





Advancing and sustaining universal coverage



People expect their health systems to be equitable. The roots of health inequities lie in social conditions outside the health system's direct control. These root causes have to be tackled through intersectoral and cross-government action. At the same time, the health sector can take significant actions to advance health equity internally. The basis for this is the set of reforms that aim at moving towards universal coverage, i.e. towards universal access to health services with social health protection.

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The central place of health equity in PHC

“If you get sick, you have to choose: you either go without treatment or you lose the farm.”¹ Nearly a century ago, the unforgiving reality of life in rural Canada prompted Matthew Anderson (1882–1974) to launch a tax-based health insurance scheme that eventually led to countrywide adoption of universal health care across Canada in 1965. Unfortunately, equally shocking lose-lose situations abound today across the world. More than 30 years after the clarion call of Alma-Ata for greater equity in health, most of the world’s health-care systems continue to rely on the most inequitable method for financing health-care services: out-of-pocket payments by the sick or their families at the point of service. For 5.6 billion people in low- and middle-income countries, over half of all health-care expenditure is through out-of-pocket payments. This deprives many families of needed care because they cannot afford it. Also, more than 100 million people around the world are pushed into poverty each year because of catastrophic health-care expenditures². There is a wealth of evidence demonstrating that financial protection is better, and catastrophic expenditure less frequent, in those countries in which there is more pre-payment for health care and less out-of-pocket payment. Conversely, catastrophic expenditure is more frequent when health care has to be paid for out-of-pocket at the point of service (Figure 2.1).

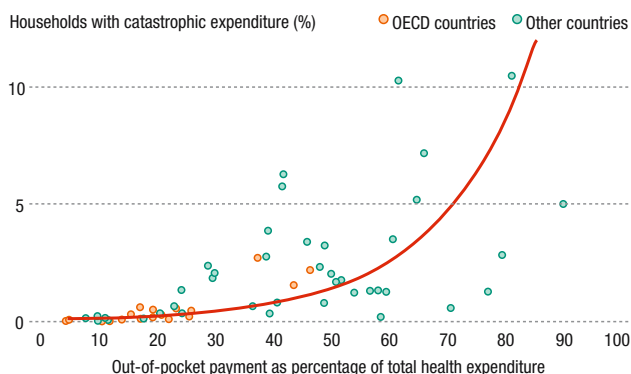
While equity marks one of PHC’s boldest features, it is one of the areas where results have been most uneven and where the premium for more effective reforms is perhaps the greatest. Out-of-pocket payments for health care are but one of the sources of health inequity. Deeply unequal opportunities for health combined with endemic inequalities in health care provision lead to pervasive inequities in health outcomes³. Growing awareness of these regressive patterns is causing increasing intolerance of the whole spectrum of unnecessary, avoidable and unfair differences in health⁴.

The extent of health inequities is documented in much more detail today. They stem from social stratification and political inequalities that lie outside the boundaries of the health system. Income and social status matter, as do the neighbourhoods where people live, their employment conditions and factors, such as personal behaviour, race and stress⁵. Health inequities also find their roots in the way health systems exclude people, such as inequities in availability, access, quality and burden of payment, and even in the way clinical practice is conducted⁶. Left to their own devices, health systems do not move towards greater equity. Most health services – hospitals in particular, but also first-level care – are consistently inequitable providing more and higher quality services to the well-off than to the poor, who are in greater need^{7,8,9,10}. Differences in vulnerability and exposure combine with inequalities in health care to lead to unequal health outcomes; the latter further contribute to the social stratification that led to the inequalities in the first place. People are rarely indifferent to this cycle of inequalities, making their concerns as relevant to politicians as they are to health-system managers.

It takes a wide range of interventions to tackle the social determinants of health and make health systems contribute to more health equity¹¹. These interventions reach well beyond the traditional realm of health-service policies, relying on the mobilization of stakeholders and constituencies outside the health sector¹². They include¹³:

- reduction of social stratification, e.g. by reducing income inequality through taxes and subsidized public services, providing jobs with

Figure 2.1 Catastrophic expenditure related to out-of-pocket payment at the point of service⁷



adequate pay, using labour intensive growth strategies, promoting equal opportunities for women and making free education available, etc.;

- reduction of vulnerabilities, e.g. by providing social security for the unemployed or disabled, developing social networks at community level, introducing social inclusion policies and policies that protect mothers while working or studying, offering cash benefits or transfers, providing free healthy lunches at school, etc.;
- protection, particularly of the disadvantaged, against exposure to health hazards, e.g. by introducing safety regulations for the physical and social environment, providing safe water and sanitation, promoting healthy lifestyles, establishing healthy housing policies, etc.);
- mitigation of the consequences of unequal health outcomes that contribute to further social stratification, e.g. by protecting the sick from unfair dismissal from their jobs.

The need for such multiple strategies could discourage some health leaders who might feel that health inequality is a societal problem over which they have little influence. Yet, they do have a responsibility to address health inequality. The policy choices they make for the health sector define the extent to which health systems exacerbate or mitigate health inequalities and their capacity to mobilize around the equity agenda within government and civil society. These choices also play a key part in society's response to citizens' aspirations for more equity and solidarity. The question, therefore, is not if, but how health leaders can more effectively pursue strategies that will build greater equity in the provision of health services.

