



IMPACT & INNOVATION SERIES



Universal Health Coverage

Discussion highlights from a 2010 Pacific Health Summit workshop

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2010 marks a key year in the worldwide movement for expanding universal health coverage (UHC). The UN Summit on Millennium Development Goals (MDGs) in September and the November World Health Report—“Health Systems Financing: the Path to Universal Coverage”—are drawing increased attention to this critical discussion. This year has also seen tremendous progress in improving maternal, newborn, and child health (MNCH), and is a critical point in the countdown to 2015 and the achievement of MDGs 4 and 5.¹

On June 23, 2010, the Pacific Health Summit,² which addressed the theme of maternal and newborn health (MNH), organized a workshop entitled “Universal Health Coverage: A *Sine Qua Non* for Improved and Sustained Maternal and Newborn Health?” This timely discussion examined current efforts to implement universal coverage through the lens of MNH, with an emphasis on financing issues. The goal of the workshop was to explore the potential impact of extending UHC coverage to women and newborns. The discussion engaged a diverse group of high-level stakeholders, who do not often come together around this theme, to explore new ideas and address existing challenges of how to accelerate the impact and reach of universal health coverage. The Question & Answer format on the following pages presents excerpts from this workshop.

¹ MDG 4: to reduce child and infant mortality; MDG 5: to reduce maternal mortality. (<http://www.unmillenniumproject.org/goals/gti.htm>)

² The Pacific Health Summit (www.pacifichealthsummit.org) began in 2005 to connect science, industry, and policy for a healthier world. The invitation-only gathering provides a unique opportunity to engage diverse stakeholders around a theme of critical importance and has a track record of fostering innovative partnerships and meaningful action. The 2010 Summit theme was maternal and newborn health. The Pacific Health Summit is co-presented by the Fred Hutchinson Cancer Research Center, Bill & Melinda Gates Foundation, Wellcome Trust, and The National Bureau of Asian Research, which serves as the Summit Secretariat.

Universal Health Coverage: A Sine Qua Non for Improved and Sustained Maternal and Newborn Health?

Excerpts from the June 23, 2010 Pacific Health Summit workshop

SETTING THE STAGE

Q What is the present status of universal health coverage implementation in select countries? What implications does this expansion have for maternal and newborn health?

Mushtaque Chowdhury

There has been tremendous global enthusiasm [for the UHC movement] since the World Health Assembly passed the universal health coverage resolution in 2005. Many lower- and middle-income countries have achieved universal health coverage, such as Thailand, Mexico, Colombia, Ghana, and likely Rwanda. Numerous others are moving quickly towards that goal, including India, South Africa, Brazil, and Vietnam. Additionally, several African countries including Kenya, Ethiopia, Uganda, Sierra Leone, and Zambia have passed resolutions or laws and legislations for universal health coverage. It is ethically right, economically feasible, and politically very timely.

Anne Mills

Shouldn't maternal and newborn health in a sense be a rallying call for advancing universal coverage? There is a very strong case for these population groups to get universal coverage—maternal, neonatal, and child healthcare could be the vanguard of the universal coverage movement.

Mickey Chopra

I feel very strongly that universal health coverage is at the heart of achieving MDGs 4 and 5. The evidence is strong: removal of financial barriers to universal healthcare is ab-

solutely critical for the achievement of these MDGs. We're now working with the Rockefeller Foundation on having our UNICEF country offices complete a more comprehensive survey of health insurance schemes in key countries. This is all part and parcel of our work with our sister agencies on improving costing and budgeting tools, and developing a universal health model for costing to work with countries. So far, two-thirds of over 70 countries [surveyed] are starting to move towards large-scale insurance programmes—this bus is leaving the station.

Maharaj Bhan

Maternal and child health is the right place to begin implementing universal coverage. But it is also important to keep in mind the challenge of secondary healthcare within the universal healthcare context. The consequences of this extend to maternal and child health; it affects the whole family with marginal income.

Andrew Donaldson

Most South Africans have universal access to primary healthcare and hospital services that is free at the point of service, though there is also a substantial private fee-for-service system and about 16% of the population have health insurance. We have a public health system that for the most part does not charge; it has a means-tested fee structure, but for most users of the public system, services are free. There was a very early decision after the 1994 democratic transition that services for women and children should be free. In the last five or six years MNCH has received a growing budget allocation, and so has been able to expand employment and make progress in service improvements, but of course HIV/AIDS takes up a large part of the increasing budgetary resources. Under consideration now is the rather difficult challenge of developing a national health insurance system, which would bring both public and private facilities and service providers into a common financing framework.

“Maternal, neonatal, and child healthcare could be the vanguard of the universal coverage movement.”

