

The NCD Alliance

Putting non-communicable diseases
on the global agenda



POLICY BRIEF

**UNIVERSAL HEALTH COVERAGE AND
NON-COMMUNICABLE DISEASES:
A MUTUALLY REINFORCING AGENDA**

INTRODUCTION

Non-communicable diseases (NCDs) — including cancer, cardiovascular disease, chronic respiratory diseases, diabetes, and mental health and neurological disorders — are now widely recognized as a major challenge to health and human development in the 21st century. They are the leading cause of death and disability worldwide, exacting a heavy and growing toll on the physical health and economic security of all countries, particularly low- and middle-income countries (LMICs). Governments have adopted a series of bold political commitments to guide the response to this global epidemic, and an ambitious global goal of achieving a 25% reduction in premature NCD mortality by 2025.

In parallel to the elevation of NCDs onto the political agenda has been the growth of a global movement towards achieving universal health coverage (UHC) —

ensuring that everyone can access the quality health services they need without experiencing financial hardship. Several recent UN resolutions and declarations have affirmed UHC as a global health priority and called on governments to accelerate progress on UHC. As of 2010, 75 countries had adopted legislation mandating universal access to services, regardless of level of income or ability to pay.¹

For almost all countries, NCDs will need to be adequately addressed if UHC is to be achieved. This policy brief analyzes the relationships between UHC and NCDs. It covers the unique challenges the NCD epidemic poses to achieving UHC, and the role of UHC in strengthening the NCD response. It also explores the implications and possible position of health, NCDs and UHC in the post-2015 development agenda.

Key Messages

- Universal health coverage (UHC) is a goal that all governments should commit to. It can help focus greater attention on coverage of quality services, health equity, and guaranteeing financial-risk protection.
- The NCD epidemic poses unique challenges to the three dimensions of UHC. Access and availability to essential NCD services remains unacceptably low in many LMICs; major inequalities exist in terms of NCD risk, access to services, and health outcomes; and the epidemic imposes a huge economic burden on national budgets and can push households into poverty.
- Attainment of UHC will be dependent on prioritizing NCD prevention and control in UHC design and implementation. When achieved, UHC can provide a powerful vehicle to accelerate progress on NCD outcomes, inequalities, and socio-economic impact.
- Equally, lessons learnt from the NCD response can help support pathways to UHC. These include a focus on health promotion and prevention, multisectoral approaches, addressing the social determinants of health, and domestic innovative financing mechanisms (including taxation on unhealthy products).
- For the post-2015 development agenda to be truly transformative for health, NCDs must be recognized as a priority and UHC must be articulated as a means to achieve improved health outcomes.

WHAT IS UNIVERSAL HEALTH COVERAGE?

The concept of universal health coverage (UHC) is rooted in the human right to the highest attainable standard of physical and mental health. The World Health Organization (WHO) defines UHC as the situation where “all people can access the health services they need without incurring financial hardship”.² There are three inter-related objectives of UHC:

1. The full spectrum of good-quality essential health services is available, according to need;
2. There is equity of access to health services, whereby the entire population is covered, not only those who can pay for services;
3. Financial-risk protection mechanisms are in place to ensure the cost of using care does not put people at risk of financial hardship.

WHO has defined health services as a set of interventions aimed at contributing to improved health across the continuum of care, including health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliation. These interventions will predominantly be delivered by the health system, yet availability and accessibility are determined by socio-economic determinants.

“Universal Health Coverage is a key instrument to enhancing health, social cohesion, and sustainable human and economic development”

— **UN General Assembly Global Health and Foreign Policy Resolution, 2012**

HOW CAN UHC STRENGTHEN THE NCD RESPONSE?

There is no “one-size fits-all” approach to UHC. Countries are embarking on different pathways, tailored to their national context. However, given the scale and geographic reach of NCDs, this epidemic will pose both challenges and opportunities for the design and implementation of UHC in almost every country.

This section summarizes the relationship between UHC and NCDs, structured around the three components of UHC: providing health services, covering populations, and covering costs.