Moving towards universal coverage

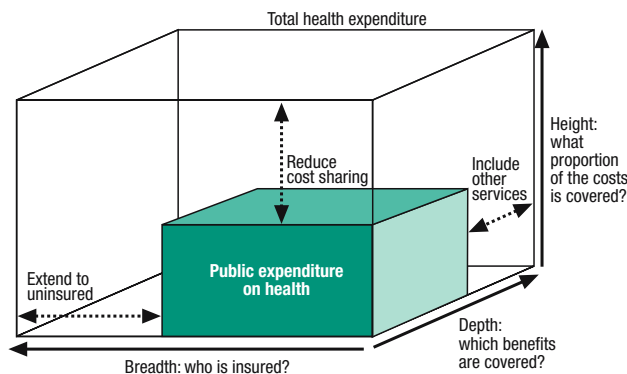
The fundamental step a country can take to promote health equity is to move towards universal coverage: universal access to the full range of personal and non-personal health services they need, with social health protection. Whether the arrangements for universal coverage are tax-based or are organized through social health insurance, or a mix of both, the principles are

the same: pooling pre-paid contributions collected on the basis of ability to pay, and using these funds to ensure that services are available, accessible and produce quality care for those who need them, without exposing them to the risk of catastrophic expenditures^{14,15,16}. Universal coverage is not, by itself, sufficient to ensure health for all and health equity – inequalities persist in countries with universal or near-universal coverage – but it provides the necessary foundation⁹.

While universal coverage is fundamental to building health equity, it has rarely been the object of an easy social consensus. Indeed, in countries where universal coverage has been achieved or embraced as a political goal, the idea has often met with strong initial resistance, for example, from associations of medical professionals concerned about the impact of government-managed health insurance schemes on their incomes and working conditions, or from financial experts determined to rein in public spending. As with other entitlements that are now taken for granted in almost all high-income countries, universal health coverage has generally been struggled for and won by social movements, not spontaneously bestowed by political leaders. There is now widespread consensus that providing such coverage is simply part of the package of core obligations that any legitimate government must fulfil vis-à-vis its citizens. In itself, this is a political achievement that shapes the modernization of society.

Industrialized countries, particularly in Europe, began to put social health protection schemes in place in the late 19th century, moving towards universalism in the second half of the 20th century. The opportunity now exists for low- and middle-income countries to implement comparable approaches. Costa Rica, Mexico, the Republic of Korea, Thailand and Turkey are among the countries that have already introduced ambitious universal coverage schemes, moving significantly faster than industrialized countries did in the past. Other countries are weighing similar options¹⁴. The technical challenge of moving towards universal coverage is to expand coverage in three ways (Figure 2.2).

The breadth of coverage – the proportion of the population that enjoys social health protection – must expand progressively to encompass

Figure 2.2 Three ways of moving towards universal coverage¹⁷

the uninsured, i.e. the population groups that lack access to services and/or social protection against the financial consequences of taking up health care. Expanding the breadth of coverage is a complex process of progressive expansion and merging of coverage models (Box 2.1). During this process, care must be taken to ensure safety nets for the poorest and most vulnerable until they also are covered. It may take years to cover the entire population but, as recent experience from a number of middle-income countries shows, it is possible to move much faster than was the case for industrialized countries during the 20th century.

Meanwhile, the *depth of coverage* must also grow, expanding the range of essential services that are necessary to address people's health needs effectively, taking into account demand and expectations, and the resources society is willing and able to allocate to health. The determination of the corresponding "essential package" of benefits can play a key role here, provided the process is conducted appropriately (Box 2.2).

The third dimension, *the height of coverage*, i.e. the portion of health-care costs covered through pooling and pre-payment mechanisms must also rise, diminishing reliance on out-of-pocket co-payments at the point of service delivery. In the 1980s and 1990s, many countries introduced user fees in an effort to infuse new resources into struggling services, often in a context of disengagement of the state and dwindling public resources for health. Most undertook these measures without anticipating the extent of the damage they would do. In many settings, dramatic declines in service use ensued, particularly among vulnerable groups²⁰, while the frequency of catastrophic expenditure increased. Some countries have since reconsidered their position and have started phasing out user fees and replacing the lost income from pooled funds (government subsidies or contracts, insurance

Box 2.1 Best practices in moving towards universal coverage

Emphasize pre-payment from the start. It may take many years before access to health services and financial protection against the costs involved in their use are available for all: it took Japan and the United Kingdom 36 years¹⁴. The road may seem discouragingly long, particularly for the poorest countries, where health-care networks are sparsely developed, financial protection schemes embryonic and the health sector highly dependent on external funds. Particularly in these countries, however, it is crucial to move towards pre-payment systems from a very early stage and to resist the temptation to rely on user fees. Setting up and maintaining appropriate mechanisms for pre-payment builds the institutional capacity to manage the financing of the system along with the extension of service supply that is usually lacking in such contexts.

Coordinate funding sources. In order to organize universal coverage, it is necessary to consider all sources of funding in a country: public, private, external and domestic. In low-income countries, it is particularly important that international funding be channelled through nascent pre-payment and pooling schemes and institutions rather than through project or programme funding. Routing funds in this way has two purposes. It makes external funding more stable and predictable and helps build the institutional capacity to develop and extend supply, access and financial protection in a balanced way.

Combine schemes to build towards full coverage. Many countries with limited resources and administrative capacity have experimented with a multitude of voluntary insurance schemes: community, cooperative, employer-based and other private schemes, as a way to foster pre-payment and pooling in preparation for the move towards more comprehensive national systems¹⁶. Such schemes are no substitute for universal coverage although they can become building blocks of the universal system¹⁸. Realizing universal coverage means coordinating or combining these schemes progressively into a coherent whole that ensures coverage to all population groups¹⁵ and builds bridges with broader social protection programmes¹⁹.

Box 2.2 Defining “essential packages”: what needs to be done to go beyond a paper exercise?

