

Questions & Answers

Universal Health Coverage and the post-2015 Framework

How does universal health coverage contribute to sustainable development?

Universal health coverage (UHC) has a direct impact on a population's health and welfare. Access to health services enables people to be more productive and active contributors to their families and communities. It also ensures that children can go to school and learn. At the same time, financial risk protection prevents people from being pushed into poverty when they have to pay for health services out of their own pockets.

Universal health coverage, requiring coverage with needed health services and with financial risk protection, is thus a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequities. Universal coverage is the hallmark of a government's commitment to improve the wellbeing of all its citizens.

How can universal health coverage contribute to continued progress on the current Millennium Development Goals (MDGs) while taking into account new health priorities?

Moving closer to universal health coverage requires increasing equitable access to all types of needed health services. This implies continuing efforts to increase the availability and quality of services linked to the current MDGs, such as for HIV/AIDS, TB, malaria, child health or maternal health. It also requires considering how best to improve availability, quality and access to key interventions targeting newer health priorities including non-communicable diseases and injuries. Universal health coverage is, therefore, a way of ensuring continued progress towards the current health MDGs, while also helping countries address the growing threat of non-communicable diseases, mental illness and injuries.



If UHC is included in the post 2015 framework, how can progress be measured?

Universal health coverage requires that people have access to the health services they need without fear of the financial consequences. Measurement is straightforward. Do people obtain the health services they need and do they have financial risk protection in doing so?

There is agreement on the range of indicators currently used to measure the health MDGs, some tracking service coverage (e.g. deliveries attended by skilled health workers) and some showing the impact of this (e.g. maternal mortality rates). There is also general agreement about the indicators that can be used to measure financial risk protection – the proportion of the population pushed into poverty by out-of-pocket health payments and/or the proportion suffering severe financial consequences (usually defined as paying more than 40% of their disposable income on health in any time period).

The indicators currently used for the health MDGs could still be used to measure progress towards a goal of universal health coverage, particularly if they are categorized by income group and other determinants of inequality to allow countries to track progress in improving access across the entire population and also within particular groups (e.g. by income level, sex, age, place of residence, migrant status and ethnic origin).

Discussions are still underway regarding indicators to measure coverage for non-communicable diseases – how to capture the large number of health interventions spanning the range of promotion, prevention, treatment and rehabilitation. A small set of **tracer indicators** needs to be chosen for the post-2015 framework, although countries themselves could monitor much larger sets. As an example, the proportion of smokers in the adult population is a good indicator of the effectiveness of anti-smoking interventions that are so critical to the control of non-communicable diseases.



Does UHC improve equity and meet the needs of vulnerable populations?

UHC is all about equity and is fundamental to providing social protection for health. The poorest populations usually face the highest health risks and need more health services.

A key element of financing for universal health coverage is that the health costs of the poor and vulnerable are shared by the society as a whole. The financing system should aim to spread the financial risks of illness across a wide population, by collecting large pools of prepaid funds that people can draw on to cover their health care costs at times of need, regardless of their ability to pay.

Ensuring access to health facilities, workers and medicines in remote, rural areas is also important, as well as providing special interventions for certain ethnic groups and stigmatized populations.

This means that countries need to monitor if they are increasing access to needed services not just for the population as a whole but for different groups as well (e.g. by income level, sex, age, place of residence, migrant status and ethnic origin).

Is UHC strong enough politically to commit decision-makers and gain public support?

Availability, affordability and access to health services are increasingly becoming election issues, engaging the attention of politicians as well as voters. People all over the world want the reassurance that they can use good quality health services without worrying whether they can afford them. It is easy for people to understand that this requires accessible health facilities, well-trained and motivated health workers, medicines and equipment, and that the costs for those services are affordable. Many governments have realized that this is a major concern among their populations and more than 80 countries are in the process of evaluating and revising their health and health financing strategies with a view to moving closer towards providing universal health coverage.

