million[1]
- GDP per capita: US$2,801[2]
- HDI: 0.662 [Rank: 112][3]
- Total expenditures on health as a % of GDP: 4.9[4]
- Deficit of social health protection coverage as % of population: 48.9[5]
- OOP as a % of THE: 58.2[5]2[4]
- % of population not covered due to financial resources deficit: 76.1[5]4[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 0.0[5]
- Maternal mortality ratio: 6.6[5]6[4]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

Over the past decades Egypt has been developing rapidly, resulting in improvements in social indices such as decreasing malnutrition and mortality among children as well as increasing life expectancy. Nevertheless, since its revolution in 2011, the country has been in a state of political instability affecting all aspects of society. Its economy continues to suffer from these political and institutional uncertainties: GDP growth has decreased to a level of only 2.2 per cent. Rising levels of unemployment may result in decreased access to health care (World Bank, 2013).

Egypt's total health expenditures as a percentage of GDP increased from 3.9 per cent in 1995 to 4.9 per cent in 2011. Absolute health expenditures more than doubled during the period of reference, while OOP as a share of total health expenditure increased from 48 to 61.2 per cent. The ILO estimates that in 2011, in total 51.1 per cent of the population was formally covered under the various laws which have come into existence from 1975 onwards and cover a variety of population subgroups (ILO, 2009).

The financing of the current system is thus pluralistic and fragmented: various schemes provide coverage to different groups of the population, providing access to different benefit packages. Both public and private providers are involved. Government clinics and hospitals, the Family Health Funds (FHF) and Patient Treatment at the Expense of the State (PTES) are tax-funded, as opposed to Social Health Insurance (HIO), which is funded by modest contributions at rates varying from 0.5 to 2 per cent for the insured and up to 3 per cent for employers (ibid.).

Government clinics and hospitals provide free primary, secondary and tertiary care for the uninsured at nominal fees, the FHF provides access to primary care to the whole family, while PTES provides financial support for tertiary care to successful applicants. For the latter, eligibility and the size of the grant are decided on a case-by-case basis. PTES is one of the main cost drivers of the Egyptian health system. Quality of care in government hospitals and clinics as well as for services offered through PTES is limited. Major problems are above all underfunding and understaffing, triggering people to opt for private insurance (ibid.).

The HIO covers various groups under different schemes, providing a comprehensive benefit package consisting of primary, secondary and tertiary health services. Dependants are not covered. Since the 1990s coverage has increased but has not been matched by a related increase in funding. It is argued that the system faces increasing underfunding, resulting in a deterioration of services. Lack of quality is the main reason for individuals opting out of the HIO (ibid.).

Major challenges for the Egyptian health system remain, both within and beyond the health sector. Issues related to health system design are predominantly related to financing: OOP amounts to 58.2 per cent of THE, and the share of population not covered due to the financial resources deficit is 76.1 per cent. In addition, gaps in rights-based approaches are significant: 48.9 per cent of the population lacks statutory coverage. Beyond the health sector, issues are above all employment-related: a large part of the Egyptian population is active in the informal sector and does not receive any health protection, resulting in health-related impoverishment.

Yemen

Table A.10

Yemen: Selected development and social health protection indicators

- Total population: 22.8 million[1]
- GDP per capita: US$1,270[2]
- HDI: 0.458 [Rank: 160][3]
- Total expenditures on health as a % of GDP: 5.5[4]
- Deficit of social health protection coverage as % of population: 58[5]
- OOP as a % of THE: 78.1[5]7[4]
- % of population not covered due to financial resources deficit: 91.9[5]1[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 78.2[5]8[5]
- Maternal mortality ratio: 20.0[5]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

Yemen is a country where the majority of the population lives in rural areas. Poverty is concentrated among rural dwellers: 84 per cent of the country's poor are located in rural areas. After a crisis that has lasted almost a year due to the Arab Spring, Yemen's economy remains under pressure: GDP growth amounts to 0.1 per cent and inflation to 17.2 per cent. It is one of the poorest countries of the Arab region, with one of the highest population growth rates in the world. It is expected not to meet any of the MDGs (World Bank, 2013).

Yemen's annual total health expenditure amounts to 5.5 per cent of GDP, leading to a significant lack of financial protection: OOP amounted to 78.1 per cent of total health expenditure in 2011. The resulting lack of access to health care constitutes a major threat to well-being of the country's population, disproportionally affecting its rural population: more than two out of three rural citizens are physically excluded from health care due to a lack of accessible health facilities (Holst and Gerricke, 2012). The burden of disease leans strongly towards diseases that are preventable, so that increasing access to prevention and primary care is therefore an important priority.

Yemen's four-tiered health system operated by the Ministry of Health currently provides primary, secondary and tertiary care as well as treatment abroad for selected cases. Alongside, a smaller subsystem exists that offers health care to company workers on a fee-for-service basis. Public spending amounts to less than one-third of total health expenditure, while one-tenth is financed by international donor funds. The most important issues faced by Yemen's health system are:

- limited financial resources;
- geographic inequities;
- insufficient and low-quality health facilities;
- low-quality and insufficient numbers of health workers; and
- lack of monitoring and information systems (ibid.).

In response to at least some of the above issues, the need to establish an affordable health-care financing mechanism is mentioned as a key component of Yemen's Poverty Reduction Strategy and Five Year Plan. In view of this, the Government has started an initiative to establish a national health insurance system. Nevertheless, since its efforts began in 2005 to map the social, economic, infrastructural and financial conditions of the country in order to develop different options for health system reform and the establishment of a national health financing scheme, as well as options for establishing social protection in health, progress has been limited. This is mainly due to limited political commitment (ibid.).

A.I.5 Europe and Central Asia

Kyrgyzstan

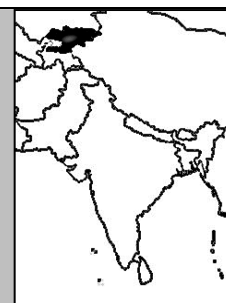


Table A.11

Kyrgyzstan: Selected development and social health protection indicators

- Total population: 5.3 million[1]
- GDP per capita: US$1,098[2]
- HDI: 0.622 [Rank: 125][3]
- Total expenditures on health as a % of GDP: 6.5[4]
- Deficit of social health protection coverage as % of population: 17.0[5]
- OOP as a % of THE: 34.4[4]8[4]
- % of population not covered due to financial resources deficit: 80.4[5]9[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 0.0[5]
- Maternal mortality ratio: 7.1[5]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

Located in Central Asia, Kyrgyzstan is a low-income country with a majority of its population living outside its cities. Of a total of 5.3 million inhabitants, almost one-third are younger than 14 years. In 1991 Kyrgyzstan became an independent country, experiencing a number of turbulent transition years characterized by a shrinking economy. In the course of the 2000s economic growth resumed and poverty levels started to decline (World Bank, 2013). Nevertheless, Kyrgyzstan still faces high poverty levels and considerable inequality: in 2007, 27 per cent of its population was living on less than US$2.15 a day and its Gini coefficient stands at 33.4 (World Bank Databank, 2013).

In the mid-1990s the Kyrgyz Government introduced an extensive reform plan which aimed at addressing issues related to health financing as well as regional inequities in resource allocation. A major component of the reform process was to diminish the influence of the State on the health system and allow a private sector to develop alongside public providers. Another component was the limitation of free services, which would from then on be offered in the form of a package of essential health-care services available to all in need. The Health Protection Law of 1992, revised in 2005, states that social fairness, equity and accessibility to health services are at the basis of health provision by the State of Kyrgyzstan. During the reforms, the financial burden posed on individuals decreased significantly, especially for the poorest 40 per cent of the population (Ainura et al., 2011).

Before transition, the health system was split between four levels of governance. During the transition years funds were gradually shifted to oblast (provincial) level in order to improve risk pooling. Mandatory health insurance was introduced in 1997 (ibid.).

Financing in Kyrgyzstan comes from three main resources:

- the public sector: general taxation and mandatory health insurance;
- private households; and
- external funds from development agencies.

Total health expenditure as a percentage of GDP was relatively high when Kyrgyzstan became independent. During the transition years it declined to 5.4 per cent of GDP, after which it increased again to a level of 6.5 per cent in 2011. In 2011, 40.3 per cent of the total health expenditure derived from private resources, of which the overall majority consisted of OOP (85.3 per cent). Public expenditure for health amounted to 59.7 per cent of THE in the same year (WHO Global Health Observatory, 2013).

The major challenges faced by the Kyrgyz health sector are mostly related to financial protection. In addition, issues related to the quality of care − especially at primary and hospital level – need to be addressed.

Poland

Table A.12

Poland: Selected development and social health protection indicators

- Total population: 38.20 million [1]
- GDP per capita: US$13,424 [2]
- HDI: 0.821 [Rank: 39] [3]
- Total expenditures on health as a % of GDP: 6.7 [4]
- Deficit of social health protection coverage as % of population: 2.5[5]
- OOP as a % of THE: 22.9[5] [1][4]
- % of population not covered due to financial resources deficit: 0.0[5]
- Staff Access Deficit (% of population not covered due to lack of professional health staff): 0.0[5]
- Maternal mortality ratio: 0.5[5]

Sources: 1 UNDESA: *World Population Prospects*, 2012. 2 UNDATA, 2011. 3 UNDP: *Human Development Indicators*, 2011. 4 WHO: Global Health Observatory, 2010/11. 5 Adapted from table under Annex III

Following political independence in 1989, Poland began the transition from a planned to a market economy. Today it is a stable democracy enjoying constant economic growth, and is well-represented in international politics. The majority of its population resides in rural areas. Before the transition its health system was based on the Semashko model, which is characterized by strong centralization and hierarchy, tight state control and almost exclusively tax-based funding (Grielen, Boerma and Groenewegen, 2000). After transition the Polish health system shifted towards a decentralized system with mandatory health insurance, complemented by state financing and territorial self-government budgets. The Ministry of Health serves as policy-maker and regulator (Sagan et al., 2011).

Article 68 of the 1997 Polish constitution stipulates that all Polish citizens – regardless of their financial circumstances – have the right to equal access to health services financed from public sources. The article explicitly mentions coverage of vulnerable populations, such as children, pregnant women, and persons with special needs, as the responsibility of the public authorities. The 1997 Law on the Universal Health Insurance specifies resource allocation with a system of financing from health contributions, based on social health insurance (SHI) rules. Currently, around 98 per cent of the Polish population is covered by compulsory health insurance (ILO, 2013a). Health financing and health provision are clearly separated: the National Health Fund (NFZ) is solely in charge of health-care financing and contracts with public and non-public health-care providers (ibid.).

From 1995 to 2011, total health expenditure as a percentage of GDP increased from 5.5 to 6.7 per cent (WHO Global Health Observatory, 2011). Financing for health care comes from four different sources:

- insurance premiums collected by the National Health Fund;
- State budget;
- local governmental unit budgets; and
- private sources

The share of government expenditure exceeds two-thirds of total health expenditure. The bulk of private expenditure consists of OOP, which have been decreasing over the past years to a share of 22.9 per cent of THE. The majority of OOP are spent on medicines, followed by medical and rehabilitation services.

Compulsory health insurance guarantees access to a broad range of health services, for which patients are exempt from paying fees. These services include, amongst others, primary care, ambulatory specialist care, hospital treatment, psychiatric care and addiction treatment, dental care, and nursing and long-term care (Article 15 of the 2004 Law on Health Care Services Financed from Public Sources). With the exception of medicines, medicinal products and auxiliary medical devices, and certain treatments and dental procedures and materials, services are fully covered. Nevertheless, as a consequence of the limited financial resources the NFZ has at hand, benefits guaranteed on paper are not always available in reality (Sagan et al., 2011).

The biggest challenge faced by Poland's health system today is its limited sources for financing social protection in health, which affects accessibility to services of adequate quality. Furthermore, the reliability of the health information system should be improved in order to ensure efficient and effective planning of human resources and infrastructure and improve the quality of care, in addition to minimizing the loss of financial resources (ibid.).

ANNEX II: The Social Protection Floors Recommendation, 2012 (No. 202)

PREAMBLE

The General Conference of the International Labour Organization,

Having been convened at Geneva by the Governing Body of the International Labour Office, and having met in its 101st Session on 30 May 2012, and

Reaffirming that the right to social security is a human right, and

Acknowledging that the right to social security is, along with promoting employment, an economic and social necessity for development and progress, and

Recognizing that social security is an important tool to prevent and reduce poverty, inequality, social exclusion and social insecurity, to promote equal opportunity and gender and racial equality, and to support the transition from informal to formal employment, and

Considering that social security is an investment in people that empowers them to adjust to changes in the economy and in the labour market, and that social security systems act as automatic social and economic stabilizers, help stimulate aggregate demand in times of crisis and beyond, and help support a transition to a more sustainable economy, and

Considering that the prioritization of policies aimed at sustainable long-term growth associated with social inclusion helps overcome extreme poverty and reduces social inequalities and differences within and among regions, and

Recognizing that the transition to formal employment and the establishment of sustainable social security systems are mutually supportive, and

Recalling that the Declaration of Philadelphia recognizes the solemn obligation of the International Labour Organization to contribute to “achiev[ing] ... the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care”, and

Considering the Universal Declaration of Human Rights, in particular Articles 22 and 25, and the International Covenant on Economic, Social and Cultural Rights, in particular Articles 9, 11 and 12, and

Considering also ILO social security standards, in particular the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Income Security Recommendation, 1944 (No. 67), and the Medical Care Recommendation, 1944 (No. 69), and noting that these standards are of continuing relevance and continue to be important references for social security systems, and

Recalling that the ILO Declaration on Social Justice for a Fair Globalization recognizes that “the commitments and efforts of Members and the Organization to implement the ILO’s constitutional mandate, including through international labour standards, and to place full and productive employment and decent work at the centre of economic and social policies, should be based on ... (ii) developing and enhancing measures of social protection ... which are sustainable and adapted to national circumstances, including ... the extension of social security to all”, and

Considering the resolution and Conclusions concerning the recurrent discussion on social protection (social security) adopted by the International Labour Conference at its 100th Session (2011), which recognize the need for a Recommendation complementing existing ILO social security standards and providing guidance to Members in building social protection floors tailored to national circumstances and levels of development, as part of comprehensive social security systems, and

Having decided upon the adoption of certain proposals with regard to social protection floors, which are the subject of the fourth item on the agenda of the session, and

Having determined that these proposals shall take the form of a Recommendation;

adopts this fourteenth day of June of the year two thousand and twelve the following Recommendation, which may be cited as the Social Protection Floors Recommendation, 2012.

I. OBJECTIVES, SCOPE AND PRINCIPLES

1. This Recommendation provides guidance to Members to:

   (a) establish and maintain, as applicable, social protection floors as a fundamental element of their national social security systems; and

   (b) implement social protection floors within strategies for the extension of social security that progressively ensure higher levels of social security to as many people as possible, guided by ILO social security standards.