In recent years, many low- and middle-income countries (55 out of a sample of 69 reviewed in 2007) have gone through exercises to define the package of benefits they feel should be available to all their citizens. This has been one of the key strategies in improving the effectiveness of health systems and the equitable distribution of resources. It is supposed to make priority setting, rationing of care, and trade-offs between breadth and depth of coverage explicit.

On the whole, attempts to rationalize service delivery by defining packages have not been particularly successful²⁴. In most cases, their scope has been limited to maternal and child health care, and to health problems considered as global health priorities. The lack of attention, for example, to chronic and noncommunicable diseases confirms the under-valuation of the demographic and epidemiological transitions and the lack of consideration for perceived needs and demand. The packages rarely give guidance on the division of tasks and responsibilities, or on the defining features of primary care, such as comprehensiveness, continuity or person-centredness.

A more sophisticated approach is required to make the definition of benefit packages more relevant. The way Chile has provided a detailed specification of the health rights of its citizens²⁵ suggests a number of principles of good practice.

- The exercise should not be limited to a set of predefined priorities: it should look at demand as well as at the full range of health needs.
- It should specify what should be provided at primary and secondary levels.
- The implementation of the package should be costed so that political decision-makers are aware of what will *not* be included if health care remains under-funded.
- There have to be institutionalized mechanisms for evidence-based review of the package of benefits.
- People need to be informed about the benefits they can claim, with mechanisms of mediation when claims are being denied. Chile went to great lengths to ensure that the package of benefits corresponds to people’s expectations, with studies, surveys and systems to capture the complaints and misgivings of users²⁶.

or pre-payment schemes)²¹. This has resulted in substantial increases in the use of services, especially by the poor²⁰. In Uganda, for example, service use increased suddenly and dramatically and the increase was sustained after the elimination of user fees (Figure 2.3)^{22,23}.

Pre-payment and pooling institutionalizes solidarity between the rich and the less well-off, and between the healthy and the sick. It lifts barriers to the uptake of services and reduces the

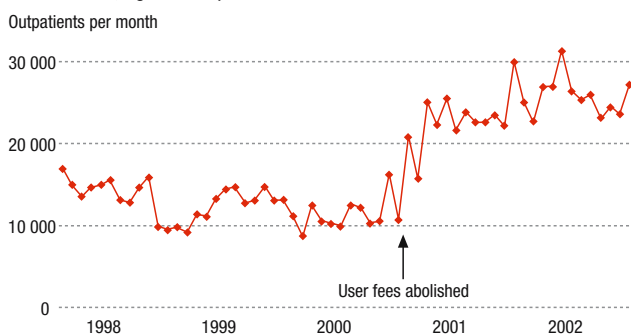
risk that people will incur catastrophic expenses when they are sick. Finally, it provides the means to re-invest in the availability, range and quality of services.

Challenges in moving towards universal coverage

All universal coverage reforms have to find compromises between the speed with which they increase coverage and the breadth, depth and height of coverage. However, the way countries devise their strategies and focus their reforms very much depends on their specific national contexts.

In some countries, a very large part of the population lives in extremely deprived areas, with an absent or dysfunctional health-care infrastructure. These are countries of mass exclusion typically brought to mind when one talks about “scaling up”: the poor and remote rural areas where health-care networks have not been deployed yet or where, after years of neglect, the health infrastructure continues to exist in name only. Such patterns occur in low-income countries

Figure 2.3 Impact of abolishing user fees on outpatient attendance in Kisoro district, Uganda: outpatient attendance 1998–2002²³



such as Bangladesh, Chad and Niger (Figure 2.4), and are common in conflict and post-conflict areas where health workers have departed and the health infrastructure has been destroyed and needs to be rebuilt from scratch.

In other parts of the world, the challenge is in providing health support to widely dispersed populations, for example, in small island states, remote desert or mountainous regions, and among nomadic and some indigenous populations. Ensuring access to quality care in these settings entails grappling with the diseconomies of scale connected with small, scattered populations; logistical constraints on referral; difficulties linked to limited infrastructure and communications capacities; and, in some cases, more specific technical complications, such as maintaining patient records for nomadic groups.

A different challenge is extending coverage in settings where inequalities do not result from the lack of available health infrastructure, but from the way health care is organized, regulated and, above all, paid for by official or under-the-counter user charges. These are situations where under-utilization of available services is concentrated among the poor, whereas users are exposed to the risks of catastrophic expenditure. Such patterns of exclusion occur in countries such as Colombia, Nicaragua and Turkey (Figure 2.4). It is particularly striking in the many urban areas of low- and middle-income countries where a

plethora of assorted, unregulated, commercial health-care providers charge users prohibitive fees while providing inadequate services.

Ways of tackling the situations described in this section are elaborated below.

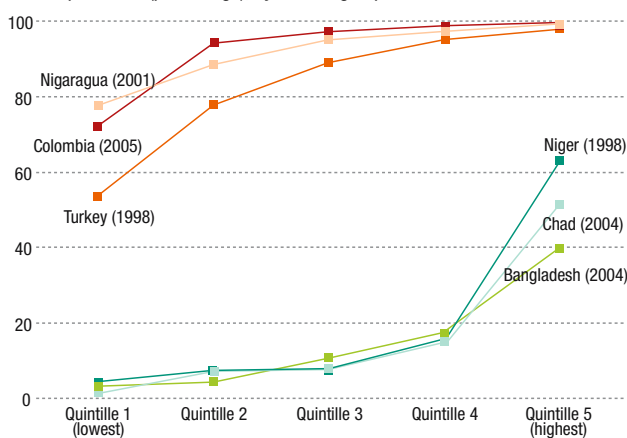
Rolling out primary-care networks to fill the availability gap

In areas where no health services are available for large population groups, or where such services are grossly inadequate or fragmented, the basic health-care infrastructure needs to be built or rebuilt, often from the ground up. These areas are always severely resource-constrained and frequently affected by conflicts or complex emergencies, while the scale of under-servicing, also in other sectors, engenders logistical difficulties and problems in deploying health professionals. Health planners in these settings face a fundamental strategic dilemma: whether to prioritize a massive scale-up of a limited set of interventions to the entire population or a progressive roll-out of more comprehensive primary-care systems on a district-by-district basis.

