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Pooling Reforms to Strengthen Health Financing for Universal Health Coverage

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LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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ACRONYMS

ADP	Additional Drug Package
CHI	Contributory health insurance
CNAM	National Health Insurance Company
COVID-19	Novel coronavirus 2019
CSMBS	Civil Servant Medical Benefit Scheme
FOSYGA	Solidarity and Guarantee Fund
LHSS	Local Health System Sustainability Project
LMIC	Low- and middle-income countries
MHIF	Mandatory Health Insurance Fund
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OOP	Out-of-pocket
PMJAY	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
POS	Mandatory Health Plan
SGBP	State Guaranteed Benefits Package
SHI	Social health insurance
UCS	Universal Coverage Scheme
UHC	Universal health coverage
WHO	World Health Organization

INTRODUCTION

Making faster progress toward universal health coverage (UHC)—ensuring that all people have access to the health services they need, when and where they need them, without financial hardship [1]—is a policy priority for many countries. Yet progress has been uneven. Between 2000 and 2020, there was a significant overall increase in UHC service coverage, but more recent disruptive events like COVID-19, the invasion of Ukraine, and ongoing effects of economic downturns have left many countries with an increased debt burden and reduced budgetary space to increase expenditure on health.

This brief focuses on how pooling arrangements—the way countries combine funding from different sources to spread the financial risk of needing to pay for health services—can be improved to accelerate progress toward UHC. It synthesizes the existing large body of normative guidance and evidence from country experiences in a way that is practical and useful, beginning with pooling as a core function of health financing for UHC; summarizing types of pooling reforms and providing country examples; discussing political considerations that may influence the feasibility or timing of technically sound improvements to pooling; and concluding with implications for countries and deeper insight into the experiences of Kyrgyzstan, Moldova, Colombia, and Thailand.

1

POOLING AS A CORE FUNCTION OF HEALTH FINANCING FOR UHC

A key step toward UHC is design and implementation of health financing policy and mechanisms that reduce reliance on out-of-pocket (OOP) payments and promote pooling of prepaid resources on behalf of some or all of the population [4]. Pooling of revenues to spread risks is one of the core functions of a health financing system, alongside revenue raising[1] and purchasing,[2] and can enable funds to be used more equitably and efficiently to provide access to good quality services with financial protection (see Box 1).

Box 1: Objectives of a health financing system

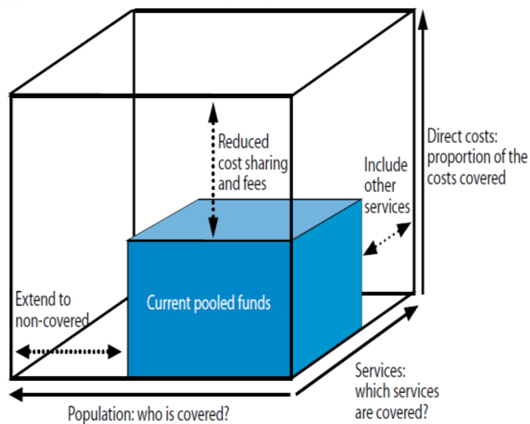
- **Financial protection** is achieved when people obtain health services without financial hardship [5]
- **Equity** is the absence of avoidable differences among population groups defined socially, economically, demographically, or geographically, in the attainment of health goals [6]
- **Efficiency** enhances the capacity to sustainably produce valued outputs; it enables the health system to produce more with the same resources [7]

To progress toward UHC, countries need to address three dimensions of coverage: health service coverage (which services are covered by pooled funding and are available to the whole population at sufficiently good quality to achieve potential health gains), financial protection (what proportion of the costs of services are covered from pooled funds) and population coverage (who has access to services covered by pooled funds) [2]. As countries decide how to equitably and efficiently expand availability and access to quality services with financial protection, they face choices and trade-offs in the allocation of limited health resources across these three dimensions.

1 **Revenue raising** refers to the amount and sources of funding for health. Main sources in low- and middle-income countries include government budgets, prepaid insurance schemes, direct OOP payments by users, and external aid.

2 **Purchasing** defines how prepaid and pooled funds are allocated for the delivery of health services through provider payment arrangements.

FIGURE 1: UHC CUBE



The World Health Organization's (WHO's) UHC cube depicted in Figure 1 provides a way to conceptualize country efforts to accelerate progress toward UHC. The blue cube of available pooled funds can be expanded along one or more of the three dimensions: to cover more costs and/or more services and/or more people [6,11]. As the WHO notes, **"UHC does not mean free access to every possible health service for every person. Every country has a different path to achieving UHC and deciding what to cover based on the needs of their people and the resources at hand"** [1]. In making these choices, countries should be guided by criteria that include maximizing financial protection, equity, and efficiency (see Box 1) [3].

Pooling of prepaid financial resources on behalf of some or all of the population to spread risks is a core function of health financing systems, alongside revenue raising and purchasing. Pooling provides an insurance function (Box 2)—allowing access to services[3] while protecting against the financial risk of needing to pay for health care [8]. The risk is spread across everyone who is covered by the pool. In this way, members with fewer health needs subsidize those with more, and, if the system for resource mobilization is progressive, those with greater financial means subsidize those with limited financial means. This reduces OOP payments and the potential for catastrophic health expenditures.

Box 2: Health insurance function vs scheme

- The **insurance function** refers to enabling access to needed health services with financial risk protection. This can be achieved through non-contributory entitlement, typically funded from general government revenues, or through contributory health insurance schemes, which link entitlement to benefits to payment of a premium.
- A **health insurance scheme** is any program that includes payment of a premium by or on behalf of each individual member. Health service benefits are linked to the premium [12].

Pooling of prepaid resources also allows the accumulated funds to be used for strategic purchasing of health services on behalf of members of the pool in ways that incentivize good quality and improve efficiency and equity.[4]

All countries pool financial resources and risks through the government budget and a growing number have also established contributory health insurance (CHI) schemes, often with the

[3] Ensuring access to services is not limited to financial access but also requires addressing physical access and availability of services to meet the needs of the target population group.

[4] More information about strategic purchasing can be found here.

intention for such schemes to become the predominant pooling mechanism for health. While both arrangements provide an insurance function (Box 2), insurance schemes that make entitlement to services conditional on contributions from members cannot ensure that everybody, including the poor, receives the health services they need without financial hardship [9].

Countries that have achieved significant progress toward UHC have relied heavily on funding from public sources[5] pooled via the government budget. In most LMICs, however, budgetary space for health is limited[6] and government allocations fall short of what is needed for UHC [10]. Budgetary space for health depends on the size of the overall public budget, the budget share allocated to health, and the efficiency of resource use [11]. Many LMICs face limited opportunities to increase the first two of these, but all have scope to increase efficiency by making better use of existing resources. This can be done by increasing the pooling of prepaid funds, pooling more efficiently by moving toward a small number of larger pools, and allocating pooled funds strategically to maximize their impact on national UHC priorities.

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[5] Public sources of funding for health include direct and indirect taxes, non-tax government revenue, compulsory prepaid contributions to national health insurance schemes (NHIS), and on-budget donor resources pooled and allocated by governments.

[6] Defined as the resources budgeted and used for health through the public financial management system

2

RECENT TRENDS IN POOLING IN LMICS

In recent years, health financing reforms in LMICs have tended to put CHI schemes—in which health benefit entitlements are linked to prepayment of contributions or premiums by or on behalf of individuals or households—at the forefront of their efforts to accelerate progress toward UHC [10].

There are a range of reasons that countries choose to initiate CHI. These may include: a desire to generate more domestic resources through the payment of premiums; a desire to have resources earmarked for the health sector and to have these resources managed outside of rigid public financial management rules; and the desire to gain political support through highly visible national health insurance entitlements. Across LMICs, however, CHI schemes have consistently demonstrated limited success in advancing financial protection, equity, and efficiency to accelerate progress toward UHC [61].

