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Addressing the Global Health Crisis:

Universal Health Protection Policies

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Abstract

This paper assesses the dimensions and extent of the global health crisis and suggests policy responses to address the crisis.

JEL Classification: I10, I130, I140, H5

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

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List of 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
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
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	Social Protection Floor
THE	total health 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

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1. Introduction

Health protection coverage is crucial for every human being and to the economy as a whole since labour productivity requires a healthy workforce and employment effects of the health sector significantly contribute to overall employment in most countries.

In fact, good health is a prerequisite for sustainable development, economic growth and equity: A labour force can only be fully productive if based on all people at working age that are not deprived by sickness, disability or low life expectancy. It is also important that all people at working age are in a position to generate income from work. Given this relationship, the economic returns on investing in health are estimated at 24 per cent of economic growth in developing countries between 2000 and 2011 taking into account increases in both national income and life years gained (The Lancet Commission, 2013).

Access to health protection is thus a key for both good health of the population and for boosting the economy. Ensuring that everyone can attend quality health care is a prerequisite for sustainable development based on equity and inclusiveness. To effectively address the global health protection crisis, universality of health coverage must involve equal access to needed health care for all people wherever they live and work, in rural or urban areas, in the formal or informal economy, no matter if one is poor or wealthy, women or men, elderly or children.

However, equitable health coverage does not occur automatically even if wealth increases. It requires inclusive policies addressing inequities resulting from access barriers both within and beyond the health sector: Within the health sector, often inequities in access to health care occur in the absence of legislation that affiliates the people to a health scheme or system, by services that are of low quality or not affordable due to high out-of-pocket payments (OOP), or just not available due to the absence of health workers to deliver needed care. It is also important to address issues beyond the health sector that induce access inequities to health care such as poverty.

Removing the root causes behind these developments involves in-depth analyses and the development of a set of comprehensive policies such as closing coverage gaps in legislation, developing fair health financing mechanisms and ensuring the availability of health services even in remote areas. Revealing the economic potential of universal health coverage also requires shaping inclusive labour market and developmental policies alleviating poverty, as unemployment and lack of income range high among the barriers to access needed health care given the need to pay for health care. Only such comprehensive policies have the potential to recover investments in health care at the national level and yield returns of investments through higher productivity and employment.

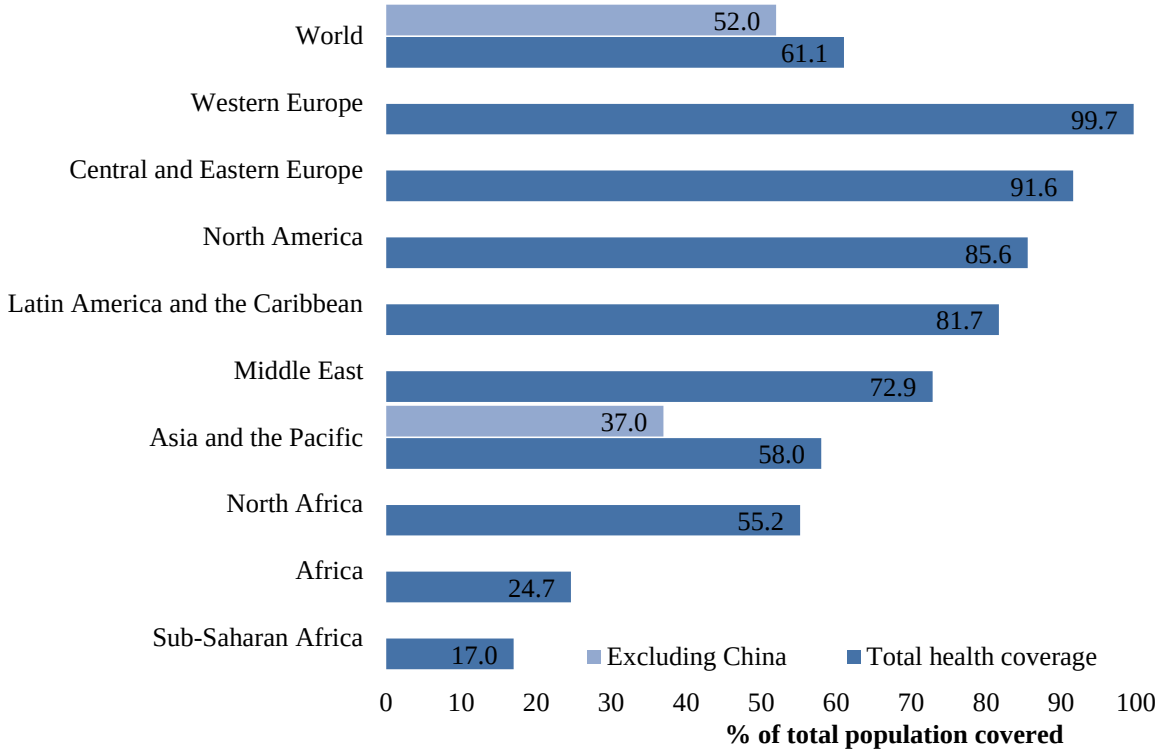
In the following we are assessing the dimensions and extent of the global health protection crisis and thus missed opportunities for sustainable development based on equally shared benefits. Further we suggest policy responses to address the crisis. We will use the framework of the Social Protection Floor approach as outlined in ILO Recommendation 202 concerning National Floors of Social Protection (2012). It stipulates that all residents and children in a given country should be guaranteed by legislation at least essential health care, prevention and maternal care. Universality thereby implies rights-based approaches that are implemented with a view to provide access to available care of acceptable quality. In addition, it is necessary that co-payments, user fees and other costs involved are affordable and that financial protection is provided in order to avoid hardship or impoverishment. Finally, effective access requires good governance of schemes and systems, which should be based on accountability, including participatory processes such as social and national dialogue.

2. The dimensions of the global health crisis

2.1. The missing right to health

Legal health coverage informs about entitlements to benefits prescribed by national law. They are a prerequisite to universal health protection that is rights-based and not just a privilege of the wealthiest part of the populations. However, nearly four-tenths (38.9 per cent) of the world's population are without any form of legal health coverage (figure 1). The most substantial gaps are found in Africa, particularly in Sub-Saharan Africa, where some 80 per cent of the population is excluded from legal coverage. Moreover, major gaps exist in Asia. For example, in India, more than 80 per cent of the population is not legally covered.

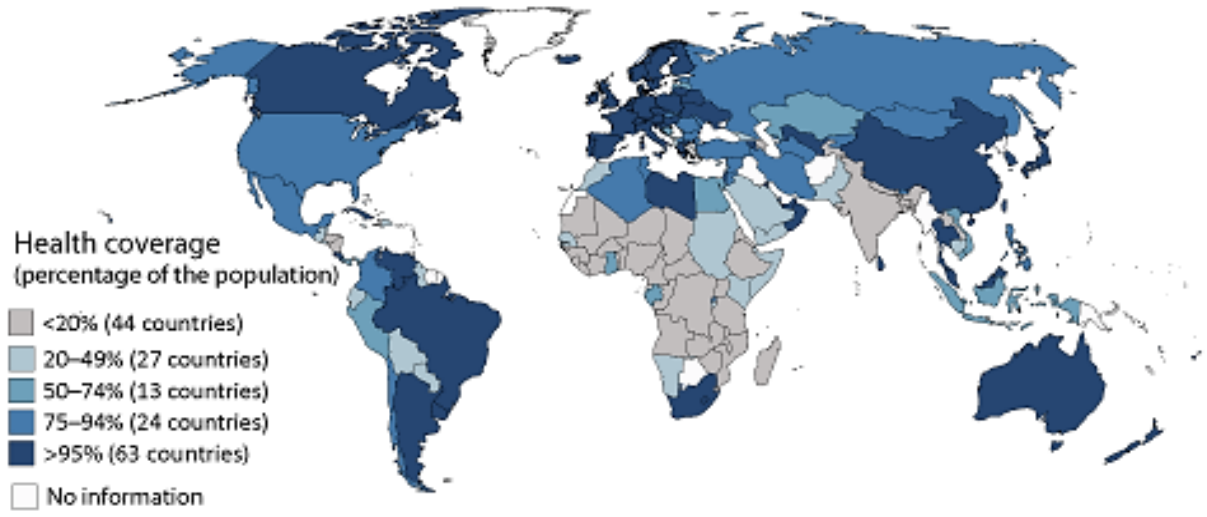
Figure 1: Proportion of population affiliated to national health services, social, private or micro-insurance schemes, by region, latest available year (percentages)



Note: Global average weighted by population.
Sources: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=36977.

In 44 countries across the world more than 80 per cent of inhabitants remain without coverage as they are not affiliated to any health system or scheme. These countries include Azerbaijan, Bangladesh, Burkina Faso, Cameroon, Haiti, Honduras, India and Nepal (figure 2).

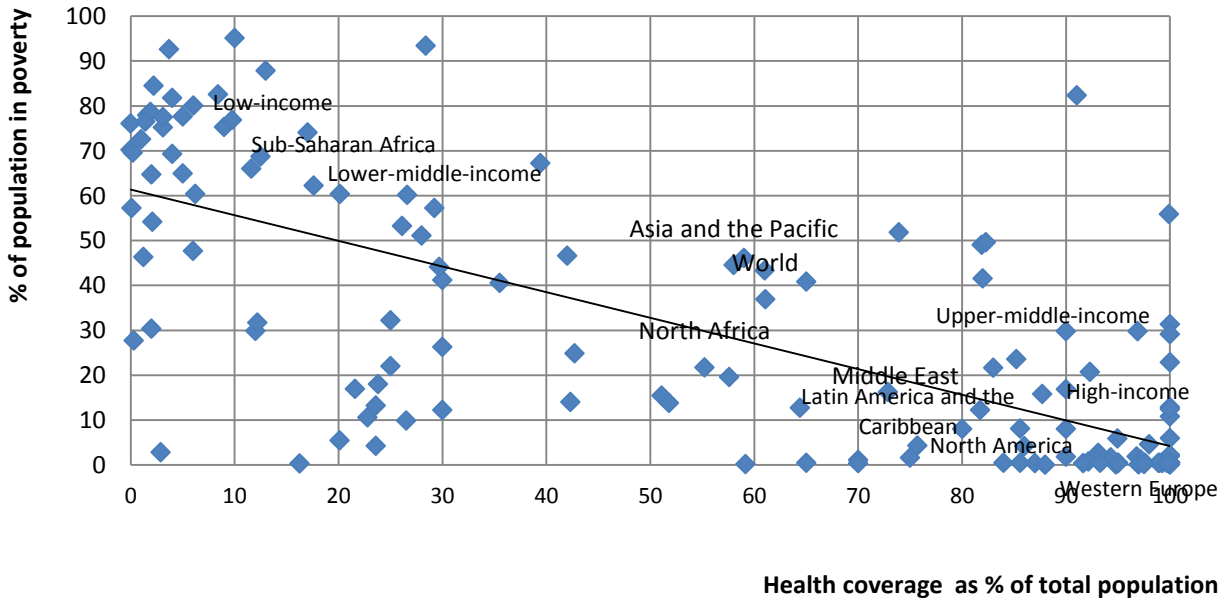
Figure 2: Proportion of population affiliated to national health services, social, private or micro-insurance schemes, globally, latest available year (percentages)



Note: Global average weighted by population.
Sources: OECD Health Statistics database; national sources for non-OECD countries (for more detailed figures, see Annex II).
Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=38197.