2. For the purpose of this Recommendation, social protection floors are nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion.

3. Recognizing the overall and primary responsibility of the State in giving effect to this Recommendation, Members should apply the following principles:

   (a) universality of protection, based on social solidarity;

   (b) entitlement to benefits prescribed by national law;

   (c) adequacy and predictability of benefits;

   (d) non-discrimination, gender equality and responsiveness to special needs;

   (e) social inclusion, including of persons in the informal economy;

   (f) respect for the rights and dignity of people covered by the social security guarantees;

   (g) progressive realization, including by setting targets and time frames;

   (h) solidarity in financing while seeking to achieve an optimal balance between the responsibilities and interests among those who finance and benefit from social security schemes;

   (i) consideration of diversity of methods and approaches, including of financing mechanisms and delivery systems;

(j) transparent, accountable and sound financial management and administration;

(k) financial, fiscal and economic sustainability with due regard to social justice and equity;

(l) coherence with social, economic and employment policies;

(m) coherence across institutions responsible for delivery of social protection;

(n) high-quality public services that enhance the delivery of social security systems;

(o) efficiency and accessibility of complaint and appeal procedures;

(p) regular monitoring of implementation, and periodic evaluation;

(q) full respect for collective bargaining and freedom of association for all workers; and

(r) tripartite participation with representative organizations of employers and workers, as well as consultation with other relevant and representative organizations of persons concerned.

II. NATIONAL SOCIAL PROTECTION FLOORS

4. Members should, in accordance with national circumstances, establish as quickly as possible and maintain their social protection floors comprising basic social security guarantees. The guarantees should 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.

5. The social protection floors referred to in Paragraph 4 should comprise at least the following basic social security guarantees:

   (a) access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;

   (b) basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;

   (c) basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and

   (d) basic income security, at least at a nationally defined minimum level, for older persons.

6. Subject to their existing international obligations, Members should provide the basic social security guarantees referred to in this Recommendation to at least all residents and children, as defined in national laws and regulations.

7. Basic social security guarantees should be established by law. National laws and regulations should specify the range, qualifying conditions and levels of the benefits giving effect to these guarantees. Impartial, transparent, effective, simple, rapid,

accessible and inexpensive complaint and appeal procedures should also be specified. Access to complaint and appeal procedures should be free of charge to the applicant. Systems should be in place that enhance compliance with national legal frameworks.

8. When defining the basic social security guarantees, Members should give due consideration to the following:

   (a) persons in need of health care should not face hardship and an increased risk of poverty due to the financial consequences of accessing essential health care. Free prenatal and postnatal medical care for the most vulnerable should also be considered;

   (b) basic income security should allow life in dignity. Nationally defined minimum levels of income may correspond to the monetary value of a set of necessary goods and services, national poverty lines, income thresholds for social assistance or other comparable thresholds established by national law or practice, and may take into account regional differences;

   (c) the levels of basic social security guarantees should be regularly reviewed through a transparent procedure that is established by national laws, regulations or practice, as appropriate; and

   (d) in regard to the establishment and review of the levels of these guarantees, tripartite participation with representative organizations of employers and workers, as well as consultation with other relevant and representative organizations of persons concerned, should be ensured.

9. (a) In providing the basic social security guarantees, Members should consider different approaches with a view to implementing the most effective and efficient combination of benefits and schemes in the national context.

   (b) Benefits may include child and family benefits, sickness and health-care benefits, maternity benefits, disability benefits, old-age benefits, survivors' benefits, unemployment benefits and employment guarantees, and employment injury benefits as well as any other social benefits in cash or in kind.

   (c) Schemes providing such benefits may include universal benefit schemes, social insurance schemes, social assistance schemes, negative income tax schemes, public employment schemes and employment support schemes.

10. In designing and implementing national social protection floors, Members should:

   (a) combine preventive, promotional and active measures, benefits and social services;

   (b) promote productive economic activity and formal employment through considering policies that include public procurement, government credit provisions, labour inspection, labour market policies and tax incentives, and that promote education, vocational training, productive skills and employability; and

   (c) ensure coordination with other policies that enhance formal employment, income generation, education, literacy, vocational training, skills and employability, that reduce precariousness, and that promote secure work, entrepreneurship and sustainable enterprises within a decent work framework.

11. (a) Members should consider using a variety of different methods to mobilize the necessary resources to ensure financial, fiscal and economic sustainability of

national social protection floors, taking into account the contributory capacities of different population groups. Such methods may include, individually or in combination, effective enforcement of tax and contribution obligations, reprioritizing expenditure, or a broader and sufficiently progressive revenue base.

(b) In applying such methods, Members should consider the need to implement measures to prevent fraud, tax evasion and non-payment of contributions.

12. National social protection floors should be financed by national resources. Members whose economic and fiscal capacities are insufficient to implement the guarantees may seek international cooperation and support that complement their own efforts.

III. NATIONAL STRATEGIES FOR EXTENSION OF SOCIAL SECURITY

13. (a) Members should formulate and implement national social security extension strategies, based on national consultations through effective social dialogue and social participation. National strategies should:

    (i) prioritize the implementation of social protection floors as a starting point for countries that do not have a minimum level of social security guarantees, and as a fundamental element of their national social security systems; and

    (ii) seek to provide higher levels of protection to as many people as possible, reflecting economic and fiscal capacities of Members, and as soon as possible.

    (b) For this purpose, Members should progressively build and maintain comprehensive and adequate social security systems coherent with national policy objectives and seek to coordinate social security policies with other public policies.

14. When formulating and implementing national social security extension strategies, Members should:

    (a) set objectives reflecting national priorities;

    (b) identify gaps in, and barriers to, protection;

    (c) seek to close gaps in protection through appropriate and effectively coordinated schemes, whether contributory or non-contributory, or both, including through the extension of existing contributory schemes to all concerned persons with contributory capacity;

    (d) complement social security with active labour market policies, including vocational training or other measures, as appropriate;

    (e) specify financial requirements and resources as well as the time frame and sequencing for the progressive achievement of the objectives; and

    (f) raise awareness about their social protection floors and their extension strategies, and undertake information programmes, including through social dialogue.

15. Social security extension strategies should apply to persons both in the formal and informal economy and support the growth of formal employment and the reduction of informality, and should be consistent with, and conducive to, the implementation of the social, economic and environmental development plans of Members.

16. Social security extension strategies should ensure support for disadvantaged groups and people with special needs.

17. When building comprehensive social security systems reflecting national objectives, priorities and economic and fiscal capacities, Members should aim to achieve the range and levels of benefits set out in the Social Security (Minimum Standards) Convention, 1952 (No. 102), or in other ILO social security Conventions and Recommendations setting out more advanced standards.

18. Members should consider ratifying, as early as national circumstances allow, the Social Security (Minimum Standards) Convention, 1952 (No. 102). Furthermore, Members should consider ratifying, or giving effect to, as applicable, other ILO social security Conventions and Recommendations setting out more advanced standards.

IV. MONITORING

19. Members should monitor progress in implementing social protection floors and achieving other objectives of national social security extension strategies through appropriate nationally defined mechanisms, including tripartite participation with representative organizations of employers and workers, as well as consultation with other relevant and representative organizations of persons concerned.

20. Members should regularly convene national consultations to assess progress and discuss policies for the further horizontal and vertical extension of social security.

21. For the purpose of Paragraph 19, Members should regularly collect, compile, analyse and publish an appropriate range of social security data, statistics and indicators, disaggregated, in particular, by gender.

22. In developing or revising the concepts, definitions and methodology used in the production of social security data, statistics and indicators, Members should take into consideration relevant guidance provided by the International Labour Organization, in particular, as appropriate, the resolution concerning the development of social security statistics adopted by the Ninth International Conference of Labour Statisticians.

23. Members should establish a legal framework to secure and protect private individual information contained in their social security data systems.

24. (a) Members are encouraged to exchange information, experiences and expertise on social security strategies, policies and practices among themselves and with the International Labour Office.

    (b) In implementing this Recommendation, Members may seek technical assistance from the International Labour Organization and other relevant international organizations in accordance with their respective mandates

ANNEX III: The multiple dimensions of health coverage

	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Mater-nal mor-tality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
Country code	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007)[2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change)[3]	Out-of- pocket expenditure in constant US$ per capita (2007)[2]	Out-of- pocket expenditure in constant US$ per capita (2011)[2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change)[3]	deficit (threshold: US$60 MDG target for 2015 in low income)[2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239)[3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23)[3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1)[3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Africa	24.7		57.1	73.6	30.5	36.0		23.2	24.5		50.6	78.0	66.5	52.3	53.5		42.9
Latin America and the Caribbean	81.7		64.4	531.8	180.8	215.1		145.2	145.8		1.2	9.2	18.0	5.2	93.2		7.5
North America	85.6		88.4	7357.2	3120.8	3415.6		861.6	828.5		0.0	0.0	0.0	0.0	99.3		2.0
Western Europe	99.7		86.2	3918.0	2597.0	2747.0		472.6	480.3		0.0	0.0	0.0	0.0	98.9		0.7
Central and Eastern Europe	91.6		67.6	496.7	258.8	287.7		99.3	127.2		0.0	7.2	0.3	0.0	99.5		2.5
Asia and the Pacific	58.0		53.4	263.5	126.7	172.9		53.3	66.6		31.2	56.5	44.2	19.6	77.6		12.5
Middle East	72.9		57.2	357.5	173.7	183.6		89.5	86.8		10.4	31.4	40.6	12.0	90.2		5.2
World[12]	61.1		59.2	851.4	422.0	479.7		125.8	133.9		26.7	47.4	38.4	20.0	78.8		14.8
Africa																	
Algeria	85.2	2005	81.8	183.9	86.2	109.4	6.1	24.0	24.7	0.8	0.0	23.1	0.0	32.5	95.2	2009	9.7
Angola	0.0	2005	72.7	135.4	52.8	57.5	2.2	21.7	25.5	4.1	0.0	43.4	32.0	62.0	49.4	2009	45.0

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Benin	9.0	2009	57.4	21.1	13.5	14.5	1.9	12.3	11.6	-1.3	72.5	91.2	66.8	81.4	84.1	2012	35.0
Botswana	...	...	95.0	410.4	411.2	220.8	-14.4	14.8	16.2	2.2	0.0	0.0	0.0	32.0	99.1	2010	16.0
Burkina Faso	1.0	2010	63.4	23.6	16.1	13.3	-4.6	9.9	9.7	-0.6	57.4	90.1	75.3	86.2	67.1	2010	30.0
Burundi	28.4	2009	56.4	13.2	6.0	4.9	-4.9	6.0	5.9	-0.2	78.3	94.5	93.2	96.2	60.3	2010	80.0
Cameroon	2.0	2009	34.9	23.8	10.3	16.7	12.9	33.6	34.9	1.0	66.0	90.0	82.0	89.9	63.6	2011	69.0
Cabo Verde	65.0	...	76.6	121.1	92.7	88.3	-1.2	26.0	27.5	1.5	0.0	49.3	62.7	79.1	75.6	2009	7.9
Central African Republic	6.0	...	56.6	10.4	8.1	7.0	-3.3	6.4	6.1	-1.2	88.4	95.7	87.5	93.0	53.8	2010	89.0
Chad	...	...	29.5	10.4	5.0	5.4	2.0	16.0	14.1	-3.1	85.8	95.7	92.1	95.6	16.6	2010	110.0
Comoros	5.0	...	57.8	24.6	16.2	17.0	1.3	13.2	12.4	-1.5	63.0	89.7	57.4	76.2	62.0	2000	28.0
Congo	...	...	68.5	59.8	26.4	33.0	5.8	16.7	15.3	-2.1	44.0	75.0	61.0	78.2	93.6	2012	56.0
Congo, Democratic Republic	10.0	2010	56.5	11.1	2.6	4.3	13.1	3.9	4.5	3.7	82.9	95.3	77.1	87.2	80.4	2010	54.0
Côte d'Ivoire	1.2	2008	35.7	28.4	11.5	15.2	7.2	36.8	36.8	0.0	77.5	88.1	73.8	85.3	59.4	2012	40.0
Djibouti	30.0	2006	68.4	71.9	49.7	54.2	2.2	21.9	25.2	3.6	0.0	69.9	57.0	75.9	78.4	2006	20.0
Egypt	51.1	2008	41.8	57.1	28.3	30.6	2.0	39.4	44.0	2.8	20.4	76.1	0.0	0.0	78.9	2008	6.6
Equatorial Guinea	...	...	68.4	845.5	211.7	496.9	23.8	77.6	237.1	32.2	0.0	0.0	75.0	86.0	65.0	2000	24.0
Eritrea	5.0	2011	48.8	6.8	3.4	3.0	-3.4	4.1	3.1	-6.7	90.4	97.2	80.7	89.2	28.0	2002	24.0

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Ethiopia	5.0	2011	66.2	11.0	5.3	6.8	6.6	3.2	4.1	5.9	83.3	95.4	88.8	93.7	10.0	2011	35.0
Gabon	57.6	2011	53.4	191.5	82.0	105.6	6.5	104.9	92.0	-3.2	0.0	19.9	0.0	0.0	87.0	2000	23.0
Gambia	99.9	2011	77.7	21.3	8.5	12.4	9.9	3.8	4.0	1.6	67.0	91.1	61.5	78.5	56.1	2010	36.0
Ghana	73.9	2010	70.9	53.2	20.1	18.1	-2.5	8.1	10.6	6.8	18.4	77.7	53.7	74.1	54.7	2008	35.0
Guinea	0.2	2010	32.6	9.7	3.6	...	...	16.4	...	...	95.5	95.9	94.9	97.2	46.1	2007	61.0
Guinea-Bissau	1.6	2011	58.7	21.8	5.9	...	...	11.8	...	...	73.7	90.9	69.5	83.0	44.0	2010	79.0
Kenya	39.4	2009	53.6	19.4	10.7	10.3	-1.0	11.1	11.8	1.5	64.7	91.9	59.2	77.2	43.8	2009	36.0
Lesotho	17.6	2009	82.1	115.9	39.7	75.9	17.5	14.1	15.2	2.0	0.0	51.5	74.3	85.6	61.5	2009	62.0
Liberia	...	...	82.3	45.2	5.5	11.8	21.1	7.7	8.4	2.2	68.7	81.1	89.3	94.0	46.3	2007	77.0
Libyan Arab Jamahiriya	100.0	2004	68.8	273.7	135.9	170.4	5.8	68.9	77.3	2.9	0.0	0.0	0.0	0.0	98.3	2007	5.8
Madagascar	3.7	2009	74.8	14.2	8.1	7.1	-3.1	2.8	2.9	0.4	80.6	94.1	82.8	90.4	43.9	2009	24.0
Malawi	...	...	85.8	26.5	10.0	16.3	13.0	2.5	3.2	7.0	61.5	88.9	86.1	92.2	71.4	2010	46.0
Mali	1.9	2008	45.7	20.4	14.5	13.6	-1.5	15.4	16.3	1.4	75.0	91.5	76.6	86.9	49.0	2006	54.0
Mauritania	6.0	2009	62.7	36.2	16.5	19.1	3.7	11.3	11.8	0.9	60.1	84.9	68.5	82.4	57.1	2007	51.0
Mauritius	100.0	2010	47.0	239.5	101.5	153.4	10.9	158.8	202.2	6.2	0.0	0.0	0.0	0.0	99.5	2010	6.0
Morocco	42.3	2007	42.0	78.1	39.9	51.0	6.3	66.4	86.2	6.7	0.0	67.3	32.7	62.3	73.6	2011	10.0
Mozambique	4.0	2011	91.0	32.0	12.1	11.5	-1.4	1.7	2.7	12.6	69.8	86.6	86.8	92.6	54.3	2011	49.0