1. Providing health services

Typically, UHC programs define a core package of health services most relevant to the country’s health needs, health system, and broader context. These services should be available to the whole population, as needed. Determining this package is a key component of UHC design.

Often, UHC requires reforms across the entire health system — including governance, financing, health workforce, medical products and technologies, information and research, and service delivery. Indeed, a comprehensive health systems approach is required to maximize UHC and ensure it is sustainable.

Health system capacity to respond to NCDs

The availability of cost-effective NCD services is severely inadequate in many LMICs, with large disparities persisting between and within countries. Studies show that mean availability of essential NCD medicines in 36 LMICs is very low, and lower than availability for medicines targeting acute diseases. In the public sector, availability for NCDs was 36% compared to 54% for acute diseases, while in the private sector the comparison was 55% versus 66%.³ A particular issue is the insufficient access to controlled opioid analgesics for pain relief and palliative care. WHO estimates that there are 5.5 billion people living with little or no access to adequate pain treatment, of which millions endure pain due to acute illness or end of life.⁴

The unacceptably low access and availability of NCD services is often a symptom of weak health systems in LMICs. Despite changing disease patterns, many health systems are still characterized by fragmented health services, designed to respond to single episodes

of care rather than chronic conditions such as NCDs. Chronic conditions pose particular challenges to health systems, which are listed in panel 1.

In recognition of these challenges, governments have made substantial political commitments to improve access to medicines and technologies and strengthen health systems. Most notably, several commitments were made in the 2011 UN Political Declaration on NCDs, one of the six objectives in the WHO Global NCD Action Plan 2013–2020 focuses on health system strengthening, as do two of the nine global NCD targets (80% availability of quality essential medicines for NCDs in public and private health facilities worldwide, and 50% of eligible people receiving drug treatment and counselling to prevent heart attacks and stroke).

Policy implications and recommendations

The pathway to UHC presents a significant opportunity to scale up cost-effective, quality-assured NCD services to populations and communities in need, as well as transform health systems to respond more effectively to chronic conditions. It can be a crucial tool to support governments implement the health system objective of the Global NCD Action Plan 2013–2020, and drive progress towards the global NCD targets. To achieve these mutually reinforcing objectives, the following recommendations should be taken into consideration:

- **Establish a comprehensive package of NCD services:** Many countries are already introducing NCD packages into UHC programs.⁶ Several frameworks have been developed by WHO and others to help guide the prioritization, structuring and costing of comprehensive NCD packages (see panel 2 on page 4). WHO estimates that scale-up of this NCD package to 80% across all LMICs by 2025 would avert 37% of the global burden of cardiovascular disease and diabetes and 6% of the global cancer burden.⁷ It is well documented that the greatest impact will be achieved through delivery of the whole package, however where resources are limited, scale-up can be achieved in a phased approach. Governments must ensure NCD services span both prevention and treatment (see panel 3 on page 4).

Panel 1: The unique features of the NCD epidemic

Chronic	NCDs are chronic in nature, and sometimes life-long. People living with NCDs often have multiple interactions with the health system over long periods, and may require disability management and long-term care.
Multi-morbidity	NCDs frequently involve “multi-morbidity” — one person may suffer from two or more NCDs, or other linked diseases. With ageing societies worldwide and improvements in healthcare, multi-morbidity is increasingly becoming the norm, rather than the exception. ⁵ It creates significant challenges for health systems that are largely configured for individual diseases, and also generates disproportionate financial pressures on health systems and individuals.
Lifecourse	NCD risk begins as early as in-utero, and risk behaviors (e.g., tobacco use, alcohol abuse, lack of physical activity) and patterns of consumption of unhealthy products may start in childhood and adolescence. Specific interventions in childhood can prevent NCDs, such as vaccinations against cancers and NCDs in the young. At the other end of the lifecourse, older people are at increased risk of developing both NCDs and NCD-related disabilities.
Comprehensive	Progress on NCDs relies on a balanced approach to prevention and treatment, with inexpensive population-based and clinical interventions simultaneously pursued. The services in a UHC package must cover the full continuum of care, including health promotion, prevention, diagnosis, treatment, rehabilitation and palliation.
Multisectoral	The health sector is just one contributor to tackling NCDs. The major NCD risk factors — namely tobacco, alcohol use, unhealthy diets and physical inactivity — are driven by sectors as broad as finance, agriculture, trade, education and transport. Social determinants and people’s living conditions also play a critical role in vulnerability to the risks and consequences of NCDs. While UHC is an invaluable contribution by the health sector, it is not enough on its own to improve health outcomes and reduce the NCD burden.