Analyses further show that the most significant gaps and thus inequities in legal health coverage are found in those countries with the highest poverty levels among the population, whereas the highest coverage rates are achieved in countries with low poverty levels, such as those in Western Europe (figure 3). A close relationship between coverage rates and income levels of countries is also apparent: the lower a country's income, the more likely it is to experience coverage gaps in social health protection.

Figure 3: Legal health coverage and poverty, latest available year (percentages)



Notes: Poverty is defined as daily per capita income of US$2 or less. R2 = 0.5684
Sources: Social health protection coverage data from the ILO Social Protection Department database; poverty data from World Bank, World Development Indicators; OECD; ADB.
Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=36980

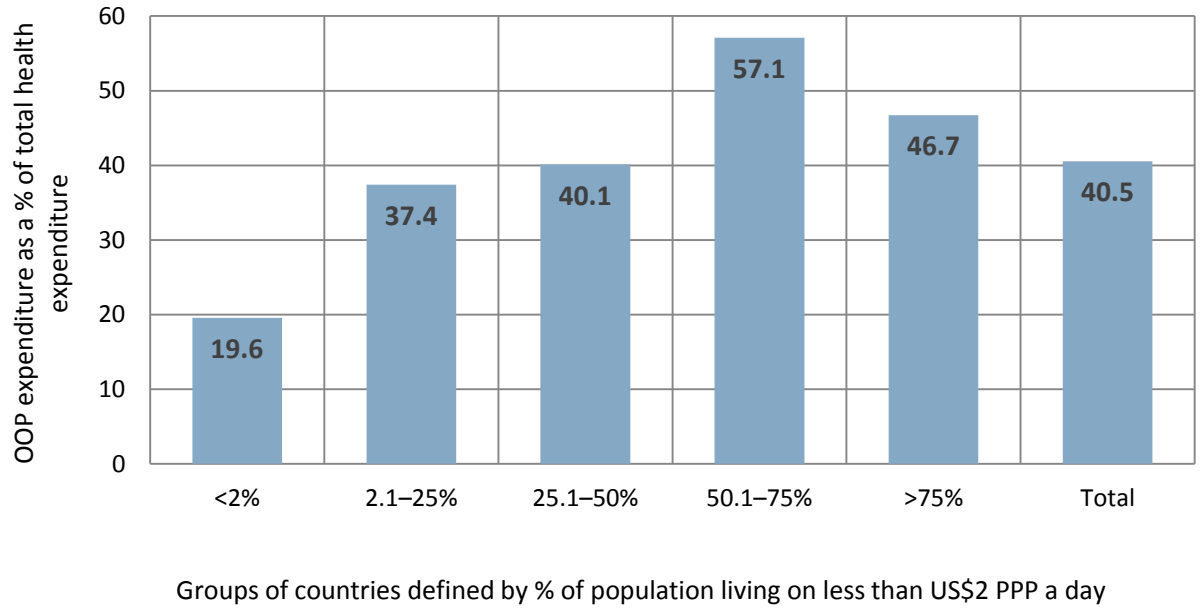
2.2. The impoverishment due to high costs of health care

Taking up health care often involves private OOP, such as user fees and co-payments by those entitled to benefits, entire costs of treatments by those lacking coverage and opportunity costs related to transport to health facilities. Such expenditure is frequently significant and might lead to impoverishment or deepened poverty for those who are poor already. In the worst case, people are totally excluded from access to any needed health care because they do not have the means to pay for it. Thus, OOP might constitute an important barrier to access health care even if most in need.

Despite these negative implications, OOP are observed in nearly all countries throughout the world: More than 40 per cent of the global burden of health expenditure is borne by private households. The regressive character of OOP stands in stark contrast to the key principles of solidarity in financing and the idea of sharing risk across different socio-economic groups.

OOP are particularly frequent where legal health coverage is absent. This is particularly the case in low-income countries. In fact, we find a positive correlation between poverty rates and shares of OOP in total health expenditure: the extent of impoverishing OOP in a country increases with the level of the population living below the poverty line. In countries where less than 2 per cent of the population are living on US$2 day, about 20 per cent of total health expenditure derives from OOP; in countries where more than 50 per cent of the population are living on US$2 a day, it amounts to as much as around 50 per cent. Thus it is the poorest and most in need, who suffer most from OOP and related inequities (figure 4).

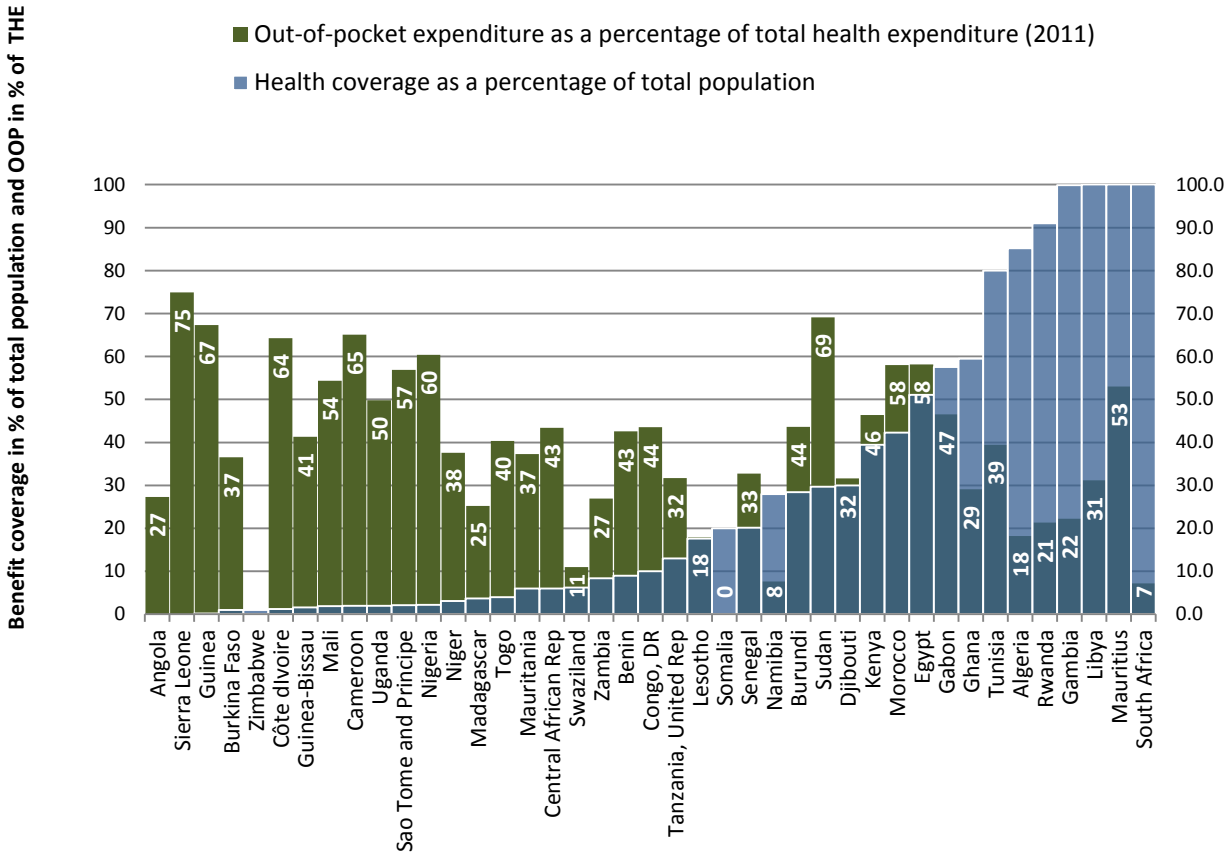
Figure 4: Share of out-of-pocket payments in total health expenditure, by proportion of the population living on less than $ 2 USD a day PPP, 2011 (percentages)



Note: Weighted by total population.
Sources: ILO calculations based on WHO data; poverty data: World Bank, ADB and CEPAL data.
Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=42859

Such payments are also common in countries that have legislation on paper, but did not fully implement or enforce it or have failed to link eligibility and affordability of health care when designing health systems and schemes. Further, OOP occur if the extent of benefits or services covered is too limited. As a result, often even the most essential care involves OOP. This includes facility-based maternity care in countries where most of the population earns less than $1 USD a day. For example, in Kenya, nearly 100 per cent of women had to pay fees amounting to more than $18 USD. In such cases, legal health coverage is an illusion and only masks an actual lack of effective access. An overview of the extent of legal health coverage and OOP in selected African countries is presented in figure 5. It reveals that in some countries with relatively high legal coverage rates, such as Mauritius and Egypt, OOP still exceeds 50 per cent of total health expenditure.

Figure 5: Legal health coverage and out-of-pocket payments in selected African countries, 2011 (percentages)



Source: Social health protection coverage: OECD and national sources; OOP payments: WHO.
Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=43300.

2.3. The lack of quality health services in the absence of health workers

One of the most important contributing factors to the global health protection crisis relates to the unavailability of health services due to missing health workers. Without a sufficient number of health workers equity in access to needed care cannot be achieved and the economic potential of health remains undisclosed. Skilled health workers – physicians, nurses and midwifery personnel - are of critical importance to ensure the availability of quality health care and thus access to needed health care (World Social Protection Report 2014/2015).