One explanation for the popularity of CHI in spite of the evidence may be information gaps. For example, risk pooling is sometimes perceived as being synonymous with insurance schemes, and UHC as synonymous with health insurance coverage or enrollment. This may be compounded by limited understanding of alternative options for pooling prepaid funds, including in ways that provide an insurance function without linking health benefits to contributions. While there is considerable technical guidance on health financing reforms in the areas of revenue raising and purchasing, pooling reforms are somewhat neglected in the literature. This report aims to help to fill the information gap.

3

POOLING ARRANGEMENTS THAT SUPPORT PROGRESS TOWARD UHC

How a country organizes pooling arrangements to advance UHC typically depends on political (for example, national elections) and technical considerations (for example, existing health financing architecture and priority health goals), as well as contextual factors (for example, macroeconomic conditions and the legal and regulatory environment) [13]. Each country is at a different point along its path toward the goal of effective health financing arrangements for UHC, and there is no one-size-fits-all approach to establishing pooling arrangements that promote financial protection, equity, and efficiency and accelerate progress toward UHC.

Reform strategies should be tailored to country context. There are tools available to help guide information collection and analysis such as the HFG Technical Efficiency Guide and the questions listed in Box 3, which are part of WHO's standardized qualitative assessment of a country's health financing system.

For some countries, existing CHI schemes can be part of the solution. Where these limit coverage to specific population groups, such as those working in the formal sector, countries may choose to supplement CHI with additional pools for those previously excluded. While this approach can improve equitable coverage, it can also contribute to inefficiency [62]. This is likely to require subsidies from public sources, such as the government budget, to cover the informal sector as well as the poor. Experience from countries shows that countries progressing

Box 3: Understanding the current context

1. Does your country's strategy for pooling revenues reflect international experience and evidence?
2. To what extent is the capacity of the health system to redistribute prepaid funds limited?
3. What measures are in place to address problems arising from multiple fragmented pools?
4. Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
5. What is the role and scale of voluntary health insurance in financing health care? [63]

toward UHC increasingly rely on public financing and that countries should have a clear understanding of the financing implications and consequently, feasibility, of potential reforms.

In the next section, we describe reform approaches that can be effective in helping countries to accelerate progress toward UHC, including where their starting point is a conventional CHI scheme. We first address technical issues and then the political considerations that may influence the feasibility of technically sound improvements to pooling.

WHAT TYPES OF POOLING REFORMS CAN COUNTRIES PURSUE?

The broad objective of pooling reforms is to move toward larger pools and reduce the fragmentation, that occurs when multiple risk pools cover distinct groups of people. Having a smaller number of larger pools increases the diversity of health risks, which enables more redistribution of financial risk and reduces the potential for adverse selection—whereby sicker people are more likely to enroll in schemes than healthy people. Mathauer et al. (2020) identify the following four types of reforms that countries—be they introducing a new pool or modifying existing arrangements—may consider in designing their own path toward UHC:

1. Moving toward compulsory or automatic coverage for the entire population
2. Merging existing pools to increase the number of pool members and diversify risks
3. Cross-subsidizing pools that have different financial and health risks
4. Harmonizing across pools (benefits, provider payment methods, and remuneration rates) [13].

Below we summarize selected country experiences with the four reform elements. As these are not necessarily exclusive approaches, some countries appear more than once, reflecting the complexity of pooling reform.

MOVING TOWARD COMPULSORY OR AUTOMATIC COVERAGE FOR THE ENTIRE POPULATION

Pooling arrangements that prioritize compulsory membership or automatic entitlement to services based on nationality or residence enable coverage of the entire population, including formal and informal sectors. Such arrangements tend to have smaller numbers of pools with larger numbers of members and greater diversity of risks. Funding sources may be general government revenues or mandatory insurance contributions with government revenue subsidies for those unable to prepay [14].

TABLE 1: ILLUSTRATIVE COUNTRIES IMPLEMENTING REFORMS TOWARD COMPULSORY OR AUTOMATIC COVERAGE

Country	Description
Kyrgyzstan	Reforms created a single, central pool with mandatory contributions from the formal sector via payroll tax and general revenue transfers on behalf of both formal and informal sectors [15].
Moldova	The 1998 Law on mandatory health insurance guarantees residents equal access to health care, all of whom must be covered by the National Health Insurance Company (CNAM). Employees and self-employed people pay mandatory premiums and the government pays on behalf of residents who are not economically active [16].
Philippines	The UHC Bill (Republic Act No. 11223) automatically enrolls all Filipino citizens in the National Health Insurance Program, a single pool providing access to the full continuum of needed health services. About 85 percent of the population is covered [17].
United Kingdom	Established by the National Health Service Act of 1946, the National Health Service (NHS) provides automatic coverage for all citizens under a single-payer system financed primarily through general taxation. The main pooling mechanism is the government budget [18].

Some countries may take an initial step by providing automatic coverage of the whole population for selected services. For example, Kenya, in 2013, introduced the Linda Mama program to provide a broad benefits package that includes antenatal care, delivery, and postnatal care. The program is financed from public resources and delivered through contracted public and private facilities. Since 2017, Linda Mama has been managed by the National Health Insurance Fund (NHIF) to improve efficiency, sustainability, and expanded access to free services. Linda Mama is expected to play a growing role as a bridge to cover, and ultimately enroll, uninsured women in the NHIF scheme [19].

MERGING EXISTING POOLS TO INCREASE THE NUMBER OF POOL MEMBERS AND THE DIVERSITY OF RISKS

A country may have multiple pools each covering a different population group, based on socioeconomic, demographic, or geographic criteria. Reducing the number of pools typically increases the number of people and the diversity of health risks in each pool. This can improve administrative efficiency (through economies of scale, integration of information systems, and fewer service providers), help to streamline benefits packages, and increase the potential for strategic purchasing to incentivize lower costs and higher-quality services.

To gain these benefits, many countries are moving to merge or consolidate multiple pools [10]. Some have established a single pool with a single benefits package, but this is most common in high-income, higher-capacity, or smaller countries [13]. There are many operational challenges to reducing fragmentation of health pools, including standardizing the benefit package, provider-purchaser mechanisms, and delivery of health care services. These challenges are connected and need to be addressed with a coordinated approach between payers, providers, and insurers. For this reason, it is advisable to reduce fragmentation at the early stages of a health insurance system [20].

TABLE 2: ILLUSTRATIVE COUNTRY EXPERIENCE WITH REFORMS TO MERGE DIFFERENT POOLS

Indonesia	Legislation passed in 2011 merged five government health funds, covering separate population groups, to enable cross-subsidization, reduce administrative costs, and provide more equitable benefits. The National Health Insurance Program, implemented in 2014, consolidated more than 300 government and other social security insurance programs into a single-payer mechanism that covers all citizens [21, 22]. While 80 percent of the population is covered, there are enduring differences in access to the benefits package in rural and urban areas [23].
Moldova	In 2004, decentralized pools at the rayon (district) level, which distributed funds unevenly across rayons, were centralized in the CNAM. The law on social health insurance (SHI) contributions specifies that all contributions are paid into one account and the government delegates all health budget funds to CNAM [24]. CNAM provides mandatory health insurance with a defined benefits package managed by a single purchasing agency, and pools payroll taxes with budget transfers [16].
Republic of Korea	In 2000, three health insurance funds—for employees, teachers and civil servants, and the self-employed—were merged into a single pool. The merger increased efficiency with significant savings in administrative costs and equalized premium contributions for the self-employed and employed. However, the self-employed contribution formula remains more regressive [25].
Ukraine	Establishing a single purchaser at the central level (the National Health Service of Ukraine) reduced fragmentation. However, national pooling exists alongside provincial-level management of health facilities, creating challenges around performance accountability [26].
Vietnam	The 2008 Law on Health Insurance integrated the health insurance program with the program for the poor, bringing together different groups funded from different sources [27]. SHI is a single pool financed by contributions and government subsidies, with a standard benefits package for all members. The program has different enrollment modalities for different groups paying premiums or receiving subsidies [28]. In 2018, coverage reached 82 percent [29].

