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Background document
Towards Universal Health Coverage: concepts, lessons and public policy challenges

Introduction

1. Universal health coverage (UHC) is defined as the situation where all people are able to use the quality health services that they need and do not suffer financial hardship paying for them.[1,2] It brings together two inter-related concepts of coverage. In public health, the term embodies the principle that all people should be able to use a range of quality health services that they need, including the appropriate mix of prevention, promotion, treatment, rehabilitation and palliative care.[3] Health economists, on the other hand, use the term to describe whether people are protected from severe financial hardship as a consequence of paying out-of-pocket for health services.[4]

2. Moving towards UHC is a process of progressive realization. It is about making progress on several fronts for all people: the available range of services (consisting of the medicines, medical products, health workers, infrastructure and information); the proportion of the costs of those services covered; and the proportion of the population covered.

UHC is important for development

3. UHC is not only a health but a development issue.[5] Coverage with needed services improves or maintains health,[6] allowing people to earn incomes and children to learn – empowering them with a means to escape from poverty. At the same time, financial coverage prevents people from being pushed into poverty because of out-of-pocket payments for health.[7,a] UHC is also a practical expression of social cohesion with concerns for ensuring that everyone, including vulnerable groups, can realise their right to health.

Progress made but more to be done

4. Political promises have underlined the link between coverage with essential health services and financial risk protection, and translating these promises into a reality at country level is not straightforward. There are complex challenges such as of low levels of national income, weak health systems, changing disease patterns, aging populations, and high economic and social inequalities that all countries face. However, while UHC will not be achieved overnight, steps can be taken now.

5. Recent progress had been made. Coverage with health services associated with the Millennium Development Goals has increased in developing countries.[8] For example, the proportion of births attended by a skilled health worker increased from 59% to 65% between 2000 and 2010 in developing countries.[8] Many countries are reducing their reliance on direct out-of-pocket payments to finance health services.[9]

6. However, much remains to be done. A high proportion of the world's 1.4 billion poor people still do not receive the health services they need.[10] Critical shortages of health workers remain in many settings[11] and sustaining or motivating health workers to deliver quality care requires additional investments and a supportive incentive environment in countries. The availability of essential medicines was, on average, only about 35% in public health facilities across the 27 developing countries with data;[12] in addition, weak procurement and distribution systems as well as irrational use of medicines are leading sources of inefficiencies in the health system.[1] In many countries, funds are still insufficient to enable much progress towards universal coverage, and levels of out-of-pocket payments remain high

[a] The idea is that the vast majority of out-of-pocket health spending – especially in developing countries – is not discretionary but rather is undertaken either to prevent an adverse health event or in response to an adverse health event.

in many of the poorest countries where people have the greatest health needs. An estimated 150 million people suffer financial catastrophe and 100 million are pushed under the poverty line each year because of out-of-pocket spending on health.[13]

7. Progress requires the ability to identify and overcome obstacles as well as the commitment and collaboration across ministries. Depending on the country, social security agencies, ministries of labour, social welfare, planning and foreign affairs may each have a role to play in ensuring social protection of the population (including vulnerable groups), in improving effective coordination across government and development partners in line with Paris Declaration principles,[14] and finally, in the inclusion of UHC as an international development goal or objective.

8. The interplay between ministries of health and finance, however, is perhaps most important as they jointly face the challenge of raising sufficient funds and using these funds efficiently to meet the increasing demands for health services from their populations. Finance ministries grapple with the need to raise revenue and the subsequent decisions to allocate funds to health and other sectors to maximise benefit. Ministries of health often struggle in advocating for investments in health and face the continual need to ensure the effective and efficient use of the funds received. Both ministries strive to be accountable for the use of funds to the population. Country experiences suggest that coordination of policy action between the two ministries is essential for countries to move closer to UHC or sustain the gains already achieved.[1]

Sustaining progress towards UHC: lessons and critical challenges emerging from country experience

9. Country reform experiences suggest a number of important lessons about policy actions that are consistent with progress towards UHC goals. These lessons are broad and do not constitute a "how-to manual" for reform; instead, they can be viewed as operational milestones that each country can adapt to its unique context. Indeed, the critical challenges lie in the area of implementation.

10. There is no single, best way to organize the health system for UHC, but there are principles that can guide the design. UHC goals (reducing the gap between the need for and use of services, improving quality, and improving financial protection) orient the broad directions for progress, but reform in any country begins with its existing system and context. The path towards UHC must be home-grown, but this does not mean that one route is as good as another. An important lesson from experience is the need for a national health reform strategy that is explicitly oriented to addressing the obstacles to progress towards UHC and provides for a coherent approach to align different components of the system. For this to be meaningful, however, it must also be embedded within a realistic fiscal framework for the health sector and take into account the nature of the political-administrative system of the country (e.g. what decisions are made at central, regional and district levels in the public sector).

