Advancing and sustaining **universal coverage**

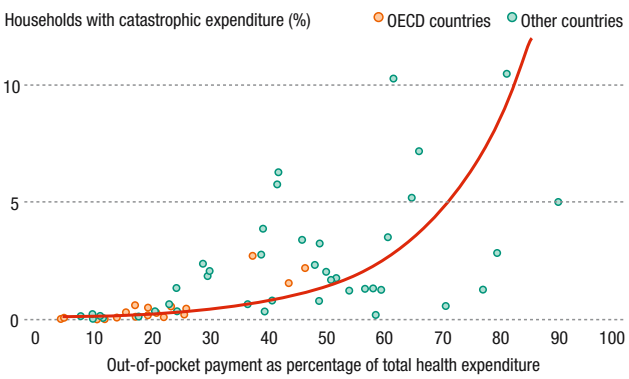
People expect their health systems to be equitable. The roots of health inequities lie in social conditions outside the health system's direct control. These root causes have to be tackled through intersectoral and cross-government action. At the same time, the health sector can take significant actions to advance health equity internally. The basis for this is the set of reforms that aim at moving towards universal coverage, i.e. towards universal access to health services with social health protection.

Chapter 2

The central place of health equity in PHC

"If you get sick, you have to choose: you either go without treatment or you lose the farm."[1] Nearly a century ago, the unforgiving reality of life in rural Canada prompted Matthew Anderson (1882–1974) to launch a tax-based health insurance scheme that eventually led to countrywide adoption of universal health care across Canada in 1965. Unfortunately, equally shocking lose-lose situations abound today across the world. More than 30 years after the clarion call of Alma-Ata for greater equity in health, most of the world's health-care systems continue to rely on the most inequitable method for financing health-care services: out-of-pocket payments by the sick or their families at the point of service. For 5.6 billion people in low- and middle-income countries, over half of all health-care expenditure is through out-of-pocket payments. This deprives many families of needed care because they cannot afford it. Also, more than 100 million people around the world are pushed into poverty each year because of catastrophic health-care expenditures[2]. There is a wealth of evidence demonstrating that financial protection is better, and catastrophic expenditure less frequent, in those countries in which there is more pre-payment for health care and less out-of-pocket payment. Conversely, catastrophic expenditure is more frequent when health care has to be paid for out-of-pocket at the point of service (Figure 2.1).

Figure 2.1 Catastrophic expenditure related to out-of-pocket payment at the point of service[1]



While equity marks one of PHC's boldest features, it is one of the areas where results have been most uneven and where the premium for more effective reforms is perhaps the greatest. Out-of-pocket payments for health care are but one of the sources of health inequity. Deeply unequal opportunities for health combined with endemic inequalities in health care provision lead to pervasive inequities in health outcomes[3]. Growing awareness of these regressive patterns is causing increasing intolerance of the whole spectrum of unnecessary, avoidable and unfair differences in health[4].

The extent of health inequities is documented in much more detail today. They stem from social stratification and political inequalities that lie outside the boundaries of the health system. Income and social status matter, as do the neighbourhoods where people live, their employment conditions and factors, such as personal behaviour, race and stress[5]. Health inequities also find their roots in the way health systems exclude people, such as inequities in availability, access, quality and burden of payment, and even in the way clinical practice is conducted[6]. Left to their own devices, health systems do not move towards greater equity. Most health services – hospitals in particular, but also first-level care – are consistently inequitable providing more and higher quality services to the well-off than to the poor, who are in greater need[7,8,9,10]. Differences in vulnerability and exposure combine with inequalities in health care to lead to unequal health outcomes; the latter further contribute to the social stratification that led to the inequalities in the first place. People are rarely indifferent to this cycle of inequalities, making their concerns as relevant to politicians as they are to health-system managers.

