



# UNIVERSAL HEALTH COVERAGE:

# A COMMITMENT TO CLOSE THE GAP



EXECUTIVE SUMMARY

SEPTEMBER 2013

# EXECUTIVE SUMMARY

SUPPORT FOR UNIVERSAL HEALTH coverage (UHC) – ensuring “that all people obtain the health services they need, of good quality, without suffering financial hardship when paying for them”<sup>1</sup> – is fast gaining momentum. The World Health Organization (WHO), the World Bank and many developing and donor countries have already adopted UHC as their top health priority.

This report focuses on how and why inequity – unfair and avoidable inequalities – should be prioritised as countries progress on the path towards UHC. It identifies policy options that governments and donors should consider when implementing reforms for UHC and estimates the effect this could have on health outcomes, setting out the implications for the post-2015 sustainable development framework.

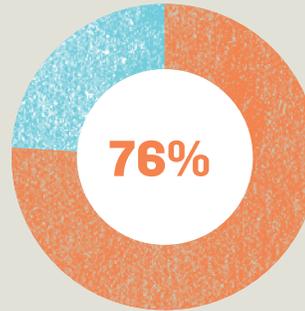
Research for this report included:

- a structured literature review to identify lessons from countries
- key informant interviews with a range of experts
- an econometric analysis to estimate the impact of more equitable health financing on mortality rates
- a Lives Saved analysis to estimate the impact of eliminating in-country wealth inequities in coverage of maternal and child health services.

**MORE EQUITABLE COVERAGE  
COULD PREVENT THE DEATH OF:**

**1.8  
MILLION  
CHILDREN**

**100,000  
MOTHERS**



**IT COULD ALSO  
MEAN A 76%  
INCREASE IN  
THE NUMBER  
OF COUNTRIES  
REACHING MDG 4**

**ADDRESSING INEQUITIES SAVES LIVES  
AND PROVIDES VALUE FOR MONEY**

Investing in equitable pathways towards UHC is the right thing to do from a moral and ethical perspective.<sup>2</sup> But making the needs of poor and vulnerable groups the first priority will also accelerate progress towards global and national aggregate targets.<sup>3,4</sup>

Research commissioned for this report using the Lives Saved Tool (LiST) estimated that the elimination of within-country wealth inequities in coverage of essential maternal and child health interventions would prevent the deaths of 1.8 million children under-five and 100,000 mothers. This would reduce child mortality by one-fifth and maternal mortality by almost one-third.<sup>5</sup>

More equitable health financing produces better value for money.<sup>6</sup> Another piece of research commissioned for this report revealed that, by increasing pooled funding as a share of national health expenditure by 10 percentage points, under-five mortality rates could fall by 15 deaths per 1,000 live births. This effect is amplified in countries where the health system is more equitable.

More equitable health financing through risk pooling could enable 13 countries currently not on track to meet Millennium Development Goal (MDG) 4 – a two-thirds reduction in the number of children dying by their fifth birthday – to achieve their target.<sup>7</sup> This is a 76% increase in the number of countries reaching MDG 4 based on current projections.<sup>8</sup>



Zaria, Nigeria- Midwife Catherine Oluwatoyin Ojo weighs Fatima, 6 months, in the Pepfar Clinic at the Ahmadu Bello University Teaching Hospital in Zaria, Nigeria.

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## UHC: A RIGHT AND AN OBLIGATION

UHC is rooted in the human right to health, which governments are obliged to fulfil.<sup>9,10</sup> It aims to ensure access to good quality health services based on need, not on the ability to pay or other social attributes. It seeks to reduce the financial hardships caused by reliance on ineffectual health systems, the volatility of markets and having to pay fees at the point of use. Those who are poorest and most excluded are not only the most vulnerable to ill-health and premature death, they are also the least likely to have access to good-quality services or protection against financial risk.

## WIDENING INEQUITIES IN HEALTH OUTCOMES AND ACCESS TO CARE

Inequities in life expectancy between and within countries remain vast.<sup>11</sup> Despite falling national rates of child mortality, many countries have seen widening gaps in survival rates between the richest and poorest populations.<sup>12</sup> It is estimated that 1 billion people do not receive the care they need each year.<sup>13</sup>

Those left behind are not a random selection. Systematically, health outcomes and access to health services are based on wealth, education, urban/rural location, gender, ethnicity and age.<sup>14</sup> For instance, 1 million children develop TB annually, with the burden highest in countries with health systems least able

**Morning registration at the inpatient clinic at a comprehensive health centre in northern Nigeria. Save the Children has been running this inpatient clinic since September 2010.**

© SAVE THE CHILDREN/LUCIA ZORO

to treat them. This adds to the inequitable burden of child mortality in countries like Afghanistan, Pakistan, and nations across sub-Saharan Africa.<sup>15,16,17</sup> These inequities are driven by social determinants,<sup>18</sup> which must be tackled both to advance social justice and to meet global and national development targets.

### **IMPOVERISHMENT AND FINANCIAL HARDSHIP FROM ACCESSING CARE**

Each year, 150 million people face financial catastrophe and 100 million are pushed into poverty due to high out-of-pocket spending (OOPS) on healthcare<sup>19</sup> – which is widely acknowledged as the most regressive form of health financing.<sup>20</sup> WHO estimates that the incidence of financial catastrophe becomes negligible only when OOPS is less than 15–20% of national expenditure on health.<sup>21</sup> This burden also falls disproportionately on those who are poor and vulnerable.