	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
Country code	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Namibia	28.0	2007	92.3	261.2	143.4	120.3	-4.3	22.4	24.0	1.7	0.0	0.0	0.0	29.7	81.4	2007	20.0
Niger	3.1	2003	62.4	12.6	7.1	7.0	-0.3	6.6	4.8	-7.7	82.4	94.7	93.9	96.6	17.7	2006	59.0
Nigeria	2.2	2008	39.6	31.5	20.5	19.9	-0.7	38.7	32.8	-4.0	57.1	86.8	27.8	59.6	34.4	2008	63.0
Rwanda	91.0	2010	78.6	49.3	13.8	23.1	13.7	6.9	8.5	5.3	27.4	79.4	71.4	84.0	69.0	2010	34.0
Sao Tome and Principe	2.1	2009	43.1	50.6	17.4	23.9	8.3	31.8	40.9	6.5	30.2	78.8	10.1	49.7	80.6	2009	7.0
Senegal	20.1	2007	67.3	45.1	25.7	28.6	2.7	16.1	16.2	0.1	36.0	81.2	81.0	89.4	65.1	2011	37.0
Seychelles	90.0	2011	94.6	414.7	407.9	464.9	3.3	24.7	27.5	2.7	0.0	0.0	0.0	0.0	99.0	2009	...
Sierra Leone	0.0	2008	25.1	17.2	5.5	9.5	14.5	40.4	47.1	3.9	85.2	92.8	91.6	95.3	60.8	2010	89.0
Somalia	20.0	2006	...	...	...	...	...	...	...	...	...	...	94.6	97.0	9.4	2006	100.0
South Africa	100.0	2010	92.8	639.6	195.4	245.2	5.8	41.1	37.1	-2.6	0.0	0.0	0.0	0.0	91.0	2003	30.0
South Sudan	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Sudan	29.7	2009	30.9	32.0	16.5	15.9	-1.0	31.4	41.0	6.8	54.1	86.6	49.4	71.7	23.2	2006	73.0
Swaziland	6.2	2006	86.9	230.2	114.2	135.5	4.4	23.0	26.4	3.5	0.0	3.7	0.0	0.0	82.0	2010	32.0
Tanzania, United Rep. of	13.0	2010	68.3	25.5	14.4	13.0	-2.6	3.4	11.0	34.6	55.4	89.3	91.1	95.0	48.9	2010	46.0
Togo	4.0	2010	59.6	26.8	8.6	16.5	17.8	14.6	12.8	-3.3	63.8	88.8	85.8	92.1	43.9	2010	30.0
Tunisia	80.0	2005	60.5	161.4	105.6	125.8	4.5	83.5	90.1	1.9	0.0	32.5	0.0	0.0	94.6	2006	5.6
Uganda	2.0	2008	52.2	22.2	6.5	10.3	12.3	17.8	18.6	1.1	60.7	90.7	51.0	72.6	58.0	2011	31.0

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Zambia	8.4	2008	73.0	63.7	20.5	28.4	8.5	12.9	11.6	-2.6	10.6	73.3	66.7	81.4	46.5	2007	44.0
Zimbabwe	1.0	2009	...	...	...	...	...	...	...	...	...	...	44.6	69.0	66.2	2011	57.0
Latin America and the Caribbean																	
Antigua and Barbuda	51.1	2007	71.8	537.2	425.3	446.2	1.2	168.6	184.5	2.3	0.0	0.0	0.0	33.1	100.0	2010	...
Argentina	96.8	2008	75.3	671.3	262.3	333.4	6.2	115.7	112.1	-0.8	0.0	0.0	0.0	16.3	99.4	2010	7.7
Aruba	99.2	2003	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Bahamas	100.0	1995	71.3	1228.0	775.3	788.5	0.4	512.3	491.5	-1.0	0.0	0.0	0.0	0.0	99.0	2008	4.7
Barbados	100.0	1995	71.0	732.0	549.3	617.8	3.0	249.3	279.6	2.9	0.0	0.0	0.0	0.0	100.0	2008	5.1
Belize	25.0	2009	76.6	200.8	123.2	154.5	5.8	53.2	54.4	0.5	0.0	16.0	0.0	39.1	94.3	2010	5.3
Bolivia (Plurinational State of)	42.7	2009	74.2	87.6	35.4	43.8	5.5	12.0	16.0	7.3	0.0	63.3	0.0	34.1	71.1	2008	19.0
Brazil	100.0	2009	68.7	769.4	181.5	233.2	6.5	147.7	159.7	2.0	0.0	0.0	0.0	0.0	98.9	2010	5.6
Colombia	87.7	2010	83.0	358.5	167.2	187.5	2.9	73.2	42.6	-12.6	0.0	0.0	7.0	47.9	99.2	2011	9.2
Costa Rica	100.0	2009	72.8	686.3	314.1	420.5	7.6	134.3	129.7	-0.9	0.0	0.0	19.9	55.2	95.3	2010	4.0
Cuba	100.0	2011	94.7	573.8	450.9	483.8	1.8	24.5	27.2	2.7	0.0	0.0	0.0	0.0	99.9	2011	7.3

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Chile	93.1	2011	62.8	675.2	228.1	313.8	8.3	211.1	248.3	4.1	0.0	0.0	50.6	72.3	99.7	2010	2.5
Dominica	13.4	2009	76.4	319.5	196.1	289.0	10.2	97.9	85.6	-3.3	0.0	0.0	0.0	0.0	100.0	2011	...
Dominican Republic	26.5	2007	60.0	177.5	97.8	129.5	7.3	87.5	104.9	4.6	0.0	25.7	0.0	26.6	95.3	2010	15.0
Ecuador	22.8	2009	50.6	167.9	74.1	93.1	5.9	114.1	125.0	2.3	0.0	29.8	0.0	19.3	89.2	2010	11.0
El Salvador	21.6	2009	67.7	170.0	112.2	128.8	3.5	69.2	65.7	-1.3	0.0	28.9	0.1	44.1	84.6	2008	8.1
Guatemala	30.0	2005	46.6	99.7	54.8	54.0	-0.4	89.4	81.3	-2.3	0.0	58.3	0.0	6.6	51.3	2009	12.0
Grenada																	
Guyana	23.8	2009	82.0	163.9	31.2	62.9	19.1	11.4	14.3	5.7	0.0	31.4	69.4	82.9	87.4	2009	28.0
Haiti	3.1	2001	77.9	44.9	6.1	8.3	8.0	10.2	1.8	-35.6	54.2	81.2	88.1	93.3	26.1	2006	35.0
Honduras	12.0	2006	54.3	...	56.1	63.3	3.1	62.1	63.0	0.4	...	...	42.6	67.9	66.3	2006	10.0
Jamaica	20.1	2007	68.5	...	106.8	111.3	1.0	69.9	68.3	-0.6	...	...	36.7	64.6	98.0	2009	11.0
Mexico	85.6	2010	52.2	...	228.2	253.7	2.7	255.6	238.6	-1.7	...	...	0.0	0.0	95.3	2009	5.0
Nicaragua	12.2	2005	60.4	...	47.2	54.1	3.5	36.2	42.1	3.9	...	...	42.6	67.9	73.7	2007	9.5
Panama	51.8	2008	73.2	514.1	242.6	387.8	12.4	112.3	154.2	8.2	0.0	0.0	0.0	19.4	83.6	2009	9.2
Paraguay	23.6	2009	43.9	154.4	37.8	60.8	12.6	50.5	88.5	15.1	0.0	35.4	0.0	39.6	84.6	2008	9.9
Peru	64.4	2010	61.7	178.1	98.4	110.1	2.9	59.6	72.6	5.1	0.0	25.5	5.8	47.3	85.0	2011	6.7
Saint Kitts and Nevis	28.8	2008	58.2	344.6	248.3	258.4	1.0	208.0	190.1	-2.2	0.0	0.0	0.0	0.0	100.0	2008	...
Saint Lucia	35.5	2003	48.9	246.2	179.9	215.8	4.7	221.8	244.9	2.5	0.0	0.0	6.3	47.5	98.5	2010	3.5

	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
Country code	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Saint Vincent and the Grenadines	9.4	2008	81.7	253.4	181.0	214.2	4.3	39.3	48.1	5.1	0.0	0.0	0.0	0.0	98.3	2010	4.8
Suriname	...	...	89.0	408.4	114.3	131.9	3.6	25.4	27.3	1.9	0.0	0.0	0.0	0.0	86.5	2006	13.0
Trinidad and Tobago	...	...	61.5	587.6	340.6	396.2	3.9	287.2	299.7	1.1	0.0	0.0	0.0	0.0	96.9	2006	4.6
Uruguay	97.2	2010	86.9	960.3	251.5	394.0	11.9	62.7	76.3	5.0	0.0	0.0	0.0	0.0	99.7	2009	2.9
Venezuela, Bolivarian Republic	100.0	2010	43.0	238.7	167.3	117.0	-8.5	185.5	181.8	-0.5	0.0	0.1	0.0	38.3	98.1	2011	9.2
North America																	
Canada	100.0	2011	85.6	4820.0	2550.7	2751.0	1.9	535.5	562.0	1.2	0.0	0.0	0.0	0.0	98.5	2010	1.2
United States	84.0	2010	88.7	7635.6	3183.3	3488.5	2.3	897.4	857.8	-1.1	0.0	0.0	0.0	0.0	99.4	2010	2.1
Asia																	
Afghanistan	...	...	20.6	11.5	2.8	5.1	15.6	21.8	25.8	4.3	89.2	95.2	86.2	92.3	38.6	2011	46.0
Armenia	100.0	2009	42.6	60.3	33.1	31.0	-1.7	43.7	49.6	3.2	0.7	74.8	0.0	0.0	99.5	2010	3.0
Azerbaijan	2.9	2006	29.9	106.7	24.8	33.2	7.6	93.4	108.5	3.8	0.0	55.3	0.0	0.0	88.6	2006	4.3
Bahrain	100.0	2006	83.4	617.2	431.9	346.2	-5.4	117.1	70.7	-11.8	0.0	0.0	0.0	21.9	97.3	2009	2.0

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Bangladesh	1.4	2003	38.7	...	5.4	7.5	8.6	9.9	12.6	6.0	...	...	75.7	86.4	31.1	2011	24.0
Bhutan	90.0	2009	84.7	78.8	63.7	58.4	-2.2	11.0	10.7	-0.7	0.0	67.0	50.9	72.6	58.2	2010	18.0
Brunei Darussalam	100.0	2010	85.2	846.5	538.2	519.9	-0.9	97.7	90.4	-1.9	0.0	0.0	0.0	0.0	99.7	2011	2.4
Cambodia	26.1	2009	43.1	22.1	5.5	8.3	11.1	13.4	21.1	12.1	55.3	90.8	55.8	75.2	71.0	2010	25.0
China	96.9	2010	65.2	181.4	44.7	89.1	18.8	41.9	55.4	7.2	0.0	24.1	0.0	29.0	99.6	2010	3.7
Cyprus	65.0	2008	50.6	1074.8	576.1	667.3	3.7	646.3	761.6	4.2	0.0	0.0	0.0	0.0	98.3	2009	1.0
Georgia	25.0	2008	35.1	109.9	25.9	34.6	7.6	103.2	123.9	4.7	0.0	54.0	0.0	0.0	97.4	2010	6.7
Hong Kong (China), Special Administrative Region	100.0	2010	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
India	12.5	2010	40.6	24.0	8.2	12.6	11.3	22.0	24.7	3.0	65.1	90.0	33.1	62.5	57.7	2009	20.0
Indonesia	59.0	2010	50.1	47.6	17.2	15.6	-2.3	21.0	22.5	1.8	20.7	80.1	31.6	61.7	79.8	2010	22.0
Iran, Islamic Republic of	90.0	2005	41.5	143.8	81.1	66.1	-5.0	101.2	97.2	-1.0	0.0	39.8	9.0	49.1	99.0	2007	2.1
Iraq	...	...	80.7	267.5	27.2	61.8	22.8	11.9	13.9	3.8	0.0	0.0	15.7	52.8	88.5	2011	6.3
Israel	100.0	2011	78.6	1907.8	968.7	1060.5	2.3	322.2	368.4	3.4	0.0	0.0	0.0	0.0	...	...	0.7
Occupied Palestinian Territory	16.2	2004	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...

