Universal coverage, beyond the numbers

A concept note from ITM, compiled by Bart Criel & Werner Soors

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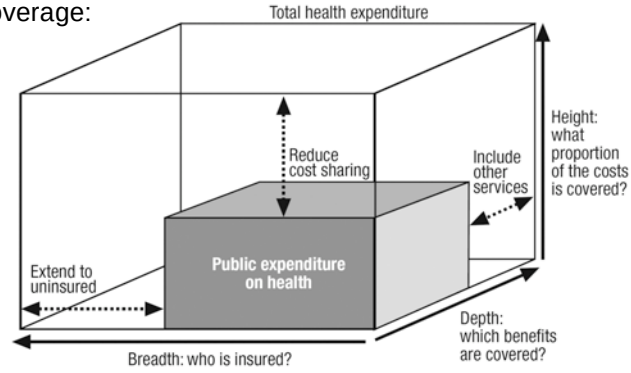
Universal coverage can be defined as access for all to quality health services if need be, with social health protection. Universal coverage is not, by itself, sufficient to ensure health for all and health equity. The roots of health inequities lie in social conditions outside the health system's direct control, to be tackled through intersectoral collaboration. Universal coverage however is the necessary foundation within the health sector on the road to health for all and health equity.[1]

Social health protection – being part and parcel of social protection – comprises protective, preventive and promotional objectives (the so-called ILO framework). *Promotional measures* aim to stabilise or enhance income (micro-credits are one example); *preventive measures* directly seek to avert deprivation (informal and formal insurance mechanisms, and other forms of risk pooling); *protective measures* in the strict sense aim to provide relief from deprivation (social assistance) to the extent that promotional and preventive measures have failed to do so.[2,3] Many social protection interventions aim to achieve more than one of these objectives.[4]

Social health protection for universal coverage results in three quantifiable dimensions of coverage: breadth, depth and height of coverage. Extending social health protection to the uninsured expands the *breadth of coverage*, i.e. the proportion of a population enjoying such protection. Increasing the range of services under cover expands the *depth of coverage*, i.e. the proportion of benefits covered. Reducing payment at the point of service delivery expands the *height of coverage*, i.e. the proportion of costs covered. The World Health Report 2008 describes this expansion in three dimensions as the *technical challenge* of moving towards universal coverage:

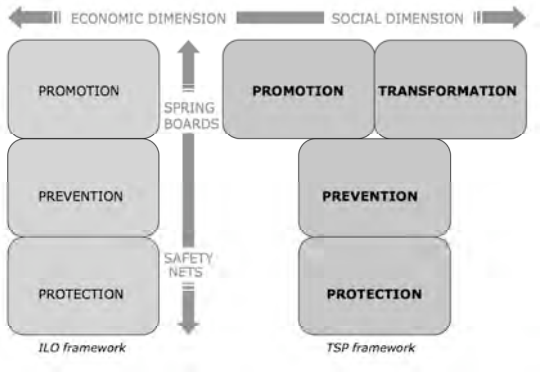


The same report also recognises that moving towards universal coverage has rarely been the object of an easy consensus: *political choices* determine how technical challenges are met. Such is the case for all decisions to widen the breadth of coverage, to pool risks between poor and non-poor and eventually to make solidarity statutory. Such is also the case for substantially increasing the depth of coverage: defining packages of benefits beyond needs' assessments, paking into account demand and expectations of the public as the ultimate stakeholder.[5] And it is the case in expanding the height of coverage, when introducing or re-introducing prepayment.

The choices made for health financing options – related to revenue collection, risk pooling, and resource allocation and service purchasing[6] – set the stage for all three dimensions of coverage. Obviously, such choices are also political. Universal coverage is thus about numbers (of people, of services, and of costs), but goes beyond that: it is also about modifying the determinants of vulnerability.

The wealth of empirical evidence in the field of health gathered by the Commission on Social Determinants of Health points in the same direction. The Commission's final report provides a strong call for redistribution, reduction of out-of-pocket health spending, increased publicly funded health spending, and establishment and strengthening of social protection. The latter is described as a major step towards securing health equity, and universal coverage as a social imperative.[7] The Commission's knowledge network on health systems underscores the need for transformation from within the health sector, based on context-specific participation, empowerment, and an authentic interpretation of primary health care as an effective response to inequity.[8] In doing so, the network robustly recalls the Alma Ata quest for tackling health inequalities that are "politically, socially and economically unacceptable".[9]

The framework of Transformative Social Protection (TSP) developed by Devereux and Sabates-Wheeler[10] provides a conceptual basis to extend *economic* protection – protection, prevention and promotion – with transformation to become real *social* protection. Transformation refers to the need for social integration and for correction of those power imbalances in all levels of society that encourage, create and sustain vulnerabilities. In short: equitable distribution of power. In the end, transformative social protection is *more effective* social protection – as transformation might well strengthen the mainstream protection, prevention and promotion. In the field of health, the TSP framework seems to offer a conceptual link for analysis of social protection on the road to universal coverage.



We have to acknowledge that both the search for universal access and for social protection have been distant objectives for a long time. Structural adjustment in the post-Alma Ata years inverted the envisaged reduction of health inequities. Likewise, the focus on macroeconomic growth for development diluted the efforts for social protection, particularly in those countries most in need. Recognition of these adverse effects is finally contributing to a renewed momentum for equity, access to health and social protection. In addition, the current financial crisis fuels both inequity and hope. As a Lancet editorial put it only weeks ago, "champions of social protection, which must include the international health community, must seize the moment".[11] Now is the time for action.

Our November 2009 seminar is the right place to reflect with our partners on the ways to do so, building upon our efforts for universal access[12] and in line with the Antwerp declaration on "Health care for all".[13] As a committed part of the health community, we have the duty. As a Belgian platform – within a rich history of social protection and equitable health care through social empowerment, and without the prescriptiveness that characterises larger players in the field – we have everything in place to do so.

Consulted readings:

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[5] Rebecca Bruni, Andreas Laupacis & Douglas Martin. Public engagement in setting priorities in health care. Canadian Medical Association Journal, 2008; 179(1): 15-18. http://www.cmaj.ca/cgi/reprint/179/1/15

[6] Pablo Gottret & George Schieber. Health financing revisited: a practitioner's guide. Washington, the World Bank, 2006. http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf

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[8] Lucy Gilson, Jane Doherty, Rene Loewenson & Victoria Francis. Challenging inequity through health systems. Final report of the Knowledge Network on Health Systems, WHO Commission on Social Determinants of Health. Witwatersrand/London, Health Systems Knowledge Network, 2007. http://web.wits.ac.za/NR/rdonlyres/3C2BD9F8-3FD4-4E45-B4BE-3855E6230FD4/0/HSKNfinalcombined20July.pdf

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[11] Health slips as the financial crisis grips. Editorial. *The Lancet*, 2009; 373(9672): 1311.

[12] http://www.itg.be/becausehealth/

[13] Declaration on "Health care for all". http://www.itg.be/internet/hca/DEC16-11EN.pdf