Some would advocate, in the name of speed and equity, an approach in which a restricted number of priority programmes is rolled out simultaneously to all the inhabitants in the deprived areas. This allows for task shifting to low-skilled personnel, lay workers and volunteers and, consequently, rapid extension of coverage. It is still central to what the global community often prescribes for the rural areas of the poorest countries²⁸, and quite a number of countries have chosen this option over the last 30 years. Ethiopia, for example, is currently deploying 30 000 health extension workers to provide massive numbers of people with a limited package of priority preventive interventions. The poor skills base is often well recognized as a limiting factor²⁹, but Ethiopia's extension workers are no longer as low skilled as they once were, and currently benefit from a year of post-Grade 10 training. Nevertheless, skill limitations reinforce the focus on a limited number of effective but simple interventions.

Scaling up a limited number of interventions has the advantage of rapidly covering the entire population and focusing resources on what is known to be cost effective. The downside is that

Figure 2.4 Different patterns of exclusion: massive deprivation in some countries, marginalization of the poor in others. Births attended by medically trained personnel (percentage), by income group²⁷



when people experience health problems, they want them to be dealt with, whether or not they fit nicely within the programmatic priorities that are being proposed. Ignoring this dimension of demand too much opens the door to “drug peddlers”, “injectors” and other types of providers, who can capitalize on commercial opportunities arising from unmet health needs. They offer patients an appealing alternative, but one that is often exploitative and harmful. Compared with a situation of utter lack of health action, there is an indisputable benefit in scaling up even a very limited package of interventions and the possibility of relying on low-skilled staff makes it an attractive option. However, upgrading often proves more difficult than initially envisaged³⁰ and, in the meantime, valuable time, resources and credibility are lost which might have allowed for investment in a more ambitious, but also more sustainable and effective primary-care infrastructure.

The alternative is a progressive roll-out of primary care, district-by-district, of a network of health centres with the necessary hospital support. Such a response obviously includes the priority interventions, but integrated in a comprehensive primary-care package. The extension platform is the primary-care centre: a professionalized infrastructure where the interface with the community is organized, with a problem solving capacity and modular expansion of the range of activities. The Islamic Republic of Iran’s progressive roll-out of rural coverage is an impressive example of this model. As one of the fathers of the country’s PHC strategy put it: “Since it was impossible to launch the project in all provinces at the same time, we decided to focus on a single province each year” (Box 2.3).

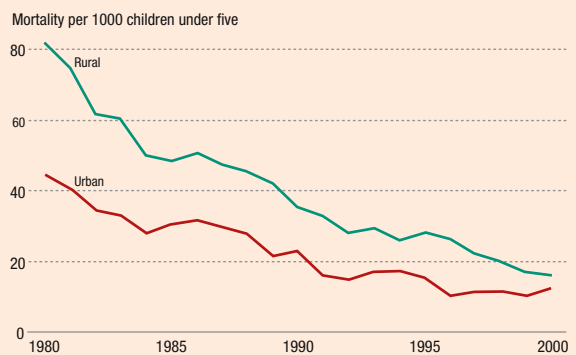
The limiting factors for a progressive roll-out of primary-care networks are the lack of a stable cadre of mid-level staff with the leadership qualities to organize health districts and with the ability to maintain, over the years, the constant effort required to build sustainable results for the entire population. Where the roll-out has been conducted as an administrative exercise, it has led to disappointment: many health districts exist in name only. But where impatience and pressure for short-term visibility has been managed

Box 2.3 Closing the urban-rural gap through progressive expansion of PHC coverage in rural areas in the Islamic Republic of Iran³¹

In the 1970s, the Iranian Government’s policies emphasized prevention as a long-term investment, allocation of resources to rural and under-privileged areas, and prioritizing ambulatory care over hospitalization. A network of district teams to manage and oversee almost 2500 village-based rural health centres was established. These centres are staffed by a team that includes a general practitioner, midwife, nurse and several health technicians. Each of the rural health centres oversees 1–5 smaller points of care known as “health houses”. With 17 000 of these health houses, over 90% of the rural population has access to health care. In remote rural areas, these health houses are staffed by *Behvarz* (multi-purpose health workers) who are selected by the community, receive between 12 and 18 months training and are then recruited by the Government. The district teams provide training based on problem-solving, as well as ongoing supervision and support.

The Government deployed this strategy progressively, extending coverage to one province at a time. Over the years, the PHC network has grown and is now able to provide services to over 24 million people in rural villages and small cities by bringing the points of care closer to where people live and work, as well as by training the necessary auxiliary health staff to provide family planning, preventive care services, and essential curative care for the majority of health problems. Rural health service utilization rates are now the same as in urban areas. The progressive roll-out of this system has helped to reduce the urban-rural gap in child mortality (Figure 2.5).

Figure 2.5 Under-five mortality in rural and urban areas, the Islamic Republic of Iran, 1980–2000³²



adequately, a blend of response to need and demand, and participation of the population and key actors has made it possible to build robust primary-care networks, even in very difficult and resource-constrained settings of conflict, and post-conflict environments (Box 2.4).