Panel 2: WHO Package of Essential NCD Interventions (PEN Package)⁸

<p>Population-based interventions addressing NCD risk factors</p>	<p>Tobacco use: Tax increases; smoke-free indoor workplaces and public places; health information and warnings about tobacco; bans on advertising and promotion.</p> <p>Harmful alcohol use: Tax increases on alcoholic beverages; comprehensive restrictions and bans on alcohol marketing; restrictions on the availability of retail alcohol.</p> <p>Unhealthy diet and physical inactivity: Salt reduction through mass media campaigns and reduced salt content in processed foods; replacement of trans-fats with polyunsaturated fats; public awareness program about diet and physical activity.</p>
<p>Individual-based interventions addressing NCDs in primary care</p>	<p>Cancer: Prevention of liver cancer through hepatitis B immunization; prevention of cervical cancer through screening (visual inspection with acetic acid [VIA]) and treatment of pre-cancerous lesions.</p> <p>CVD and diabetes: Multi-drug therapy (including glycemic control for diabetes mellitus) to individuals who have had a heart attack or stroke, and to persons with a high risk (>30%) of a CVD event in the next 10 years; providing aspirin to people having an acute heart attack.</p>

- **Strengthen quality assurance:**

As governments scale up services in order to increase coverage, the quality of services must be maintained. A particular challenge for NCDs is ensuring safe, quality-assured essential NCD medicines and technologies due to poor quality control, procurement practices and regulation. In Rwanda for example, 20% of hypertensive medicines purchased on the market were of substandard content and 70% were of insufficient stability.¹⁰ Quality assurance systems and mechanisms established for other health issues, such as HIV/AIDS, could be drawn upon to improve quality and access for NCDs. Research, innovation, and cost-effectiveness are critical elements for improving quality of care.

- **Maximize opportunities to integrate health services:**

There is an imperative to pursue opportunities and solutions that integrate health services, with the aim of reducing cost, improving efficiency and achieving better outcomes. The “universalism” of UHC can help shift focus away from vertical, siloed health programs towards an integrated approach, particularly at primary healthcare level. It also provides an opportunity to build on past and current investments in LMICs for other health issues. Existing service delivery platforms for related health issues, such as for HIV/AIDS, TB, and maternal health, can be used to introduce risk assessment, early diagnosis and management of NCDs.¹¹ Furthermore, the training of the health workforce can be expanded to include NCDs (see panel 4).

- **Reorient health systems for chronic care:**

The implementation of UHC can assist LMICs in reorienting and strengthening their health systems to respond to chronic conditions, such as NCDs and multi-morbidity. NCDs require health systems that provide person-centered care with improved outreach and self-management to effectively manage and monitor risk factors, illness episodes and multi-morbidity over many years.¹²

- **Complement UHC with action to address social determinants:**

While UHC is an invaluable contribution by the health sector, it is not enough on its own to improve health outcomes and reduce the NCD burden. Addressing the social determinants, and adopting health-in-all-policies (HiAP) and whole-of-government approaches must be pursued as complementary and mutually reinforcing efforts to UHC.

