THE GLOBAL PUSH FOR UNIVERSAL HEALTH COVERAGE

What is Universal Health Coverage?

Universal Health Coverage (UHC) means everyone can access the quality health services they need without financial hardship.

WHO: All people, including the poorest and most vulnerable.

WHAT: Full range of essential health services, including prevention, treatment, hospital care and pain control.

HOW: Costs shared among entire population through pre-payment and risk-pooling, rather than shouldered by the sick. Access should be based on need and unrelated to ability to pay.

UHC is a means to promote the human right to health.

Countries of all income levels are pursuing policy reforms to achieve UHC.

- More than 80 countries since 2010 have asked the World Health Organization (WHO) for technical assistance in moving toward UHC.[1]
- The emerging economies of Brazil, Russia, India, China and South Africa (BRICS)—representing almost half the world's population—are all taking steps toward UHC.
- In December 2012, the United Nations passed a landmark resolution endorsing UHC.[2] Since then, the World Bank Group and WHO have identified UHC as a top priority for sustainable development.

"UHC is the single most powerful concept that public health has to offer."—*Margaret Chan, Director-General, WHO, 21 May 2012*

Why Invest in UHC?

UHC helps to lift people out of poverty and drives economic growth.

- UHC is critical because 1 billion people lack access to basic health care, and another 100 million fall into poverty trying to access it.[3]
- Nearly a third of households in Africa and Southeast Asia have to borrow money or sell assets to pay for health care.[4]
- Health improvements drove a quarter of full income growth in developing countries between 2000 and 2011. At this rate of return, every US$1 invested in health would produce US$9-US$20 of growth in full income over the next 20 years.[5]

Core Tenets of UHC

Prioritize the Poorest

- UHC efforts, first and foremost, should ensure coverage of the poor and vulnerable.
- Health inequities are widening. For example, over the past two decades, measles vaccination rates in Africa jumped to 75% among the richest fifth of the population, but stagnated at 33-36% among the poorest fifth.[6] UHC helps to close these gaps.

Increase Reliance on Public Funding

- Public financing is essential for UHC to cover people who cannot contribute financially. This involves increased government resource generation and allocation to health, and more efficient spending. For example, Mexico moved toward UHC by increasing public spending on health by an average of 5% annually from 2000 to 2006.[7]
- In the Abuja Declaration of 2001, African governments recognized this by pledging at least 15% of public spending to health, although these targets have largely not been met.

Reduce, if Not Eliminate, Out-Of-Pocket Spending

- High out-of-pocket spending—the fees patients pay upon receipt of health services—is one of the biggest health reasons people fall into poverty when accessing care, or choose to forgo care.
- In Thailand, the proportion of families facing catastrophic health care costs in the lowest income group dropped from 4% in 2000 to 0.9% in 2006, through UHC reforms.[8]

Develop the Health System

- UHC is not simply about health financing. If the medicines, health workers and health facilities do not exist, for example, it is difficult to move toward UHC. Thailand supplemented its health financing reforms with extensive modifications to its health system to ensure that good quality health services were available where needed.

Country-Specific Pathways to UHC

There is no one-size-fits-all approach. Countries are taking different pathways:

Country	MEXICO	RWANDA	THAILAND	BRAZIL	GHANA
(GDP/capita)	($9,741)	($619)	($5,473)	($11,339)	($1,604)
Reform	**2003: Seguro Popular.** Publicly funded "insurance" system for poor and informal sector, to reduce disparities with social security in formal sector.	**2003: Mutuelle de Santé.** Heavily subsidized community-based health insurance system integrated into a national network combining local accountability with national pooling and cross-subsidization.	**2001: Universal Coverage Scheme**. Newest and largest scheme covering everyone not included in the two schemes for formal sector workers.	**1988: Unified Health System (SUS).** Publicly-funded services run at the municipal level.	**2004: National Health Insurance Scheme.** National network of community-based insurance schemes combined with national social-security (formal sector) insurance scheme.
Financing & Benefits Covered	Government budget transfers. Original idea of enrollee premium tied to income largely dropped. Package covers 95% of causes for hospital admission.	Budget transfers (from tax revenues and donor aid) combined with sliding scale member contributions. National benefits plan with some scope for variation by each Mutuelle branch; must at least cover all services/drugs at health centers.	Solely general government revenues. Strong incentives for efficiency through various forms of active purchasing, global budgets and provider payment. Comprehensive benefits, includes both curative and preventive care; recently added HIV treatment.	General federal government revenues pooled at municipal level. Comprehensive benefits, divided into three tiers: basic, specialized and high complexity.	General tax revenue, mainly 2.5% levy on VAT, combined with payroll tax of social security beneficiaries (formal sector) and limited premium contributions from beneficiaries (except most vulnerable). National pool with fee-for-service payment to fund a benefits package that covers 95% of reported health problems.