It takes a wide range of interventions to tackle the social determinants of health and make health systems contribute to more health equity[11]. These interventions reach well beyond the traditional realm of health-service policies, relying on the mobilization of stakeholders and constituencies outside the health sector[12]. They include[13]:

- reduction of social stratification, e.g. by reducing income inequality through taxes and subsidized public services, providing jobs with

adequate pay, using labour intensive growth strategies, promoting equal opportunities for women and making free education available, etc.;

- reduction of vulnerabilities, e.g. by providing social security for the unemployed or disabled, developing social networks at community level, introducing social inclusion policies and policies that protect mothers while working or studying, offering cash benefits or transfers, providing free healthy lunches at school, etc.;
- protection, particularly of the disadvantaged, against exposure to health hazards, e.g. by introducing safety regulations for the physical and social environment, providing safe water and sanitation, promoting healthy lifestyles, establishing healthy housing policies, etc.);
- mitigation of the consequences of unequal health outcomes that contribute to further social stratification, e.g. by protecting the sick from unfair dismissal from their jobs.

The need for such multiple strategies could discourage some health leaders who might feel that health inequality is a societal problem over which they have little influence. Yet, they do have a responsibility to address health inequality. The policy choices they make for the health sector define the extent to which health systems exacerbate or mitigate health inequalities and their capacity to mobilize around the equity agenda within government and civil society. These choices also play a key part in society's response to citizens' aspirations for more equity and solidarity. The question, therefore, is not if, but how health leaders can more effectively pursue strategies that will build greater equity in the provision of health services.

Moving towards universal coverage

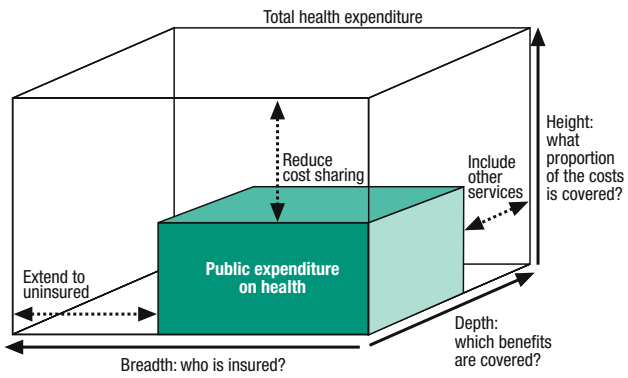
The fundamental step a country can take to promote health equity is to move towards universal coverage: universal access to the full range of personal and non-personal health services they need, with social health protection. Whether the arrangements for universal coverage are tax-based or are organized through social health insurance, or a mix of both, the principles are the same: pooling pre-paid contributions collected on the basis of ability to pay, and using these funds to ensure that services are available, accessible and produce quality care for those who need them, without exposing them to the risk of catastrophic expenditures[14,15,16]. Universal coverage is not, by itself, sufficient to ensure health for all and health equity – inequalities persist in countries with universal or near-universal coverage – but it provides the necessary foundation[9].

While universal coverage is fundamental to building health equity, it has rarely been the object of an easy social consensus. Indeed, in countries where universal coverage has been achieved or embraced as a political goal, the idea has often met with strong initial resistance, for example, from associations of medical professionals concerned about the impact of government-managed health insurance schemes on their incomes and working conditions, or from financial experts determined to rein in public spending. As with other entitlements that are now taken for granted in almost all high-income countries, universal health coverage has generally been struggled for and won by social movements, not spontaneously bestowed by political leaders. There is now widespread consensus that providing such coverage is simply part of the package of core obligations that any legitimate government must fulfil vis-à-vis its citizens. In itself, this is a political achievement that shapes the modernization of society.

Industrialized countries, particularly in Europe, began to put social health protection schemes in place in the late 19th century, moving towards universalism in the second half of the 20th century. The opportunity now exists for low- and middle-income countries to implement comparable approaches. Costa Rica, Mexico, the Rebublic of Korea, Thailand and Turkey are among the countries that have already introduced ambitious universal coverage schemes, moving significantly faster than industrialized countries did in the past. Other countries are weighing similar options[14]. The technical challenge of moving towards universal coverage is to expand coverage in three ways (Figure 2.2).

The breadth of coverage – the proportion of the population that enjoys social health protection – must expand progressively to encompass

Figure 2.2 Three ways of moving towards universal coverage[17]



the uninsured, i.e. the population groups that lack access to services and/or social protection against the financial consequences of taking up health care. Expanding the breadth of coverage is a complex process of progressive expansion and merging of coverage models (Box 2.1). During this process, care must be taken to ensure safety nets for the poorest and most vulnerable until they also are covered. It may take years to cover the entire population but, as recent experience from a number of middle-income countries shows, it is possible to move much faster than was the case for industrialized countries during the 20th century.