RISK ADJUSTMENT OR CROSS-SUBSIDIZATION ACROSS POOLS

In a country with multiple pools, risk adjustment of the revenue generated by each pool can mitigate differences in risks and available resources across pools without changing the structure of pooling [13]. This can take the form of government programs to reallocate funds across pools so that each pool receives an appropriate level of revenue given the average health risks and members ability to pay. Alternatively, insurers can transfer funds between pools to match the level of revenue generated per capita to the level of risk in each pool. In effect, this reallocation creates a virtual single pool that offers standardized access to the same package of benefits. Such systems are primarily found in higher-income countries such as Germany, Netherlands, Switzerland, Czech Republic, and Slovakia [30]. Virtual pooling can also be facilitated with interoperable digital information systems that aggregate data as in Burundi and Germany [31].

Introducing a new pool to create a government-subsidized non-contributory coverage scheme for the informal sector is another approach to cross-subsidization that can improve equitable access. Over time, the benefits package and per capita expenditure levels can be harmonized across the new and existing pools. LMICs that have successfully implemented this reform include Colombia, Gabon, Mexico, Peru, and Thailand.

TABLE 3: ILLUSTRATIVE COUNTRY EXPERIENCE WITH CROSS-SUBSIDIZATION OR RISK ADJUSTMENT ACROSS POOLS

Colombia	Citizens must join one of two health insurance schemes with similar benefit packages: a contributory regime for formal workers and others who can pay and a subsidized regime for the unemployed, informal sector, and the poor. An 'equalization fund,' financed by revenues of the contributory scheme, enables subsidies and pooling across the two schemes [32]. Funds are distributed on a risk-adjusted, capitation basis to public and private health maintenance organizations. By 2013, approximately 96 percent of the population was covered, with more than half completely subsidized [33].
Germany	Multiple pools function as a virtual single pool as a result of a risk adjustment scheme that redistributes contributions from formal sector premiums. A 2001 risk adjustment reform act added a high-expenditure pool to reduce incentives for selection against expensive cases. Membership in a pool is compulsory and citizens can choose their benefit package [34].
Thailand	In 2001, the Universal Coverage Scheme (UCS) introduced a new pool to cover the population (about 75 percent) not covered either by SHI for private sector employees or the Civil Servant Medical Benefit Scheme (CSMBS) for government employees and dependents. The UCS replaced and integrated the previous Low Income Scheme and voluntary health insurance programs, and is funded from general tax revenues. While the three schemes are not integrated, the benefits packages they offer are very similar [35].

HARMONIZATION OF FEATURES SUCH AS BENEFITS, PROVIDER PAYMENT METHODS, AND REIMBURSEMENT RATES

Countries may make some progress toward achieving UHC goals by supplementing CHI schemes with parallel pools that cover otherwise uninsured people [13]. While parallel pools extend coverage, helping to make sure that everyone is included, they can also increase inefficiency (through fragmentation, as described above) and inequality. Equity cannot be improved without similar levels of funding and benefits across the pools. Where comprehensive reforms toward merging such schemes into one pool are not possible in the short term, countries can achieve some of the benefits of merger by harmonizing key features across pools, such as the benefits package, provider payment mechanisms, and information systems.

TABLE 4: ILLUSTRATIVE COUNTRY EXPERIENCES HARMONIZING ACROSS POOLS

Colombia	In 2012, the government passed new regulations calling for health insurance coverage of the same services for all children under 18 years of age and, in 2013, for the elderly. New regulations also called for all citizens to have the same mandatory benefits package regardless of the health insurance scheme to which they are affiliated [36].
India	The PMJAY combines funds from central and state government budgets with donor funds to cover services for the poor, providing an opportunity to harmonize benefits across multiple separate state-level insurance scheme pools. PMJAY builds on existing financial protection programs and has been designed to either take over or operate alongside state-based programs to expand service coverage and financial protection. State health authorities can choose to continue to provide existing programs alongside the national program or to integrate them [35].
Thailand	Political resistance did not allow for integrating pools under a single scheme. Instead, the country pursued functional integration by harmonizing the benefit package across three pools. For example, all three schemes implemented universal coverage for emergency care and nembers move across the three schemes based on criteria such as employment and age. However, the three schemes continue to be fragmented with different provider payment mechanisms [35].
Lao PDR	In 2016, the NHIS was launched, requiring low co-payments at the point of care for non-insured Lao citizens and exemptions for the poor, mothers, and children under 5. Since 2019, all four existing health insurance schemes have been integrated under the NHIS, with a harmonized benefits package. Population coverage increased to 94 percent [38].

POLITICAL CONSIDERATIONS FOR POOLING REFORM APPROACHES

Political economy considerations can influence countries' pooling reform pathways. Similar reform strategies and approaches may not produce the same results in different countries or even at different times in the same country [39]. Politically informed strategies should strategically sequence key actions to take advantage of opportunities for change created by political and socioeconomic events, such as national elections or shocks, while holding true to the purpose of reform efforts. Identifying and leveraging political windows of opportunity—where reforms align with other political interests—can enable more transformative approaches and large-scale change at a rapid pace. These 'big-bang' moments are usually complemented by more gradual approaches to operationalizing the adopted reforms.

TABLE 5: ILLUSTRATIVE COUNTRY EXPERIENCES WITH BIG-BANG REFORM EFFORTS

Country	Experience
Ghana	The 2003 National Health Insurance Act was a 'big bang' approach that established the National Health Insurance Authority as the single national health insurance fund and strategic purchasing agency financed primarily through a value-added, tax-based National Health Insurance Levy [23]. A presidential campaign focused on abolishing the 'cash and carry' user fee system and establishing health insurance opened a political window of opportunity for rapid design, adoption, and scale-up of the NHIS [40].
Republic of Korea	Universal population coverage was achieved in 1989 through expansion of the NHIS, after a 1987 presidential campaign in which the incumbent and government presidential candidates committed to universal health insurance coverage [41].
Thailand	UHC was central to the political manifesto of the winning party in the 2001 election, precipitating a bold decision to finance the UCS through tax revenues. The decision was made for both political and practical reasons, as the additional resources were within the government's fiscal capacity. Policy formulation and operational design were enabled by technical expertise within the Ministry of Health and strategic use of evidence [35].

In other contexts, political resistance and limited technical and fiscal capacity may enable only small-scale reform efforts implemented at a slow pace. Resistance to more universal and equitable pooling arrangements can be particularly strong where better-off groups perceive that they will lose preferential access to resources or services [42]. Incremental reform pathways can be easier to manage politically and financially and enable countries with existing CHI schemes to improve equity and efficiency within the framework of existing institutional mechanisms. In countries like the UK and Ghana, reforms can be described as a combination of 'big bang' and incremental reforms.

TABLE 6: ILLUSTRATIVE COUNTRY EXPERIENCES WITH INCREMENTAL REFORM PATHWAYS

Ghana	Operationalization of the NHIS has been iterative, building on previous efforts to establish mutual health organizations [40]. The 2003 Act establishing the NHIS was revised and replaced in 2012 by Act 852, which established a single-payer system and integrated District Mutual Health Insurance Schemes as branches of the National Health Insurance Authority [43].
Turkey	The Health Transformation Program was strategically introduced at an opportune moment of sustained economic growth and support from a parliamentary majority. Benefits for the informal sector and the poor were gradually increased and legislation to merge pools was delayed until benefits and services were improved for all citizens [41].
Vietnam	In 1992, SHI was introduced; in 1998, a single-pool voluntary scheme with co-payments began; and in 2005, eligibility requirements, benefits package, and co-payment mechanism were revised. The 2009 Law on Health Insurance expanded coverage with government subsidies and introduced a roadmap for compulsory enrollment for the entire population. In 2014, the law was amended to reclassify eligibility categories, eliminate the voluntary scheme, schedule premium increases, change the revenue collection mechanism, and revise the benefits package [44].