ILO estimates that globally 10.3 million additional health workers are required to close the current gaps and to ensure the delivery of universal health care. The majority of these are needed in developing countries, mainly in Asia (7.1 million) and Africa (2.8 million) (figure 6). This estimation is based on a threshold of 41.1 health workers per 10,000 populations that are necessary to provide quality services to all in need.

Figure 6: Number of skilled health workers required to close global and regional gaps in universal health coverage, ILO estimate, 2014

Source: ILO calculations based on WHO Global Health Observatory.
Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=44517.

Hence, the global health workforce is not only too small in numbers; it is also unequally distributed across countries. According to the latest available data, in numerous countries – including, for example, Haiti, Niger, Senegal and Sierra Leone – as many as 10,000 people have to rely on services provided by five or fewer health workers. By contrast, in a high-income country such as Finland there are 269 health workers for 10,000 people (table 1).

Table 1: Numbers of health workers per 10,000 population, selected countries, latest available year

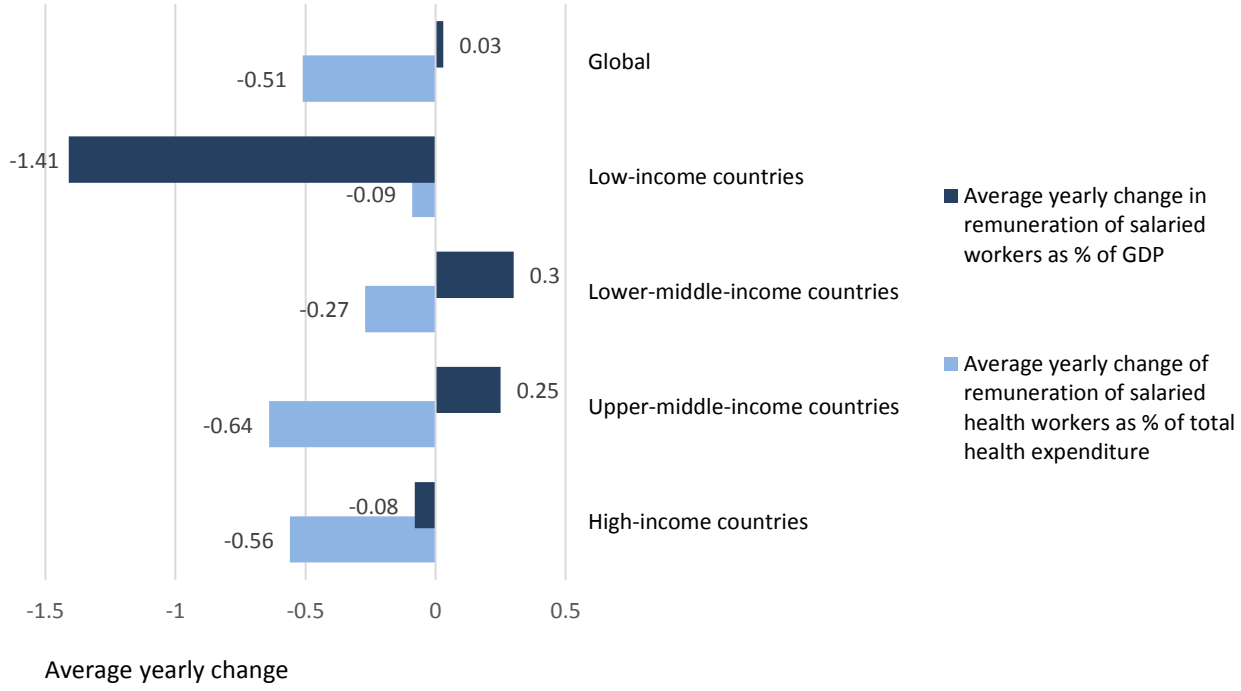
Country	No. of health workers per 10,000 of population
Niger	1.56
Sierra Leone	1.88
Central African Republic	2.95
Haiti	3.6
Mozambique	3.67
Senegal	4.79
Bangladesh	5.74
Gambia	9.7
Norway	195
Switzerland	215
Finland	268

Source: Based on WHO Global Health Observatory.

Moreover, decent working conditions, particularly decent wages are missing in many countries and even declined in recent years: the wage bills of health workers have fallen, sometimes drastically. In the Democratic Republic of Congo and Myanmar, for example, they declined by about 40 per cent during economic crises between 2007 and 2009 (UNICEF 2010).

In fact, the wages are often so poor that the workers in the lowest-paid categories are faced with the risk of impoverishment: In countries such as Sudan, Egypt and Myanmar, health-sector wages are only 1 per cent above the poverty line of $ 2 USD a day ($ USD PPP, 2009). In other countries, while the wage bills of health workers were stable in nominal terms, they declined in real terms as a result of falling purchasing power. Over the first decade of this century, the remuneration of salaried health workers as a proportion of GDP remained nearly unchanged globally and decreased in terms of total health expenditure (figure 7). In addition, delays in payment are frequent in many countries.

Figure 7: Yearly change in health workers' remuneration as proportion of total health expenditure and GDP, by national income level, 2000–10 (percentages)



Source: Based on ILO calculations (see Statistical Annex B.11).
Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=44517.

Consequently, health workers have to gain income elsewhere resulting in absenteeism. Further, due to low wages, they might be tempted to request informal payments. In addition, high turn-over rates and a brain drain of workers seeking better wages outside of their home countries is often the impact of poor wages and working conditions: At the global level, health-worker migration from poorer to richer countries is constantly increasing: Between 2007 and 2012 more than 230,000 migrant health workers took up job opportunities in health-care services in the United States (OECD, 2013). This further reduces the availability of health services in poorer countries.

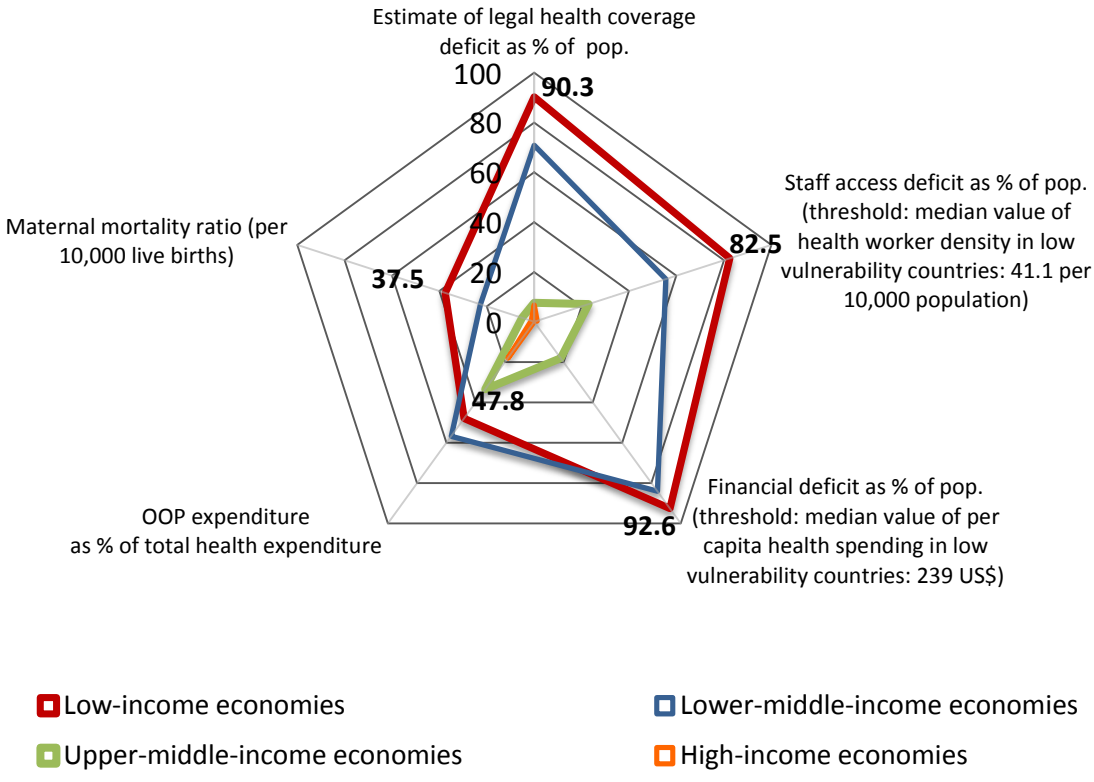
3. The magnitude of the global crisis

3.1. Gaps in affordability, availability and financial protection for quality health care

The global deficit in access to health care services consists of multiple partly interrelated dimensions that contribute to the current health protection crisis: Gaps in legal health coverage, availability, affordability and financial protection of quality services. Indicators that reflect best these aspects include the population coverage of legislation, deficits in the density of health workers, health financing deficits and private expenditure in the form of OOP. Finally, maternal mortality rates can be used to show the overall performance of the health system.

ILO uses relative thresholds to identify the related deficits in health workforce density and financing. In 2014, they amount to 41.1 health workers per 10,000 population and to 239 USD public health expenditure per person and year. These thresholds are derived from population weighted median values of related data in countries that are considered low vulnerable by ILO. They are characterised by enabling socio-economic environments for UHC - namely low levels of poverty, extent of informal economy and fairness of financing in terms of risk pooling (statistical details are presented in Annex II).

Figure 8: The global access deficit to health care by level of country income 2012/2013



Source: ILO 2014c

Figure 8 provides a comprehensive overview of the global access deficit to health care in countries grouped by income level. Concerning low income countries, it reveals that

- more than 90 per cent of the population remains without any legal health coverage to provide access to the most essential health care;
- more than 80 per cent of the population lacks access to health care due to the absence of health workers needed to provide such services;
- the current financial deficit exceeds 90 per cent of necessary expenditure to cover the costs of quality health care;
- with OOP accounting for more than 45 per cent of total health expenditure, the affordability of health services and financial protection is a severe problem and financial hardship as a result of private health expenditure is assumed to be very prevalent;
- the maternal mortality ratio is estimated to be as high as 37.5 deaths per 10,000 live births in low-income countries, and is often directly related to gaps in the availability of skilled health workers, particularly midwives.