Detailed profiles at jointlearningnetwork.org

Toward UHC as a Global Objective

Consensus is emerging that making UHC a global objective will accelerate health and development goals.

- With the Millennium Development Goals (MDGs) 2015 deadline approaching, UN member states are debating a new global development agenda. UHC has been proposed as either an umbrella health goal or a component of a health goal, defined in terms of health outcomes. Each reflects widespread agreement that UHC has an important role in the next phase of global health and development.
- WHO and the World Bank Group have developed a framework for countries to measure UHC progress.[9] This framework demonstrates that UHC can be measured nationally and globally, with targets for coverage of health services and financial protection.

Better Health and Equity through UHC

UHC can enhance efforts to address the most pressing needs in global health.

- Expanding coverage has been shown to prolong life especially among underserved populations.[10]
- Maternal, newborn and child survival improve more rapidly with equitable health financing for UHC.[11]
- UHC can reduce gender disparities in health—including unmet need for family planning—through appropriate design, implementation and monitoring.[12]
- Reducing or eliminating out-of-pocket spending is critically important to promote access to health services and health workers and to prevent impoverishment for vulnerable populations, including those affected by HIV.[13]
- UHC can help address new health priorities, including non-communicable diseases (NCDs), by increasing coverage of preventative and clinical services. In parallel to action on the social determinants of health, UHC can help achieve a 25% reduction in NCD mortality by 2025.[14]

"Achieving UHC and equity in health are central to reaching the global goals to end extreme poverty by 2030 and boost shared prosperity."—*Jim Yong Kim, President, World Bank Group, 6 December 2013*

Save the Children

The NCD Alliance
Putting non-communicable diseases on the global agenda

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One Million Community Health Workers Campaign

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References
1. Chan M. WHO Director-General Remarks to Global Vaccine and Immunization Research Forum. March 2014.
2. UNGA resolution A/67/L.36.
3. WHO. Universal Health Coverage: Report by the Secretariat. January 2013.
4. Kruk ME et al. Borrowing and Selling to Pay for Health Care in Low- and Middle-Income Countries. Health Affairs. July/August 2009.
5. The Lancet Commission on Investing in Health. Global Health 2035: A world converging within a generation. The Lancet. December 2013.
6. UNICEF. Progress for Children: Achieving the MDGs with Equity. September 2010.
7. Garcia-Diaz R et al. Analysis of the distributional impact of out-of-pocket health payments: evidence from a public health insurance program for the poor in Mexico. Journal of Health Economics. December 2011.
8. Oxfam. Universal Health Coverage: Why health insurance schemes are leaving the poor behind. October 2013.
9. World Bank Group, WHO. Monitoring progress towards universal health coverage at country and global levels. May 2014.
10. Sommers BD, Long SK, Balcker K. Changes in mortality after Massachusetts health care reform. Ann. Intern. Med. May 2014.
11. Gertler P, Giovagnoli P, Martinez S. Rewarding provider performance to enable a healthy start to life: evidence from Argentina's Plan Nacer. May 2014.
12. Quick J, Jay J, Langer A. Improving women's health through universal health coverage.
13. International HIV/AIDS Alliance. Health in the post-2015 development framework. June 2014.
14. Marmot M. Universal health coverage and social determinants of health. The Lancet. October 2013.