The distinction between rapid deployment of priority interventions and progressive roll-out of primary-care networks is, in practice, often not as straightforward as described above. However, for all the convergence, trying to balance speed and sustainability is a real political dilemma³⁰. Mali, among others, has shown that, given the choice, people willingly opt for progressive roll-out, making community health centres – whose infrastructure is owned and personnel employed by the local community – the basis of functional health districts.

Crucially, concern for equity should not be translated into a “lowest common denominator” approach: equal access for all to a set of largely unsatisfactory services. Quality and sustainability are important, particularly since nowadays the multitude of varied and dynamic governmental, not-for-profit and for-profit private providers of various kinds are in dire need of alignment. Progressive roll-out of health services provides the opportunity to establish welcome leadership coherence in health-care provision at district level. Typical large-scale examples of this approach in developing countries are the contracting out of district health services in Cambodia, or the incorporation of missionary “designated district hospitals” in East Africa. Nevertheless, there is no getting away from the need for massive and sustained investment to expand and maintain health districts in the long term and from the fact that this represents a considerable challenge in a context of sluggish economic growth and stagnating health expenditure.

Extending health-care networks to underserved areas depends on public initiative and incentives. One way to accelerate the extension of coverage is to adjust budget allocation formulae (or contract specifications) to reflect the extra efforts required to contact hard-to-reach populations. Several countries have taken steps in this direction. In January 2004, for example, the United Republic of Tanzania adopted a revised formula for the allocation of basket funds to districts that includes population size and under-five mortality as a proxy for disease burden and poverty level, while adjusting for the differential costs of providing health services in rural and

low-density areas. Similarly, allocations to districts under Uganda’s PHC budget factor in the districts’ Human Development Index and levels of external health funding, in addition to population size. Supplements are paid to districts with difficult security situations or lacking a district hospital²⁰. In Chile, budgets are allocated on a capitation basis but, as part of the PHC reforms, these were adjusted using municipal human development indices and a factor to reflect the isolation of underserved areas.

Overcoming the isolation of dispersed populations

Although providing access to services for dispersed populations is often a daunting logistical challenge, some countries have dealt with it by developing creative approaches. Devising mechanisms to share innovative experiences and results has clearly been a key step, for example, through the “Healthy Islands” initiative, launched at the meeting of Ministers and Heads of Health in Yanuca, Fiji, in 1995³⁴. The initiative brings together health policy-makers and practitioners to address challenges to islanders’ health and well-being from an explicitly multi-sectoral perspective, with a focus on expanding coverage of curative health-care services, but also reinforcing promotive strategies and cross-sectoral action on the determinants of health and health equity.

Through the Healthy Islands initiative and related experiences, a number of principles have emerged as crucial to the advancement of universal coverage in these settings. The first concerns collaboration in organizing infrastructure that maximizes scales of efficiency. An isolated community may be unable to afford key inputs to expand coverage, which includes infrastructure, technologies and human resources (particularly the training of personnel). However, when communities join forces, they can secure such inputs at manageable costs³⁵. A second strategic focus is on “mobile resources” or those that can overcome distance and geographical obstacles efficiently and affordably. Depending on the setting, this strategic focus may include transportation, radio communications, and other information and communications technologies. Telecommunications

Box 2.4 The robustness of PHC-led health systems: 20 years of expanding performance in Rutshuru, the Democratic Republic of the Congo

Rutshuru is a health district in the east of the country. It has a network of health centres, a referral hospital and a district management team where community participation has been fostered for years through local committees. Rutshuru has experienced severe stress over the years, testing the robustness of the district health system.

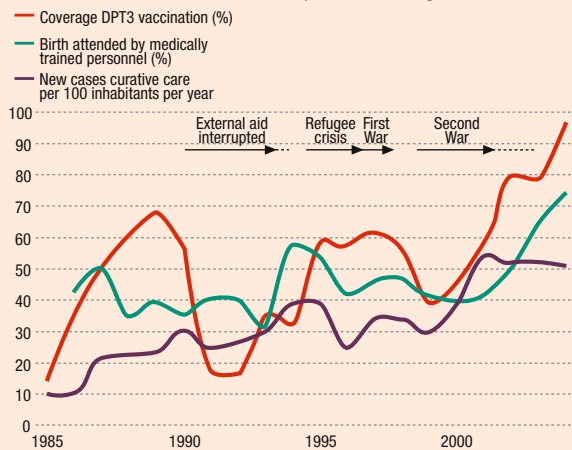
Over the last 30 years, the economy of the country has gone into a sharp decline. GDP dropped from US\$ 300 per capita in the 1980s to below US\$ 100 at the end of the 1990s. Massive impoverishment was made worse as the State retreated from the health sector. This was compounded by an interruption of overseas development aid in the early 1990s. In that context, Rutshuru suffered inter-ethnic strife, a massive influx of refugees and two successive wars. This complex of disasters severely affected the working conditions of health professionals and access to health services for the 200 000 people living in the district.

Nevertheless, instead of collapsing, PHC services continued their expansion over the years. The number of health centres and their output increased (Figure 2.6), and quality of care improved for acute cases (case-fatality rate after caesarean section dropped from 7% to less than 3%) as well as for chronic patients (at least 60% of tuberculosis patients were treated successfully). With no more than 70 nurses and three medical doctors at a time, and in the midst of war and havoc, the

health centres and the district hospital took care of more than 1 500 000 disease episodes in 20 years, immunized more than 100 000 infants, provided midwifery care to 70 000 women and carried out 8 000 surgical procedures. This shows that, even in disastrous circumstances, a robust district health system can improve health-care outputs.

