What does universal health coverage mean?

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Lancet 2014; 383: 277–79

Published Online
August 15, 2013
http://dx.doi.org/10.1016/S0140-6736(13)60955-1

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The recent UN General Assembly resolution calling for universal health coverage (UHC) was testimony to the continuing high-level political commitment to achievement of global health goals—an achievement that has the potential to transform health systems, especially for the poorest people.[1] Fulfilment of this potential, however, requires a clear definition of the term UHC otherwise it could suffer the same fate of the refrain of Health for All, which received high-level political support but failed to produce sufficiently widespread policy and budgeting changes to realise its aims. Ambiguously, UHC has been labelled universal health coverage (the term used in this Viewpoint), universal health care, universal health-care coverage, or universal coverage.[2] Descriptions of what UHC entails are equally diverse, with no consistent framework to guide policy makers seeking improved equity of access and use of services to achieve more equitable health outcomes.

Such imprecision can lead to unintended policy consequences. For example, UHC is often used to mean an expansion of service provision or health financing to remove access barriers. This notion is exemplified in the UN General Assembly resolution that adopted the language of a 2005 World Health Assembly resolution background paper describing UHC as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access".[3] This description seems to imply that equity is a natural consequence of implementation of UHC policies. However, examples from country implementation show that the extent to which equity is improved through UHC policies is conditional on how UHC terms and policies are defined, designed, implemented, and sequenced.[4–6]

An empirically grounded framework to guide definition of each word in UHC is needed upfront to establish practical boundaries on what policies can achieve, creating a normative and operational means by which to gauge national strategies and progress. Otherwise, important considerations that should affect policy outcomes could remain unaddressed. We suggest that the starting point of such a framework is to define each term—universal, health, and coverage—that provokes discrepancies in interpretation. These areas of uncertainty hinder the ability to develop a consensus about what UHC means, and make it difficult to create an objective set of UHC metrics, which is needed well before analysis and effective resolution of the barriers to UHC can occur.

In the context of UHC, the term universal has been defined as a legal obligation of the state to provide health care to all its citizens, with particular attention to ensure inclusion of all disadvantaged and excluded groups.[7] Yet, noble as a commitment to universality sounds, it might do little to change policies under which many governments either deliberately or passively refuse to grant access to health services to some people living within their national borders. So-called stateless people, such as refugees, undocumented migrants, nomadic people, or those denied birth registration, are often seen by authorities as without legal entitlement to any rights to health care.[8]

Other people are excluded because of systematic discrimination based on disability, sex, sexual orientation, religion, ethnic origin, or political affiliation. Being female, or a member of a religious or ethnic minority, can be the basis for denial of access to health and other social services even for legal citizens.[9] If UHC is to be a credible development benchmark, there must be clarity about how global aspirations of health for all are balanced against how a state defines citizenship and sets limits to its obligations under UHC.

Health is another contested term. The UN General Assembly resolution implies a much broader definition of health than provision of basic or essential health services could achieve. It calls for UHC and social health insurance to deliver equitable opportunities for the "highest attainable standard of physical and mental health" including "work on determinants of health".[1] This perspective is strongly supported by civil society groups desiring global UHC targets that would oblige and support national action on social determinants to reduce inequities, and mandate actions beyond the health sector.[10]

However, in most countries the move towards UHC gradually expands access starting from a narrow set of essential health services that are accessible to public and private sector wage earners.[11] But this approach has often increased health inequities since these groups are more likely to access these services than are poor people or those working in informal sectors.[12] To address inequities, experiences from countries that have adopted a broader definition of health indicate that UHC policies might require, at a minimum, establishment of a comprehensive social health platform that provides a continuum of care across an individual's lifespan for communicable and non-communicable diseases. This platform would encompass other essential policies, such as those for childhood nutrition and education, occupational health, retirement health insurance, and, in some countries, traditional health systems.[13] This approach, however, would require buy-in from a range of sectors and ministries who might have difficulty regarding health as their primary concern. Clarity is needed about how much of health UHC policies address, whether or not they include other sectors, and, correspondingly, what degree of health inequities UHC can plausibly act upon.