Would it be better to have separate targets for each of the individual disease areas rather than them being under the umbrella of UHC?

The question is: how many health-specific goals will it be possible to include in the post-2015 framework? Many other sectors are pushing to include additional goals on areas they argue were neglected in the current MDGs – e.g. climate change and the environment. The United Nations has made a commitment to act to reduce the burden of non-communicable diseases in addition to addressing the unfinished agenda for the current health-MDGs. Most observers feel that it is unlikely that it will be possible to have more health-specific goals than in the current set, and many are predicting that it will be possible to have only one. If that turns out to be true, an umbrella goal that covers all of the important health problems seems to be the appropriate solution, each of them can then have separate targets and indicators.

Is not UHC a too ambitious goal?

Universal Health Coverage is a dynamic process. It is not about a fixed minimum package, it is about making progress on several fronts: the range of services that are available to people; the proportion of the costs of those services that are covered; and the proportion of the population that are covered. Few countries reach the ideal, but all – rich and poor – can make progress. It thus has the potential to be a universal goal. Countries will move towards this goal at different paces depending on disease problems, levels of income and many other factors. In human rights terms, there needs to be a vision of where the country wants to go, and how it plans to get there, with a clear indication of how it aims to improve the availability and quality of services over time.

Could this progressive implementation be an excuse for countries not fulfilling their responsibilities towards the right to health?

Countries, with the meaningful participation of all stakeholders including communities, would set their own goals and targets for improving access to services, increasing availability and quality, and improving financial risk protection. At the global level, the targets for expanding coverage in each area (e.g. HIV, TB, malaria, maternal and child health, non-communicable diseases and injuries) will be set by international consensus depending partly on the time frame adopted in the post-2015 framework. The availability of a common set of indicators would make possible to compare countries' implementation and help them move more rapidly to improving access, availability, quality and financial risk protection across a range of health needs.

Is UHC a way to promote private insurance?

UHC is a way to increase access to health care for all without fear of financial ruin. The way countries do this will vary according to their incomes, institutions and values. Two things are clear from country experience.

First, the health costs of the poor need to be met by government revenue. Governments do that in different ways. In the United Kingdom, for example, everybody receives health services paid directly by the state with resources raised by general taxation. In Thailand's Universal Coverage Scheme, the government pays the insurance premiums of the poor from general revenues. Countries cannot provide health services to everyone by relying principally on voluntary private insurance.

Second, fragmentation of insurance systems – where the rich or the formal sector have their own forms of health insurance while the poor are covered by government separately – makes it very difficult to ensure solidarity between the rich and poor and between the healthy and the sick. Fragmentation should be avoided wherever possible as once it exists, it is very difficult to prevent the development of a two or three-tier system with different standards of health services for rich and poor.



Isn't UHC simply a means to an end rather than an end in itself?

UHC is certainly a means to an end. It improves health and protects household incomes, and through this improves educational and economic opportunities – all critical components of human development.

At the same time, people are reassured when they have access to affordable, quality health services. This sense of security is a critical part of human welfare. It is part of the role of governments to ensure every citizen can access a range of services that they need – in education, water and sanitation, justice or health.



What is the role of civil society and communities to support UHC?

Many civil society organisations (CSOs) are actively engaged in increasing coverage with certain interventions needed by stigmatized or vulnerable groups. Others take a broader view of the need to expand coverage across a range of diseases and conditions as well as supporting communities to obtain better financial risk protection. Some CSOs are promoting that health should get a higher share of overall government budgets or that the funds should be used more equitably. Some focus on more affordable medicines.

People run the risks of contracting many different types of diseases and conditions over their lives and communities are interested in ensuring they receive the appropriate services, at an affordable price, to promote and maintain their health overall. How CSOs can work together on this broader agenda while continuing to focus on their particular interests is critical. More than that, it is the meaningful participation of CSOs in the decision making process (definition, monitoring and evaluation) of national health and health financing strategies that can help to increase the range and quality of health services and the extent of financial risk protection for the population.