In addition to these deficits in effective access to health care, it should be noted that in most countries certain groups, such as the rural population, women, the elderly, minorities and people with special needs such as those affected by HIV/AIDS, are even more likely to face barriers to access than the general population (Scheil-Adlung and Kuhl, 2012).

Further, when comparing different groups of countries, or different schemes within countries, it is important to be aware that the scope of benefits provided by the various systems and schemes may vary significantly. Depending on economic, financial, epidemiological and social conditions, the scope of benefits might range from providing a limited number of public health and clinical interventions in primary care facilities to comprehensive benefit packages, limited by the exclusion of some services. Thus the figure above does not reflect the wide disparities in effective access to care both within and across countries.

3.2. Rural areas: Globally most neglected

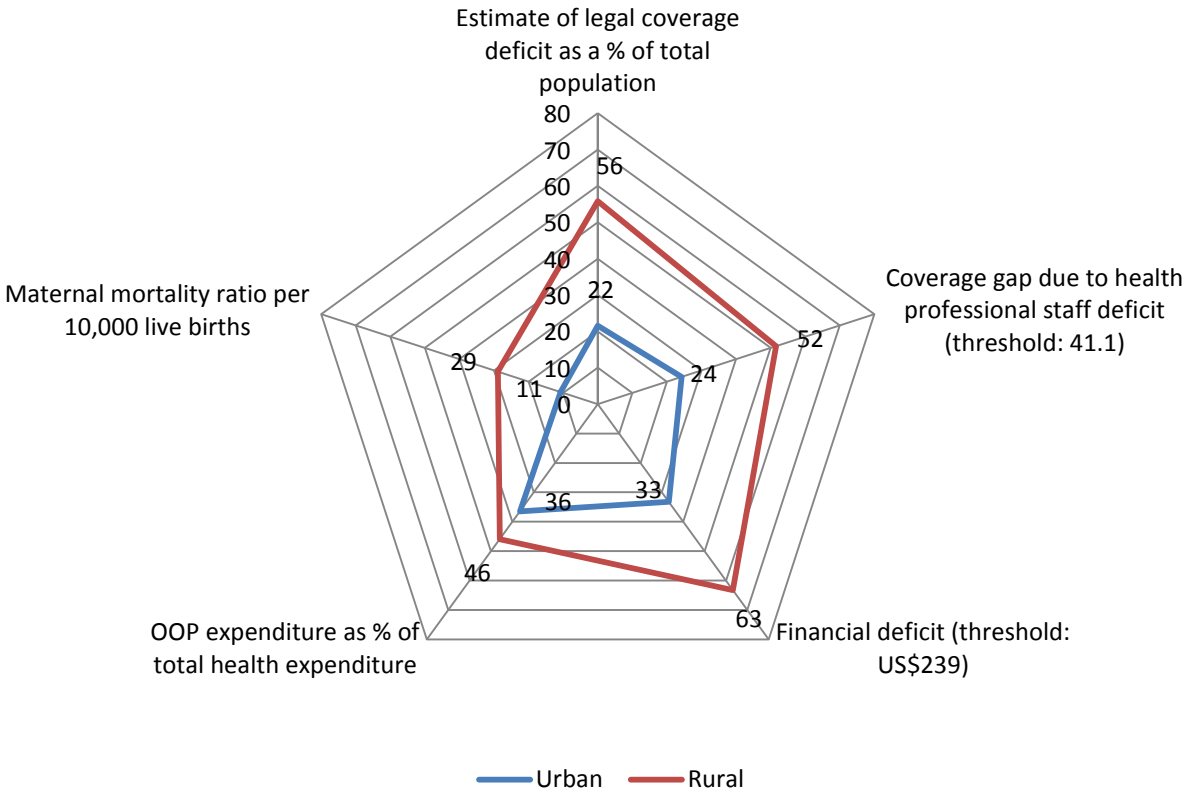
When analysing the gaps and deficits observed at global level through a rural/urban lens, inequities become even more visible: In many countries, the place of living and working defines if access to needed health care is available, affordable and financially protected. Figure 9 reveals the large global and regional differences and inequities in rural/urban health coverage and related gaps towards universal health protection:

- 56 per cent of the global population living in rural areas are deprived from legal health coverage while 22 per cent of the global urban population is experiencing coverage gaps.
- 52 per cent of the rural population cannot access needed health services as the number of health workers is too low to deliver these services; in urban areas this concerns 24 per cent of the population.
- 63 per cent of the rural population has no or only inadequate access to health care services due to financial deficits in health expenditure compared to 33 per cent of the urban population.

- Also, OOP is with 46 per cent of total health expenditure significantly higher in rural than in urban areas where it amounts to 36per cent.

- As a result of the above inequities, maternal mortality ratios are globally nearly 3 times higher in rural than in urban areas.

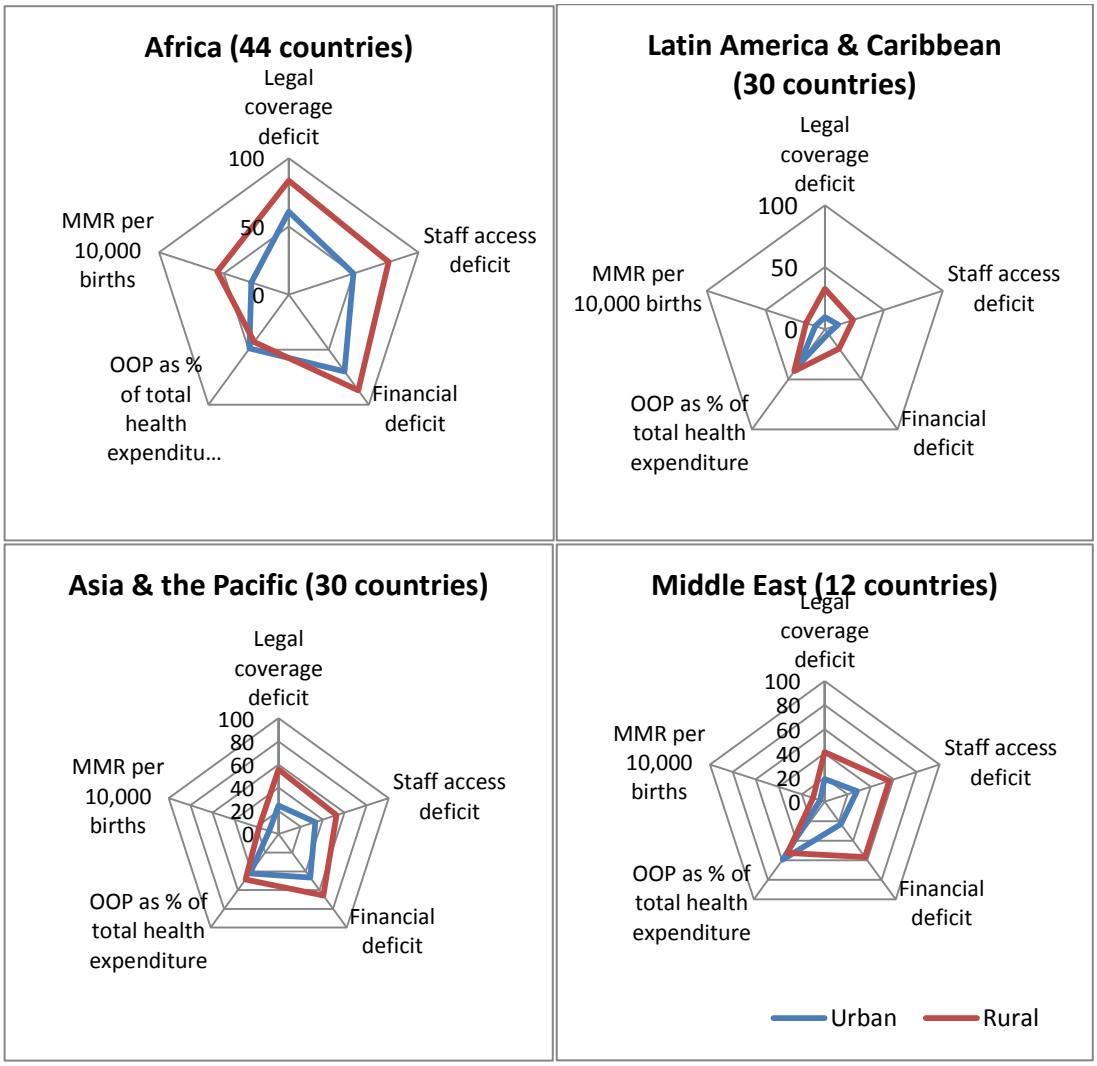
Figure 9: The global health access deficit of rural and urban populations, 2011/2012



Source: ILO 2015 forthcoming

Significant inequities between rural and urban areas exist in all regions of the world. The globally highest inequities between the rural and urban populations are found in Africa, Asia and the Pacific. However, significant inequities also exist in other regions. For example, the financial deficit in the Latin America & the Caribbean region predominantly affected the rural population. Further, more than twice of the rural population is hampered to access health services due to the absence of sufficient numbers of health workers (figure 10).