Meanwhile, the *depth of coverage* must also grow, expanding the range of essential services that are necessary to address people's health needs effectively, taking into account demand and expectations, and the resources society is willing and able to allocate to health. The determination of the corresponding "essential package" of benefits can play a key role here, provided the process is conducted appropriately (Box 2.2).

The third dimension, *the height of coverage*, i.e. the portion of health-care costs covered through pooling and pre-payment mechanisms must also rise, diminishing reliance on out-of-pocket co-payments at the point of service delivery. In the 1980s and 1990s, many countries introduced user fees in an effort to infuse new resources into struggling services, often in a context of disengagement of the state and dwindling public resources for health. Most undertook these measures without anticipating the extent of the damage they would do. In many settings, dramatic declines in service use ensued, particularly among vulnerable groups[20], while the frequency of catastrophic expenditure increased. Some countries have since reconsidered their position and have started phasing out user fees and replacing the lost income from pooled funds (government subsidies or contracts, insurance

Box 2.1 Best practices in moving towards universal coverage

Emphasize pre-payment from the start. It may take many years before access to health services and financial protection against the costs involved in their use are available for all: it took Japan and the United Kingdom 36 years[14]. The road may seem discouragingly long, particularly for the poorest countries, where health-care networks are sparsely developed, financial protection schemes embryonic and the health sector highly dependent on external funds. Particularly in these countries, however, it is crucial to move towards pre-payment systems from a very early stage and to resist the temptation to rely on user fees. Setting up and maintaining appropriate mechanisms for pre-payment builds the institutional capacity to manage the financing of the system along with the extension of service supply that is usually lacking in such contexts.

Coordinate funding sources. In order to organize universal coverage, it is necessary to consider all sources of funding in a country: public, private, external and domestic. In low-income countries, it is particularly important that international funding be channelled through nascent pre-payment and pooling schemes and institutions rather than through project or programme funding. Routing funds in this way has two purposes. It makes external funding more stable and predictable and helps build the institutional capacity to develop and extend supply, access and financial protection in a balanced way.

Combine schemes to build towards full coverage. Many countries with limited resources and administrative capacity have experimented with a multitude of voluntary insurance schemes: community, cooperative, employer-based and other private schemes, as a way to foster pre-payment and pooling in preparation for the move towards more comprehensive national systems[18]. Such schemes are no substitute for universal coverage although they can become building blocks of the universal system[18]. Realizing universal coverage means coordinating or combining these schemes progressively into a coherent whole that ensures coverage to all population groups[15] and builds bridges with broader social protection programmes[19].

Box 2.2 Defining "essential packages": what needs to be done to go beyond a paper exercise?

In recent years, many low- and midde-income countries (55 out of a sample of 69 reviewed in 2007) have gone through exercises to define the package of benefits they feel should be available to all their citizens. This has been one of the key strategies in improving the effectiveness of health systems and the equitable distribution of resources. It is supposed to make priority setting, rationing of care, and trade-offs between breadth and depth of coverage explicit.

On the whole, attempts to rationalize service delivery by defining packages have not been particularly successful[24]. In most cases, their scope has been limited to maternal and child health care, and to health problems considered as global health priorities. The lack of attention, for example, to chronic and noncommunicable diseases confirms the under-valuation of the demographic and epidemiological transitions and the lack of consideration for perceived needs and demand. The packages rarely give guidance on the division of tasks and responsibilities, or on the defining features of primary care, such as comprehensiveness, continuity or person-centredness.

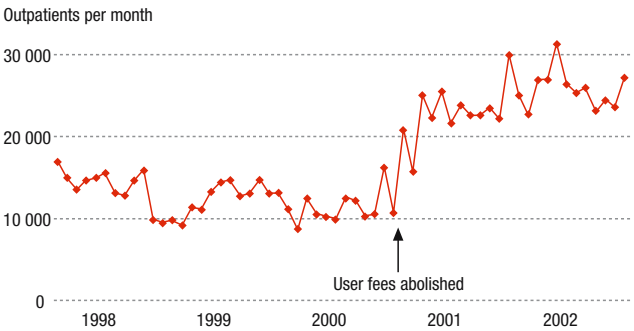
A more sophisticated approach is required to make the definition of benefit packages more relevant. The way Chile has provided a detailed specification of the health rights of its citizens[25] suggests a number of principles of good practice.

