Why universal coverage is the key to improved health for developing countries

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Meeting in the impressive atrium of Berlin’s Allianz Stiftungsforum Pariser Platz in November 2010, an International Ministerial Conference of World Health Organization member states and the leading international development agencies gathered to witness the launch of the World Health Report 2010–*Health Systems Financing: The Path to Universal Coverage*. I WHO Director General Margaret Chan described universal coverage as necessary, feasible and achievable in all countries, including lower-income countries.

The commitment to universal coverage in Berlin was, apparently, universal. Every agency – from WHO and the World Bank, to bilateral donors including AusAID, to non-government agencies such as Oxfam and Save the Children – endorsed the call of the World Health Report. Widespread acceptance of the universal coverage approach marks a return to treating health care as a public good, following a long period that opened in the 1990s when greater emphasis was given to market approaches in the delivery of health services.

Dean of the Harvard School of Public Health Julio Frenk told the Berlin conference there are three pillars of global health – technical, political and ethical. The technical challenge facing the international community is clear: to achieve the Millennium Development Goals, health overseas development assistance must double. But is universal coverage the best investment?

Effectively, acceptance of the universal coverage approach builds on the principle of extending public health services to all who need them, which characterised the primary health care approach of the 1970s. Universal coverage differs, however, to the extent that it is broader and based more securely on the development of the health system as whole – at primary, secondary and tertiary levels. II

Writing in *The Lancet* in November 2010, Davidson Gwatkin raised the legitimate concern that, developing countries, universal coverage programs built on providing social health insurance for the formal employment sector, and relying on the trickle-down effect for the poor and informal workers, risks creating greater inequality in access to health services. III He advocated ‘progressive universalism’ based on the determination to ensure that the poor gain as much benefit as the rich.

By way of example, recent universal coverage reforms in both Brazil IV and Mexico V first targeted coverage on the poor in deprived municipalities before expanding to more well-off areas or focused on people not already covered by insurance, who are mostly poor.
An approach built on first targeting the poor is evident too in Cambodia, a developing low-income country. There, more than three-quarters of all those who live below the poverty line (approximately 27% or the total population or about 3 million people) are currently covered by health equity funds that meet all the patient costs of accessing government health services. This has been achieved before social health insurance measures for formal sector employees have been implemented and is the centre piece of the country’s emerging universal coverage strategy. This is an achievement of international significance that has received too little recognition.

Assessing the labour market effects of universal coverage in a recent World Bank working paper, Adam Wagstaff and Wanwiphang Manachotphong demonstrate that the successful implementation of the universal coverage scheme in Thailand from 2001 encouraged increased employment especially among married women, reduced formal-sector employment among married men and increased informal-sector employment (especially among married women, and especially in the agricultural sector).vi

Wagstaff and Manachotphong believe that universal coverage may therefore cause market distortions that negatively affect investment and growth and lead to reduced protection against non-health risks. This research gives rise to some further questions: whether the financial security against health costs provided to the informal sector increases flexibility in the labour market; whether women may be encouraged to take up productive jobs which they had not previously had the opportunity to enter; or whether men have had greater opportunity to move from lower-paid, less-productive formal sector jobs to more rewarding self-employment. If the response to these questions was positive, it may be that universal coverage could encourage higher productivity.

An emerging criticism of universal coverage is that it is simply unaffordable for, and lies beyond the administrative capacity of, lower-income countries. This view contradicts the argument put forward by the World Health Report and echoes a similar view once famously presented by Julia Walsh and Kenneth Warren, that a selective implementation of the 1970s primary health care approach was needed because of cost.vii The selective approach set the stage for the demise of the primary health care strategy.

However, commentators like Joe Kutzin, the head of health financing at WHO, argue that universal coverage is a journey and not a destination.viii Universal coverage is not a one-off program implemented in a single stroke. Rather it is a strategy for increasing access to health services across the population over time through successive steps that account both for the needs of the poor and for the costs associated with wider population coverage. Rather than being unaffordable, the approach proposes a change in fiscal priorities in many countries where government health spending is undervalued.

Thailand provides an example, associated with steadily improving health outcomes, of a previously less-developed country that began the journey towards universal coverage along a gradual path, which opened in the 1980s with the first establishment of prepayment schemes. It was achieved in 2002 when the government allocated budget funding to pay the costs of access for the poor and the informal sector.ix
Meeting the need for access to health services for the poor is critical to the universal coverage perspective. The potential weaknesses in the strategy so far revealed through these different research efforts pose a challenge that health planners and international agencies must meet if health coverage is to be equitable and effective.

As a means to achieve the Millennium Development Goals for health, universal coverage plays the role of admitting all sections of the population to available services. Effective vertical interventions (like GAVI’s support for vaccination) and health systems strengthening programs (implemented with support from the World Bank or WHO, for example) have played a crucial role in strengthening the supply of health services. Universal coverage supports the demand side, expanding access to services for those who need them. The two must go hand in hand to achieve effective health outcomes.

There is now an historic opportunity – no more so than in a country like Cambodia, for example – for development partners, including AusAID, to invest in universal coverage measures that protect the poor and extend access to health services. This would justly redistribute income at a time of widening income disparities in developing countries, it would assist economic growth through improved health, and it could encourage greater labour mobility with the security of improved financial protection.

Disclaimer: The views expressed in this commentary are those of the author alone and do not in any way reflect the views or opinions of the Nossal Institute for Global Health, AusAID or any other party.

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3 Davidson Gwatkin. 2010. Universal health coverage: friend or foe of health equity? The Lancet. Published online, November 16, DOI:10.1016/S0140-6736(10)62058-2.