Anne Mills, Head, Faculty of Public Health and Policy & Professor, Health Economics and Policy, London School of Hygiene & Tropical Medicine

Q Is the way in which we address universal health coverage, at its' core, an ideological conversation rather than a technical one? Should we be technical and scientific in our approach to universal health coverage rather than ideological?

Armin Fidler

Universal coverage means very different things to different people, and we need to recognize that. In essence, it is a conversation about social protection, especially for vulnerable populations like mothers and children. It's about social safety nets, and it's about health. But first and foremost it's about making sure that the poor don't fall through the cracks when they experience a catastrophic health risk.

K. Srinath Reddy

Commitment to equity has to be clearly driven by an ideological commitment. You may call it political will, you may call it ideology, but if the commitment to equity is not there, a mere technical evaluation will not really serve the purpose.

The technical inputs are clearly necessary, but they have to be coupled with the fundamental commitment.

Anne Mills

It's not possible to answer the question of technical versus ideological and political, because you need a diverse portfolio of strategies. But one of the things that is absolutely critical, which Thailand's example demonstrates, is that the technical design is incredibly important, particularly on the cost side. The lesson of history is that countries need a mix of financial strategies.

Cesar Victora

This relates to the issue of social participation. If you look at how decisions about health coverage were made in Brazil, they were not primarily led by scientific evidence about which interventions are effective. Rather, they were based on concerns about the huge discrepancies between the health of the rich and poor—strong evidence about which something had to be done. To tackle these inequalities Brazil first adopted a national service health system, and then focused on geographical targeting to improve coverage among the poor.



Armin Fidler, Suwit Wibulpolprasert, Mushtaque Chowdhury (left to right)

FINANCING

Q What are some of the current financing challenges around implementing universal coverage? What innovative finance approaches are addressing these challenges?

Andrew Donaldson

South Africa's institutional reform challenge is a test as to whether one can build a more equal system that is part public and part private. It's also about whether one can put financing mechanisms into place so that private hospitals can become providers to publicly-funded arrangements, and

public hospitals can also be providers to the medically insured. I think it is possible to get that right, and we've made some progress in small public-private projects in which local groups of doctors are making use of public facilities and sharing expensive resources. Scaling up these small projects is of course much more difficult.

David de Ferranti

The way forward for universal coverage requires financial innovation across the full spectrum—not just in technology, but also in service and delivery. For example, conditional cash transfers create impact by replacing financial barriers

with incentives. If we are looking for the contents of the tool kit of issues and instruments that policymakers think about and use to try to make progress on maternal and newborn health, I would certainly hope that includes attention to removing the financial barriers and arrangements that make it possible for mothers and households to use facilities.

K. Srinath Reddy

We cannot look at financing issues in isolation; we have to look at the health system as a whole, which is supportive of universal health. What services are covered? In many cases, what is called ‘universal health coverage’ is restricted only to hospitalization costs, not to outpatient costs, and that’s a major contributor to catastrophic expenditure in many countries. So we also have to look at the range of services.



“The technical inputs are clearly necessary, but they have to be coupled with the fundamental commitment.”

K. Srinath Reddy, President, Public Health Foundation of India

Q Are donors forcing the hands of countries around UHC? What are the dynamics of country-donor relations for UHC? Who or what will drive UHC funding in the future?

Cesar Victora

Brazil can afford to not depend on donors because it is a middle income country, unlike many other countries. I think that’s very important, because we can set our own rules. We have a very independent, assertive policy—both internal and external—so we can afford to not be beholden to advice from international organizations.

Armin Fidler

Donors such as the World Bank can be helpful with financing and technical assistance, but what I have seen work best is bringing countries together to learn from each other. This kind of twinning arrangement, where you bring someone to Thailand and say, ‘how did you solve that problem?’ enables practitioner to practitioner dialogue. If we can create that platform of exchange, then this is something we should be doing more of with partners, and donors should be supportive.

Zulfiqar Bhutta

One key issue is the role and responsibility of Bretton Woods Institutions³ in UHC, as they help many states do their restructuring. In Pakistan, we are in the middle of a financial restructuring, with major support from the International Monetary Fund. In the last two years of that process, most of the economic restructuring has focused on taxation, cost recoveries, and similar things; there has been no support for protecting MNCH. How can we at least ensure that in the adjustment processes around financial support mechanisms to countries this vital area of UHC and of public health [MNCH] can be protected?