These results were achieved with modest means. Out-of-pocket payments amounted to US\$ 0.5 per capita per year. Nongovernmental organizations subsidized the district with an average of US\$ 1.5 per capita per year. The Government's contribution was virtually nil during most of these 20 years. The continuity of the work under extremely difficult circumstances can be explained by team work and collegial decision-making, unrelenting efforts to build up and maintain a critical mass of dedicated human resources, and limited but constant nongovernmental support, which provided a minimum of resources for health facilities and gave the district management team the opportunity to maintain contact with the outside world.

Figure 2.6 Improving health-care outputs in the midst of disaster: Rutshuru, the Democratic Republic of the Congo, 1985–2004³³



Three lessons can be learnt from this experience. In the long run, PHC-led health districts are an organizational model that has the robustness to resist extremely adverse conditions. Maintaining minimal financial support and supervision to such districts can yield very significant results, while empowering and retaining national health professionals. Local health services have a considerable potential for coping with crises³³.

can enable less skilled frontline health-centre staff to be advised and guided by experts at a distance in real time³⁶. Finally, the financing of health care for dispersed populations poses specific challenges, which often require larger per capita expenditure compared to more clustered populations. In countries whose territories include both high-density and low-density populations, it is expected that dispersed populations will receive some subsidy of care. After all, equity does not come without solidarity.

Providing alternatives to unregulated commercial services

In urban and periurban contexts, health services are physically within reach of the poor and other vulnerable populations. The presence of multiple health-care providers does not mean, however, that these groups are protected from diseases, nor that they can get quality care when they need it: the more privileged tend to get better access to the best services, public and private, easily coming out on top in a *de facto* competition for scarce

resources. In the urban and increasingly in the rural areas of many low- and middle-income countries – from India and Viet Nam to sub-Saharan Africa – much health care for the poor is provided by small-scale, largely unregulated and often unlicensed providers, both commercial and not-for-profit. Often, they work alongside dysfunctional public services and capture an overwhelmingly large part of the health-care market, while the health promotion and prevention agenda is totally ignored. Vested interests make the promotion of universal coverage paradoxically more difficult in these circumstances than in areas where the challenge is to build health-care delivery networks from scratch.

These contexts often combine problems of financial exploitation, bad quality and unsafe care, and exclusion from needed services^{37,38,39,40,41,42,43,44,45,46}. The Pan American Health Organization (PAHO) has estimated that 47% of Latin America's population is excluded from needed services⁴⁷. This may be for broader reasons of poverty, ethnicity or gender, or because the resources of the health system are not correctly targeted. It may be because there are no adequate systems to protect people against catastrophic expenditure or from financial exploitation by unscrupulous or insensitive providers. It may have to do with the way people, rightly or wrongly, perceive health services: lack of trust, the expectation of ill-treatment or discrimination, uncertainty about the cost-of-care, or the anticipation that the cost will be unaffordable or catastrophic. Services may also be untimely, ineffective, unresponsive or plain discriminatory, providing poorer patients with inferior treatment^{48,49,21}. As a result, health outcomes vary considerably by social class, even in well-regulated and well-funded health-care systems.

In addressing these patterns of exclusion within the health-care sector, the starting point is to create or strengthen networks of accessible quality primary-care services that rely on pooled pre-payment or public resources for their funding. Whether these networks are expanded by contracting commercial or not-for-profit providers, or by revitalizing dysfunctional public facilities is not the critical issue. The point is to ensure that they offer care of an acceptable standard. A

critical mass of primary-care centres that provide an essential package of quality services free-of-charge, provides an important alternative to sub-standard, exploitative commercial care. Furthermore, peer pressure and consumer demand can help to create an environment in which regulation of the commercial sector becomes possible. More active involvement of municipal authorities in pre-payment and pooling schemes to improve the supply of quality care is probably one of the avenues to follow, particularly where ministries of health with budgetary constraints also have to extend services to underserved rural areas.

Targeted interventions to complement universal coverage mechanisms

Rising average national income, a growing supply of health-care providers and accelerated progress towards universal coverage are, unfortunately, not sufficient to eliminate health inequities. Socially determined health differences among population groups persist in high-income countries with robust, universal health-care and social-service systems, such as Finland and France^{11,50}. Health inequalities do not just exist between the poor and the non-poor, but across the entire socioeconomic gradient. There are circumstances where other forms of exclusion are of prime concern, including the exclusion of adolescents, ethnic groups, drug users and those affected by stigmatizing diseases⁵¹. In Australia, Canada and New Zealand, among others, health equity gaps between Aboriginal and non-Aboriginal populations have emerged as national political issues^{52,53,54}. In other settings, inequalities in women's access to health care merit attention⁵⁵. In the United States, for example, declines in female life expectancy of up to five years in over 1000 counties point to differential exposure and clustering of risks to health even as the country's economy and health sector continues to grow⁵⁶. For a variety of reasons, some groups within these societies are either not reached or insufficiently reached by opportunities for health or services and continue to experience health outcomes systematically inferior to those of more advantaged groups.