Panel 3: Mexico's Seguro Popular

Seguro Popular (Popular Health Insurance), Mexico's UHC program, was introduced in 2003 with the aim of ensuring full access to healthcare for 50 million Mexicans by 2010. Subsidized by the federal and state governments, it covers the 52% of the Mexican population that was not previously covered by the social security system. It was recognized early on that the sustainability of the program depended on tackling some of the key determinants of health and NCDs. Therefore by law, at least 20% of the financial resources for *Seguro Popular* must be used for health promotion and prevention interventions.⁹

Panel 4: Health workforce, NCDs and UHC

Achieving UHC depends on human resources for health, without which national health systems cannot function. Yet today there is a global shortage of 7.2 million health workers.¹³ UHC requires improvements in health workforce recruitment, training, deployment, management, and retention. Community health workers (CHWs) and broader community systems are becoming increasingly important in sustaining and expanding decentralized health systems, particularly in LMICs. In countries such as Nepal, South Africa, Brazil, and Bangladesh, CHWs are supporting the expansion of NCD treatment and delivering comprehensive prevention services (including screening of hypertension and diabetes in the community), particularly to populations which are marginalized and do not use formal health services.

“With limited resources in all our countries, universal health coverage will become even more difficult unless more attention is given to prevention of illness and promotion of health”

— **Dr Aaron Motsoaledi**

South Africa Minister of Health, WHO Africa Region
NCD Stakeholder Dialogue, March 2013

2. Covering populations

UHC is described as the practical expression of equity and human rights. It provides a framework for addressing health inequities, and ensuring that disparities in access, uptake, coverage, and impact of health services are minimized across populations.

Inequalities in the NCD burden

NCDs are a public health issue in which major inequalities exist in terms of vulnerability and risk, access to services, and health outcomes. 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.

Within most countries, there is a strong socio-economic gradient for NCD outcomes. People of low socio-economic status and those who live in poor or marginalized communities have a higher risk of dying from NCDs than those in more advantaged groups.

Although the socio-economic patterns of major NCD risk factors differ by region and country, studies have demonstrated that smoking rates, blood pressure, and several other NCD risk factors are often higher in groups with low socio-economic status. In fact, social inequalities in risk factors account for more than half of the absolute inequalities in important NCD outcomes.¹⁴ Thus, equitable reductions in risk factor exposure are essential to reduce social inequalities in NCD outcomes.

There is also persistent inequality in access to NCD services, linked in part to stigma and discrimination. Populations in low-income countries and people with low socio-economic status have worse physical and financial access to health care, especially as related to timely diagnosis and treatment of NCDs. This limited access to screening, diagnosis, and treatment often leads to poor prognosis and survival in people with NCDs in LMICs.

Policy implications and recommendations:

With its intrinsic focus on equity, UHC provides a powerful vehicle to accelerate progress on reducing inequalities in health and NCDs. Health inequalities can be reduced by feasible actions by the health system, as well as other sectors that address broader social, economic, and environmental issues. The following recommendations should be taken into consideration, to ensure UHC design and implementation supports progress on NCDs:

- **Embrace progressive universalism:**

UHC policies must be pro-poor and make equity and universality explicit from the outset. The temptation to start with the “easiest to reach” in the formal sector must be avoided at all costs, as this will only exacerbate health inequalities. Governments must commit to “progressive universalism” — a determination to include people who are poor from the beginning,⁶ and aim for 100% coverage, including for NCDs.

- **Target vulnerable populations:**

A reduction of NCDs in vulnerable, marginalized or underserved populations is necessary to achieve substantial, equitable decreases in the total NCD burden. Targeted NCD interventions are required to complement population-wide approaches, particularly for indigenous people, women, children and the elderly.¹⁵



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Suaahara staff field test a health communication material in District of Dolakha, Nepal.

- **Empower communities and civil society:**

To eliminate the stigma and discrimination experienced by people living with NCDs, communities and patient networks need to be empowered to know and claim their right to health, as well as hold their governments accountable for delivering UHC. As the HIV/AIDS response has highlighted, strengthening civil society is core to reducing inequities and improving access and coverage. Community-based approaches in HIV/AIDS which have been particularly successful in mobilizing demand for quality services, as well as increasing accountability, should be drawn upon to support progress on UHC and NCDs.