4

IMPLICATIONS FOR COUNTRIES

There is no one-size-fits-all approach to pooling that will be appropriate in all settings, and reform strategies should be tailored to country context. How a country organizes and reforms its pooling arrangements to advance UHC typically depends on the domestic political landscape (e.g., national elections), technical considerations (e.g., existing health financing architecture), and contextual factors (e.g., macroeconomic conditions and the legal and regulatory environment) [13]. Efforts to improve pooling must build on a solid analysis and understanding of the mechanisms currently in use for pooling—how does pooling fit into the country's broader health financing system and how well does it provide the desirable attributes that evidence suggests can help to accelerate progress toward UHC?[7]

Where countries have achieved significant reform to national pooling mechanisms, it has been a mainly gradual and sometimes decades-long process. The following country case studies provide a more detailed account of long-term efforts to extend coverage to people previously excluded from contributory health insurance schemes while also reducing the number of pools required to cover the entire population. They illustrate three different configurations that can enable a country to achieve the benefits of having a small number of large pools with diverse risks: a single pool in Kyrgyzstan and Moldova; two cross-subsidized harmonized pools in Colombia; and three harmonized pools in Thailand.

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[7] There are tools available to help guide information collection and analysis such as USAID's Technical Efficiency Guide and WHO's Health financing progress matrix of a country's health financing system.

CASE STUDY 1: MERGING POOLS TOWARD A SINGLE POOL IN KYGRYZSTAN AND MOLDOVA

Box 4: Impact of Kygryzstan's and Moldova's Pooling on Objectives of Health Financing

- **Financial protection:** Provides protection for the entire population through mandatory or automatic enrollment. Funded from public sources or premium payments with public subsidy for those unable to pay.
- **Equity:** Covers entire population with standard benefits package. Funded or subsidized by government revenues.
- **Efficiency:** Managed by a single entity with streamlined administrative costs. Does not require targeting because it covers everyone.

Kyrgyzstan and Moldova have made significant progress toward UHC by implementing reforms to move toward a single universal pool (see Box 4). Kyrgyzstan is a lower-middle income country and Moldova a higher-middle income country. Both have relatively small formal sectors, high poverty rates, and limited budgetary space for health. In addition, both countries share a history as former Soviet Republics with health systems characterized by high levels of inefficiency and input-based financing, primarily from state budgetary resources. While the health systems were able to provide universal access to basic services and financial protection, this became unaffordable once the countries transitioned from the centralized Soviet system [46, 47]. In both countries, the government's commitment to UHC is evident in an increasing role for general budget revenues. Introduction of a centralized pool together with reforms that promoted a purchaser-provider split, a single-payer system, and strategic purchasing enabled improved geographic distribution of funds and promoted competition among providers to incentivize increased productivity and reduced costs.

KYRGYZSTAN

Reforms in Kyrgyzstan have merged pools to establish a large national pool—the Mandatory Health Insurance Fund (MHIF)—that combines general government revenues, payroll tax contributions from the formal sector, and other sources of revenue such as co-payments. The introduction of the MHIF national pool enabled several key changes: redistribution from richer to poorer geographic areas, introduction of a purchaser-provider split, and output-based provider payment [48]. Combined with ensuring adequate general budget revenues to subsidize services for most of the population, these reforms improved coverage, equity, and efficiency [46]. Additional reforms are needed to reduce funding gaps, including by improving efficient procurement of medicines and reducing excess hospital capacity contributing to inefficiency in purchasing (hospitals are funded irrespective of performance) [47]. Financial protection, equity, and efficiency could be improved by merging the State-Guaranteed Benefits Programme (SGBP) and the Additional Drug Package (ADP), which would de-link contributions and entitlement, to enable the same benefit package for those who pay contributions and those who do not [48].

TABLE 7: SUMMARY OF POOLING ARRANGEMENTS IN KYRGYZSTAN

Organization	• The MHIF pools money from different sources, including general tax revenues (known as the republican budget) and mandatory formal sector payroll tax contributions (Social Fund) [48]. • The MHIF funds the SGBP for all citizens and the additional ADP for those who contribute through the payroll tax. The MHIF contracts with semi-autonomous public health facilities, some private facilities, and private pharmacies [46].
Financing	• General tax revenues comprise just over 70 percent of the pool; payroll tax contributions from the formally employed (through the Social Fund) account for 15 percent; the remainder comes from co-payments for publicly provided services, special earmarked funds, and premium payments by people in the informal sector [47]. • Patient co-payments are required for hospitals and some drugs and vary across oblasts (provinces), insurance status (those who do not contribute through payroll taxes pay more), referral, and exemption status [47].
Enrollment	• Mandatory for the formally employed. The informal or self-employed sectors can purchase MHIF insurance or may be eligible for government subsidies [46]. • The state contributes on behalf of children under 5 years of age, pensioners, students, soldiers, and veterans.
Benefits package	• The SGBF entitles all members to free emergency care, a basic package of primary care services, specialist outpatient services with referral, and inpatient services with referral and co-payment; includes caps on hospital and high-technology services and medicines. • ADP provides additional access to medicines at reduced prices and reduced inpatient co-payment for people who pay mandatory contributions.
Provider payment	• Pay for performance for primary health care since 2018 [48]. • Case-based payment to hospitals; capitation-based to primary care facilities.
Key pooling reforms	• 1997: introduction of a mandatory health insurance contribution. • Progressive centralization of the purchasing function under the MHIF. • 2001: introduction of the SGBP at the oblast level. • 2006: sub-national oblast pools were merged at the national level under the MHIF.
Impact on financial protection	• The MHIF covers about 66 percent of the population through mandatory enrollment and 34 percent through government-subsidized payments [46]. • Single-payer reform replaced informal payments with co-payments, reducing financial burden, catastrophic payments, and geographic and financial barriers. • Costing and financing gaps in the SGBP and ADP continue to drive OOP payments and persistent informal payments[8] for hospital services [46].
Impact on equity	• About one-third of the population receives government subsidies for MHIF contributions and geographic inequalities have been reduced [46]. • The SGBP is a universal package for both formal and informal sectors available to members of both the MHIF and Social Fund.
Impact on efficiency	• The MHIF acts as the single purchaser with an output-based provider-payment system and case-based payment for hospital services (but no specific provider-payment mechanism for outpatient specialist care or same-day surgery, which leads to unnecessary admissions). An increased share of health expenditures is allocated to more cost-effective primary care, as a result of strategic purchasing [4947].

[8] Informal payments are in-kind or cash payments providers outside of the official payment channels or are purchases that are meant to be covered by the health care system.

Success factors	• Small size of the population (5 million) is conducive to reforms to centralize pooling [50]. • An incremental reform approach addressed health financing arrangements, strengthened primary health care, and rationalized the hospital care network [46]. • Government navigated political opposition by choosing not to reduce allocations to Bishkek city, instead gradually increasing allocations to underfunded areas [4850].

[8]Informal payments are in-kind or cash payments providers outside of the official payment channels or are purchases that are meant to be covered by the health care system.

REPUBLIC OF MOLDOVA

Similar to Kyrgyzstan, Moldova's reforms introduced publicly financed mandatory health insurance managed by a single purchasing agency. The CNAM is a single national pool that covers the formal sector, with contributions paid through payroll deductions, and the informal sector, with contributions subsidized by the government [47]. Reforms began by addressing fragmentation of funding and service delivery, and then focused on progressively expanding coverage to population groups eligible for subsidies and coverage of additional essential medicines, resulting in increased health service use and fewer people reporting unmet need due to cost. Moldova has also implemented strategies (such as discounts and threat of court action) to enforce mandatory enrollment, but with mixed results. Ultimately equity would be improved by delinking contributions and entitlement and improving availability of services such as specialist and dental care [49].

TABLE 8: SUMMARY OF POOLING ARRANGEMENTS IN MOLDOVA

Organization	• CNAM is a single national pool and purchasing agency for all health insurance revenues. Enrollment is mandatory and coverage reached 88 percent in 2018. Voluntary health insurance provides supplemental coverage for 2 percent of the population [46].
Financing	• Payroll tax contributions (flat-rate fee for self-employed). • Transfers from the state budget for the non-working population: children under 18; pupils and students; pregnant women and new mothers; people with disabilities; retirees; registered unemployed people; caregivers for people with disabilities; parents with four or more children; families receiving social assistance; refugees; organ donors [46].
Enrollment	• CNAM covers three categories: formal sector (55 percent of CNAM revenue, about one-third of members); self-employed (about 1 percent of revenue, less than 2 percent of members); and people covered by government contributions (44 percent of revenue, about two-thirds of members). • Voluntary health insurance is purchased by less than 2 percent of the population, mainly the formally employed, to supplement CNAM or provide access to private health care [46].
Benefits package	• Entitlement to the publicly financed benefits package depends on insurance status. • All residents—members and non-members of CNAM—are entitled to emergency services, primary health care, care for priority conditions, selected screening programs, medicines, and inpatient care. • All other publicly financed health services are available only to CNAM members. • Co-payments for covered outpatient prescriptions without caps or exemptions [46].
Provider payment	• Outpatient based on capitation; inpatient based on negotiated volume (number of patients hospitalized) with providers.