Figure 10: Regional inequities between rural and urban populations in access to health services, 2011/2012

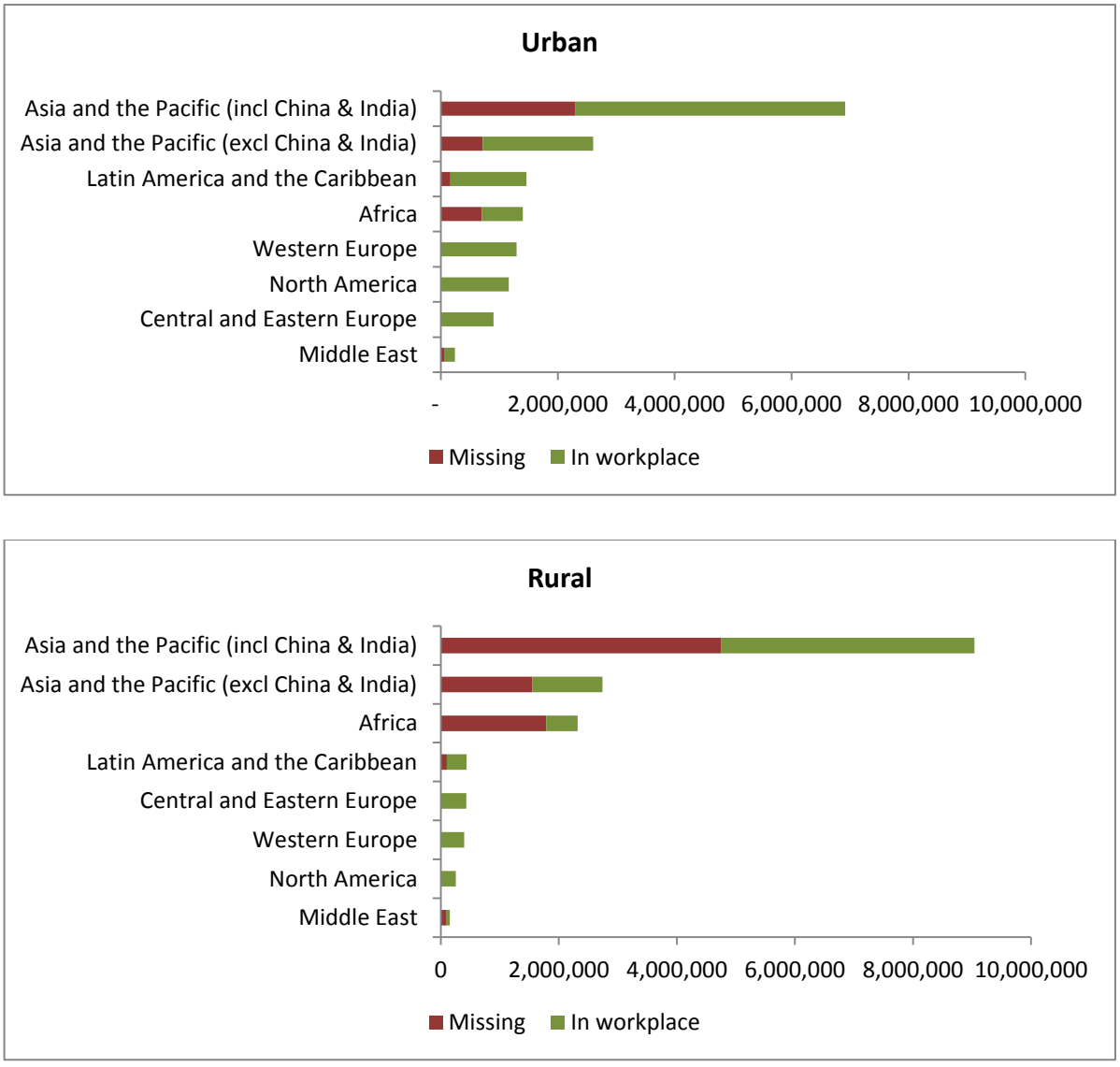


Source: ILO 2015 forthcoming

Large differentials are also apparent in Asia & the Pacific and the Middle East: They mostly concern the rural population which is largely excluded from legal coverage, underserved in the absence of sufficient numbers of health workers and experiences a higher financial deficit than the urban population.

With regards to the availability of health workers in rural and urban areas it is interesting to note that nearly 70 per cent (7 million out of 10.3 million) of the additional health workers that are globally needed to achieve universal health protection are missing in rural areas. Further, the vast majority of the health workers are missing in rural areas of Asia & the Pacific and Africa (figure 11).

Figure 11: Available and missing health workers in urban and rural areas, by region, 2011/2013



Source: ILO 2015 forthcoming

3.3. Effects of fiscal consolidation measures on the health crisis

Fiscal consolidation policies aiming at economic recovery by reducing government deficits and debts might result in the opposite if they focus on health care. This is due to the fact that contracting public budgets for health protection has the potential to reduce economic productivity and increase poverty. The impacts of such policies can also be observed in the current health crisis both, in OECD countries and in low and middle income countries.

While, only a few countries managed over the last years to increase at least legal health protection – e.g. the USA, China, and the Philippines – many others implemented fiscal consolidation measures impacting negatively on the availability and affordability of health services and of essential drugs such as antibiotics, and the creation and maintenance of infrastructure. As a result, per capita health spending fell significantly between 2009 and 2011 in 11 OECD countries, in Greece and Ireland by 11.1 and 6.6 per cent respectively

(ILO 2014c). A selection of recent announcements of fiscal consolidation policies in the area of health protection is available in table 2.

Table 2: Announced fiscal consolidation policies and associated fiscal savings, selected countries, 2007–14

Country	Year	Reform	Fiscal savings
Botswana	2007–11	Reduction in government per capita expenditure on health of 14.4% in constant US$	
Bulgaria	2009	Budget of Ministry of Health reduced	Budget reduced from 713 million Lev (BGN) in 2008 to BGN537 million in 2009 and BGN570 million in 2010 (total reduction of US$100 million)
Cyprus	2011	Postponement of implementation of new national health insurance system	
Czech Republic	2010	Ministry of Health budget reduced by about 30% in 2010 compared to 2008	US$107.18 million
Hungary	2010	Volume limits to inpatient services Increased user charges	1.3% average annual drop in government expenditure on health, from US$476.6 to US$452.0 per capita
Estonia	2009	Estonian Health Insurance Fund (EHIF) budget reduced. Health insurance budget reduced by 1% and Ministry of Health expenditure reduced by 24% between 2008 and 2009	EHIF spending reduced by 263,699,000 EEK (US$22.48 million)
Greece	2011	Removal of certain preventive care provisions Agreement to reduce public health expenditure in 2012 from 1.9 to 1.33% of GDP as part of request for support from IMF 3.7% average annual drop in government expenditure on health, from US$1 281.2 to US$1 100.9 per capita	Health budget for 2011 reduced by €1.4 billion
Lithuania	2010	Law on Sickness and Maternity amended to reduce maternity benefit from full pay to 90% of pay	
Malawi	2011	Suspension of UK aid to Malawi Government, much of which funded the health sector	IRIN (UN service for coordination of humanitarian affairs) estimates that before cuts US$49 million worth of UK DFID aid to Malawi went to health sector

Mongolia	2009	Amendment to health budget reduced public salaries by 3%, spending on staff training by 55%, allocation for medicines and vaccines by 20%, other goods and services by 17%, and domestic investment for capital projects by 20%	Health sector budget decreased by 23 billion tughrik (US$13.5 million)
Romania	2008–11	Ministry of Health budget reduced by 4,969 million new leu (RON) in 2008 to RON 4,417 million in 2011	US$171 million
Slovenia	2010	Reductions in non-acute spa treatment, certain medicines, non-urgent ambulance services, dental prostheses and some ophthalmologic appliances	
Sri Lanka	2007–11	Government expenditure raised by 0.7%; average annual OOP increased by 5.6% (constant US$ per capita)	
Tanzania, United Rep.	2007–11	Government expenditure reduced by 2.6%; average annual OOP increased by 34.6% (constant US$ per capita)	
Ukraine	2007–11	Government expenditure increased by 0.4%; average annual OOP increased by 7.8% (constant US$ per capita)	
United Kingdom	2010	Health in Pregnancy Grant of £190 for each expectant mother cut from Jan. 2011	Parliament estimates savings of £40 million in costs in 2010/11 and £150 million in each succeeding year
	2012	Health and Social Care Act 2012 "cuts the number of health bodies	Exact savings unknown; Government cites goal as NHS making "up to £20 billion worth of efficiency savings by 2015"

Source: ILO Social Protection Department database on measures adopted in response to the crisis since 2007/8.

In summary, governments in Africa, Asia and Europe announced general budget cuts impacting on health ministries and severe cutbacks in public health expenditure. As a result, the supply of health care will be reduced in a range of areas caused e.g. by

- the postponement of important reforms;
- imposed volume limits on some services; and
- the removal of benefits such as preventive care.

Also concerned are wages of health workers as described above (figure 7).

At just the same time as health protection is threatened by fiscal consolidation measures, an increased demand for public health services occurred, e.g. in Greece and Cyprus, often in close relationship to impacts of the measures taken, such as loss of employment and income (ILO, 2014c).

Overall, the impact of fiscal consolidation measures has been to stall or even reverse progress towards universal health coverage by sharpening inequities in access to health care, increasing the financial burden on private households, reducing benefits and thus increasing exclusion.

As for their impact on the economy, it can be concluded that, rather than curing the symptoms of debts and deficits, fiscal consolidation measures in the area of health protection have acted as barriers to economic recovery by weakening the productivity of the workforce and reducing employment of much-needed health workers. In addition, these measures have had negative impacts on the right to work and on adequate standards of living, particularly those of the most vulnerable segments of the population that have been hit hardest by budget cuts.

4. Addressing the health protection crisis: Universal health protection policies creating sustainable development

Countries that are most affected by the health protection crisis are characterized by significant coverage and access deficits. Thus, health protection cannot boost the economy and contribute to inclusive growth and sustainable development.

This can be only be achieved by increasing solidarity in the context of universal coverage if health care schemes and systems are well designed and embedded in appropriate economic and labour market policies. In such an environment, universal health protection has the potential to enhance productivity, employment, income generation and to alleviate poverty.

The economic impacts of investments in health care regarding sustainable development and economic growth may be summarized as follows:

- Increased labour productivity through reduced absenteeism and disability;
- Growing labour force due to reductions in disability, mortality and increased life expectancy;
- Employment effects and job growth arising from the improved physical capacities of workers and from both direct employment in the health sector and multiplier effects in industry, local businesses and other sectors;
- Increasing economic activities due to the contribution of the health sector to the economy
- Income generation, based on increased ability to work;
- In the longer term, growing tax bases arising from the indirect economic effects of investments in health will generate more public funds;
- Stabilization of the economy in times of crises, by cushioning the impacts of economic crises on individual health and ensuring continued employment for those in the health sector and related sectors;
- Poverty alleviation, through minimizing the private health expenditure of those who are poor or near poverty.

Given these close relationships between health protection and the economy at large, investments will recover large parts of health expenditure at the national level. Thus,

providing effective access to health care for all in need can contribute to a virtuous cycle of mutual reinforcement that takes place between the development of a health protection system, sustained economic growth and population health and wellbeing (Kim et al. 2013).

Country examples include Thailand, where the introduction of universal health protection has crowded in economic activities, accounting for economic gains of as much as 1.2 times of the original spending (McManus 2012). Other country examples such as Rwanda indicate that well-managed expansions of health protection policies and a fast growing economy are complementary to each other (Kim et al. 2013).