- **Enabling policies, regulations and laws:**

Because access to health services is influenced by social, cultural and economic determinants, efforts to reduce inequalities need to focus on the broader enabling environment. Comprehensive, multisectoral and “whole-of-society” approaches are required, with action coordinated across a wide range of sectors and stakeholders. Policies, laws and regulations that improve opportunities and capabilities for economic productivity and social participation, and facilitate healthy lifestyles and environments are needed to complement the health system response.¹⁴

- **Strengthen information systems:**

Strong surveillance and information systems that can provide appropriately disaggregated data, are critical for identifying where inequities exist, informing the planning process, and monitoring implementation. Disaggregation by age, income level, sex, disability, migration status, and place of residence is essential to facilitate effective monitoring of both NCDs and UHC.

3. Covering costs

An effective health financing system is essential to fund UHC. According to WHO, the three main functions of a financing system are: 1) raising sufficient financial resources to cover the costs of the health system; 2) pooling resources to protect people from the financial consequences of ill health; 3) purchasing or providing health services to ensure the optimal use of available resources.

The economic burden of NCDs

The NCD epidemic poses challenges to these financing functions, by imposing a huge economic burden on national and household budgets. These diseases collectively impede economic growth by impacting on labor productivity, resulting in foregone national income, and trapping populations into chronic poverty.

At the national level, NCDs are contributing to extreme rises in direct medical costs which are draining health budgets. For LMICs, the cumulative lost output associated with the four main NCDs is projected to exceed US\$7 trillion between 2011 and 2025. This is roughly equivalent to \$500 billion per year, or 4% of the Gross Domestic Product of LMICs in 2010.¹⁶

At the household level, people with NCDs are driven into chronic poverty by direct or out-of-pocket payments (OOP) for health care costs — which is widely acknowledged as the most regressive form of health financing. In Africa, it is estimated that 100 million people are forced into poverty annually due to the exorbitant costs of NCDs, stifling development.¹⁷ For example, in Ghana, the lowest paid government worker will use 15 days' wages to pay for 1 month of the lowest price hypertension and diabetes treatment from a private pharmacy.¹⁸ OOP payments for NCD treatment and care can constitute a major barrier to access and are often an important source of financial hardship, catastrophic expenditure, and inequity.

Panel 5: Elena, Mexico

Elena, who lived in a rural area of Veracruz, was diagnosed with type 2 diabetes two years before Mexico started their UHC reform in 2003. Her husband was a farm worker who supported his wife, five children, and his parents, earning less than US\$300 per month. The family faced potential expenses for her medical treatment of more than US\$100 per month, so the family had to sell some of their belongings. But even then, the family could not afford regular treatment for Elena. Consequently, Elena regularly had uncontrolled diabetes as she had no access to glucose self-monitoring and insulin.¹⁹

Panel 6: Taxation on unhealthy products

Tobacco taxation: It is estimated that a 50% increase in tobacco excise taxes would generate US\$1.42 billion in additional funds in 22 low-income countries for which data are available. Many countries have introduced tobacco taxation; for example, in the Philippines, where new tobacco and alcohol taxes raised more than \$750 million in their first year, of which much was set aside to cover free health care for vulnerable populations.²⁰

Sugar-sweetened beverages taxation: Taxation on empty calories, such as sugar-sweetened beverages, can reduce the prevalence of obesity and generate public revenue. For example, to combat the world's highest obesity rate, Mexico enacted a "soda tax" in January 2014. Although it is too early to measure the impact, the National Institute of Public Health estimates that a 10% tax will reduce the 163 litres of soda Mexicans drink each year to 141 per year, preventing up to 630,000 diabetes cases by 2030.²¹

Alcohol taxation: Taxation on alcohol can reduce the prevalence of alcohol related disease and generate revenue earmarked for health promotion. For example, the Thai Health Promotion Foundation (ThaiHealth) is an independent state agency set up in 2001 and funded by a 2% surcharge tax of tobacco and alcohol excise tax. It currently spends approximately \$100 million on health promoting activities a year.²²

Policy implications and recommendations

In order to sufficiently respond to the interrelationship between NCDs and financing systems for UHC, the following recommendations and lessons learnt should be taken into consideration:

- **Leverage domestic innovative financing mechanisms:**

The response to NCDs has promoted innovative financing mechanisms to support domestic resource mobilization. Taxation on unhealthy products — such as tobacco, alcohol, saturated fats, and sugar-sweetened beverages — is particularly relevant to financing UHC. These are prioritized in the WHO Global NCD Action Plan 2013–2020, and The Lancet Commission on Investing in Health identified tobacco taxation as "the single most important opportunity for national governments worldwide to curb NCDs"⁶ Taxation on unhealthy products has the dual benefit of improving the health of the population through reduced consumption, while raising more funds. See panel 6 for some case studies.