- The exercise should not be limited to a set of predefined priorities: it should look at demand as well as at the full range of health needs.
- It should specify what should be provided at primary and secondary levels.
- The implementation of the package should be costed so that political decision-makers are aware of what will *not* be included if health care remains under-funded.
- There have to be institutionalized mechanisms for evidence-based review of the package of benefits.
- People need to be informed about the benefits they can claim, with mechanisms of mediation when claims are being denied. Chile went to great lengths to ensure that the package of benefits corresponds to people's expectations, with studies, surveys and systems to capture the complaints and misgivings of users[26].

or pre-payment schemes)[21]. This has resulted in substantial increases in the use of services, especially by the poor[20]. In Uganda, for example, service use increased suddenly and dramatically and the increase was sustained after the elimination of user fees (Figure 2.3)[22,23].

Pre-payment and pooling institutionalizes solidarity between the rich and the less well-off, and between the healthy and the sick. It lifts barriers to the uptake of services and reduces the risk that people will incur catastrophic expenses when they are sick. Finally, it provides the means to re-invest in the availability, range and quality of services.

Figure 2.3 Impact of abolishing user fees on outpatient attendance in Kisoro district, Uganda: outpatient attendance 1998–2002[23]



Challenges in moving towards universal coverage

All universal coverage reforms have to find compromises between the speed with which they increase coverage and the breadth, depth and height of coverage. However, the way countries devise their strategies and focus their reforms very much depends on their specific national contexts.

In some countries, a very large part of the population lives in extremely deprived areas, with an absent or dysfunctional health-care infrastructure. These are countries of mass exclusion typically brought to mind when one talks about "scaling up": the poor and remote rural areas where health-care networks have not been deployed yet or where, after years of neglect, the health infrastructure continues to exist in name only. Such patterns occur in low-income countries

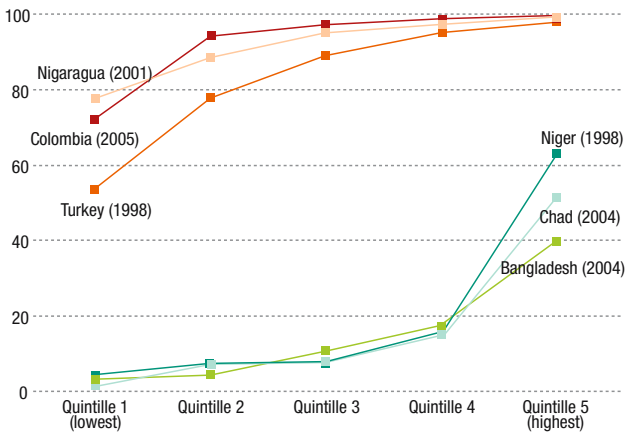
such as Bangladesh, Chad and Niger (Figure 2.4), and are common in conflict and post-conflict areas where health workers have departed and the health infrastructure has been destroyed and needs to be rebuilt from scratch.

In other parts of the world, the challenge is in providing health support to widely dispersed populations, for example, in small island states, remote desert or mountainous regions, and among nomadic and some indigenous populations. Ensuring access to quality care in these settings entails grappling with the diseconomies of scale connected with small, scattered populations; logistical constraints on referral; difficulties linked to limited infrastructure and communications capacities; and, in some cases, more specific technical complications, such as maintaining patient records for nomadic groups.

A different challenge is extending coverage in settings where inequalities do not result from the lack of available health infrastructure, but from the way health care is organized, regulated and, above all, paid for by official or under-the-counter user charges. These are situations where underutilization of available services is concentrated among the poor, whereas users are exposed to the risks of catastrophic expenditure. Such patterns of exclusion occur in countries such as Colombia, Nicaragua and Turkey (Figure 2.4). It is particularly striking in the many urban areas of low- and middle-income countries where a plethora of assorted, unregulated, commercial health-care providers charge users prohibitive fees while providing inadequate services.

Ways of tackling the situations described in this section are elaborated below.