Discussions of the term coverage typically note that access to essential services cannot be removed from barriers such as the financial hardships associated with payment. However, definitions of coverage must go past mere accessibility of services to incorporate an assessment of effective utilisation.[14] Two aspects should be made explicit if UHC policies are to be effective: the appropriateness, and the quality, of coverage. Appropriateness warrants careful consideration because in many countries perverse provider incentives, underinvestment in promotive and preventive services, and insufficient attention to reduction of risk conditions or promotion of healthy lifestyles all skew coverage towards curative and more fiscally lucrative interventions.[15] Correspondingly, although the 2010 WHO definition of UHC promotes quality services, it does not provide specific and practical policy guidance about the quality needed to achieve effective coverage that reduces preventable death and illness.[16,17]

Imprecision of these three terms hinders discussions around key policy questions for UHC, such as who to include, for which services, with what level of quality, and to what extent it can increase equity. If universal only means that eventually everyone will benefit from UHC, with those currently unreached remaining the last to benefit, present inequities could worsen. Measurement of equity of health will depend on whether it is defined only by rates of preventable illness and death, or broadly to include mental health and psychosocial wellbeing. Equitable coverage could have very different targets if accessibility to services is the endpoint, or if measures of appropriate use and quality are also included. Simply scaling up of present policies and approaches to UHC will not contribute to the reversal of growing inequities in health outcomes within countries unless policies and strategies are explicitly and measurably pro-equity in conception, focus, and implementation.[18] Also necessary is the political will and engagement of civil society to promote a rights-based approach and to institutionalise accountability to meet the needs of disadvantaged people.[19]

The Millennium Development Goals (MDGs) offer lessons for the translation (or mistranslation) of imprecise goals into policies and actions. The MDG focus on national aggregates masked growing inequities, and led to health coverage policies that sometimes exacerbated, rather than reduced, disparities.[20] UHC will most likely need to be unpacked into measurable subtargets that can indicate to governments, partners, and each inhabitant whether progress towards UHC is also reducing disparities in health outcomes. Another lesson of the MDGs relates to their slow uptake and acceptance, partly because of the lack of a participatory process in their formulation. Clarification of the terms in UHC offers an opportunity for a wide range of stakeholders to participate in shaping of national goals. Issues of citizenship and the scope of services, for example, are often recast as technical or financial protection problems rather than areas needing an open dialogue on social values and priorities. UHC dialogues can help to probe the distributive effects of policies, to avoid development of two-tier systems with different standards for rich and for poor people. Clarity is also needed about what UHC is not. Otherwise, UHC risks being dissipated as an easy slogan to adopt without necessarily changing the standard approach.

How might a transparent and inclusive discussion about the implications and trade-offs of various ways to define the elements of UHC come about? Recent country experiences using the outputs of an equity-based analysis show that assessment of mechanisms driving patterns of inequity in a specific country is possible.[21] This approach is being used to help national and subnational authorities to understand and address the primary causes of low access, and inappropriate and poor quality coverage.[22] Successes and lessons from the MDGs can help to make UHC a practical guide for policies instead of an aspirational slogan. The term universal necessitates a focus on equity, with the path to UHC explicitly a gap-narrowing one that prioritises the attainment of greatly improved health outcomes for those who are at present left behind. Similarly, the term health must take into account social determinants, including beliefs, values, and expressed needs of various subpopulations, and consider how actions beyond the health sector can be implemented. For the term coverage, its results must be considered, moving from measurement of access to assessment of utilisation, appropriateness, and quality. Finally, consistent participation of civil society and the private sector, with government and development partners, is essential to forge a true consensus about what UHC means within each country, so that the relevant causal pathways and mechanisms hindering and enabling UHC can be fully diagnosed.

We welcome UHC and the opportunity that it provides to hold open and inclusive discussions about the creation of pro-equity UHC indicators under the post-2015 global development agenda. A genuinely broad-based consensus on a precise operational framework would make UHC achievement a more inclusive and country-led process, rather than simply one swayed by global pundits. Development of such a framework would demystify UHC and encourage sensible measures for tracking and global comparisons, build on lessons learnt during the pursuit of the MDGs, and contribute meaningfully to the post-2015 agenda.

Contributors
All authors contributed to the conceptualisation of this report and approved the final draft. TO'C wrote the first draft and collated comments from reviewers and authors for subsequent iterations. KR and MC contributed ideas about content and structure, and drafted revised sections of the report.

Conflicts of interest
We declare that we have no conflicts of interest

Acknowledgments
We thank Alyssa Sharkey for her valuable insights on drafts of this paper.

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