Key reforms and timeline	• 1998: mandatory health insurance system created by law. • 2004: CNAM established as the national pooling and purchasing entity by centralizing and pooling local government budgets with payroll tax revenues [24]; mandatory health insurance with a defined benefits package introduced [46]. • 2009: Law on Mandatory Health Insurance amended to allow people registered under the Law on Social Support to receive fully subsidized health insurance. • 2010: all citizens entitled to free primary health care and pre-hospital emergency services, with government funding allocated to improve rural access [46].
Impact on financial protection	• CNAM coverage increased but about 12 percent of eligible people cannot pay premiums and do not qualify for public subsidies. Only about 15 percent of self-employed are covered [46]. • People reporting unmet need due to cost decreased from over 25 percent in 2008 to just under 15 percent in 2016 [46]. • Informal payments are embedded in the culture and include: (1) conditioned payments demanded by providers or which patients feel obliged to pay in order to access good-quality care; (2) voluntary facilitation payments (e.g. to obtain specialist care without a referral or to skip a queue); and (3) gifts to express gratitude [51]. • Increased service use has increased co-payments for medicines and accessing services without referrals and outside of the CNAM benefits package [46]. OOP was 36 percent in 2019, down from 46.2 percent in 2015 [51]. • Catastrophic spending is linked to outpatient medicines and concentrated among the poorest, rural residents and pensioners; in 2016, incidence among households was 17 percent—higher than in Kyrgyzstan [46]. • The percentage of uncovered unemployed people fell to 2 percent in 2016 [46].
Impact on equity	• Primary health care and other priority services are universally accessible [53]. • Additional benefits for the insured undermine equity goals. • National pooling combined with output-based payment of providers reduced differences in public spending per person across districts [46]. • More population groups have been included in government subsidies for CNAM. • In 2018, the 12 percent of the eligible population still not covered by CNAM were most likely to be of lower socioeconomic status [47].
Impact on efficiency	• CNAM manages a split between purchasing and provision, acting as the single purchaser with an output-based provider-payment system [46]. • A 2008 WHO review found that administration of the system is efficient—with low costs compared to other countries, streamlining of work due to centralizing financing, and funding of medical facilities through CNAM bank account payments rather than through the state treasury [24].
Success factors	• Small population (3 million) may be more conducive to reforms to centralize pooling [50]. • The official unemployment rate is low, averaging 5 percent between 2008 and 2018 [46]. • From 2004 to 2017, the government committed to allocate at least 12 percent of its budget to health every year [46]. • A high level of consensus and coordination, including with international donors, enabled strong and consistent implementation of reforms [53].

CASE STUDY 2: TWO LARGE HARMONIZED PARALLEL POOLS FOR UNIVERSAL COVERAGE IN COLOMBIA

Through a long process of major structural reforms involving the discontinuation or transformation of old social insurance institutions, Colombia reduced fragmentation and improved equality in health financing [54, 55]. Coverage for the entire population has been expanded with two parallel pools that cover the formal sector (comprising employees and self-employed people) and the informal sector (comprising informal workers, low-income self-employed, and unemployed).

Limiting the number of pools to two enables greater diversity of risk than multiple pools targeted to specific population groups.

Subsequent reforms have established explicit cross-subsidization between the pools through an 'equalization' fund that is distributed on a risk-adjusted, capitation basis to Health Promotion Entities (EPSs), which purchase services from public and private providers on behalf of the pools [54, 55]. Furthermore, the creation of a single set of health services standardized the benefits plan across the schemes. Additional reforms may be needed to equalize the capitation payment unit (the amount of resources allocated to each member for services included in the Health Benefit Plan or *Plan de Beneficios de Salud*) across schemes, as this is currently higher for the contributory scheme [53].

Box 5: Impact of Colombia's pooling on objectives of health financing

- **Financial protection:** Mandatory or automatic enrollment provides protection for the entire population. Funded from premium payments with public subsidy for those unable to pay.
- **Equity:** Cross-subsidization channels funding from the contributory to the subsidized scheme, between people in higher and lower income groups.
- **Efficiency:** Management of both schemes is standardized under the General System of Social Security in Health, creating quality-centered competition among service providers and insurers.

TABLE 9: SUMMARY OF POOLING ARRANGEMENTS IN COLOMBIA

Organization	• The General System of Social Security in Health unifies social security, public, and private financing institutions with two parallel pools: o Contributory scheme for all formal sector workers and others who can pay o Subsidized for the unemployed, informal sector workers and the poor [55]. • The Solidarity and Guarantee Fund (FOSYGA) was created to manage cross-subsidies from the contributory scheme to the subsidized scheme and was replaced by the *Administradora de los Recursos del Sistema General de Seguridad Social en Salud* in 2017. • People switch between schemes depending on their employment status.
Financing	• Contributory scheme is funded by payroll contributions set at different levels for formal sector workers and others with capacity to pay. • Subsidized scheme is funded by taxes and transfers from contributory scheme.
Enrollment	• Contributory scheme is mandatory for employees and self-employed workers. • Enrollment in the subsidized (non-contributory) scheme is mandatory for informal workers and low-income self-employed workers. The eligible population for the subsidized regime corresponds to people registered in the Identification System of Potential Beneficiaries of Social Programs (SISBEN). Territorial entities and the EPSs carry out validation and registration to provide services [56].
Benefits package	• Members of both the contributory and subsidized schemes are entitled to the same comprehensive package [33]. Members of both the contributory and subsidized schemes can chose their EPS and the EPS selects its public or private providers [58].
Provider payment	• The EPS purchases services from public or private health provider institutions [57]. EPSs can select the most appropriate provider payment modality for primary care: capitation, fee-for-service, bundled payments, and pay-for-event; secondary care is fee-for-service or bundled payments; and tertiary care is case-based [58].
Governance	• Regulation and oversight of health insurers and providers falls under SuperSalud (a public entity).

Key reforms	• 1993: mandatory universal health insurance was created through the contributory and subsidized scheme, with FOSYGA to manage subsidies from the contributory to the subsidized pool and finance promotion and prevention interventions [54, 58]. • 2002: introduction of a quality assurance system for both schemes with licensing and accreditation for public and private health care facilities and providers [58]. • 2007: legal reform to improve stewardship, financing, and quality of services [53]. • 2011: introduction of the Mandatory Health Plan (*Plan Obligatorio de Salud in Spanish or* POS) for all residents and portability of benefits across the country [53]. • 2015: introduction of the Health Benefit Plan or *Plan de Beneficios de Salud.*
Impact on financial protection	• 97 percent of the population was covered by 2020 and expansion has mostly benefited the poorest under the subsidized scheme [58]. • OOP expenditures are the low, falling from 43.7 percent of current health expenditures in 1993 to 14.9 percent in 2019 [58].
Impact on equity	• Equity has improved through a standardized benefits package and expansion of provision of full subsidies to more than half the population [33].
Impact on efficiency	• While efficiency has improved, there is room to improve strategic purchasing to improve provider incentives to reduce costs and improve quality of services [53].
Success factors	• Rapid progress toward UHC has been attributed to policy leadership by the government and institutional capacity within the Ministry of Health and Social Protection to manage conflicting interests and tension between key players [53].

CASE STUDY 3: THREE LARGE HARMONIZED PARALLEL POOLS FOR UNIVERSAL COVERAGE IN THAILAND

Box 6: Impact of Thailand's pools on objectives of health financing

- **Financial protection:** Three schemes provide comprehensive benefits for the entire population, without requiring co-payments.
- **Equity:** General taxation as the main source of financing enables redistribution; people are automatically transferred across schemes.
- **Efficiency:** Harmonization of features of the three schemes has improved efficiency.