	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
Country code	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Japan	100.0	2010	83.6	3552.2	2459.7	3192.7	6.7	493.4	656.7	7.4	0.0	0.0	0.0	0.0	99.8	2011	0.5
Jordan	75.0	2006	75.3	295.3	130.4	160.9	5.4	78.3	58.6	-7.0	0.0	0.0	0.0	0.0	99.1	2007	6.3
Kazakhstan	70.0	2001	58.5	266.1	79.4	117.5	10.3	71.8	84.2	4.0	0.0	0.0	0.0	0.0	99.4	2010	5.1
Korea, Democratic People's Republic	...	...	...	...	4.7	...	...	...	...	...	...	...	0.0	0.0	100.0	2009	8.1
Korea, Republic of	100.0	2010	67.1	1084.7	676.2	920.1	8.0	420.7	527.9	5.8	0.0	0.0	0.0	0.0	99.9	2009	1.6
Kuwait	100.0	2006	83.9	1258.2	631.5	697.3	2.5	155.0	137.0	-3.0	0.0	0.0	0.0	0.0	98.6	2010	1.4
Kyrgyzstan	83.0	2001	65.6	46.8	18.9	22.2	4.1	16.6	12.8	-6.3	45.1	80.4	0.0	0.0	98.3	2010	7.1
Lao People's Democratic Republic	11.6	2009	60.3	22.2	5.6	9.5	14.4	12.6	7.7	-11.7	62.6	90.7	57.3	76.1	37.0	2010	47.0
Lebanon	48.3	2007	43.5	270.8	189.0	122.2	-10.3	213.0	270.6	6.2	0.0	0.0	0.0	0.0	98.0	2004	2.5
Malaysia	100.0	2010	58.3	201.6	114.4	137.4	4.7	76.7	88.2	3.5	0.0	15.6	0.0	0.0	98.6	2010	2.9
Maldives	30.0	2011	50.9	277.3	172.0	182.7	1.5	72.1	201.9	29.4	0.0	0.0	0.0	0.0	94.8	2009	6.0
Mongolia	81.9	2009	60.3	96.9	34.0	42.7	5.8	25.0	29.6	4.4	0.0	59.5	0.0	0.0	99.0	2010	6.3
Myanmar	...	...	19.3	4.4	0.6	0.8	6.1	4.4	4.9	3.2	94.7	98.2	41.0	67.0	70.6	2010	20.0
Nepal	0.1	2010	51.7	...	5.7	7.5	7.0	9.2	10.4	3.3	...	...	72.8	84.8	36.0	2011	17.0
Oman	97.0	2005	88.6	529.7	268.7	290.5	2.0	40.1	41.2	0.6	0.0	0.0	0.0	0.0	98.6	2008	3.2
Pakistan	26.6	2009	37.0	11.0	6.1	5.3	-3.5	13.9	12.3	-3.0	81.8	95.4	43.0	68.1	45.0	2011	26.0

	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
Country code	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD) [3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011) [2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff [2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births) [5]
Philippines	82.0	2009	44.1	42.5	17.8	19.5	2.3	28.0	32.7	4.0	41.1	82.2	0.0	0.0	62.2	2008	9.9
Qatar	100.0	2006	86.4	1533.6	1093.4	942.2	-3.7	207.4	163.6	-5.8	0.0	0.0	0.0	0.0	100.0	2012	0.7
Saudi Arabia	26.0	2010	82.0	621.0	361.4	369.3	0.5	85.9	98.0	3.3	0.0	0.0	0.0	31.0	100.0	2011	2.4
Singapore	100.0	2010	39.6	904.8	306.2	483.2	12.1	799.8	941.3	4.2	0.0	0.0	0.0	0.0	99.7	2011	0.3
Sri Lanka	100.0	2010	54.1	52.2	25.5	26.2	0.7	21.7	27.0	5.6	35.7	78.2	0.0	41.2	98.6	2007	3.5
Syrian Arab Republic	90.0	2008	49.0	49.5	30.1	30.9	0.6	31.3	32.1	0.7	25.6	79.3	0.0	23.6	96.2	2009	7.0
Tajikistan	0.3	2010	39.9	21.6	4.8	8.4	15.1	15.8	17.1	2.0	72.6	91.0	0.0	0.0	88.4	2007	6.5
Thailand	98.0	2007	86.3	174.2	78.5	93.1	4.4	14.9	16.7	2.8	0.0	27.1	24.7	57.9	99.4	2009	4.8
Timor-Leste	...	...	96.0	44.4	40.2	23.4	-12.7	1.1	1.3	3.6	15.8	81.4	26.9	59.1	29.6	2010	30.0
Turkmenistan	82.3	2011	60.8	78.4	60.5	90.2	10.5	31.4	58.2	16.7	0.0	67.2	0.0	0.0	99.5	2006	6.7
United Arab Emirates	100.0	2010	83.8	1374.5	569.9	743.2	6.9	283.3	161.7	-13.1	0.0	0.0	0.0	24.0	100.0	2010	1.2
Uzbekistan	100.0	2010	56.1	49.6	14.6	23.3	12.5	18.8	21.8	3.7	21.7	79.2	0.0	0.0	99.6	2006	2.8
Viet Nam	61.0	2010	44.3	42.0	20.4	24.3	4.5	28.4	34.2	4.7	41.4	82.4	6.6	47.7	91.9	2011	5.9
Yemen	42.0	2003	21.9	19.4	13.9	10.1	-7.7	32.4	37.9	4.0	73.5	91.9	61.0	78.2	35.7	2006	20.0
Europe																	
Albania	23.6	2008	45.0	114.6	77.2	97.4	6.0	94.1	121.6	6.6	0.0	52.1	0.0	0.0	99.3	2009	2.7

Country code	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
	Extent of coverage		**Financial resources: Composition, level and trends (2011)**										**Human resources (and access indicators)**		**Live births attended by skilled health staff**		**Maternal mortality rate (2010)**
					Trends in government expenditure on health (constant US$ per capita)			**Trends in out-of-pocket expenditure** (constant US$ per capita)									
Andorra	...	...	80.4	2458.3	1781.6	1792.9	0.2	570.3	479.4	-4.2	0.0	0.0	0.0	0.0	...	...	...
Austria	99.3	2010	83.7	4417.3	3073.0	3283.9	1.7	667.5	710.1	1.6	0.0	0.0	0.0	0.0	98.6	2009	0.4
Belarus	100.0	2010	73.3	225.1	165.2	164.6	-0.1	56.3	62.2	2.5	0.0	5.8	0.0	0.0	99.9	2009	0.4
Belgium	99.0	2010	80.9	4013.4	2637.5	2991.5	3.2	752.9	753.4	0.0	0.0	0.0	0.0	0.0	99.4	2009	0.8
Bosnia and Herzegovina	59.2	2004	68.7	338.2	181.0	238.3	7.1	103.0	109.8	1.6	0.0	0.0	0.0	0.0	99.9	2009	0.8
Bulgaria	87.0	2008	57.1	...	169.6	180.9	1.6	118.3	141.4	4.6	...	...	0.0	0.0	99.6	2008	1.1
Croatia	97.0	2009	85.4	...	673.9	658.5	-0.6	96.4	113.8	4.2	...	...	0.0	0.0	99.9	2010	1.7
Czech Republic	100.0	2011	84.9	1279.5	782.7	872.1	2.7	121.1	157.6	6.8	0.0	0.0	0.0	0.0	99.7	2010	0.5
Denmark	100.0	2011	86.8	5772.4	4133.2	4354.2	1.3	683.0	673.2	-0.4	0.0	0.0	0.0	0.0	98.5	2011	1.2
Estonia	92.9	2011	81.4	803.5	479.7	531.5	2.6	133.8	125.2	-1.7	0.0	0.0	0.0	0.0	99.4	2011	0.2
Finland	100.0	2010	80.8	3496.7	2585.4	2733.8	1.4	672.1	700.4	1.0	0.0	0.0	0.0	0.0	98.6	2011	0.5
France	99.9	2011	92.5	4582.5	3066.6	3090.5	0.2	274.9	300.5	2.3	0.0	0.0	0.0	0.0	97.5	2010	0.8
Germany	100.0	2010	87.6	4270.1	2883.1	3126.7	2.0	467.9	511.5	2.3	0.0	0.0	0.0	0.0	98.6	2008	0.7
Greece	100.0	2010	70.2	1626.0	1281.2	1100.9	-3.7	646.6	498.9	-6.3	0.0	0.0	0.0	0.0	...	...	0.3
Hungary	100.0	2010	73.8	800.9	476.6	452.0	-1.3	179.9	182.6	0.4	0.0	0.0	0.0	0.0	99.1	2010	2.1
Iceland	100.0	2010	81.8	3259.4	4014.9	3507.0	-3.3	780.5	795.2	0.5	0.0	0.0	0.0	0.0	...	...	0.5
Ireland	100.0	2011	85.5	3882.0	2773.0	2740.6	-0.3	501.5	565.8	3.1	0.0	0.0	0.0	0.0	99.8	2010	0.6

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)		Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)					Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Italy	100.0	2010	80.1	2751.0	2009.5	2083.2	0.9	527.8	537.4	0.5	0.0	0.0	0.0	0.0	99.8	2009	0.4
Latvia	70.0	2005	62.7	...	313.5	246.0	-5.9	180.2	166.7	-1.9	...	...	0.0	0.0	98.8	2010	3.4
Liechtenstein	95.0	2008	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Lithuania	95.0	2009	73.6	...	426.4	436.0	0.6	155.2	170.6	2.4	...	...	0.0	0.0	100.0	2006	0.8
Luxembourg	97.6	2010	88.6	7790.5	5260.2	5247.0	-0.1	765.3	712.8	-1.8	0.0	0.0	0.0	0.0	100.0	2003	2.0
Malta	100.0	2009	66.6	...	894.6	910.3	0.4	416.6	482.5	3.7	...	...	0.0	0.0	99.8	2010	0.8
Moldova, Republic of	75.7	2004	55.1	123.1	44.3	61.7	8.6	44.8	60.8	7.9	0.0	48.5	0.0	0.0	99.5	2005	4.1
Monaco	...	...	93.0	6699.8	4257.0	5149.3	4.9	341.1	407.0	4.5	0.0	0.0	0.0	0.0	...	...	...
Montenegro	95.0	2004	70.0	464.3	234.4	285.9	5.1	94.8	128.2	7.8	0.0	0.0	0.0	0.0	99.5	2009	0.8
Netherlands	98.9	2010	94.9	5690.2	3683.2	4091.3	2.7	264.1	242.8	-2.1	0.0	0.0	0.0	0.0	100.0	2007	0.6
Norway	100.0	2011	86.4	7767.2	4676.8	4767.4	0.5	835.5	755.7	-2.5	0.0	0.0	0.0	0.0	99.1	2010	0.7
Poland	97.5	2010	77.1	693.5	394.5	485.7	5.3	137.9	155.9	3.1	0.0	0.0	0.0	0.0	99.8	2010	0.5
Portugal	100.0	2010	72.7	1679.6	1194.6	1147.3	-1.0	456.1	489.1	1.8	0.0	0.0	0.0	0.0	100.0	2001	0.8
Romania	94.3	2009	80.8	...	227.2	252.9	2.7	47.8	61.2	6.4	...	...	0.0	0.0	98.5	2009	2.7
Russian Federation	88.0	2011	64.6	521.2	216.1	240.6	2.7	100.1	142.5	9.2	0.0	0.0	0.0	0.0	99.7	2009	3.4
San Marino	...	...	85.3	...	2900.1	2486.1	-3.8	471.7	432.6	-2.1	...	...	0.0	0.0	100.0	2008	...
Serbia	92.1	2009	63.8	396.9	237.3	253.0	1.6	134.7	147.4	2.3	0.0	0.0	0.0	0.0	99.7	2010	1.2
Slovakia	94.8	2010	74.3	...	491.1	563.9	3.5	191.3	231.5	4.9	...	...	0.0	19.7	99.5	2009	0.6

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)										Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
					Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)									
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD) [3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011) [2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff [2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births) [5]
Slovenia	100.0	2011	...	...	964.9	1079.9	2.9	177.9	192.1	1.9	...	...	0.0	0.0	99.9	2009	1.2
Spain	99.2	2010	...	...	1497.1	1611.0	1.8	424.9	440.4	0.9	...	...	0.0	0.0	...	...	0.6
Sweden	100.0	2011	83.1	4428.5	3284.8	3459.1	1.3	665.8	723.4	2.1	0.0	0.0	0.0	0.0	...	...	0.4
Switzerland	100.0	2010	75.0	6840.3	3527.0	4209.7	4.5	1819.0	1609.0	-3.0	0.0	0.0	0.0	0.0	100.0	2006	0.8
The Former Yugoslav Republic of Macedonia	94.9	2006	61.7	206.1	143.9	144.6	0.1	79.4	90.1	3.2	0.0	13.8	0.0	0.0	99.7	2011	1.0
Turkey	86.0	2011	83.9	583.9	117.2	153.7	7.0	37.7	33.1	-3.2	0.0	0.0	0.0	3.4	91.3	2008	2.0
Ukraine	100.0	2011	58.5	155.3	84.7	86.1	0.4	47.5	64.1	7.8	0.0	35.0	0.0	0.0	98.7	2007	3.2
United Kingdom	100.0	2010	90.8	3277.3	2721.1	2902.8	1.6	339.8	322.3	-1.3	0.0	0.0	0.0	0.0	99.0	1998	1.2
Oceania																	
Australia	100.0	2011	80.2	4761.1	2220.9	2305.7	0.9	593.3	665.4	2.9	0.0	0.0	0.0	0.0	99.1	2008	0.7
Cook Islands	...	...	92.5	568.2	358.5	418.6	4.0	30.7	33.9	2.6	0.0	0.0	0.0	0.0	100.0	2009	...
Fiji	100.0	2010	79.0	132.7	101.9	92.4	-2.4	21.0	28.4	7.8	0.0	44.5	0.0	35.2	99.7	2010	2.6
Kiribati	...	...	98.7	174.7	127.6	89.6	-8.4	...	1.5	...	0.0	26.9	0.0	0.0	98.3	2010	...
Marshall Islands	...	...	87.4	458.3	394.5	387.9	-0.4	58.7	58.6	0.0	0.0	0.0	0.0	26.4	86.2	2007	...
Micronesia	...	...	91.0	348.2	247.2	...	...	17.8	...	...	0.0	0.0	0.0	7.1	100.0	2009	10.0

Country code	Extent of coverage		Financial resources: Composition, level and trends (2011)		Trends in government expenditure on health (constant US$ per capita)			Trends in out-of-pocket expenditure (constant US$ per capita)					Human resources (and access indicators)		Live births attended by skilled health staff		Maternal mortality rate (2010)
	Estimate of legal health coverage as a percentage of total population [1,6]	Year	Percentage of health expenditure not financed by out of pocket [2,3,7]	Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Government expenditure on health in constant US$ per capita (2007) [2]	Government expenditure on health in constant US$ per capita (2011)[2]	Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	% live births attended by skilled health staff[2,4]	Year	Maternal mortality rate (modelled estimate, per 10,000 live births)[5]
Nauru	...	...	92.2	630.2	333.0	257.1	-6.3	13.9	23.0	13.5	0.0	0.0	0.0	0.0	97.4	2007	...
New Zealand	100.0	2011	89.5	3280.7	1970.2	2301.6	4.0	273.9	290.4	1.5	0.0	0.0	0.0	0.0	95.7	2007	1.5
Niue	...	...	99.2	2171.1	1348.5	...	...	10.3	...	...	0.0	0.0	0.0	0.0	100.0	2007	...
Palau	...	...	88.4	821.9	667.3	597.2	-2.7	92.6	92.5	0.0	0.0	0.0	0.0	0.0	100.0	2010	...
Papua New Guinea	...	...	88.3	69.6	27.5	35.9	6.8	4.3	5.3	5.5	31.3	70.9	80.7	89.2	42.7	2011	23.0
Tonga	...	...	88.9	194.8	141.9	112.8	-5.6	17.1	15.0	-3.1	0.0	18.5	0.0	0.0	99.0	2010	11.0
Tuvalu	...	...	...	...	415.1	430.4	0.9	0.5	...	...	...	...	0.0	0.0	93.1	2007	...
Western Samoa	...	...	92.9	230.8	120.3	147.6	5.3	12.6	12.0	-1.2	0.0	3.4	0.0	43.6	80.8	2009	10.0
Solomon Islands	...	...	97.0	130.0	53.4	88.8	13.6	2.2	2.9	6.8	0.0	45.6	5.2	47.0	70.1	2007	9.3
Vanuatu	100.0	2010	93.1	124.4	83.5	76.3	-2.2	5.8	6.0	0.5	0.0	48.0	28.6	60.1	74.0	2007	11.0

Sources
1 Non-OECD countries: consult detailed sources available at: http://www.social-protection.org/gimi/gess/
RessFileDownload.do?ressourceId=37218;
OECD countries: OECD Health Data 2011 , Health care coverage. Information available at: http://www.
oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.
2 World Health Organization, Global Health Expenditure database, http://apps.who.int/nha/database/
DataExplorerRegime.aspx, accessed May 2014.
3 ILO calculation based on World Health Organization, Global Health Expenditure database or Global Health Observatory.
4 World Health Organization, Global Health Observatory, http://apps.who.int/gho/data/view.main, accessed
May 2014.
5 World Bank, World Development Indicators database, http://data.worldbank.org/data-catalog/worlddevelopment-indicators, accessed May 2014.