4.1. Guaranteeing the right to adequate health care for all

Given the critical importance of human rights to health both to individuals and to sustainable development, it is important that countries and development partners across the world be aligned in support of the objective of establishing universal coverage.

In recognition of this imperative, the right to health protection has been at the core of the ILO mandate since its foundation in 1919. The extension of such coverage to all in need has been a priority since 1944, as stated in the Declaration of Philadelphia. The first formulation of guidance to achieve universal coverage dates back to the same year, when the ILO's constituents adopted the Medical Care Recommendation, 1944 (No. 69) which states: "The medical care service should cover all members of the community, whether or not they are gainfully occupied" (para. 8).

Since then, this objective and the specific means for its realization have been spelt out in numerous ILO Conventions and Recommendations, most recently in the Social Protection Floors Recommendation, 2012 (No. 202), which emphasizes that in each country, all residents and children should be guaranteed access to health care, and that this should include at least essential health care, prevention and maternal care, financed through social protection systems and schemes so as to avoid financial access barriers, e.g. through excessive out-of-pocket payments. Recommendation No. 202 specifies the need for

- Legal health coverage by a social health protection system or scheme, e.g. through entitlements to benefits prescribed by national law; that is, rights-based protection (contrasting to e.g. charitable provision) through national health services and/or national, social or private health insurance schemes operated in line with certain conditions; and

- Guaranteed access to at least essential health care that meets the criteria of availability, accessibility, acceptability and quality (AAAQ)[1] , without risk of hardship or increased risk of poverty due to the financial consequences of gaining such access.

Universality of health protection implies that in all countries, rights-based approaches, anchored and framed in legislation, should exist to cover the whole population, including workers in the formal and informal economy and their families. The implementation and enforcement of these approaches is a prerequisite for access to health care when needed.

[1] These criteria have been set out in UN (2000).

According to Recommendation No. 202, universal health coverage further requires effective access to at least essential health care as defined at national level and also income replacement during periods of sickness, provided equally to all in need. This necessitates the availability of acceptable quality care, which entails a sufficient number of skilled health workers for service delivery and adequate funds e.g. for drugs and infrastructure. In addition, it is necessary that co-payments, user fees and other costs involved in taking up care are affordable and that financial protection is provided in order to avoid hardship or impoverishment. Finally, effective access requires good governance of schemes and systems, which should be based on accountability, including participatory processes such as social and national dialogue.

Thus, the Recommendation defines a concept of universal coverage in health that entails taking into account both legal coverage and access to health care: only the combination of both will lead to meaningful protection for the population and ensure equitable access as a matter of right to services that meet the AAAQ criteria. The ILO has developed tools and indicators for measuring the status quo and progress towards universal health coverage on both dimensions.

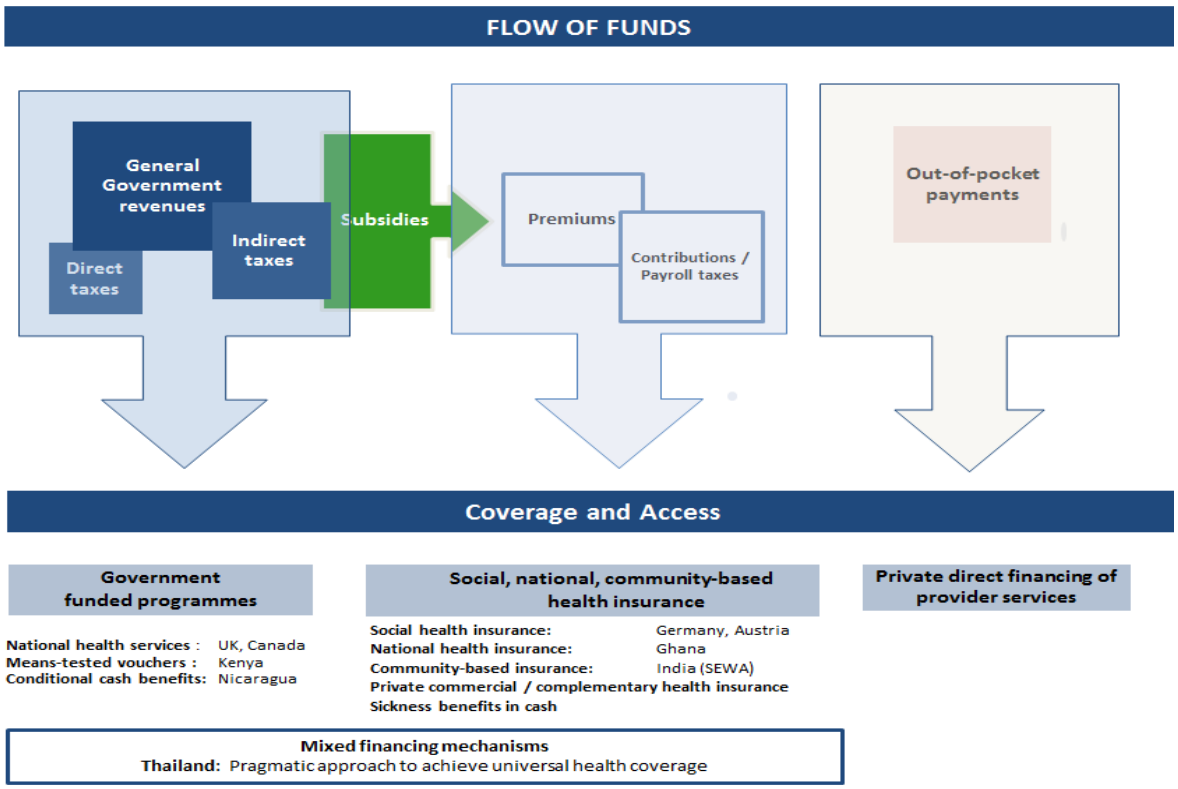
The notion of universal health coverage was also developed over the years in other UN agencies, particularly the World Health Organization (WHO), which referred to it in, for example, a resolution of the World Health Assembly (WHO, 2011b) encouraging countries to aim for universal coverage. Today, the principle of universal health coverage has gained momentum and the UN General Assembly has asked the WHO and other UN agencies, including the ILO, to give high priority to working jointly towards universal health coverage in the context of wider approaches to social protection, in consultation with UN member States (UN, 2012c).

4.2. Fair financing of health protection for sustainable development

Developing national financing mechanisms that generate sufficient funds is a key to tackle gaps in health protection and progress towards universality and sustainable development. Generally, sources of funds include taxes and contributions from employers and employees. While very frequent, OOP are not considered as a source of funding health protection by ILO. Also premium payments in the context of private health insurance – if based on premiums calculated on risks and limiting the extent of benefits to the principle of equivalence of payments made – are not considered as a fair financing mechanism given the need for burden sharing and financial protection of the sick when in need of expensive health care.

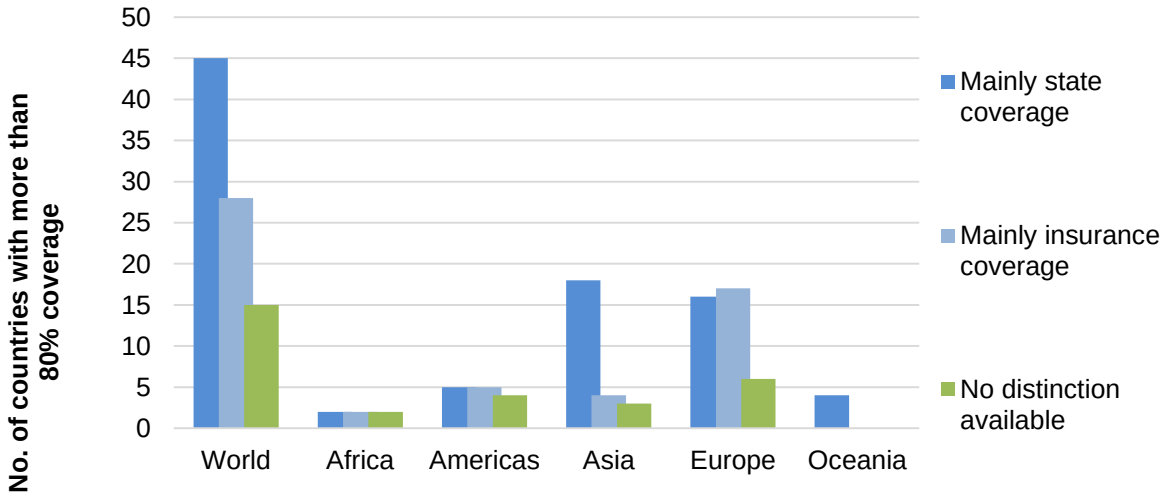
Taxes can be used for fully tax funded systems, such as National Health Services e.g. in the UK or as subsidies e.g. to cover the expenditure of the poor in national health insurance schemes such as in Ghana. Contributions equally shared by employees and employers are found in social insurance schemes such as in Germany. Both tax and contribution collection can be designed efficiently and effectively to create sufficient fiscal space for universal health protection that stimulates sustainable development. An overview of the flow of funds for health financing is provided in figure 12.

Figure 12: Flow of funds for health coverage and access



Based on tax and/or contribution funding, globally 88 countries, have achieved high legal coverage rates of at least 80 per cent of the population. As shown in figure 13, the majority of countries (45) are using mainly state coverage mechanisms – thus taxes – , whereas 28 countries used mainly insurance mechanisms – thus employer and employee contributions – and the remaining 15 countries applied both mechanisms in unspecified combinations. An analysis of the available information by region indicates a preference for state mechanisms among countries with high coverage rates in Asia and the Pacific, whereas in Europe, Africa and the Americas there is approximately equal inclination towards state and insurance mechanisms.

Figure 13: Financing mechanisms used by number of countries with health coverage rates of the population of 80 and more per cent, 2014 or latest available year



Source: ILO Social Protection Department database. Detailed data and sources available at: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=37218.