Thus, it is necessary to embed universal coverage in wider social protection schemes and to complement it with specially designed, targeted forms of outreach to vulnerable and excluded groups⁵⁷. Established health-care networks often do not make all possible efforts to ensure that everyone in their target population has access to the full range of health benefits they need, as this requires extra efforts, such as home visits, outreach services, specialized language and cultural facilitation, evening consultations, etc. These may, however, mitigate the effect of social stratification and inequalities in the uptake of services⁵⁸. They may also offer the opportunity to construct comprehensive support packages to foster social inclusion of historically marginalized populations, in collaboration with other government sectors and with affected communities. Chile's *Chile Solidario* (Chilean Solidarity) model of outreach to families in long-term poverty is one example (Box 2.5)⁵⁹. Such targeted measures may include subsidizing people – not services – to take up specific health services, for example, through vouchers^{60,61} for maternal care as in India and Yemen, for bednets as in the United Republic of Tanzania^{62,63}, for contraceptive uptake by adolescents⁶⁴ or care for the elderly uninsured as in the United States⁶⁵. Conditional cash transfers, where the beneficiary is not only enabled, but compelled to take up services is another model, which has been introduced in several countries in

Latin America. A recent systematic review of six such programmes suggests that conditional cash transfers can be effective in increasing the use of preventive services and improving nutritional and anthropometric outcomes, sometimes improving health status⁶⁶. However, their overall effect on health status remains less clear and so does their comparative advantage over traditional, unconditional, income maintenance, through universal entitlements, social insurance or – less-effective – means-tested social assistance.

Targeted measures are not substitutes for the long-term drive towards universal coverage. They can be useful and necessary complements, but without simultaneous institutionalization of the financing models and system structures that support universal coverage, targeted approaches are unlikely to overcome the inequalities generated by socioeconomic stratification and exclusion. This is all the more important since systematic evaluation of methods to target the excluded is scarce and marred by the limited number of documented experiences and a bias towards reporting preferentially on successful pilots⁶⁷. If anything definite can be said today, it is that the strategies for reaching the unreached will have to be multiple and contextualized, and that no single targeting measure will suffice to correct health inequalities effectively, certainly not in the absence of a universal coverage policy.

Box 2.5 Targeting social protection in Chile⁵⁹

Established by law, the Chilean social protection programme (*Chile Solidario*) involves three main components to improve conditions for people living in extreme poverty: direct psycho-social support, financial support and priority access to social programmes. The direct psycho-social support component involves families in extreme poverty being identified according to pre-defined criteria and invited to enter into an agreement with a designated social worker. The social worker assists them to build individual and family capacities that help them to strengthen their links with social networks and to gain access to the social benefits to which they are entitled. In addition to psycho-social support, there is also financial support in terms of cash transfers and pensions, as well as subsidies for raising families or covering water and sanitation costs. Finally, the social protection programme also provides preferential access to pre-school programmes, adult literacy courses, employment programmes and preventive health visits for women and children.

This social protection programme complements a multisectoral effort targeting all children aged 0–18 years (*Chile Crece Contigo* – Chile Grows with You). The aim is to promote early childhood development through pre-school education programmes, preventive health checks, improved parental leave and increased child benefits. Better access to child-care services is also included as is enforcing the right of working mothers to nurse their babies, which is designed to stimulate women's insertion into the employment market.

Mobilizing for health equity

Health systems are invariably inequitable. More and higher quality services gravitate to the well-off who need them less than the poor and marginalized⁸. The universal coverage reforms required to move towards greater equity demand the enduring commitment of the highest political levels of society. Two levers may be especially important in accelerating action on health equity and maintaining momentum over time. The first is raising the visibility of health inequities in public awareness and policy debates: the history of progress in the health of populations is intimately linked to the measurement of health inequalities. It was the observation of excess mortality among the working class that informed the “Great Sanitary Awakening” reforms of the Poor Laws Commission in the United Kingdom in the 1830s⁶⁸. The second is the creation of space for civil society participation in shaping the PHC reforms that are to advance health equity: the history of progress in universal coverage is intimately linked to that of social movements.

Increasing the visibility of health inequities

With the economic optimism of the 1960s and 1970s (and the expansion of social insurance in industrialized countries), poverty ceased being a priority issue for many policy-makers. It took Alma-Ata to put equity back on the political agenda. The lack of systematic measurement and monitoring to translate this agenda into concrete challenges has long been a major constraint in advancing the PHC agenda. In recent years, income-related and other health inequalities have been studied in greater depth. The introduction of composite asset indices has made it possible to re-analyze demographic and health surveys from an equity viewpoint⁶⁹. This has generated a wealth of documentary evidence on socioeconomic differentials in health outcomes and access to care. It took this acceleration of the measurement of poverty and inequalities, particularly since the mid-1990s, to bring first poverty and then, more generally, the challenge of persisting inequalities to the centre of the health policy debate.

Measurement of health inequities is paramount when confronting the common misper-

ceptions that strongly influence health policy debates^{70,71}.

- Simple population averages are sufficient to assess progress – they are not.
- Health systems designed for universal access are equitable – they are a necessary, but not a sufficient condition.
- In poor countries, everybody is equally poor and equally unhealthy – all societies are stratified.
- The main concern is between countries’ differences – inequalities within countries matter most to people.
- Well-intended reforms to improve efficiency will ultimately benefit everybody – they often have unintended inequitable consequences. Measurement matters for a variety of reasons².
- It is important to know the extent and understand the nature of health inequalities and exclusion in a given society, so as to be able to share that information and translate it into objectives for change.
- It is equally important, for the same reasons, to identify and understand the determinants of health inequality not only in general terms, but also within each specific national context. Health authorities must be informed of the extent to which current or planned health policies contribute to inequalities, so as to be able to correct them.
- Progress with reforms designed to reduce health inequalities, i.e. progress in moving towards universal coverage, needs to be monitored, so as to steer and correct these reforms as they unfold.