Notes
n.a: Not applicable.
…: Not available.
6 Estimate of health coverage as a percentage of total population. Coverage includes affiliated members
of health insurance or estimation of the population having free access to health care services provided
by the State. Consult detailed data and sources available at: http://www.social-protection.org/gimi/gess/
RessourceDownload.action?ressource.ressourceId=37218.
7 Out-of-pocket expenditure as a percentage of total health expenditure: see table B.10.
8 Percentage of the population not covered due to professional health staff deficit (based on 1. median value in low vulnerability group of countries or 2. WHO threshold).
The ILO staff access deficit indicator reflects the supply side of access availability – in this case the
availability of human resources at a level that guarantees at least basic, but universal, effective access to
everybody. To estimate access to the services of skilled medical professionals (physicians and nursing and
midwifery personnel), it uses as a proxy the relative difference between the density of health professionals
in a given country and its median value in countries with a low level of vulnerability (population access
to services of medical professionals in countries with low vulnerability is thus used as a threshold for other countries). The relative ILO threshold corresponds to the median value in the group of countries assessed as 'low vulnerable' (regarding the structure of employment and poverty). Based on 2011 data from WHO (number of physicians, nursing and midwifery personnel per 10,000), the estimated median value is 41.1 per 10,000 population when weighted by total population. Another way to look at it is to refer to population not covered due to a deficit from the supply side (see second part of example below). Then, the ILO staff access deficit indicator estimates the dimension of the overall performance of health-care delivery as a percentage of the population that has no access to health care if needed. This value is above the minimum set by WHO for primary care delivery, which is 23 per 10,000. Professional staff includes physicians and nursing and midwifery personnel as defined by WHO. See Indicator definitions and metadata
(http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=3105, accessed May 2014).
9 WHO threshold: It has been estimated, in the *World Health Report 2006*, that countries with fewer than 23 physicians, nurses and midwives per 10,000 population generally fail to achieve adequate coverage rates for selected primary health-care interventions as prioritized by the Millennium Development Goals framework (WHO Health Statistics 2012, pp. 82: http://www.who.int/gho/publications/world_health_
statistics/WHS2012_IndicatorCompendium.pdf, accessed May 2014).
10 Coverage gap due to financial resources deficit based on median value in low vulnerability group of countries. The ILO financial deficit indicator follows the same principle as the access deficit indicator
regarding total health spending (in US$ per capita and per year) except out-of-pocket payments. The
relative median value in 2011 in group of countries assessed as 'low vulnerable' is estimated at 239 US$
per capita and per year.
11 According to the World Health Organization, ensuring access to the types of interventions and treatments
needed to address MDGs 4, 5 and 6 requires on average "little more than US$ 60 per capita [annually] by
2015": WHO, *The World Health Report: Health systems financing: The path to universal coverage*, World
Health Organization (Geneva, 2010).
12 Aggregate measures are weighted by total population (2012) from United Nations Population Division, *UN World Population Prospects*, 2012 Revision.
13 Example of calculation of the ILO Coverage gap due to health professional staff deficit using a relative
threshold.

	Algeria	Burkina Faso
Total of health professional staff [A=B+C]	106776	7671
Number of nursing and midwifery personnel [B]	65919	7129
Number of physicians [C]	40857	542
Total population (in thousands) [D]	38482	10051
Number of health professional per 10 000 persons [F=A/D*10]	27.75	7.63
The ILO staff access deficit indicator [(threshold-value$_{\text{country X}}$)/benchmarck * 100]	32.5	81.4
If referring to population covered:		
Total population covered if applying threshold* (thousands) [E=A/threshold*10]	25980	1866
Total population **not** covered due to health professional staff deficit (thousands) [F=D-E]	12502	8185
Percentage of total population **not** covered due to health professional staff deficit G=F/D*100	32.5	81.4

ANNEX IV: Total (public and private) health expenditure not financed by private households' out-of-pocket payments (percentage)

Major area, region or country	2011	2010	2009	2008	2007	2006	2005	2000	1995
Africa									
Northern Africa									
Algeria	81.8	80.9	80.3	80.6	78.5	75.7	73.6	74.2	76.1
Egypt	41.8	40.6	42.9	43.5	42.5	44.9	40.5	42.0	52.0
Libyan Arab Jamahiriya	68.8	70.0	68.8	67.6	66.4	65.1	65.4	50.8	49.6
Morocco	42.0	42.8	43.7	43.0	42.7	42.0	40.2	45.9	47.3
Sudan	30.0	30.5	32.4	35.9	36.7	37.7	40.0	33.6	19.4
Tunisia	60.5	59.8	60.7	60.1	58.6	59.2	59.2	63.9	59.6
Sub-Saharan Africa									
Angola	72.7	72.4	83.4	80.3	73.1	77.3	66.9	73.7	78.1
Benin	57.4	55.5	57.5	55.3	53.8	52.8	52.3	44.3	45.1
Botswana	95.4	95.5	95.4	96.1	97.0	95.8	95.3	86.1	82.2
Burkina Faso	63.4	67.1	62.6	61.9	62.8	60.6	61.9	43.1	42.3
Burundi	57.9	59.5	57.8	58.7	62.3	53.3	52.0	48.4	49.5
Cameroon	34.9	33.5	30.0	24.4	26.7	27.2	27.8	25.3	28.1
Cabo Verde	76.6	77.3	77.8	77.9	78.4	78.6	76.4	74.5	81.6
Central African Republic	55.7	54.9	51.6	60.2	57.5	53.0	53.8	53.7	46.2
Chad	29.5	27.5	22.4	24.2	25.8	34.4	43.1	44.7	37.0
Comoros	57.8	57.2	42.6	57.4	55.0	53.4	50.5	42.1	61.7
Congo	68.7	62.8	51.9	60.2	61.5	63.4	59.7	58.0	59.9
Congo, Democratic Republic of	60.3	55.9	62.5	60.8	49.7	45.5	43.5	26.4	31.5
Côte d'Ivoire	35.7	31.2	32.7	30.6	29.0	20.7	21.5	27.7	23.8
Djibouti	68.4	68.8	69.0	68.3	69.5	67.1	68.8	68.3	60.7
Equatorial Guinea	68.4	59.4	67.6	59.3	74.4	72.0	64.0	51.2	57.0
Eritrea	48.8	45.2	44.6	56.9	45.3	45.6	38.8	39.1	47.9

Ethiopia	65.8	64.1	62.9	61.5	65.2	63.9	68.5	63.2	50.7
Gabon	53.4	51.8	46.6	43.7	43.9	42.7	42.3	42.0	37.9
Gambia	80.5	80.0	79.7	76.5	76.8	80.3	79.0	64.6	63.5
Ghana	68.6	71.8	71.0	71.6	74.7	71.3	78.6	67.0	73.0
Guinea	31.9	37.4	28.1	22.6	18.6	17.7	18.4	19.8	20.9
Guinea-Bissau	58.7	60.4	57.9	52.6	55.3	52.1	53.9	51.0	55.8
Kenya	54.1	54.2	56.3	53.7	55.9	56.9	55.4	56.8	57.9
Lesotho	84.4	82.4	80.3	78.2	76.6	71.5	67.3	64.6	57.9
Liberia	78.9	75.4	76.9	65.0	62.0	57.1	58.3	62.0	...
Madagascar	74.8	71.6	73.2	75.1	77.1	78.5	79.4	82.3	75.3
Malawi	85.5	85.3	86.3	86.8	83.6	91.2	91.2	78.1	70.6
Mali	45.7	43.8	46.4	46.9	48.6	48.5	48.3	33.5	52.3
Mauritania	62.7	67.8	64.8	54.2	60.2	64.3	64.8	68.4	61.3
Mauritius	47.0	50.0	45.1	41.3	43.5	49.9	56.0	64.2	66.4
Mozambique	90.4	87.8	89.0	93.8	91.9	89.7	89.8	87.8	86.9
Namibia	90.6	90.7	91.1	91.9	91.5	96.8	96.3	94.4	93.7
Niger	62.4	57.3	58.0	58.5	53.9	56.3	52.4	55.3	51.6
Nigeria	39.6	34.6	34.3	40.0	36.5	35.9	32.1	38.3	28.8
Rwanda	78.9	77.7	77.0	76.4	76.4	77.8	83.6	75.2	73.7
Sao Tome and Principe	43.1	43.2	47.5	37.3	45.3	47.4	65.4	56.7	54.5
Senegal	67.1	66.1	65.3	63.8	65.2	66.7	65.9	42.1	35.8
Seychelles	94.6	94.5	95.0	94.8	94.4	94.7	93.4	82.9	85.3
Sierra Leone	23.4	22.6	27.9	14.5	15.0	20.8	26.0	25.3	19.5
Somalia	...	...	...	...	...	...	...	44.8	43.5
South Africa	92.8	92.6	92.2	91.5	90.6	81.9	81.6	87.0	86.0
South Sudan	44.6	34.8	29.5	32.4	...	...	...	...	...
Swaziland	86.6	85.7	85.9	86.7	86.4	86.0	86.3	81.5	86.5
Tanzania, United Republic of	67.5	68.1	85.4	84.5	85.1	77.7	62.7	52.7	52.2
Togo	59.6	54.3	54.0	47.0	43.5	45.1	39.9	36.9	43.0
Uganda	52.2	50.1	48.7	46.8	46.7	48.3	51.2	58.5	49.6
Zambia	74.7	73.3	69.8	68.2	67.3	73.6	72.6	60.8	65.0

Zimbabwe	...	...	...	...	...	...	...	77.4	83.5

Asia and the Middle East

Asia

Afghanistan	20.6	27.2	27.1	24.6	16.2	17.7	14.6	...	...
Armenia	42.6	44.9	47.5	48.2	45.1	42.3	33.4	22.9	34.1
Azerbaijan	29.9	30.8	31.5	28.3	27.4	21.6	17.6	36.7	33.6
Bangladesh	38.7	38.7	38.7	37.9	36.7	38.8	37.4	42.0	38.7
Bhutan	84.6	85.4	85.5	86.5	85.3	78.3	74.9	79.3	69.2
Brunei Darussalam	85.2	85.6	85.3	86.2	84.7	84.2	84.3	86.7	78.1
Cambodia	43.1	40.8	38.9	38.0	45.6	43.0	39.7	28.9	31.3
China	65.2	64.7	62.5	59.6	55.9	50.7	47.8	41.0	53.6
Georgia	35.1	30.9	33.5	35.8	29.2	27.8	23.2	17.5	5.2
India	40.2	38.2	37.3	35.8	33.9	31.8	29.7	32.0	32.4
Indonesia	50.1	51.6	51.6	51.6	51.5	48.3	46.1	53.5	53.4
Japan	83.6	83.8	84.0	84.2	83.9	83.0	84.6	84.6	86.0
Kazakhstan	58.5	59.6	59.7	59.0	52.8	59.0	62.5	51.5	64.5
Kiribati	98.7	98.8	...	...	...	...	...	...	...
Korea, Democratic Peoples Republic									
Korea, Republic of	67.1	67.9	67.6	65.8	65.3	64.3	62.1	58.5	48.1
Kyrgyzstan	65.6	61.3	60.8	57.7	54.9	51.9	44.0	50.2	60.8
Lao People's Democratic Republic	60.3	58.2	69.9	42.9	43.6	45.7	37.7	40.4	64.2
Malaysia	64.6	66.8	68.3	64.7	63.6	63.8	61.2	65.7	66.8
Maldives	50.9	71.9	80.1	79.1	73.5	72.1	70.0	76.7	84.9
Mongolia	60.3	60.0	59.0	60.8	58.9	55.9	53.3	88.1	88.4
Myanmar	19.0	18.5	17.8	14.9	15.7	18.4	9.4	13.8	19.0
Nepal	45.2	43.5	47.0	44.7	42.2	54.0	51.1	31.2	30.4
Pakistan	36.8	36.8	34.5	35.3	37.9	43.6	40.5	36.8	27.8
Philippines	44.1	46.4	45.5	42.6	44.8	47.7	50.8	59.5	50.0
Singapore	39.6	39.8	39.2	35.7	33.9	33.5	33.8	47.3	51.1
Sri Lanka	54.1	55.4	57.4	57.4	58.5	57.5	55.6	58.3	54.3
Taiwan, China									
Tajikistan	39.9	33.5	32.2	27.7	27.0	25.4	26.3	21.2	41.9

Thailand	86.5	86.1	84.9	85.5	85.5	82.6	72.8	66.3	57.4
Timor-Leste	96.0	96.4	97.1	97.4	97.5	97.9	98.1	97.1	...
Turkey	83.9	83.8	84.0	82.6	78.2	78.0	77.2	72.4	70.3
Turkmenistan	60.8	60.4	55.9	51.1	65.8	70.5	68.4	81.8	60.5
Uzbekistan	56.1	53.9	52.0	51.0	46.9	49.2	52.0	45.7	55.9
Viet Nam	43.9	41.5	43.1	39.1	44.3	37.9	32.4	34.0	37.1
Middle East									
Bahrain	85.1	85.7	82.7	82.8	80.8	79.2	78.3	77.7	78.4
Iran, Islamic Republic of	41.5	42.0	40.6	46.4	48.3	49.7	45.1	43.8	46.4
Iraq	81.7	81.2	78.1	74.6	69.5	63.8	67.3	1.1	...
Israel	78.6	79.6	79.2	80.0	79.7	76.8	74.1	83.0	73.7
Jordan	75.3	75.2	77.4	68.1	64.1	60.0	59.2	61.0	75.6
Kuwait	83.9	82.2	86.8	80.3	80.7	82.8	81.7	77.6	83.0
Lebanon	43.5	44.6	55.3	57.3	54.7	56.4	60.6	47.6	44.7
Oman	88.6	88.4	87.7	86.5	88.0	88.4	89.4	88.3	89.9
Qatar	86.4	84.0	84.2	84.0	84.1	84.1	84.2	72.3	65.4
Saudi Arabia	81.7	80.0	78.4	79.8	82.8	84.2	83.5	81.5	65.8
Syrian Arab Republic	49.0	46.0	46.0	46.5	49.1	48.5	50.5	40.4	39.7
United Arab Emirates	83.8	82.9	84.6	75.0	70.4	70.2	69.9	83.9	85.1
Yemen	21.9	22.1	24.6	32.0	30.8	36.7	35.2	56.3	34.5