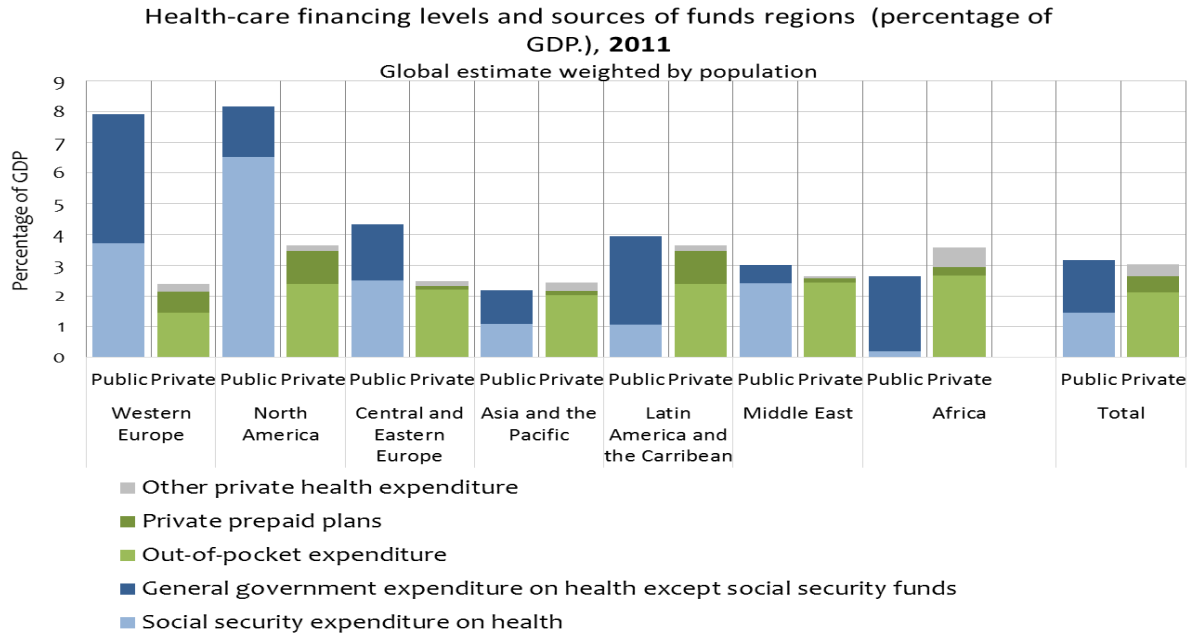
The impact of the choice of financing mechanisms on sustainable development depends on the redistribution and equity results induced: Health financing mechanisms can be based on fair burden sharing – if they involve a large risk pool such as taxes or social health insurances based on contributions shared by employers and employees – or they can be impoverishing such as excessive private OOP. Further, OOP have regressive impacts on income and thus create barriers to affordability of health care, particularly for the poor. Thus, OOP should not be considered as a financing mechanism for health care at all.

Against this background, countries are advised to consider the national social, economic and cultural context when developing health financing mechanisms such as tax funded National Health Services, or contribution-based national or social health insurances or any mixed financing mechanism. Specific considerations to be taken into account in health care settings include:

- Burden of disease
- Poverty rate
- Size of the informal economy
- Performance of the existing system/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

Without income generation for health protection through adequate financing mechanisms quality health care services for all will remain out of reach and inequalities persist. This is reflected globally in countries that base among others health financing largely on impoverishing OOP such as in Africa (figure 14) where health care funding through private, un-pooled expenditure is equivalent to public funds.

Figure 14: Sources of health-care financing, by region, 2011 (percentage of GDP)



Source: ILO calculations based on WHO Global Health Observatory, 2011 data. Population: UN World Population Prospects, 2012 Revision. / Link: http://www.social-protection.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=41677.

Often countries decide to use a mix of financing mechanisms. The reasons for using mixed financing mechanisms are often linked to the desire to generate sufficient funds from different sources and to make best use of the respective advantages of the different mechanisms, such as large risk pools, generation of stable revenues and reaching out to populations in remote areas. An overview of observations on some aspects of performance of key financing mechanisms towards sustainable development is provided in table 3.

Table 3: Performance of selected financing mechanisms towards sustainable development

Favourable factors	Unfavourable factors
Tax-based health protection: National health services	
• Risks are pooled for the whole population • Potential for administrative efficiency and cost control • Redistributes high and low risk and high and low income in the population covered	• Risks of unstable funding and often underfunding due to competing public expenditure • Inefficient due to lack of incentives and effective supervision
Contribution-based social and national health insurance schemes	
• Generates stable revenues • Often strong support from the population • Provides access to a broad package of quality services • Involvement of social partners • If subsidized, coverage of the poor	• Requires administrative effectiveness and efficiency which might have to be developed
Premium-based private health insurance	
• Preferable to out-of-pocket expenditure • Increases financial protection and access to health services for those able to pay • Encourages better quality and cost-efficiency	• High administrative costs • Ineffective in reducing cost pressures on public health systems • Inequitable without subsidized premiums • Requires administrative and financial infrastructure and capacity

4.3. Making services available through decent work for all

The health workforce is crucial to ensure sustainable development based on the availability and thus accessibility of quality health care services for all in need.

Based on ILO calculations, to achieve universal health protection and equitable access to needed health care, the world needs about 26 million physicians, nurses and

midwives. However, of the 26 million needed health workers in 2014, as much as 10.3 million health workers are globally missing: The urban areas of the world are short of 3 million health workers, and the rural areas are short of 7 million.

Currently, these workers are not trained and not employed to provide urgently needed quality services. This crisis needs to be urgently addressed in order to realize the right to health for all that is heavily depending on the service delivery through skilled doctors, nurses and midwives.

The health worker crisis is rooted in failure of paying attention to the most valuable asset of health systems: Those who care. Addressing the global shortage requires an action plan consisting of multiple measures ranging from training and recruiting a sufficient number of health workers and distributing them in an equitable way within countries to providing them with decent working conditions.

Providing decent working conditions can considerably increase retention rates and thus reduce the very high turn-over rates in some countries and especially among rural areas. This includes adequate wages that are necessary to ensure quality health care and to prevent health workers from migrating to countries where better conditions are offered.

In this context it is also important to address wage disparities across regions, and between general practitioners and specialists. Public authorities need to be exemplary employers and procurers. Thus, expenditure of public funds and any contract for health-care provision must include clauses ensuring decent wages.[2] At the same time, non-financial incentives are needed to increase work motivation and reduce turn-over rates, e.g. through recognition, career development, and further qualification.

Key instruments to achieve the necessary conditions include laws and regulations, collective agreements and other mechanisms for negotiation between employers' and workers' representatives, and arbitration awards. The right to organize and bargain for all health-care workers is crucial. Collective bargaining is the best way to negotiate workplace arrangements that attract the necessary number and quality of health-care workers.

Finally, with regard to migration of health workers, bilateral and multilateral arrangements are needed with a view to compensate for training costs and avoiding brain drain.

Upholding decent work conditions is particularly important in times of economic and financial crises, when the demand for health care services and the workload are usually increasing.

In general terms, decent working conditions for health workers, universal health protection and sustainable development go hand in hand. It leads to reduced absenteeism and create spill over effects to the whole economy.

4.4. Providing financial protection for equity in access

Providing financial protection when sick is crucial to ensure that needed health care and loss of income is available. This requires access to health services that are not impoverishing e.g. in terms of private OOP and income replacement during sickness. In many countries, both criteria are not or insufficiently fulfilled. During recent financial and

[2] ILO Labour Clauses (Public Contracts) Convention, 1949 (No. 94).

economic crises, it could be observed that OOP even increased: In Tanzania the average annual increase in OOP between 2007 and 2011 amounted to as much as 34.6 per cent, in Equatorial Guineas to 32.2 per cent and in countries such as Cambodia, Paraguay and Turkmenistan to between 12 and 16 per cent (table 4). Thus, the extent of financial protection in times of sickness is reduced.

The shift of burden for health care from the public purse to individuals and households has a particularly severe effect on lower income groups, given the regressive impact of OOP. As a result, gaps in coverage and access between rich and poor are widening.

Table 4: Average annual increase in OOP, selected countries, 2007–11 (percentages)

Country	Average annual increase in OOP, 2007-2011 (%, constant US$ per capita)
Tanzania	34.6
Equatorial Guinea	32.2
Turkmenistan	16.7
Paraguay	15.1
Cambodia	12.1
Russian Federation	9.2
China	7.2
Sri Lanka	5.6
Rwanda	5.3

Source: WHO, National Health Accounts, 2013.

Also financial protection from loss of income is far from universal. Sickness benefits and sick leave are crucial to addressing deteriorating health, health-related poverty and loss of productivity. Paid sick leave induces economic returns due to improved health and economic productivity as it

- allows workers to recuperate rapidly;
- prevents more serious illness and disability developing;
- reduces the spreading of diseases to co-workers and beyond.

On the other hand, working while sick might result in high economic costs due to a higher number of people in need of treatment for even more severe signs of ill-health. (Economist Intelligence Unit, 2014). Also, the lower productivity of sick workers has been found to slow down growth and development. Thus the absence of sick leave creates economic costs and avoidable health expenditure (Scheil-Adlung and Sandner, 2010).

There are widespread inequalities both within and across countries concerning the provision of financial protection of loss of income during sickness and related sick leave. Mostly concerned are workers in the informal economy and their families. These gaps need to be closed in order to achieve universal health coverage resulting in equitable shared wealth and sustainable development.

Box 1

Financial protection of loss of income during sickness and paid sick leave

While paid sick leave legislation exists for formal sector workers in 145 of about 190 countries globally, the benefits provided differ widely with regards to definition of work, wages covered, level of income replacement, duration of payments and other specific conditions.

Provisions include both time off work and wage replacement during sickness.

• In countries that offer financial protection for loss of income during sickness, income replacement rates vary between lump sums (in 14 per cent of all countries) and 100 per cent of wages (in 21 per cent of all countries). More than half of countries provide for replacement rates of between 50 and 75 per cent of wages.

• The wage replaced also varies, and may be limited, for example by a ceiling or the exclusion of supplements. The wage replacement might further be subjected to means testing and waiting times. The period of leave also varies widely: out of a total of 145 countries reviewed, 102 countries provide for one month or more, while seven provide under seven days.

However, even in countries where financial protection for loss of income during sickness exists, workers in the informal economy are usually totally excluded from income replacement during sickness. Even those who are covered frequently face barriers to accessing paid sick leave, given the fear of losing their jobs, particularly in times of economic crisis and/or high unemployment

Source: Scheil-Adlung and Sandner, 2010.