Despite policy-makers’ long-held commitment to the value of equity in health, its definition and measurement represent a more recent public health science. Unless health information systems collect data using standardized social stratifiers, such as socioeconomic status, gender, ethnicity and geographical area, it is difficult to identify and locate inequalities and, unless their magnitude and nature are uncovered, it is unlikely that they will be adequately addressed⁷². The now widely available analyses of Demographic and Health Survey (DHS) data by asset quintiles



have made a major difference in the awareness of policy-makers about health equity problems in their countries. There are also examples of how domestic capacities and capabilities can be strengthened to better understand and manage equity problems. For example, Chile has recently embarked on integrating health sector information systems in order to have more comprehensive information on determinants and to improve the ability to disaggregate information according to socioeconomic groups. Indonesia has added health modules to household expenditure and demographic surveys. Building in capabilities, across administrative database systems, to link health and socioeconomic data through unique identifiers (national insurance numbers or census geo-codes) is key to socioeconomic stratification and provides information that is usually inaccessible. However, this is more than a technical challenge. Measuring health systems' progress towards equity requires an explicit deliberative process to identify what constitutes a fair distribution of health against shortfalls and gaps that can be measured⁷³. It relies on the development of institutional collaboration between multiple stakeholders to ensure that measurement and monitoring translates into concrete political proposals for better equity and solidarity.

Creating space for civil society participation and empowerment

Knowledge about health inequalities can only be translated into political proposals if there is organized social demand. Demand from the communities that bear the burden of existing inequities and other concerned groups in civil society are among the most powerful motors driving universal coverage reforms and efforts to reach the unreached and the excluded.

The amount of grassroots advocacy to improve the health and welfare of populations in need has grown enormously in the last 30 years, mostly within countries, but also globally. There are now thousands of groups around the world, large and small, local and global, calling for action to improve the health of particularly deprived social groups or those suffering from specific health conditions. These groups, which were virtually non-existent in the days of the Alma-Ata, constitute a powerful voice of collective action.

Box 2.6 Social policy in the city of Ghent, Belgium: how local authorities can support intersectoral collaboration between health and welfare organizations⁷⁶

In 2004, a regional government decree in Flanders, Belgium, institutionalized the direct participation of local stakeholders and citizens in intersectoral collaboration on social rights. This now applies at the level of cities and villages in the region. In one of these cities, Ghent, some 450 local actors of the health and welfare sector have been clustered in 11 thematic forums: legal help; support and security of minors; services for young people and adolescents; child care; ethnic cultural minorities; people with a handicap; the elderly; housing; work and employment; people living on a "critical income"; and health.

The local authorities facilitate and support the collaboration of the various organizations and sectors, for example, through the collection and monitoring of data, information and communication, access to services, and efforts to make services more pro-active. They are also responsible for networking between all the sectors with a view to improving coordination. They pick up the signals, bottlenecks, proposals and plans, and are responsible for channelling them, if appropriate, to the province, region, federal state or the European Union for translation into relevant political decisions and legislation.

A steering committee reports directly to the city council and integrates the work of the 11 forums. The support of the administration and a permanent working party is critical for the sustainability and quality of the work in the different groups. Participation of all stakeholders is particularly prominent in the health forum: it includes local hospitals, family physicians, primary-care services, pharmacists, mental health facilities, self-help groups, home care, health promotion agencies, academia sector, psychiatric home care, and community health centres.

This complex web of collaboration is showing results. Intersectoral coordination contributes to a more efficient local social policy. For the period 2008–2013, four priority themes have been identified in a bottom-up process: sustainable housing, access to health care, reduced thresholds to social rights, and optimization of growth and development. The yearly action plan operationalizes the policy through improvement projects in areas that include financial access to health care, educational support, care for the homeless, and affordable and flexible child care. Among the concrete realizations is the creation of Ghent's "social house", a network of service entry points situated in the different neighbourhoods of the city, where delivery of primary care is organized with special attention to the most vulnerable groups of people. The participating organizations report that the creation of the sectoral forums, in conjunction with the organization of intersectoral cooperation, has significantly improved the way social determinants of health are tackled in the city.

The mobilization of groups and communities to address what they consider to be their most important health problems and health-related inequalities is a necessary complement to the more technocratic and top-down approach to assessing social inequalities and determining priorities for action.

Many of these groups have become capable lobbyists, for example, by gaining access to HIV/AIDS treatment, abolishing user fees and promoting universal coverage. However, these achievements should not mask the contributions that the direct engagement of affected communities and civil society organizations can have in eliminating sources of exclusion within local health services. Costa Rica's "bias-free framework" is one example among many. It has been used successfully to foster dialogue with and among members of vulnerable communities by uncovering local practices of exclusion and barriers to access not readily perceived by providers and by spurring action to address the underlying causes of ill-health. Concrete results, such as the reorganization of a maternity hospital around the people's needs and expectations can transcend the local dimension, as was the case in Costa Rica when local reorganization was used as a template for a national effort⁷⁴.

However, there is much the health system itself can do to mitigate the effects of social inequities and promote fairer access to health services at local level. Social participation in health action becomes a reality at the local level and, at times, it is there that intersectoral action most effectively engages the material and social factors that shape people's health prospects, widening or reducing health equity gaps. One such example is the Health Action Zones in the United Kingdom, which were partner-based entities whose mission was to improve the well-being of disadvantaged groups. Another example is the work of the municipality of Barcelona, in Spain, where a set of interventions, including the reform of primary care, was followed by health improvements in a number of disadvantaged groups, showing that local governments can help reduce health inequities⁷⁵.

Local action can also be the starting point for broader structural changes, if it feeds into relevant political decisions and legislation (Box 2.6). Local health services have a critical role to play in this regard, as it is at this level that universal coverage and service delivery reforms meet. Primary care is the way of organizing health-care delivery that is best geared not only to improving health equity, but also to meeting people's other basic needs and expectations.



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