Europe

Western Europe									
Andorra	80.4	80.4	77.9	77.7	77.7	78.5	77.8	73.4	73.3
Austria	83.7	84.1	84.1	84.0	83.5	83.4	83.2	84.9	84.9
Belgium	80.9	80.6	81.1	79.7	79.1	79.5	81.4	78.7	80.4
Cyprus	50.6	50.6	50.5	50.3	52.2	53.4	53.0	44.1	36.7
Denmark	86.8	86.8	86.8	86.5	86.1	86.2	86.0	85.3	83.7
Finland	80.8	80.8	81.5	80.9	80.7	80.9	81.5	77.7	77.3
France	92.5	92.6	92.6	92.4	93.0	93.4	93.4	92.9	92.4
Germany	87.6	88.1	88.2	87.9	87.6	87.5	87.8	89.6	90.0
Greece	70.2	71.9	72.8	69.2	68.0	64.8	62.7	62.2	54.1

Iceland	81.8	81.8	83.4	84.0	84.0	83.4	82.8	81.5	84.4
Ireland	85.5	84.8	87.7	85.6	86.1	85.6	85.9	91.8	89.3
Italy	80.1	80.4	80.3	80.3	79.9	80.1	79.5	75.5	73.4
Luxembourg	88.6	88.6	88.4	87.6	87.8	88.5	88.4	88.2	93.8
Malta	66.1	66.6	67.5	67.0	68.9	70.4	71.1	73.4	68.9
Monaco	93.0	93.0	93.0	93.0	93.0	93.0	93.0	93.0	93.0
Netherlands	94.9	94.9	94.7	93.8	94.0	94.4	92.9	91.0	90.4
Norway	86.4	86.3	85.4	85.2	85.0	84.6	84.3	83.3	82.2
Portugal	72.7	74.0	74.1	73.1	74.5	74.9	76.1	75.7	76.1
San Marino	85.3	85.3	84.0	85.7	86.1	86.0	86.4	89.4	89.9
Spain	79.9	80.3	80.9	79.8	79.6	78.9	77.9	76.4	76.5
Sweden	83.1	83.2	83.6	83.6	83.5	83.4	83.3	86.2	86.7
Switzerland	75.0	74.9	75.3	75.2	69.4	69.2	69.4	67.0	66.9
United Kingdom	90.8	91.1	90.9	90.8	89.9	90.1	90.2	88.6	89.1
Central and Eastern Europe									
Albania	44.5	42.3	45.0	47.1	47.5	48.5	47.4	36.2	49.5
Belarus	73.3	80.2	73.1	72.5	76.4	77.8	80.1	86.0	81.4
Bosnia and Herzegovina	68.7	68.6	68.8	67.7	63.7	60.1	57.3	57.6	47.1
Bulgaria	56.8	57.1	56.6	59.6	59.4	58.2	62.1	60.9	74.0
Croatia	85.4	85.4	85.5	85.5	87.6	86.6	86.6	86.1	86.5
Czech Republic	84.9	85.1	85.6	84.3	86.8	88.7	89.3	90.3	90.9
Estonia	81.4	82.2	83.5	81.8	78.9	75.0	79.6	79.9	89.8
Hungary	73.8	73.8	74.7	74.3	74.6	75.8	75.0	73.7	84.0
Latvia	60.4	62.7	64.7	66.3	65.1	67.6	59.4	55.9	66.3
Lithuania	72.1	73.6	73.5	73.0	73.4	70.0	68.3	73.9	77.6
Moldova, Republic of	55.1	55.1	56.3	54.9	54.3	53.9	55.3	57.1	72.6
Montenegro	70.0	69.5	73.9	73.1	72.0	70.9	72.0	71.8	70.0
Poland	77.1	77.9	77.3	77.2	75.4	74.4	73.9	70.0	72.9
Romania	80.6	80.8	79.4	82.4	82.7	80.2	81.5	81.2	74.5
Russian Federation	64.6	63.7	72.8	72.7	70.3	70.0	68.7	70.0	83.1
Serbia	63.8	63.6	64.8	64.9	65.2	67.1	70.1	74.7	75.3
Slovakia	73.8	74.3	74.7	75.1	74.0	74.6	77.4	90.5	88.5
Slovenia	87.0	87.1	87.6	87.9	86.8	88.2	87.4	88.5	88.8

The Former Yugoslav Republic of Macedonia	61.7	62.2	65.2	67.3	64.5	65.2	62.0	57.8	58.7
Ukraine	58.5	59.5	58.0	60.6	65.3	63.7	62.5	55.9	64.2
Latin America and the Caribbean									
Antigua and Barbuda	71.8	74.1	71.5	72.7	72.7	72.1	70.8	73.1	70.8
Argentina	78.1	78.6	79.9	77.4	74.3	70.9	70.1	71.0	72.0
Bahamas	71.1	71.2	71.6	70.8	70.3	72.7	70.5	79.1	75.9
Barbados	71.0	71.8	66.6	72.2	71.0	71.4	71.3	73.6	75.7
Belize	76.6	76.4	76.1	74.3	72.8	70.8	68.1	61.3	69.9
Bolivia, Plurinational State of	74.2	73.7	73.2	73.2	76.8	78.8	73.7	67.4	72.2
Brazil	68.7	69.4	67.7	67.9	66.0	64.0	62.4	62.0	61.3
Chile	62.8	63.5	64.2	60.5	60.6	60.1	59.3	63.5	61.2
Colombia	83.0	82.8	80.7	75.5	71.7	76.1	78.2	87.8	61.9
Costa Rica	77.0	76.0	75.3	72.9	71.3	73.1	75.2	81.2	79.4
Cuba	94.7	95.2	95.8	95.4	94.9	92.3	92.0	90.8	90.2
Dominica	78.2	76.8	71.6	68.2	68.8	71.0	68.7	72.4	72.0
Dominican Republic	60.0	61.0	59.6	61.6	58.2	56.8	52.6	52.9	43.0
Ecuador	48.0	48.8	47.9	45.7	47.1	45.0	37.7	41.4	67.4
El Salvador	67.7	66.2	65.1	64.0	63.6	66.2	56.6	48.2	39.3
Grenada	49.3	46.3	50.3	46.3	48.6	51.1	49.1	52.0	43.5
Guatemala	46.6	47.1	48.5	46.8	45.6	44.8	46.0	46.5	40.8
Guyana	82.0	82.1	85.1	83.8	74.3	77.7	84.4	86.9	83.7
Haiti	95.2	76.1	63.3	56.1	58.9	58.4	42.5	49.6	54.5
Honduras	52.1	52.7	54.3	47.3	49.0	48.6	52.1	56.5	58.5
Jamaica	67.1	69.0	68.8	67.0	66.0	71.1	67.4	69.2	70.6
Mexico	53.5	52.9	52.2	50.8	49.1	48.7	48.3	49.1	43.8
Nicaragua	57.8	60.4	60.4	58.0	58.0	58.0	60.1	57.4	64.9
Panama	72.9	75.0	78.6	74.2	70.3	73.7	75.4	74.1	73.1
Paraguay	43.9	39.9	48.5	48.9	46.4	48.4	46.1	47.9	42.1
Peru	62.5	62.9	64.2	67.4	64.6	64.1	67.8	66.4	61.7
Saint Kitts and Nevis	58.6	58.3	51.8	51.6	55.6	60.0	57.0	62.7	61.4

Saint Lucia	47.1	55.1	55.6	49.0	45.3	50.9	47.8	53.5	65.2
Saint Vincent and the Grenadines	81.7	82.0	84.4	84.0	82.1	82.0	80.9	82.3	84.8
Suriname	89.0	88.6	89.0	87.5	88.6	88.5	85.2	79.5	90.6
Trinidad and Tobago	60.8	64.5	56.8	58.3	58.5	62.1	61.0	50.8	54.3
Uruguay	86.9	86.3	85.7	87.8	86.4	85.4	84.1	85.8	86.9
Venezuela, Bolivarian Republic of	42.6	44.4	49.0	47.8	50.6	48.7	49.3	46.8	49.4
North America									
Canada	85.6	85.8	85.8	85.4	85.3	85.0	85.4	84.1	84.0
United States	88.7	88.2	88.0	87.5	87.3	87.2	86.8	85.5	85.4
Oceania									
Australia	80.2	81.3	81.4	81.9	82.0	81.3	81.4	80.2	83.9
Cook Islands	92.5	92.9	92.8	92.0	92.1	92.9	94.3	90.5	91.3
Fiji	79.0	80.4	78.2	84.5	84.6	86.3	88.2	90.2	87.6
Marshall Islands	87.4	87.9	88.3	88.2	87.6	87.6	87.0	90.9	87.1
Micronesia	91.0	91.6	90.9	90.6	93.3	92.8	93.6	93.9	95.2
Nauru	92.2	92.1	92.5	95.6	96.1	94.4	93.9	96.8	96.2
New Zealand	89.5	89.5	89.4	88.8	88.5	86.2	85.9	84.6	83.8
Niue	99.2	99.2	99.3	99.2	99.2	99.2	99.0	98.5	98.4
Palau	88.4	89.1	87.9	88.7	89.3	88.3	87.5	85.6	77.9
Papua New Guinea	88.3	86.2	84.6	88.0	87.8	86.4	86.9	89.8	93.6
Solomon Islands	97.0	96.5	96.9	95.9	96.2	96.1	96.6	96.8	96.0
Tonga	88.9	87.3	85.9	89.8	89.8	91.9	92.0	77.1	72.6
Tuvalu	...	...	...	...	...	...	...	...	...
Vanuatu	93.1	94.4	94.4	94.5	93.8	88.0	80.6	83.3	80.9
Western Samoa	92.8	92.1	90.9	91.2	91.0	90.6	87.2	81.0	75.4

Sources

This indicator is calculated using the national health accounts estimates available in the World Health Organization Statistical System (Global Health Expenditure database, http://apps.who.int/nha.

For further information on Estimating out-of-pocket (OOP) expenditures, see http://www.who.int/entity/nha/methods/estimating_OOPs_ravi_final.pdf?ua=1

Notes

…: Not available.

Definitions

Out-of-pocket spending by private households (OOPs) is the direct outlay of households, including gratuities and payments in kind, made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. It includes household payments to public services, non-profit institutions and non-governmental organizations. It includes non-reimbursable cost -sharing, deductibles, co-payments and fee-for-service, but excludes payments made by companies that deliver medical and paramedical benefits, whether required by law or not, to their employees. It excludes payments for overseas treatment.

Total (public and private) health-care expenditure not financed by private households' out-of-pocket payments

The effective level of financial protection provided to the population by social health protection systems is measured here by a proxy indicator expressed as a percentage of total (public and private) health-care expenditure in the country not financed by private households through out-of-pocket payments. The proxy is more or less equivalent to the percentage of total (public and private) health-care expenditure in the country financed either by general Government or by pre-paid private insurance, by employers or NGOs.

ANNEX V: Classification of countries by level of vulnerability

Vulnerability level defined as combined levels of

(1) Incidence of poverty based on the international poverty line of income or consumption at or below US$ 2PPP a day
(2) Non-waged employment as a proxy indicator of informal economy
(3) Countries with low vulnerability: health expenditure not financed by out-of-pocket payments to a level above 40 % of total health expenditure

Very low vulnerability

Andora
Argentina
Australia
Austria
Bahamas
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Canada
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Germany
Hungary
Iceland
Ireland
Isles of Mans
Israel
Italy
Japan
Jordan
Kazakhstan
Korea, Republic of
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Mauritius
Montenegro
Netherlands
New Zealand
Norway
Poland
Portugal
Romania
Russian Federation
Serbia
Seychelles
Singapore
Slovakia
Slovenia
Spain
Sweden
Switzerland
Taiwan, China
Ukraine
United Kingdom
United States
Uruguay
Occupied Palestinian Territory

Low vulnerability

Albania
Algeria
Armenia
Belize
Bolivia
Brazil
Chile
Colombia
Costa Rica
Dominican Republic
Ecuador
Egypt
El Salvador
Fiji
Gabon
Guyana
Iran, Islamic Republic of
Iraq
Jamaica
Kyrgyzstan
Malaysia
Maldives
Mexico
Morocco
Panama
Paraguay
Peru
Republic of Moldova
South Africa
Suriname
Syrian Arab Republic
Thailand
The former Yugoslav Republic of Macedonia
Trinidad and Tobago
Tunisia
Turkey
Venezuela

High vulnerability

Azerbaijan
Bhutan
Botswana
Cambodia
Cameroon
Cabo Verde
China
Côte d`Ivoire
Djibouti
Georgia
Guatemala
Honduras
Indonesia
Kenya

Lesotho Mauritania Mongolia Namibia Nicaragua Pakistan Philippines Saint Lucia Sao Tome and Principe Sri Lanka Sudan Swaziland Tajikistan Timor-Leste Turkmenistan Viet Nam Yemen	Togo Uganda Zambia Zimbabwe
Very high vulnerability	
Angola Bangladesh Benin Burkina Faso Burundi Central African Republic Chad Congo Congo, Democratic Republic of Ethiopia Gambia Ghana Guinea Guinea-Bissau Haiti India Lao Peoples Democratic Republic Liberia Madagascar Malawi Mali Mozambique Nepal Niger Nigeria Papua New Guinea Rwanda Senegal Sierra Leone Somalia Tanzania, United Republic of	

Source: ILO 2014

ANNEX VI: Global tools and support on social protection in health

The ILO Toolbox

The Global Extension of Social Security platform (GESS)

www.social-protection.org

GESS is a global knowledge-sharing platform on the extension of social security. It aims to facilitate the exchange of information and ideas, capture and document experiences, identify knowledge gaps, create new knowledge and promote innovation. To achieve this goal, GESS relies on the contributions of its users and the dialogue and exchange between them. It cooperates with all the actors involved in the extension of social security, such as policy-makers and technical teams from ministries of employment but also NGOs and other civil society organizations. In addition to providing knowledge about social security, the GESS platform is also a way for professionals and experts to communicate directly about their work and get in touch with other specialists and people who work in their field, for instance via the online forum.