Figure 2.4 Different patterns of exclusion: massive deprivation in some countries, marginalization of the poor in others. Births attended by medically trained personnel (percentage), by income group[27]



Rolling out primary-care networks to fill the availability gap

In areas where no health services are available for large population groups, or where such services are grossly inadequate or fragmented, the basic health-care infrastructure needs to be built or rebuilt, often from the ground up. These areas are always severely resource-constrained and frequently affected by conflicts or complex emergencies, while the scale of under-servicing, also in other sectors, engenders logistical difficulties and problems in deploying health professionals. Health planners in these settings face a fundamental strategic dilemma: whether to prioritize a massive scale-up of a limited set of interventions to the entire population or a progressive roll-out of more comprehensive primary-care systems on a district-by-district basis.

Some would advocate, in the name of speed and equity, an approach in which a restricted number of priority programmes is rolled out simultaneously to all the inhabitants in the deprived areas. This allows for task shifting to low-skilled personnel, lay workers and volunteers and, consequently, rapid extension of coverage. It is still central to what the global community often prescribes for the rural areas of the poorest countries[28], and quite a number of countries have chosen this option over the last 30 years. Ethiopia, for example, is currently deploying 30 000 health extension workers to provide massive numbers of people with a limited package of priority preventive interventions. The poor skills base is often well recognized as a limiting factor[29], but Ethiopia's extension workers are no longer as low skilled as they once were, and currently benefit from a year of post-Grade 10 training. Nevertheless, skill limitations reinforce the focus on a limited number of effective but simple interventions.

Scaling up a limited number of interventions has the advantage of rapidly covering the entire population and focusing resources on what is known to be cost effective. The downside is that

when people experience health problems, they want them to be dealt with, whether or not they fit nicely within the programmatic priorities that are being proposed. Ignoring this dimension of demand too much opens the door to "drug peddlers", "injectors" and other types of providers, who can capitalize on commercial opportunities arising from unmet health needs. They offer patients an appealing alternative, but one that is often exploitative and harmful. Compared with a situation of utter lack of health action, there is an indisputable benefit in scaling up even a very limited package of interventions and the possibility of relying on low-skilled staff makes it an attractive option. However, upgrading often proves more difficult than initially envisaged[30] and, in the meantime, valuable time, resources and credibility are lost which might have allowed for investment in a more ambitious, but also more sustainable and effective primary-care infrastructure.

The alternative is a progressive roll-out of primary care, district-by-district, of a network of health centres with the necessary hospital support. Such a response obviously includes the priority interventions, but integrated in a comprehensive primary-care package. The extension platform is the primary-care centre: a professionalized infrastructure where the interface with the community is organized, with a problem solving capacity and modular expansion of the range of activities. The Islamic Republic of Iran's progressive roll-out of rural coverage is an impressive example of this model. As one of the fathers of the country's PHC strategy put it: "Since it was impossible to launch the project in all provinces at the same time, we decided to focus on a single province each year" (Box 2.3).

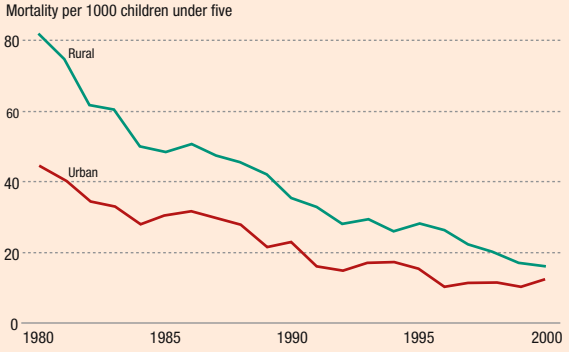
The limiting factors for a progressive roll-out of primary-care networks are the lack of a stable cadre of mid-level staff with the leadership qualities to organize health districts and with the ability to maintain, over the years, the constant effort required to build sustainable results for the entire population. Where the roll-out has been conducted as an administrative exercise, it has led to disappointment: many health districts exist in name only. But where impatience and pressure for short-term visibility has been managed adequately, a blend of response to need and demand, and participation of the population and key actors has made it possible to build robust primary-care networks, even in very difficult and resource-constrained settings of conflict, and post-conflict environments (Box 2.4).