Thailand achieved UHC by creating three parallel pools for different segments of the population: civil servants (government employees, retirees, and dependents); private sector employees; and the remaining 75 percent of the population [59]. Thailand's incremental reform approach spanned four decades, gradually extending financial risk protection to priority population groups while ensuring a functioning service delivery system. The three-pool system replaced multiple insurance schemes that targeted different population groups and primarily used general taxation to finance coverage. Subsequent reforms have sought to harmonize pools, for example, by offering very similar benefit packages. Although the country achieves good health outcomes at low cost, additional reforms may be needed to improve equity and efficiency, particularly in the higher spending levels for the civil servant scheme. Harmonization of provider payment mechanisms under the universal coverage scheme could also help to achieve greater efficiency.

TABLE 10: SUMMARY OF POOLING ARRANGEMENTS IN THAILAND

Organization	• The entire population is covered by one of the three pools • CSMBS for government employees and retirees and their dependents • SHI for private-sector employees • UCS for those not covered by CSMBS or SHI.
Financing	• General taxes (non-contributory) for CSMBS. • Equal payroll contributions from employers, employees, and government for SHI. • General taxes (non-contributory) for UCS [60].
Enrollment	• Enrollment for CSMBS is compulsory for government employees. • Enrollment in SHI is compulsory for formal sector employees. • All citizens are eligible for UCS and to enroll, must register with a provider network. • Members automatically transfer between pools as their employment status changes. • Unique identification numbers facilitate registration of all members of UCS with a preferred provider network [59].
Benefits package	• Harmonized comprehensive package is offered under all three schemes.
Provider payment	• SHI and UCS use capitation and diagnostic-related groups payment within a global budget in addition to fixed-fee payment for some services. The entire global budget is disbursed to providers transferring financial risk and incentivizing cost containment. • CSMBS uses fee-for-service payment for outpatient services and case-based payments for inpatient services that favor higher-cost hospitals [59].
Governance	• CSMBS is managed by the Ministry of Finance, SHI by the Ministry of Labor, and UCS by the National Health Security Office, an autonomous public agency. • The benefits package has been harmonized across the three schemes and closed-end provider payment is harmonized across SHI and UCS.
Key reforms	• 1975: tax-financed low-income scheme for poor and vulnerable populations provided free care on the basis of means testing and excluded high-cost services. • 1980: tax-financed CSMBS introduced for government employees with fee-for-service reimbursement. • 1983: voluntary health insurance introduced for the informal sector with low-cost annual premium; benefit package comparable to low-income scheme. • 1990: Pay-roll tax-financed SHI introduced for private sector employees; capitation. • 2001: UCS rolled out nationwide with harmonized benefits and purchasing methods, to cover the 30 percent of the population still uninsured. • The UCS benefits package has been gradually expanded [59].
Impact on financial protection	• Household OOP payments fell from 34 percent of total health expenditure in 2000 to 12 percent in 2014 and unmet health-care needs are low [59].
Impact on equity	• All citizens have access to comprehensive health services; by 2015, population coverage across the three schemes was 98.5 percent. • Use of health services increased more in the poorest than richest wealth quintile [5959].
Impact on efficiency	• Lack of harmonization in provider-payment mechanisms inhibits efficiency and negotiating power of the pools. SHI and UCS are more efficient than CSMBS as they rely primarily on closed-end payment as opposed to fee-for-service. CSMBS expenditure per capita is four times higher than that of UCS [59].
Success factors	• Increased fiscal space, political leadership and commitment, and strong primary health care system were enabling factors for implementation of the UCS, improved access to services and better health outcomes [5959]. • Continuously increasing government allocation to UCS ensures that funding is keeping pace with increasing requirements.

CONCLUSION

There is no one-size-fits-all approach to pooling that will be appropriate in all settings, but the evidence is clear that the objective should be to have a small number of large pools with diverse risks. Countries can incorporate more of these desirable attributes into their health financing systems over time but need to make sure that the reforms they choose to implement take into consideration the following country-specific factors:

- **The broader economic and health financing context.** This is critical for determining the most appropriate pooling and prepayment mechanisms. For instance, the evidence shows that CHI alone can support significant progress toward UHC only in high-income and high-capacity contexts. LMICs that introduce CHI for the formal sector and plan to extend it to cover the informal sector often find themselves stuck at a relatively low level of coverage, unable to sustain initial gains (for example, when there is an economic downturn) or grappling with inequitable coverage. The conditions under which countries should consider alternative or complementary pooling mechanisms to CHI include: a large informal sector, low growth, and high levels of inequality.
- **The political context**. The literature we reviewed points to the importance of political economy considerations, in addition to technical factors, for understanding countries' pooling reform pathways and success factors. Technical capacity must be coupled with political economy analyses so that reform efforts are strategically pursued at opportune moments—where reforms align with political interests or processes—and to be appropriately adjusted to emerging pathways. This can help to mitigate resistance to more universal and equitable pooling arrangements, especially where better-off groups perceive that they will lose preferential access to resources or services.
- **The mechanisms currently in use for pooling.** The WHO Health financing progress matrix is a useful resource for understanding how pooling fits into a country's broader health financing system, how pooling works, and how well it provides the desirable attributes that evidence suggests can help to accelerate progress toward UHC. The HFG's Technical Efficiency Guide can be used to diagnose inefficiencies related to fragmentation in pooling.
- **The evolution of pooling over time**. It is important to understand why countries have chosen existing pooling mechanisms as well as what reform efforts have previously been attempted and the outcomes that were achieved. There are always steps a country can take to move closer to desired pooling arrangements and understanding a country's previous efforts can help to determine the steps that are likely to succeed in the current context.

A sound understanding of these factors can provide a basis for major stakeholders to consider the role different pooling mechanisms can play in extending service coverage and financial protection to the whole population. As set out in this document, this includes the role of public resources (tax revenue and mandatory contributions) and of the government budget as a pooling mechanism, in addition to insurance schemes.

Before embarking on reforms, countries should assess and ensure technical capacity to design, plan, and implement reforms that move pooling mechanisms closer to the main desirable attributes of compulsory or automatic inclusion and reducing fragmentation. Even where strong technical capacity exists, none of the reforms described in this document are easy. As set out in the case studies, where countries have achieved significant reform to national pooling mechanisms it has been a mainly gradual and sometimes decades-long process. Success factors include capacity to analyze and understand the political economy of health financing reforms; anticipate and respond strategically to political windows of opportunity; sequence implementation of reforms to reduce political resistance; and facilitate the consultation and compromise needed to advance reform without undermining core objectives.