In addition to extensive information on SPFs, and statistics and indicators on social protection, information on the extension of social security is provided in a variety of different classifications, for instance, by policy area, by country, by policy instrument and classified on the basis of current issues related to social protection. Furthermore, information on ILO tools and models is available, such as actuarial and budgeting tools as well as micro-simulation tools. Information is offered in the form of plain text, data, key readings, databases, and interactive materials such as videos and within various workspaces.

The GESS Platform explains the role of SPFs for universal SHP and related ILO strategies. Special attention is given to vulnerable populations. The most important resources on the topic are listed in the “Library” as well in the “Links” sections. Finally, the sections “News & Calendar” and “Training” show upcoming events and current issues in SHP.

Social Security Inquiry

http://www.ilo.org/dyn/ilossi/ssimain.home

Reliable social security statistics are a prerequisite for good governance and policy-making. However, in many countries the quantitative knowledge base on social security is incomplete and often does not follow international statistical standards. The ILO Social Security Inquiry identifies statistical information on social security, including employment-related social security schemes, public health, welfare and anti-poverty programmes and non-public schemes of different types transferring goods, services or cash to poor and vulnerable households.

Responding to the lack of social security statistics beyond OECD countries, the primary purpose of the Inquiry is not just to collect data but also:

- to promote common statistical standards, which all institutions administering or supervising social security schemes should follow in order to ensure good governance in the field of social policy; and

- to assist countries in building their capacity in this field.

Information is classified by country. The Inquiry provides scheme information, population data, and data on a range of social security indicators.

NORMLEX

www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:1:0

NORMLEX, created in 2012, is an information system which combines information on international labour standards (such as ratification information, reporting requirements, comments of the ILO's supervisory bodies, etc.) with information on national labour and social security laws. It provides comprehensive and user-friendly information on these topics, merging the data of a number of databases that used to be, or still are, available separately, such as NATLEX, APPLIS and ILOLEX.

All Conventions, Protocols and Recommendations can be found in the NORMLEX information system, in addition to ratification comparative data. The latter is available organized by country, ILO region and by number of Convention, sorted by "Fundamental", "Government" or "All".

NATLEX

http://www.ilo.org/dyn/natlex/natlex_browse.home

NATLEX, one of the databases that have been incorporated in NORMLEX, is still available as a separate entity. It contains national labour, social security and related human rights legislation maintained by the ILO's International Labour Standards Department. Records in NATLEX provide abstracts of legislation and relevant citation information, indexed by keywords and by subject classifications. NATLEX contains over 80,000 records covering 196 countries and over 160 territories and subdivisions. Information is accessible either by country or by subject.

ILO STAT

http://www.ilo.org/ilostat/

ILO STAT is the new ILO database of labour statistics, providing annual and infra-annual labour market statistics for over 100 indicators and 230 countries, areas and territories. The "Yearly indicators" dataset contains standardized indicators for purposes of greater comparability across countries and relies heavily on the official submission of data by national authorities. The "Short term indicators" dataset contains monthly, quarterly and semi-annual data drawn from official websites of national authorities and is updated on a monthly basis. Most of the series formerly available on ILO LABORSTA – the old database for labour statistics – were migrated to ILO STAT.

ILO LABORSTA

http://laborsta.ilo.org/

ILO LABORSTA is a database on labour statistics, providing data and metadata for over 200 countries or territories on topics such as (un)employment, wages, strikes and lockouts as well as on international labour migration. Statistics – until 2010 − are available by topic, country and publication. However, the database will not be updated. New data will now be available on the ILO STAT website.

ILO models

- **Population projections (ILO-POP)**

http://www.ilo.org/public/english//protection/socfas/download/pop_eng1.pdf

The population projection model (ILO-POP) is a member of the ILO model family, developed by the Financial, Actuarial and Statistical Services Branch of the ILO. ILO-POP produces population forecasts that – in contrast to other ILO models − follow standard UN methodology for demographic projections on the basis of an initial population structure combined with mortality, fertility and migration assumptions. This model is also used as a standard input producer for the ILO actuarial pension and social budget models that require long-term population forecasts. Population forecasting models have recently been elaborated to take into account the effects of the HIV/AIDS epidemic on mortality.

- **Pension model (ILO-PENS)**

http://www.socialsecurityextension.org/gimi/gess/RessFileDownload

The ILO Pension Model (ILO-PENS) is a projection model used for the actuarial valuation of pension schemes. It provides actuarial estimates of future expenditure and contributions base, and it simulates the future development of the fund under different financing methods. ILO-PENS forms a part of the ILO model family for quantitative financial analysis, with the objective of providing comprehensive perspectives in a consistent manner under certain national economic circumstances.

- **Health model (ILO-HEALTH)**

ILO-HEALTH is the latest arrival in the ILO social protection modelling family and is still in the testing process. It is designed as a tool to undertake stand-alone assessments of the financial status and development of national health-care systems and is also applicable for generating inputs for the health part of the ILO Social Budget model (ILO-SOCBUD). As health care systems are so diverse, the ILO does not provide a generic health-care financing model.

International support for achieving universal health protection coverage

ILO Decent Work Agenda

The Decent Work concept formulated by the ILO’s constituents – governments, employers and workers – is based on the understanding that work represents a source of personal dignity and contributes to family stability, peace in the community, democracies that deliver for people, and economic growth that expands opportunities for productive jobs and enterprise development. The overall goal of Decent Work is to effect positive change in people’s lives at the national and local levels.

The Decent Work Agenda should be interpreted in the context of social justice and fair globalization. It consists of four pillars:

1. Employment − the principal route out of poverty is through work and income.

2. Rights – the absence of which will not empower people to escape from poverty.

3. Social protection − as a safeguard of income and underpinning health, in order to ensure good health, inclusion and productivity.

4. Dialogue − the participation of employers' and workers' organizations in shaping and ensuring appropriate and sustainable government policy for poverty reduction.

The importance of strengthening linkages between rights, employment and development was underlined in the ILO Declaration on Social Justice for a Fair Globalization, 2008 (ILO, 2008a) and the report of the World Commission on the Social Dimension of Globalization (2004).

Social Protection Floor Initiative

Since the ILO's founding in 1919, it has emphasized the role of social protection in health to reduce poverty, generate income and increase wealth. The Universal Declaration of Human Rights (1948) reiterated the importance of both social protection and health for the well-being of individuals:

- Art 22: The right to social security:

> Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

- Art 25: The right to health:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

The United Nations further defined the right to health in their International Covenant on Economic, Social and Cultural Rights (ICESCR), a multilateral treaty adopted by the UN Assembly, coming into force on 3 January 1976. It consists of thirty articles, all of which grant economic, social and cultural rights, including the right to health (Art. 12):

- Art. 12:

> The enjoyment of the highest attainable standard of physical and mental health […] Provision for the reductions of […] infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational, and other diseases; and the creation of conditions which could assure to all medical service and medical attention in the event of sickness.

A number of ILO Conventions and Recommendations set standards in the area of social protection in health. Most recently, the human right to health and social security is

reflected in the Social Protection Floors Recommendation, 2012 (No. 202) and the joint UN Social Protection Floor Initiative: an effort to promote access to basic services such as health care and income support for all in need. It takes a comprehensive approach to social protection in health, addressing both the supply and demand sides of social protection extension and emphasizing the importance of ensuring effective access.

SPFs aim at guaranteeing services and transfers over the life cycle. Children, the working-age population lacking sufficient income, and older persons are targeted. The focus on equity and inclusion requires special attention to vulnerable groups by taking into account key characteristics that cut across all age groups, such as gender, socio-economic status, ethnicity and disability.

Recognizing the strategic importance and necessity of ensuring universal social protection, the United Nations System Chief Executives Board (UN-CEB) adopted in April 2009 the Global Initiative for a Universal Social Protection Floor (SPF-I) as one of nine initiatives in response to the current social security crisis.

WHO Rio Political Declaration on Social Determinants of Health

During the WHO World Conference on Social Determinants of Health in October 2011, the Rio Political Declaration on Social Determinants of Health was adopted, expressing the global political commitment to applying the social determinants of health approach to policy-making in order to reduce inequities in health.

The WHO defines the social determinants of health as "the conditions in which people are born, grow, live, work and age, including the health system". These circumstances are shaped by many factors, including the distribution of resources, money and power. Policy-making and politics play an important role in this context. According to the WHO, the social determinants of health are the main causes for health inequities between individuals, cities, countries and regions. The WHO Commission on Social Determinants of Health (2005–08) declared health care a common good, not a market commodity. The Commission advocated financing the health-care system through general taxation and/or mandatory universal insurance.

Providing for Health (P4H): Social Health Protection Network

The Providing for Health (P4H) partnership is a global network for universal health coverage (UHC) and social health protection. It includes representatives of international organizations such as the World Bank, WHO and the ILO, as well as bilateral institutions and governments. It is engaged in supporting low- and middle-income countries and serves as a platform for exchange of information and coordination of technical support across sectors, as well as closing gaps and scaling up support for universal health coverage. Related work is carried out at country, regional and/or global level.

The International Health Partnership (IHP+)

IHP+ is a group of developing and donor countries as well as international organizations such as the ILO who dedicate themselves to improving the health of citizens in developing countries. By signing the IHP+ Global Compact for achieving the health-related Millennium Development Goals, IHP+ partners cooperate to realize internationally agreed objectives, principles for effective aid and development cooperation within the health sector.

Results are achieved through mobilizing national governments, development agencies and civil society in order to provide support at country level, including a range of tools, guidelines and frameworks aiming at implementing extension strategies including monitoring and evaluation.

Bibliography

Ainura, I.; Akkazieva, B.; Ibraimov, A.; Manzhieva, E.; Reche, B. 2011. "Kyrgyzstan: Health system review", in Health Systems in Transition, Vol. 13, No. 3, pp. 1–152.

Alcorn, T.; Beibei, B. 2011. "China progresses with health reform but challenges remain", in The Lancet, Vol. 377, Issue 9777, pp. 1557–1558. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2960625-9/fulltext.

Anuranga, C.; Chandrasiri, J.; Wickramasinghe, R.; Rannan-Eliya, R. P. 2012. The impact of out-of-pocket expenditures on families and barriers to use of maternal and child health services in Cambodia: Evidence from the Cambodia Socio-Economic Survey 2007, RETA–6515 Country Brief (Manila, Asian Development Bank).

Begum, S., Sen, B. 2005. "Pulling rickshaws in the city of Dhaka: A way out of poverty?", in Environment and Urbanization, Vol. 17, No. 2, pp. 11–25. Available at: http://eau.sagepub.com/content/17/2/11.full.pdf.

Bilgel, M., Carrieri , V. 2013. "Health in the cities: When the neighborhood matters more than income", in Journal of Health Economics, Vol. 32, No. 1, pp. 1-11. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23178203.

Bonilla-Chacín M., Aguilera N. 2013. "The Mexican Social Protection System in Health", in Universal Health Coverage Studies Series (UNICO) No. 14 (Washington DC, World Bank). Available at: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Images/MexicanSocialProtectionSysteminHealth.pdf.

Chen, M.; Chen; W.; Zhao, Y. 2012. "New evidence on financing equity in China's health care reform: A case study on Gansu province, China", in BMC Health Services Research, Vol. 12, pp. 466-479. Available at: http://link.springer.com/content/pdf/10.1186%2F1472-6963-12-466.pdf.

Doetinchem, O.; Lamontagne E.; Greener R. 2010. Health insurance and AIDS: A review of experiences (Geneva, UNAIDS).

Department of Health (DoH) of the Republic of the Philippines. 2013. Toward financial risk protection: Health care financing strategy of the Philippines 2010–2020, Health Sector Reform Agenda Monographs, No. 10 (Manila). Available at: http://de.scribd.com/doc/35105401/Health-Care-Financing-Strategy-2010-2020-Philippines.

Domínguez Ugá, M. A.; Soares Santos, I. 2007. "An analysis of equity in Brazilian health system financing", in Health Affairs, Vol. 26, No.4, pp. 1017–1028. Available at: http://content.healthaffairs.org/content/26/4/1017.full.

European Commission. 2013. "Investing in Health", Commission Staff Working Document; URL: http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf.

European Roma Rights Center. 2006. "Ambulance not on the way: The disgrace of health care for Roma in Europe (Budapest)". Available at: http://www.errc.org/cms/upload/media/01/E6/m000001E6.pdf
Földes, E.; Covaci, A. 2012. "Research on Roma health and access to healthcare: State

of the art and future challenges”, in International Journal of Public Health, Vol. 57, No. 1, pp. 37–39. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3282005/pdf/ 38_2011_Article_312.pdf.

Frenk, J.; Gómez-Dantés, O.; Knaul, F. M. 2009. “The democratization of health in Mexico: Financial innovations for universal coverage”, in Bulletin of the World Health Organization, Vol. 87, pp. 542−548. Available at: http://www.who.int/bulletin/volumes/87/7/08-053199/en/.

Ghana Statistical Service. 2008. Ghana Living Standards Survey, Report of the fifth round (GLSS5). Available at: http://www.statsghana.gov.gh/docfiles/glss5_report.pdf.

Global Health Workforce Alliance, 2012. *Making health workers count - Global Health Workforce Alliance* - Annual Report 2012. Alliance document. Available at : http://www.who.int/workforcealliance/knowledge/resources/ghwa_annualreport2012 _en_web.pdf?ua=1

Govinda Rao, M.; Choudhury, M. 2012. Health care financing reforms in India, NIPFP Working Paper No. 2012-100 (New Delhi, National Institute of Public Finance and Policy). Available at: http://www.nipfp.org.in/newweb/sites/default/files/wp_2012_100.pdf.

Gragnolati, M.; Lindelow, M.; Couttolenc, B. 2013. Twenty years of health system reform in Brazil (Washington, DC, World Bank). Available at: http://elibrary.worldbank.org/content/book/9780821398432.

Grielen, S. J.; Boerma, W. G. W.; Groenewegen, P. P. “Unity or diversity: Task profiles of general practitioners in Central and Eastern Europe”, in European Journal of Public Health, Vol. 10, No. 4, pp. 249−254.Hady et al. (p. 94)

Hipgrave, D. 2011. Perspectives on the progress of China’s 2009–2012 health system reform (Melbourne, Nossal Institute for Global Health, University of Melbourne).

Holst, J.; Gerricke, C. A. 2012. “Healthcare financing in Yemen”, in International Journal of Health Planning and Management, Vol. 27, No. 3, pp. 198−225. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22532485.