Box 2.3 Closing the urban-rural gap through progressive expansion of PHC coverage in rural areas in the Islamic Republic of Iran[31]

In the 1970s, the Iranian Government's policies emphasized prevention as a long-term investment, allocation of resources to rural and under-privileged areas, and prioritizing ambulatory care over hospitalization. A network of district teams to manage and oversee almost 2500 village-based rural health centres was established. These centres are staffed by a team that includes a general practitioner, midwife, nurse and several health technicians. Each of the rural health centres oversees 1–5 smaller points of care known as "health houses". With 17 000 of these health houses, over 90% of the rural population has access to health care. In remote rural areas, these health houses are staffed by *Behvarz* (multi-purpose health workers) who are selected by the community, receive between 12 and 18 months training and are then recruited by the Government. The district teams provide training based on problem-solving, as well as ongoing supervision and support.

The Government deployed this strategy progressively, extending coverage to one province at a time. Over the years, the PHC network has grown and is now able to provide services to over 24 million people in rural villages and small cities by bringing the points of care closer to where people live and work, as well as by training the necessary auxiliary health staff to provide family planning, preventive care services, and essential curative care for the majority of health problems. Rural health service utilization rates are now the same as in urban areas. The progressive roll-out of this system has helped to reduce the urban-rural gap in child mortality (Figure 2.5).

Figure 2.5 Under-five mortality in rural and urban areas, the Islamic Republic of Iran, 1980–2000[32]



The distinction between rapid deployment of priority interventions and progressive roll-out of primary-care networks is, in practice, often not as straightforward as described above. However, for all the convergence, trying to balance speed and sustainability is a real political dilemma[30]. Mali, among others, has shown that, given the choice, people willingly opt for progressive roll-out, making community health centres – whose infrastructure is owned and personnel employed by the local community – the basis of functional health districts.

Crucially, concern for equity should not be translated into a "lowest common denominator" approach: equal access for all to a set of largely unsatisfactory services. Quality and sustainability are important, particularly since nowadays the multitude of varied and dynamic governmental, not-for-profit and for-profit private providers of various kinds are in dire need of alignment. Progressive roll-out of health services provides the opportunity to establish welcome leadership coherence in health-care provision at district level. Typical large-scale examples of this approach in developing countries are the contracting out of district health services in Cambodia, or the incorporation of missionary "designated district hospitals" in East Africa. Nevertheless, there is no getting away from the need for massive and sustained investment to expand and maintain health districts in the long term and from the fact that this represents a considerable challenge in a context of sluggish economic growth and stagnating health expenditure.

Extending health-care networks to underserved areas depends on public initiative and incentives. One way to accelerate the extension of coverage is to adjust budget allocation formulae (or contract specifications) to reflect the extra efforts required to contact hard-to-reach populations. Several countries have taken steps in this direction. In January 2004, for example, the United Republic of Tanzania adopted a revised formula for the allocation of basket funds to districts that includes population size and under-five mortality as a proxy for disease burden and poverty level, while adjusting for the differential costs of providing health services in rural and low-density areas. Similarly, allocations to districts under Uganda's PHC budget factor in the districts' Human Development Index and levels of external health funding, in addition to population size. Supplements are paid to districts with difficult security situations or lacking a district hospital[20]. In Chile, budgets are allocated on a capitation basis but, as part of the PHC reforms, these were adjusted using municipal human development indices and a factor to reflect the isolation of underserved areas.

Overcoming the isolation of dispersed populations

Although providing access to services for dispersed populations is often a daunting logistical challenge, some countries have dealt with it by developing creative approaches. Devising mechanisms to share innovative experiences and results has clearly been a key step, for example, through the "Healthy Islands" initiative, launched at the meeting of Ministers and Heads of Health in Yanuca, Fiji, in 1995[34]. The initiative brings together health policy-makers and practitioners to address challenges to islanders' health and well-being from an explicitly multi-sectoral perspective, with a focus on expanding coverage of curative health-care services, but also reinforcing promotive strategies and cross-sectoral action on the determinants of health and health equity.

Through the Healthy Islands initiative and related experiences, a number of principles have emerged as crucial to the advancement of universal coverage in these settings. The first concerns collaboration in organizing infrastructure that maximizes scales of efficiency. An isolated community may be unable to afford key inputs to expand coverage, which includes infrastructure, technologies and human resources (particularly the training of personnel). However, when communities join forces, they can secure such inputs at manageable costs[35]. A second strategic focus is on "mobile resources" or those that can overcome distance and geographical obstacles efficiently and affordably. Depending on the setting, this strategic focus may include transportation, radio communications, and other information and communications technologies. Telecommunications