4.5. Embedding universal health protection in national floors of social protection

While health protection can boost economic growth and sustainable development, other policy sectors need to be aligned to address key issues that are observed in the health sector but originate from issues beyond: Inequities in access to health care are frequently deriving from lack of work and income and poverty. Thus labour market policies, e.g. transforming informal into formal economies, unemployment, and poverty alleviation policies are of particular importance to achieve progress regarding universal health coverage that results in sustainable development and inclusive growth.

An adequate policy framework providing guidance on related policies is available in ILO Recommendation 202 concerning national floors of social protection. The Recommendation focuses on progress on achieving universal health protection and socio-economic complementary policies (table 5).

Universal health protection policies: According to Recommendation 202, the objective of health protection policies is to strive for universal coverage that meets the criteria of availability, accessibility, acceptability and quality and aims at higher levels of protection as outlined in Convention No. 102. Further, achieving policy coherence is of key importance.

Key policy principles to be applied include universality defined as access to quality services for all in need that is based on rights, social inclusion, non-discrimination, responsiveness to basic and special needs, participation including social dialogue.

Essential components of benefits to be guaranteed include in-kind benefits such as curative, preventive and maternal care based on an adequate level of quality health services (inpatient / outpatient) and drugs. Further, cash benefits should be included to provide financial protection (e.g. transport costs and reduction / abolition of impoverishment due to health expenditure.

In order to be inclusive, financing should be based on solidarity in financing by increasing risk- pooling and minimizing unpooled private health expenditure e.g. due to user fees,

constrained benefit packages, low quality. A diversity of financing mechanisms and delivery, including tax- and contribution/ premium-based systems can be applied.

Complementary policies: The suggested health protection policies should be accompanied by supportive complementary policies that focus on analysing and closing gaps in social security coverage, benefits and services with a view to alleviating poverty.

Further, it is considered highly important to develop fiscal space, ensuring financial and economic sustainability and monitoring progress.

Finally, achieving policy coherence with social, economic and employment policies such as promoting formal employment as well as strengthening capacities of the social security schemes and systems is of particular importance.

Table 5: Embedding health protection coverage in social protection floor policies based on ILO Recommendation No. 202

Objectives	•Universal coverage providing access to a nationally defined set of goods or services for essential health care, including preventive and maternal care •Meeting the criteria of availability, accessibility, acceptability and quality •Aiming at achieving higher levels of protection as outlined in Convention No. 102 •Achieving policy coherence
Policy principles	•Universality (access to quality services for all in need) • Rights-based approach •Social inclusion •Non-discrimination •Responsiveness to basic and special needs •Participation including social dialogue
Key components of essential health benefits	•In-kind benefits including curative, preventive and maternal care based on an adequate level of quality health services (inpatient / outpatient) and drugs •Cash benefits providing financial protection e.g. transport costs,and reduction / abolition of impoverishment due to health expenditure
Financing	•Solidarity in financing by increasing risk- pooling and minimizing unpooled private health expenditure e.g. due to user fees, constrained benefit packages, low quality •Diversity of financing mechanisms and delivery ,including tax- and contribution/ premium-based systems
Complementary policies	•Analysing gaps in social security coverage, benefits and services with a view to poverty alleviation •Developing fiscal space, ensuring financial and economic sustainability and monitoring progress •Coherence with social, economic and employment policies such as promoting formal employment •Strengthening capacities and monitoring of the social security system

If well designed and implemented such health protection policies embedded in national social protection floors can be a catalyst for sustainable development, economic growth and equity. Scaling up global and national health coverage rates and providing effective access to necessary health benefits, particularly in low- and middle-income countries, will end the downward spiral of ill-health and poverty and contribute to more equitably shared prosperity. Further, in addressing equally the needs for essential health care and income support, the policies suggested provide ample scope for tackling the root causes of inequities in access to health care and contributing to universal coverage of social protection in health. When implementing coherent policies across the social, economic and health sectors, governments should emphasize poverty alleviation and labour market policies in order to avoid unintended increase in inequality and to create economic spill-over effects.

5. Conclusions

Health protection is a human right for everybody. However, the world is facing a severe health protection crisis. In the absence of health protection, care is often not accessible, available, affordable or of acceptable quality. This is a tragedy for the 40 per cent of the global population that is excluded from this right. In low income countries as much as about 90 per cent of the population is excluded from rights to health protection. Within countries, those most concerned are living in rural areas.

Further, high shares of OOP increase and deepen poverty, the shortage of skilled health workers, especially in rural areas, widens the availability and the access gap to needed health care. All of these barriers to access health care for individuals are at the same time barriers for sustainable development and economic growth given the impacts on the workforce, productivity and employment. Given the potential gains in health, development and economic progress health protection for all is a fundamental for all countries. Now is the time to progress towards health protection for all and end the unpreparedness for epidemics like Ebola that kill uncountable people and force the economies of whole countries to a standstill.

However, closing gaps and deficits will not happen automatically through market forces or economic growth. Achieving progress towards health protection for all requires well designed and frequently evaluated policies as well as considering lessons learnt. Needed is a policy framework that addresses specific issues observed in health protection but also issues beyond that cause barriers to universal health protection, such as uncoordinated social and economic policies as most recently experienced with impacts of austerity policies (ILO 2014).

Progressing towards universal protection in health requires at country level three important steps:

1. Identify the extent of gaps and deficits in legal coverage, availability and affordability of services as well as assess the financial deficit that needs to be closed. This involves assessing access barriers such as fragmentation of coverage e.g. due to a large number of uncoordinated schemes and systems that might reduce the positive impacts of risk-pooling and cross-subsidization, and result in inaccessibility of needed services due to various reasons ranging from poverty to place of living.

2. Develop an enabling policy framework addressing issues within the health sector and root causes of these issues beyond the health sector such as poverty, informal economy and unemployment. Thus, it is necessary to align health protection policies aiming at universal protection with e.g. economic, labour market and social policies by focusing on poverty alleviation and income generation.

3. Implement inclusive legislation in line with fiscal space assessments and closing gaps in accessibility of health care e.g. due to gaps in financial protection and a sufficient number of health workers that are trained, recruited, provided with decent working conditions and distributed in an equitably way across rural and urban areas. It also requires fair financing mechanisms and adequate benefit packages in order to be meaningful for the population covered and the economy as a whole. Closing these gaps would lead to the highest rates of return in terms of sustainability, economic growth and equity in the world's poorest countries.

An enabling framework of such policies is provided in ILO Recommendation 202 concerning National Floors of Social Protection. It connects the right to health protection with the underlying social and economic determinants and addresses these links at the systemic level, both within and beyond the health sector. Key issues such as the lack of decent working conditions for the entire workforce or specific sectors are addressed by focusing on decent working conditions and coordination of social and labour market policies that aim at poverty alleviation, increasing employment and transforming informal into formal economies.

Besides technical knowledge it is important that committed governments, social partners and civil society jointly develop a political vision of health protection for all and best ways to realize objectives that match the needs of the population in terms of availability, affordability and quality. Thus, social dialogue is essential when progressing – whether the issues are of an administrative or managerial nature within a scheme or system, or result from incoherent policies at the national, regional or community level.

The above policy options have the potential to effectively fight the global health protection crisis, achieve health protection for all and develop economic returns of investments – in all countries, and at all levels of national income.

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Annexes

Annex I: Total (public and private) health-care 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

Major area, region or country	2011	2010	2009	2008	2007	2006	2005	2000	1995
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

Major area, region or country	2011	2010	2009	2008	2007	2006	2005	2000	1995
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

Major area, region or country	2011	2010	2009	2008	2007	2006	2005	2000	1995
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

Major area, region or country	2011	2010	2009	2008	2007	2006	2005	2000	1995
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/database accessed May 2014).
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

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 II: 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		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]
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

	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]
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
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

	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]
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
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

	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)
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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]
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
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

	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]
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
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

	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)
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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
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	...

	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)
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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
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

	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)
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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]
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
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

Country code	Extent of coverage: Estimate of legal health coverage as a percentage of total population [1,6]	Extent of coverage: Year	Financial resources: Composition, level and trends (2011): Percentage of health expenditure not financed by out of pocket [2,3,7]	Financial resources: Composition, level and trends (2011): Per capita health expenditure not financed by private households' out-of-pocket payments (USD)[3]	Trends in government expenditure on health (constant US$ per capita): Government expenditure on health in constant US$ per capita (2007) [2]	Trends in government expenditure on health (constant US$ per capita): Government expenditure on health in constant US$ per capita (2011)[2]	Trends in government expenditure on health (constant US$ per capita): Trends in per capita government expenditure on health (constant USD per capita | 2007–11; (% average annual change) [3]	Trends in out-of-pocket expenditure (constant US$ per capita): Out-of- pocket expenditure in constant US$ per capita (2007) [2]	Trends in out-of-pocket expenditure (constant US$ per capita): Out-of- pocket expenditure in constant US$ per capita (2011) [2]	Trends in out-of-pocket expenditure (constant US$ per capita): Trends in per capita OOP expenditure on health (constant US$ per capita | 2007–11; % average annual change) [3]	Financial resources: Composition, level and trends (2011): deficit (threshold: US$60 MDG target for 2015 in low income) [2,9,10]	Financial resources: Composition, level and trends (2011): Coverage gap due to financial resources deficit, % (threshold: median in low vulnerability in low income US$239) [3,10]	Human resources (and access indicators): Coverage gap due to health professional staff deficit (WHO benchmark: 23) [3,8,9]	Human resources (and access indicators): Coverage gap due to health professional staff deficit: (benchmark relative: 41.1) [3,8,13]	Live births attended by skilled health staff: % live births attended by skilled health staff [2,4]	Live births attended by skilled health staff: Year	Maternal mortality rate (2010): Maternal mortality rate (modelled estimate, per 10,000 live births) [5]
Occupied Palestinian Territory	16.2	2004	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
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

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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
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

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]
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
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

	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]
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
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	...

Country code	Extent of coverage: Estimate of legal health coverage as a percentage of total population [1,6]	Year	Financial resources: Composition, level and trends (2011): 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]	Trends in government expenditure on health (constant US$ per capita): 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]	Trends in out-of-pocket expenditure (constant US$ per capita): 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]	Human resources (and access indicators): 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: % live births attended by skilled health staff [2,4]	Year	Maternal mortality rate (2010): Maternal mortality rate (modelled estimate, per 10,000 live births) [5]
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
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	...

	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]
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
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$_{country\ x}$)/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