Houweling, T.; Ronsmans, C.; Campbell, O.; Kunst, A. 2007. “Huge poor−rich inequalities in maternity care: An international comparative study of maternity and child care in developing countries”, in Bulletin of the World Health Organization, Vol. 85, No. 10, pp. 745−754. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636501/pdf/06-038588.pdf.

International Labour Office/Organization (ILO). 1944. Declaration concerning the aims and purposes of the International Labour Organization (Declaration of Philadelphia) (Geneva). Available at: http://www.ilo.org/.

—. 1952. Social Security (Minimum Standards) Convention, 1952 (No. 102). Available at: http://www. ilo.org.

—. 2008a. ILO Declaration on Social Justice for a Fair Globalization, adopted by the International Labour Conference, 97th Session, Geneva, 2008. Available at: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---cabinet/documents/ publication/wcms_099766.pdf.

—. 2008b. *Social health protection: An ILO strategy towards universal access to health care* (Geneva, ILO). Available at: http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=5956.

—. 2009. *ILO considerations on the social health insurance reform project in Egypt* (Geneva). Available at: http://www.social-protection.org/gimi/gess/RessFileDownload.do; jsessionid=12b238401489f9583cacbc2248e769200036a15dd854487a695f5729109809f2.e3aTbhuLbNmSe3qSa40? ressourceId=14306.

—. 2010a. *World Social Security Report 2010/2011: Providing coverage in times of crisis and beyond* (Geneva). Available at: http://www.ilo.org/gimi/gess/RessFileDownload.do?ressourceId=15263.

—. 2010b. *Maternity at work: A review of national legislation*, 2nd ed., ILO Conditions at Work and Employment Branch (Geneva). Available at: http://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_124442.pdf.

—. 2011a. *Social security for social justice and a fair globalization* (Geneva). Available at: http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/ documents/meetingdocument/wcms_152819.pdf.

—. 2011b. *Social protection floor for a fair and inclusive globalization, Report of the Social Protection Floor Advisory Group chaired by Michelle Bachelet* (Geneva). Available at: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/-publ/documents/publication/wcms_165750.pdf.

—. 2012a. Social Protection Floors Recommendation, 2012 (No. 202) (Geneva). Available at: http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID:3065524.

—. 2012b. *Global Employment Trends for Women 2012* (Geneva). Available at: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/ publication/wcms_195447.pdf.

—. 2013a. *Costing an essential health-care package: A macro-approach* (Geneva).

—. 2013b. "*Social health protection*", in ILO Global Extension of Social Security (GESS) (Geneva). Available at: http://www.social-protection.org/gimi/gess/ShowTheme.do?tid=3049&ctx=0.

—. 2013c. "Regions and countries", in ILO Global Extension of Social Security (GESS) (Geneva). Available at: http://www.social-protection.org/gimi/gess/ ShowCountryProfiles.do?ctx=0).

—. 2014. *World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice* (Geneva). Available at: http://www.socialsecurityextension.org/gimi/gess/ShowTheme.do?tid=3985

Jack, W.; Lewis, M. 2009. *Health investments and economic growth: Macroeconomic evidence and microeconomic foundations*, Policy Research Working Paper 4877 (Washington, DC,World Bank). Available at: http://elibrary.worldbank.org/docserver/ download/4877.pdf?expires=1377939763&id=id&accname=guest&checksum=06B7492DC15ACE7147EFD4D3E8C73D34.

Khan, M., Grübner, O., Krämer, A. 2012. "*Frequently used healthcare services in urban slums of Dhaka and adjacent rural areas and their determinants*", in Journal of Public Health, Vol. 34, pp. 261─271. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22241915.

Knaul FM, González-Pier E, Gómez-Dantés O, García-Junco D, Arreola-Ornelas H, Barraza-Lloréns M et al. 2012. "The quest for universal health coverage: achieving social protection for all in Mexico", in The Lancet, Vol. 380, No. 9849, pp.1259–79.

Krumova, T.; Ilieva, M. 2008. *The health status of Romani women in Bulgaria*, (Veliko Turnovo, Center for Interethnic Dialogue and Tolerance "Amalipe"). Available at: http://amalipe.com/files/publications/Health%20report_AMALIPE_last.pdf.

Leive A.; K. Xu. 2008. "*Coping with out-of-pocket health payments: Empirical evidence from 15 African countries*", in Bulletin of the World Health Organization, Vol. 86, pp. 849–856 (Geneva, WHO). Available at: http://www.who.int/bulletin/volumes/86/11/07-049403.pdf.

Lizza, R. 2013. "Obamacare's Three Per Cent", The New Yorker, 30 October 2013, Available at: http://www.newyorker.com/online/blogs/newsdesk/2013/10/obamacares-three-per-cent.html.

Makaka, A.; Breen, S.; Binagwaho, A. 2012. "*Rwanda innovates to sustain universal health-care coverage*", in ISSA Social Security Observer, No. 17. Available at: http://www.issa.int/News-Events/News2/Rwanda-innovates-to-sustain-universal-health-care-coverage.

McCoy, D.; Bennett, S.; Witter, S.; Pond, B.; Baker, B.; Gow, J.; Chand, S.; Ensor, T.;

McPake, B. 2008. "*Salaries and incomes of health workers in sub-Saharan Africa*", in The Lancet, Vol. 371, pp. 675–681. Available at: http://www.who.int/alliance-hpsr/resources/alliancehpsr_peermccoybennett2008.pdf.

National Institute of Statistics, Rwanda. 2008. *Rwanda service provision assessment survey 2007* (Calverton, MD, Ministry of Health Rwanda and Macro International Inc.). Available at : http://pdf.usaid.gov/pdf_docs/PNADN524.pdf.

Normand, C.; Weber, A. 2009. *Social health insurance: A guidebook for planning* (Homburg, Verlag für Akademische Schriften).

Obermann, K.; Scheil-Adlung, X.. 2013, ESS PAPER 39. *Costing an essential health care benefit package within the national floors of social protection framework: An innovative ILO approach for countries with limited availability of reliable data* (Geneva, ILO).

Organisation for Economic Co-operation and Development (OECD). 2011. *Providing and paying for long-term care* (Paris). Available at: http://www.oecd.org/els/healthsystems/47836116.pdf.

Perkins. M.; Brazier, E.; Themmen, E.; Bassane, B.; Diallo, D.; Mutunga, A.; Mwakajonga, T.; Ngobola, O. 2009. "*Out-of-pocket costs for facility-based maternity care in three African countries*", in Health Policy Plan, Vol. 24, No. 4, pp. 289−300.

Romualdez, A.; dela Rosa, J.; Flavier, J.; Quimbo, S.; Hartigan-Go, K.; Lagrada, L.; David, L. 2011. "*The Philippines health system review*", in Health Systems in Transition, Vol. 1, No. 2. Available at:

http://www.wpro.who.int/philippines/areas/health_systems/financing/philippines_health_system_review.pdf.

Sagan, A.; Panteli, D.; Borkowski, W.; Dmowski, M.; Domański, F. et al. 2011. "*Poland: Health system review*", in Health Systems in Transition, Vol. 13, No. 8, pp. 1–193. Available at: http://www.euro.who.int/__data/assets/pdf_file/0018/163053/e96443.pdf.

Salisu, A.; Prince, V. 2008. *Health care in Ghana* (Vienna, Austrian Red Cross and ACCORD). Available at: http://www.ecoi.net/file_upload/90_1236873017_accord-health-care-in-ghana-20090312.pdf.

Scheil-Adlung, X. 2013. "*Health protection: More than financial protection*", in: A. Preker, A. et al.: Scaling up affordable health insurance: Staying the course (Washington, World Bank).

—. 2013a. "*Revisiting policies on universal coverage in health in low income countries: Realizing the payoffs of national social protection floors*", in International Social Security Review (Geneva, ISSA).

—. 2013b. "*Through the ILO Lens: Health workforce benchmarks for UHC must strive for sustainable development*", World Health Bulletin article.

—. 2013c. *Older workers: How does ill health affect work and income*? (Geneva, ILO)

—. Junghardt, J. Forthcoming. *The recent global crisis and : Addressing inequities in access to health care through national social protection floors.*

—. Bonan, J. 2012. *Can the European elderly afford the financial burden of health and long-term care?* Assessing impacts and policy implications (Geneva, ILO). Available at: http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=30228.

—. Bonnet, F. 2011. "*Beyond legal coverage: Assessing the performance of social health protection*", in: International Social Security Review, Vol. 64, No. 3, pp. 21−38. Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1468-246X.2011.01400.x/pdf.

—. Kuhl, C. 2011. *Addressing inequities in access to health care for vulnerable groups in countries of the European region* (Geneva, ILO). Available at: http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=25201.

—. Sandner, L. 2010. *Wage continuation during sickness: Observations on paid sick leave provisions in times of crisis* (Geneva, ILO). Available at: http://www.social-protection.org/gimi/gess/RessShowRessource.do;jsessionid=dd5995414c62ce20c8c6e149d6755c376d67e4f64b593364fc2b2663b83aa28f.e3aTbhuLbNmSe3eNai0?ressourceId=17463.

—. Sandner, L. 2010b. *Paid sick leave: Incidence, patterns, and expenditure in times of crises.* (Geneva,ILO). Available at: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_207675.pdf

—. Bonnet, F.; Wiechers, T.; Ayangbayi, T. 2010. *New approaches to measuring deficits in social health protection coverage in vulnerable countries* (Geneva, ILO). Available at: http://www.who.int/healthsystems/topics/financing/healthreport/BP56MeasurementILO.pdf.

Schieber, G.; Cashin, C.; Saleh, K.; Lavado, R., 2012. *Health financing in Ghana* (Washington, DC, World Bank). Available at: http://ideas.repec.org/b/wbk/wbpubs/11977.html.

Stanciole, E.; Huber, M. 2009. *Access to health care for migrants, ethnic minorities, and asylum seekers in Europe* (Vienna, European Centre for Social Welfare and Research). Available at: http://www.euro.centre.org/data/1254748286_82982.pdf.

Suhrcke, M.; Rocco, L.; McKee, M. 2007. *Health: A vital investment for economic development ineastern Europe and central Asia* (Geneva, WHO). Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/74739/E90569.pdf.

United Nations Children's Fund (UNICEF). 2010. *Understanding urban inequalities in Bangladesh: A prerequisite for achieving Vision 2021* (Dhaka).

United Nations Development Programme (UNDP). 2005. *Prescription for healthy development: Increasing access to medicines, UN Millennium Project, Report of the Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines, Working Group on Access to Essential Medicines* (Sterling, Va., Earthscan).

—. 2011. *Sharing innovative experiences: Successful social protection floor experiences, UNDP Special Unit for South−South Cooperation* (Geneva). Available at: http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=20840.

—. 2013a. *Critical policy areas in the fight against child labour* (New York). Available at: http://www.un.org/en/globalissues/briefingpapers/childlabour/critpolicy.shtml.

—. 2013b. *The Millennium Development Goals Report 2013* (New York). Available at: http://www.undp.org/content/dam/undp/library/MDG/english/mdg-report-2013-english.pdf).

United Nations Population Fund (UNFPA). 2012. UNFPA Support to Maternal Health (2000−2011), Volume 2 annexes, Evaluation Branch, Division for Oversight Services (New York).

Wirtz, V. J.; Santa-Ana-Tellez, Y.; Servan-Mori, E.; Avila-Burgos, L. 2012. "*Heterogeneous effects of health insurance on out-of-pocket expenditure on medicines in Mexico"*, in Value in Health, Vol. 15, pp. 593–603. Available at: http://www.ispor.org/ValueInHealth/ShowValueInHealth.aspx?issue=97ef293d-8ced-4cee-b03b-44f915f7042d.

World Bank. 2010a. *Global Monitoring Report 2010* (Washington, DC.). Available at: http://siteresources.worldbank.org/INTGLOMONREP2010/Resources/6911301-1271698910928/GMR2010WEB.pdf.

—. 2010b. Bangladesh health sector profile 2010 (Washington, DC). Available at: http://www-wds.worldbank.org/external/default/WDSContentServer /WDSP/IB/2012/05/16/000333037_20120516002400/Rendered/PDF/688850ESW0P 1130rofile0final0Dec028.pdf.

—. 2013. Country profiles. Available at: http://www.worldbank.org/en/country (accessed August 2013).

World Commission on the Social Dimension of Globalization. 2004. *A fair globalization: Creating opportunities for all* (Geneva, ILO).

World Health Organization (WHO). 2006. *The World Health Report 2006*: *Working together for health* (Geneva). Available at: http://www.who.int/whr/2006/whr06_en.pdf.

—. 2007. *Financing long-term care programmes in health systems* (Geneva). Available at: http://www.who.int/health_financing/documents/dp_e_07_6-longtermcare.pdf.

—. 2009a. *Natural ventilation for infection control in health-care settings*. Guideline (Geneva).

—. 2009b. *Screening donated blood for transfusion-transmissible infections. Recommendations* (Geneva, WHO).

—. 2010a. World Health Statistics, Part I: Health-related Millennium Development Goals (Geneva). Available at: http://www.who.int/whosis/whostat/EN_WHS10_Part1.pdf.

—. 2011a. The World Medicines Situation 2011, 3rd edition (Geneva). Available at: www.who.int/medicines/organization/par/World_Medicines_Situation.pdf.

—. 2011b. Health-related Millennium Development Goals, Report by the Secretariat, Sixty-fourth World Health Assembly, Provisional Agenda item 13.3, A64/11, 7 April (Geneva). Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_13-en.pdf

—. 2013. *Out-of-pocket health payments and catastrophic expenditures* (Geneva). Available at: http://www.who.int/health_financing/catastrophic/en/index.html.

Databases

International Labour Office (ILO). LABORSTA. Available at: laborsta.ilo.org.

—. Social Security Enquiry. Social Security statistics. Available at: http://www.ilo.org/dyn/ilossi/ssimain.home.

—. STAT. Labour market statistics. Available at: http://www.ilo.org/ilostat/.

—. TRAVAIL. Conditions of work and employment laws. Available at: http://www.ilo.org/dyn/travail/travmain.home.

Organisation for Economic Co-operation and Development (OECD). OECD STAT. Available at: http://www.oecd-ilibrary.org/statistics.

United Nations (UN). UNDATA. Available at: http://data.un.org/.

United Nations Department of Economic and Social Affairs (UNDESA). 2012. World Population Prospects: The 2012 Revision. Available at: http://www.un.org/en/development/desa/population/.

United Nations Development Programme (UNDP). Data & Statistics: International Human Development Indicators. Available at: http://hdr.undp.org/en/statistics/.

World Health Organization (WHO). Global Health Observatory Data Repository. Health statistics, including health systems and related expenditures. Available at: http://apps.who.int/gho/data/view.main.

World Bank. DataBank: World development indicators. Available at: http://databank.worldbank.org/data/home.aspx.