BIBLIOGRAPHY

1. https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
2. Universal Health Coverage 2030. 2021. *State of Commitment to Universal Health Coverage: Synthesis 2021*. https://www.uhc2030.org/news-and-stories/news/state-of-commitment-to-universal-health-coverage-synthesis-2021-555541/
3. World Health Organization. 2022. *Health system performance assessment: a framework for policy analysis.* https://www.who.int/publications/i/item/9789240042476.
4. World Health Organization. 2014. *Making Fair Choices on the Path to Universal Health Coverage.* https://www.who.int/publications/i/item/9789241507158
5. World Health Organization. 2022c. *Financial Protection*. https://www.who.int/health-topics/financial-protection#tab=tab_1
6. World Health Organization. 2022d. *Health Equity.* https://www.who.int/health-topics/health-equity#tab=tab_1
7. Cylus, Nathan, Irene Papanicolas, and Peter C. Smith. 2016. "A Framework for Thinking About Health System Efficiency. Health System Efficiency: How to Make Measurement Matter for Policy and Management [Internet]*." European Observatory on Health Systems Policies* (46). https://www.ncbi.nlm.nih.gov/books/NBK436891/
8. Kutzin, Joseph. 2000. *Toward Universal Health Care Coverage: A Goal-Oriented Framework for Policy Analysis. HNP Working Paper.* https://openknowledge.worldbank.org/handle/10986/13772
9. World Health Organization. 2020a. *Guidance Paper- Assessing Country Health Financing Systems: The Health Financing Progress Matrix.* https://www.who.int/publications/i/item/9789240017405
10. Hanson, Kara, Nouria Brikci, Darius Erlangga, Abebe Alebachew, Manuela De Allegri, Dina Balabanova, Mark Blecher, Cheryl Cashin, Elexo Esperato et al. 2022. "The Lancet Global Health Commission on Financing Primary Health Care: Putting People at the Centre." *The Lancet Global Health* 10(5). https://doi.org/10.1016/s2214-109x(22)00005
11. Barroy, Helene, and Sanjeev Gupta. 2021. "Fifteen Years Later: Moving Forward Heller's heritage on Fiscal Space for Health." *Health Policy and Planning* (36):1239-1245. https://doi.org/10.1093/heapol/czab033
12. Watson, Julia, Abdo S. Yazbeck, and Lauren Hartel. 2021. "Making Health Insurance Pro-poor: Lessons from 20 Developing Countries." *Health Systems & Reform* 7. https://doi.org/10.1080/23288604.2021.1917092
13. Mathauer, Inke, Lluis Vinyals Torres, Joseph Kutzin, Melitta Jakab, and Kara Hanson. 2020. "Pooling Financial Resources for Universal Health Coverage: Options for Reform." *Bulletin of the World Health Organization* 98(2):132-139. https://doi.org/10.2471/BLT.19.234153
14. Tandon, Ajay and K. Srinath Reddy. 2021. "Redistribution and the Health Financing Transition." *Journal of Global Health* (11): 16002. https://doi.org/10.7189/jogh.11.16001
15. Kutzin, Joseph. 2013. "Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy." *Bulletin of the World Health Organization* 91(8):602-11. https://doi.org10.2471/BLT.12.113985
16. World Health Organization. 2020c. *Can People Afford to Pay for Health Care? New Evidence on Financial Protection in the Republic of Moldova.* https://apps.who.int/iris/bitstream/handle/10665/331667/9789289054959-eng.pdf
17. World Health Organization. 2019b. *UHC Act in the Philippines: A New Dawn for Health Care.* https://www.who.int/philippines/news/feature-stories/detail/uhc-act-in-the-philippines-a-new-dawn-for-health-care
18. Greengross, Peter, Ken Grant, and Elizabeth Collini. 1999*. The History and Development of the UK National Health Service 1948-1999.*

https://assets.publishing.service.gov.uk/media/57a08d91e5274a31e000192c/The-history-and-development-of-the-UK-NHS.pdf

19. Dutta, Arin, Thomas Maina, Megan Ginivan, and Sayaka Koseki. 2018. *Health Policy Plus: Kenya Health Financing System Assessment: Time to Pick the Best Path.* http://www.healthpolicyplus.com/ns/pubs/11323 11587_KenyaHealthFinancingSystemAssessment.pdf
20. Bazyar, Mohammad, Arash Rashidian, Minoo Alipouri Sakha, Mohammad Reza Vaez Mahdavi, and Leila Doshmangir. 2020a. "Combining Health Insurance Funds in a Fragmented Context: What Kind of Challenges Should Be Considered?" *BMC Health Services Research* 20(26). Https://doi.org/10.1186/s12913-019-4858-7
21. Bazyar, Mohammad, Arash rashidian, Vahid Yazdi-Feyzabadi, and Anahita Behzadi. 2020b. "The Experiences of Merging Health Insurance Funds in Turkey, Thailand, South Korea, and Indonesia: What lessons can be learned?" *Research Square.* https://doi.org/10.21203/rs.3.rs-15701/v2
22. Kresnowati, Lily and Mahlil Ruby. 2022. "Indonesia's Progress Toward UHC: A Single Payer's Perspective on the JKN [PowerPoint slides]." https://thedocs.worldbank.org/en/doc/a900ebb6b3caa6b3823d75724e0673ed-0200022022/related/AHFF-Lunch-session-Deep-Dive-Indonesia.pdf
23. Atim, Chris, Indu Bhushan, Mark Blecher, Ramana Gandham, Vikram Rajan, Jonatan Daven, and Olusoji Adeyi. 2021. "Health Financing Reforms for Universal Health Coverage in Five Emerging Economies." *Journal of Global Health* 11 (16005). https://doi.org/10.7189/jogh.11.16005
24. Shishkin, Sergey, Gintaras Kacevicius, and Mihai Ciocanu. 2008. *Evaluation of Moldova's 2004 Health Financing Reform: World Health Organization.* https://www.euro.who.int/__data/assets/pdf_file/0008/78974/HealthFin_Moldova.pdf
25. Yip, Winnie and Reem Hafez. 2015. *Reforms for Improving the Efficiency of Health Systems: Lessons from 10 Country Cases*. https://apps.who.int/iris/bitstream/handle/10665/185989/WHO_HIS_HGF_SR_15.1_eng.pdf?sequence=1&isAllowed=y
26. World Health Organization. 2021b. *Aligning Health and Decentralization Reform in Ukraine.* https://www.who.int/europe/publications/i/item/WHO-EURO-2021-2593-42349-58635
27. Somanathan, Aparnaa, Huong Lan Dao, Tran Van Tien. 2013. *Integrating the Poor Into Universal Health Coverage in Vietnam: UNICO Studies Series 24.* https://documents1.worldbank.org/curated/en/323521468320704369/pdf/749450NWP0VIET00Box374316B00PUBLIC0.pdf
28. Social Protection. 2022. *Social Health Insurance, SHI (Non-Contributory Component).* https://socialprotection.org/discover/programmes/social-health-insurance-shi-non-contributory-component
29. World Health Organization. 2022f. *Universal Health Coverage in Viet Nam.* https://www.who.int/vietnam/health-topics/universal-health-coverage#:~:text=Universal%20health%20coverage%20(UHC)%20means,%2C%20rehabilitation%2C%20and%20palliative%20care
30. Mathauer, Inke, Priyanka Saksena and Joe Kutzin. 2019. "Pooling Arrangements in Health Financing Systems: A Proposed Classification." *International Journal for Equity In Health* 18 (198). https://doi.org/10.1186/s12939-019-1088-x
31. World Health Organization. 2021c. *Digital Technologies for Health Financing: What are the Benefits and Risks for UHC? Some initial Reflections.* https://www.who.int/publications/i/item/9789240031005
32. Social Protection. 2014. *International Labour Office: Universalizing Health Protection Colombia.* https://www.socialprotection.org/gimi/RessourcePDF.action;jsessionid=UbvtHQhd61MEJEPXsuCPOqVBUsAF0SUZDqnVP-40zIPlyn3Jcc10!539423187?id=48019