Simon Wright

One important issue is minimizing the impact donors have on government decisions. This is about more than just the advice that donors give, it is about the very principle that donors circumvent governments by actually delivering ser-

³ The Bretton Woods Institutions are the International Monetary Fund and The World Bank Group. (<http://www.brettonwoodsproject.org/item.shtml?x=320747>)

vices outside of the government system. This is the kind of factor that will undermine a government's accountability to its people. In countries where a society knows and is able to assert its entitlements, governments are more likely to come up with systems and schemes that will deliver that entitlement. For example, Sierra Leone has gone to a lot of trouble to communicate to citizens about the new free healthcare policy, and to put in place mechanisms such as free telephone hotlines for reporting health facilities still charging fees. We'll probably see less progress in countries where people are less empowered.

David de Ferranti

There just is not enough money right now to meet all the needs. How will this problem be solved? Will aid go on rising in the future? Unlikely, given that the donor countries have huge debt. Will private sector direct investment increase? Unlikely; companies have been hammered in the last few years. So where will this capital come from? There is another source if we can figure out a way to tap it, and that is local savings, which in some countries is building up. For example, pension funds amount to around \$1.3 trillion in countries in Africa, Asia, and Latin America. Not merely billions, but trillions.



DIFFERENT SECTORS, DIFFERENT ROLES

Q In countries with or moving towards a high degree of universal coverage, how is the private health sector involved? What are the respective roles of NGOs, civil society, and international agencies?

Armin Fidler

What has worked is involving the government—the public sector—in financing and risk pooling. There is a role for the private sector and the public sector for a pluralistic provision, perhaps under contractual arrangements. This is what I have seen, what my colleagues have seen, that has worked in many different countries.

David de Ferranti

The tough question is how to pay for and organize UHC,

because clearly subsidies will be required; that's a matter of public policy. Getting that right is where the tough questions lie; it's a balancing act. There may be differing ways in which actors inside and outside the state—NGOs and others—can help in implementation and provision. One view, which I subscribe to, is that public financing and public stewardship is the way to go.

Suwit Wibulpolprasert

Private health insurers cover less than 2% of the population [in Thailand]. These are mainly large companies, so we cover [healthcare costs] primarily through public health insurance. But we do involve private providers, which represent about one-quarter of the total health resources. We work very closely with the private sector: we involve them, we contract with them to provide UHC services.

IMPACT



What evidence exists regarding whether UHC improves health outcomes? Has UHC brought equity to health systems? What is the impact on healthcare workers?

Cesar Victora

In 1989 Brazil created and implemented its national health system, which included universal healthcare. About five years later, it was clear that even though open universal access existed in theory, facilities were still concentrated in the wrong places: they were in the south of the country and in the cities—the richer parts of the country. And therefore there was another major reform in 1994: the creation of the Family Health Strategy.⁴

Now ten years after the implementation of Brazil's last major healthcare reform strategy, we have 97% facility delivery amongst the poorest quintile, and about 98%-99% among the rest of the population. We have virtually eradicated this massive difference between rich and poor, at least in access to facilities. Brazil has already met the MDG 1 indicator of underweight.... We're going to meet MGD 4 next year.... Universal coverage certainly played a role. We're not so sure about MGD 5. Why? As part of Brazil's universal coverage, we have maternal audit committees in virtually every city in the country, and we're measuring mortality more accurately than ever before, so it looks like [the mortality rate] is not falling, but I strongly believe that if we had the right measurement, we'd also be detecting a sizeable reduction in maternal mortality.

⁴ This strategy used geographical targeting to deploy Family Health teams of doctors, nurses, and community health workers, and for communities, be they rural communities or the urban slums. Coverage is very high: over 27,000 teams are deployed throughout Brazil's 5560 municipalities. (<http://www.who.int/bulletin/volumes/86/4/08-030408/en/index.html>)



Cesar Victora, Mickey Chopra (left to right)

Suwit Wibulpolprasert

What can a low- to middle-income country like Thailand cover through universal health coverage? We cover everything except drugs outside of the National Essential Drug List, cosmetic surgery, and organ transplants, except for kidney transplants. We cover almost all services, from upper respiratory tract infections to brain surgery, heart surgery, coronary bypasses, lens extraction, renal replacement therapy, and cancer treatment. There is no co-payment: you pay nothing, and you get the service. Annual, independent polls show that the public satisfaction with this system is quite high, always at more than 85%.

We also see satisfaction rising among health workers, from around 50% in 2004 to over 60% in 2009. We hope that it will continue to rise. How? Because in 2009 we gave them the biggest financial incentive I have ever seen. If you are a new medical graduate and you agree to work in the most remote rural areas—we have about 70 districts—in one month you can earn more than one month of my salary, and I have worked for the government for 32 years. So we are showing how much we value our health workers, and as a result we hope to see more satisfaction and more engagement. This is only possible because of our universal health coverage.

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Suwit Wibulpolprasert, Senior Advisor on Disease Control, Office of the Permanent Secretary, Ministry of Public Health, Thailand