Health financing reforms (raising and pooling funds) for UHC

11. One clear lesson from experience is that the objectives of universal financial protection and equity in the use of needed services are best served when health systems rely predominantly on compulsory prepaid funds – from general government revenues, compulsory social insurance contributions, or a combination. No country in the world has attained universal population coverage on the basis of voluntary contributions and certainly not by relying on out-of-pocket payments. Furthermore, reducing fragmentation in the way that prepaid funds are pooled enables greater ability to redistribute on behalf of persons with greater health needs.[1,15,16]

12. Relying predominantly on compulsory prepaid funds and reducing fragmentation is easier said than done for many countries, of course. Efforts to increase funding through wage-linked social insurance contributions risk exacerbating inequalities between contributors and those outside of formal employment, and may also have adverse effects on employment and economic competitiveness. Further, the ability to mobilize sufficient compulsory revenues is constrained in lower income countries where much of the population is not engaged in regular, formal employment. Premium contribution for persons outside the formal sector, even where this is legally compulsory, has proven very difficult to enforce. Thus, as part of the effort to ensure inclusion of vulnerable groups and persons outside the formal sector in a manner consistent with fiscal and macroeconomic policy concerns, a growing number

of countries, across income levels, are pooling together general public revenues with compulsory insurance contributions or using them in an explicitly complementary manner.[9,16]

13. The centrality of public funding for UHC makes close coordination between national health and finance authorities an imperative. This also raises critical challenges, particularly balancing the health system's needs for a stable and predictable flow of funds with the demands placed on the finance authorities from all sectors, as well as balancing the health system's need to use the funds flexibly with the requirements of the public sector financial management system for clear lines of accountability in the use of these funds. For poorer countries in particular, fiscal realities greatly constrain the ability to rely predominantly on public funding, making the challenges and tradeoffs to be weighed even more difficult. Still, countries do not need to be rich to make progress towards UHC; experience suggests that political commitment is essential, both to provide funding and to ensure effective use of resources.

Making promises and being held accountable for keeping them

14. In many countries, the drive for UHC is embedded in constitutional provisions guaranteeing a "right to health", equal access to health services, or a related provision. In effect, such provisions are a promise that governments are meant to fulfil, and countries have introduced a number of mechanisms for their populations to progressively realize these rights. The specification of benefits – the entitlements and obligations of the population with regard to health services – is at the core.

15. No health system in the world can provide everything for everyone: each country faces tradeoffs with regard to what services will be provided, to whom, and with what level of affordability. The prioritization across the three dimensions of coverage – population, service, and cost – is perhaps the most difficult political challenge on the path towards UHC, and it is ongoing as new health services and technologies are developed. What is especially problematic, however, is when a system does not keep its promises, i.e. when services that are meant to be guaranteed for the population are not provided in practice. This may manifest as lack of service availability, or the need for patients to pay informally for services that are meant to be provided as per the defined benefits package.

16. Thus, making the promise is not sufficient, countries have also introduced mechanisms to enable citizens to hold governments accountable for delivering on these promises. Communication is essential so that people are actually aware of their entitlements. Countries also use related measures to enable people to take action to demand their rights, including complaints mechanisms and redress in courts. And system design can support this as well: information to enable transparent monitoring is key.

Delivering on the promise of high quality and efficient health services

17. An essential "platform" for UHC is extensive geographical coverage of health service delivery systems to ensure equitable access to care by the population. The primary level of care, i.e. services that are "close to client", are the priority for strengthening, recognizing that it is also important to ensure a balance between services focusing on individuals (e.g. treatment, palliation) and those focusing on populations (e.g. population-based prevention and promotion). Universal coverage with needed health services in turn incorporates many different components, including universal access to essential medicines and health products, sufficiently motivated and well-distributed health workers of the right mix, and information systems that provide timely information for decision-making. Political commitment to UHC can provide a springboard for health system investments and reforms that are essential for ensuring service availability. Alignment of financing and service delivery is critical, both for ensuring that promised entitlements are funded and that the incentives are in place to promote their efficient and high-quality delivery. This requires both an ability to balance what is promised in terms of services with the resources expected to be available, and to use methods of provider payment that enable a package to not merely be declared but actually purchased. One major challenge facing many countries in this regard is having an idea of the resource requirements to provide the package. To the extent that the existing health service delivery system exhibits inefficiencies, any projection of resource needs based on a current cost analysis may simply "lock in" these inefficiencies. Hence, aligning resources with benefits is not a mechanical accounting exercise but rather an ongoing process of ensuring that providers face incentives that encourage reduction of inefficiencies over time, thus enabling more and better services to be provided for a given level of funding.

Monitoring progress and promoting accountability for UHC

18. Plans must not only translate broad goals and strategies into concrete objectives and detailed implementation steps, they should do so in a way that can be measured. The aim of this is two-fold: to enable progress to be assessed and specific implementation strategies to be evaluated and adjusted, and to ensure public accountability for performance and the use of public funds. This is again politically challenging because, even with an excellent plan, not every contingency can be anticipated. If the political environment demands a radical change of direction each time problems are detected, sustaining progress is difficult.

19. Establishing and strengthening the evidence platform for UHC is essential. This includes both the regular monitoring of progress, e.g. using National Health Accounts for regular tracking of health expenditure including household survey-based estimates of out-of-pocket spending by different population groups, or the use of routine health information systems or surveys to track coverage with needed health services. It also requires policy research and analysis to ensure lessons learned from implementation are rapidly incorporated and linked to decision-making to enable mid-course corrections. Strengthening and sustaining national capacities to generate and analyse evidence, and effective translation of this into policy decisions, is the mark of a sustainable, adaptable health system.

20. There is great demand for a monitoring framework for UHC covering both of its components – coverage with needed health services of good quality and coverage with financial risk protection – both for countries to adapt to their national needs as well as for international monitoring, particularly in the context of the process for the establishment of the post-2015 international sustainable development goals. WHO and the World Bank have initiated joint work on this framework and aim to have a complete draft by July 2013.

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