33. Guerrero, Ramiro, Sergio Prada, Ana Melissa Perez, Jorge Duarte, and Andrews Felipe Aguirre. 2015. *Universal Health Coverage Assessment: Colombia.* http://gnhe.org/blog/wp-content/uploads/2015/05/GNHE-UHC-assessment_Colombia-1.pdf
34. Institute for Quality and Efficiency in Health Care. 2015. *Health care in Germany: The German health care system*. https://www.ncbi.nlm.nih.gov/books/NBK298834/
35. Tangcharoensathien, Viroj, Walaiporn Patcharanarumol, Anond Kulthanmanusorn, Nithiwat Saengruang and Hathairat Kosiyaporn. 2019. "The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries." *Health Systems and Reform* 5(3): 195-208. https:doi.org/10.1080/23288604.2019.1630595
36. Torres, Fernando Montenegro and Oscar Bernal Acevedo. 2013. *The World Bank Colombia Case Study: The Subsidized Regime of Colombia's National Health Insurance System.* https://openknowledge.worldbank.org/bitstream/handle/10986/13285/749610NWP0COLO00Box374316B00PUBLIC0.pdf?sequence=1&isAllowed=y
37. Angell, Blake J., Shankar Prinja, Anadi Gupt, Vivekanand Jha, and Stephen Jan. 2019. "The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the Path to Universal Health Coverage in India: Overcoming the Challenges of Stewardship and Governance." *Public Library of Science* 16(3): e1002759. https://doi.org/10.1371/journal.pmed.1002759
38. World Health Organization. 2021d. *WHO Continues to Support the Ministry of Health to Improve Equitable Access to Healthcare Services Through Strengthening Social Health Protection Schemes in Lao People's Democratic Republic.* https://www.who.int/laos/news/detail/08-11-2021-who-continues-to-support-the-ministry-of-health-to-improve-equitable-access-to-healthcare-services-through-strengthening-social-health-protection-schemes-in-lao-people-s-democratic-republic
39. Sparkes, Susan, Jesse Bump, Ece Ozcelik, Joseph Kutzin, Michael Reich. 2019. "Political Economy Analysis for Health Financing Reform." *Health Systems and Reform* 5(3). https://doi.org/10.1080/23288604.2019.1633874
40. Blanchet, Nathan and Osei B. Acheampong. 2013. *Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana.* https://www.hfgproject.org/wp-content/uploads/2014/02/Building-on-Community-based-Health-Insurance-to-Expand-National-Coverage-The-Case-of-Ghana.pdf
41. Preker Alexander S., Daniel Cotlear, Soonman Kwon, Rifat Atun, and Carlos Avila. 2021. "Universal Health Care in Middle-Income Countries: Lessons from Four Countries." *Journal of Global Health* (11):16004. https://doi.org/10.7189/jogh.11.16004
42. Croke, Kevin, Mariana Binti Mohd Yusoff, Zalilah Abdullah, Ainul Nadziha Mohd Hanafiah, Khairiah Mokhtaruddin, Emira Soleha Ramli, Nor Filzatun Borhan, Yadira Almodovar-Diaz, Rifat Atun, and Amrit Kaur Virk. 2019. "The Political Economy of Health Financing Reform in Malaysia." *Health Policy and Planning* 34: 732-739. https://doi.org/10.1093/heapol/czz089
43. JLN Network Manager. 2021. *Earmarking in Ghana: Impacts on the Financial Sustainability of the National Health Insurance Scheme.* https://www.jointlearningnetwork.org/?s=earmarking+in+ghana
44. Le, Quynh Ngoc, Leigh Blizzard, Lei Si, Long Thanh Giang, and Amanda Neil. 2020. "The Evolution of Social Health Insurance in Vietnam and its Role Toward Achieving Universal Health Coverage." *Health Policy OPEN* 1. https://doi.org/10.1016/j.hpopen.2020.100011
45. World Health Organization. 2010. *The World Health Report. Health Systems Financing: The Path to Universal Coverage.* https://apps.who.int/iris/handle/10665/44371
46. Jakab, Baktygul Akkazieva, and Jarno Habicht. 2018. *Can People Afford to Pay for Health Care? New Evidence on Financial Protection in Kyrgyzstan.* https://www.euro.who.int/__data/assets/pdf_file/0007/381589/kyrgyzstan-fp-eng.pdf
47. Garam, Iuliana, Mariana Zadnipru, Valeriu Doronin, Andrei Matei, and Ilaria Mosca. 2020. *Can People Afford to Pay for Health Care? New Evidence on Financial Protection in the Republic of Moldova.* https://apps.who.int/iris/bitstream/handle/10665/331667/9789289054959-eng.pdf

48. Lima, Joana Madureira, Aigul Sydykova, Triin Habicht, and Jen Wilkens. 2021. *Health Financing in Kyrgyzstan: Obstacles and Opportunities in the Response to COVID-19.* https://www.who.int/europe/publications/i/item/WHO-EURO-2021-2604-42360-58654
49. Giuffrida, Antonio, Melitta Jakab, and Elina M. Dale. 2013. *Toward Universal Coverage in Health: The Case of the State Guaranteed Benefit Package of the Kyrgyz Republic.* https://documents1.worldbank.org/curated/en/685631468278090377/pdf/750060NWP0Box30l0Coverage0in0Health.pdf
50. Kutzin, Joseph, Melitta Jakab, and Sergey Shishkin. 2009. "From Scheme to System: Social Health Insurance Funds and the Transformation of Health Financing in Kyrgyzstan and Moldova." *Advances in Health Economics and Health Services Research* 21: 291-312. https://doi.org/10.1108/S0731-2199(2009)0000021014
51. Taryn Vian, Feeley FG, Domente S. Framework for addressing out-of-pocket and informal payments for health services in the Republic of Moldova. 2014. https://www.euro.who.int/__data/assets/pdf_file/0009/256158/Framework-for-addressing-out-of-pocket-and-informal-payments-for-health-services-in-the-Republic-of-Moldova.pdf
52. WHO Europe. 2022. *Health systems in action: Republic of Moldova.* https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-republic-of-moldova-2022
53. Shishkin, Sergey and Matthew Jowett. 2012. *A Review of Health Financing Reforms in the Republic of Moldova*. https://www.euro.who.int/__data/assets/pdf_file/0009/166788/E96542.pdf
54. International Labour Office. 2014. *Universalizing Health Protection: Colombia.* https://www.socialprotection.org/gimi/RessourcePDF.action;jsessionid=UbvtHQhd61MEJEPXsuCPOqVBUsAF0SUZDqnVP-40zIPlyn3Jcc10!539423187?id=48019
55. Escobar, Maria-Luisa, Ursula Giedion, Antonio Giuffrida, and Amanda L. Glassman. 2010. *Colombia: After a Decade of Health System Reform*. https://www.brookings.edu/wp-content/uploads/2016/07/fromfewtomany_chapter.pdf
56. Results for Development Institute. 2011. *Should India Create a Single National Risk Pool? Some Lessons from Thailand, Mexico, and Colombia.* https://www.r4d.org/wp-content/uploads/R4D-PHFI-Risk-Pooling-Technical-Note-11-April-2011-final.pdf
57. Ministerio de Salud y Protección Social. Protección social. https://www.minsalud.gov.co/proteccionsocial/Regimensubsidiado/Paginas/regimen-subsidiado.aspx
58. Glassman, Amanda, Maria-Luisa Escobar, Antontio Giuffrida, and Ursula Giedion. 2009. *From Few to Many: Ten Years of Health Insurance Expansion in Colombia.* https://publications.iadb.org/publications/english/document/From-Few-to-Many-Ten-Years-of-Health-Insurance-Expansion-in-Colombia.pdf
59. Tangcharoensathien Viroj, Woranan Witthayapipopsakul, Warisa Panichkriangkrai , Walaiporn Patcharanarumol, and Anne Mills. 2018. "Health Systems Development in Thailand: A Solid Platform for Successful Implementation of Universal Health Coverage." The *Lancet* 391(10126): 1205-1223. https//doi.org/10.1016/S0140-6736(18)30198-3
60. Tangcharoensathien, Viroj, Kanjana Tisayaticom, Rapeepong Suphanchaimat, Vuthiphan Vongmongkol, Shaheda Viriyathorn, and Supon Limwattananon. 2020. "Financial Risk Protection of Thailand's Universal Health Coverage: Results from Series of National Household Surveys Between 1996 and 2015". *International Journal for Equity in Health* 19(163). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01273-6
61. Cotlear, D, Somil Nagpal, Owen Smith, A. Tandon, and R. Cortez. 2015. *Going Universal: How 24 Developing Countries Are Implementing Universal Health Coverage Reforms from the Bottom Up* [Internet]. https://documents1.worldbank.org/curated/en/936881467992465464/pdf/99455-PUB-Box393200B-OUO-9-PUBDATE-9-28-15-DOI-10-1596-978-1-4648-0610-0-EPI-210610.pdf

62. 23 United Stated Agency for International Development. 2018. *Health Finance and Governance Project Technical Efficiency Guide: Fragmented Risk Pool Management.* https://rise.articulate.com/share/-xWeCMdb3GNTRuj-NI8AaQUsvMx6J6b4#/lessons/Iqp84bjXI_BxLDk9z5e2Wd0_ILP42_jf
63. World Health Organization. 2020b. *Country Assessment Guide: The Health Financing Progress Matrix.* https://www.who.int/publications/i/item/9789240017801

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