Whereas many Asian countries such as India, Bangladesh and Cambodia have high rates of OOPS, other low- and middle-income countries (LMICs) – including Sri Lanka, Thailand and Malaysia – have kept it lower.<sup>22</sup>

### **ADDRESSING INEQUITIES THROUGH UHC**

UHC must be the response to these inequities. Health systems in LMICs are typically underfunded<sup>23</sup> and weak.<sup>24</sup> Within the health system, financing policy reforms are critical to ensure that those who are poor and vulnerable are not left behind. How resources are collected, pooled and spent affect equity in financing of the system, access to essential services, and protection from the risk of financial hardship.<sup>25</sup>



### **LESSONS FOR COUNTRIES**

As countries design health system reforms to progress towards UHC, it is critical that the poor and vulnerable benefit first. This report has identified some of the emerging lessons on how this can be done in LMICs:

- The level and progressivity of funding for the health sector must increase. This will require the elimination of OOPS, at least for vulnerable populations and priority services, with greater reliance on mandatory mechanisms



for prepayment from taxation, whereby contributions are made according to ability to pay and disassociated from healthcare needs.

- Health sector resources must be pooled across the population to allow the redistribution of resources and cross-subsidisation by the healthy and wealthy to cover the costs of care for the poor and sick. Strategic use of resources to tailor the benefit package to meet the needs of poor and vulnerable people, including a minimum of free primary healthcare, and aligning the incentives

of healthcare providers through payment mechanisms, will help to ensure more equitable coverage.

- Quality concerns in service delivery must be addressed. While financing is necessary, it is not sufficient to secure progressive pathways towards UHC. Coordinated reforms across the whole system, and beyond the health sector, are needed to address other barriers to demand and supply.

- The quantity, quality and use of disaggregated data is critical to inform planning process, monitoring, evaluation and accountability. Effective government stewardship is essential for regulation, strategic planning and effective collaboration with other actors. Wider enabling factors include political will, and sufficient, effective support from development partners.

This list is far from exhaustive. Nevertheless, it is indicative of the opportunities for policy reform to reduce coverage gaps – an important step to address inequities in health outcomes.

Identifying an equitable pathway in any country is no easy task. Setting priorities and managing trade-offs is complex and challenging, and must start with the existing context, including: the policy landscape; structures of the health system and public administration; disease burden and distribution of health needs across sub-population groups; fiscal space; strength of key interest groups; and political landscape. The sequencing of reforms will be defined by assessing opportunities and constraints.

### **A CATALYST FOR PROGRESS**

The post-2015 development framework offers a critical opportunity to galvanise more equitable approaches to health, including better data, more accountability and greater political will. Universal birth and death registration systems must be a priority and should capture the country's socio-economic characteristics.<sup>26</sup> In order to measure progress in achieving health equity, coverage must be measured across all segments of society, with targets of both gap reductions and increased national averages set.

The proportion and depth of impoverishment by household characteristics are the best measures of progress for financial risk protection. All countries must undertake household expenditure surveys that include appropriate health questions, which is currently not the case.

Accountability mechanisms at local, national, regional and global levels are essential to ensure that duty bearers deliver on their promises. Donors must honour commitments and practise the principles of effective aid, shifting from a vertical disease-specific preference to horizontal investments to strengthen health systems and build domestic capacities.

### **TIME FOR ACTION**

The means and resources exist to bring an end to preventable mortality and foster healthy lives, eliminating inequities in access to good-quality healthcare. Equitable progress towards UHC must be the health system's response to this challenge. As more and more countries commit to UHC and embark on this journey, it is crucial that addressing inequity is prioritised.

Investing in equitable progress towards UHC will save lives. It will improve health status, increase productivity, and contribute to economic growth and stronger household resilience.

Governments and development partners have the opportunity and the responsibility to make a major difference to those who are poorest and most disadvantaged by prioritising equitable pathways towards UHC. The cost of inaction is high,<sup>27,28,29</sup> and the current momentum must be seized to maximise the opportunity of country commitments to UHC to promote equity.

## ENDNOTES

- 1 [SEE: HTTP://WWW.WHO.INT/FEATURES/QA/UNIVERSAL\\_HEALTH\\_COVERAGE/EN/INDEX.HTML](http://www.who.int/features/qa/universal_health_coverage/en/index.html)
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PUBLISHED BY  
SAVE THE CHILDREN

1 ST JOHN'S LANE. LONDON EC1M 4AR UK | +44 (0)20 7012 6400  
SAVETHECHILDREN.ORG.UK

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COVER PHOTO: LOPUKE AKULINO, 8 MONTHS, WITH HER MOTHER  
NAKINAI ROSA, AT THE SAVE THE CHILDREN-SPONSORED RIWOKO  
PRIMARY HEALTH CARE CENTER (PHCC) IN KAPOETA NORTH, EASTERN  
EQUATORIA. SAVE THE CHILDREN ALSO SPONSORS A NUMBER OF  
SMALLER PRIMARY HEALTH CARE UNITS (PHCUS), ALL MANAGED AND  
STAFFED BY THE GOVERNMENT OF SOUTHERN SUDAN MINISTRY OF  
HEALTH. 10 DECEMBER 2009

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DESIGN BY LUIS VILCHES