- **Enhance international and south-south cooperation:**

For some LMICs, domestic funds may need to be augmented by international development assistance, at least in the medium term. Development partners' support can be catalytic in helping countries implement pathways towards UHC. To support progress on NCDs under the UHC framework, the international community's support must always be based upon the aid effectiveness principles (including country ownership), and have a health system strengthening and integration approach, rather than expand existing vertical health programs. Given the global nature of NCDs, there should be particular efforts to facilitate south-south and north-south cooperation. Emerging donors, such as the BRICS which themselves have significant NCD burdens and are embarking on pathways to UHC, can play an important role in facilitating south-south cooperation. The provision of technical assistance on fiscal policies, and funding of population, policy and implementation research on scaling up NCD interventions are two priority areas for south-south cooperation.

- **Improve financial risk protection:**

Given that people living with NCDs face high risk of catastrophic health expenditure due to the long-term nature of their illness and OOP payments, a fundamental goal of any health system must be the provision of financial risk protection (FRP). Three essential elements to improving financial protection are: expansion of prepayment and risk pooling over time to cover everyone, elimination of OOP

expenses at the point of service delivery for the poor for high-value health interventions, and provision of a more comprehensive benefit package as resources grow. Prepayment and risk sharing through tax-based or obligatory health insurance are the most efficient and equitable ways to increase population coverage and promote equity simultaneously.

• **Expand social protection schemes:**

Removing the financial barriers implicit in direct-payment systems will help poorer people obtain NCD care, but it will not guarantee it. Transport costs and lost income can be as prohibitive as the charges imposed for the service. Many countries are exploring ways to overcome these barriers by expanding social protection schemes to support NCDs, including Kyrgyzstan, Mexico, Thailand and Rwanda.¹² For example, conditional cash transfers where people receive money if they take certain action to improve their health (usually linked to prevention), have increased the use of services in some cases. Other

options include vouchers and refunds to cover transport costs, and microcredit schemes. In the case of Rwanda, funding from HIV programs has been used to expand health insurance coverage for poor sections of the population to improve access to health services, including those for NCDs.

• **Explore mixed models:**

Given the multisectoral nature of NCDs and the increasing role of the private sector in global health and human development, governments embarking on UHC pathways should consider mixed models that draw upon the strengths of both the public and private sector. Public-private partnerships (PPPs) can help develop and deliver innovations and solutions to support attainment of UHC in LMICs. In doing so, the state's ultimate responsibility for safeguarding the health of its citizens must be upheld, and the right governance structures need to be in place to ensure that equity of access to care is preserved and costs are effectively managed.

UHC AND NCDs IN THE POST-2015 ERA

As examples from Mexico, Thailand, Philippines, Rwanda and other countries demonstrate, commitment to UHC can be a powerful driver to improve health outcomes and equity for NCD prevention and control. Both at national and global levels, the goal of achieving UHC can help focus greater attention on health equity, coverage of quality services, strengthening and integration of health systems, and guaranteeing financial security and human rights for all.

As the expiry date of the Millennium Development Goals (MDGs) approaches, there is growing consensus for a new global health agenda for the post-2015 era. Under an overarching outcome-focused health goal, it is expected there will be an expanded scope of health priorities with the notable additions of NCDs and UHC. The WHO Global Monitoring Framework for NCDs is guiding the technical details of the NCD mortality target, and the UHC target is informed by the WHO/World Bank Monitoring Framework for UHC.

There can be no doubt that as a target for health in the post-2015 framework, UHC has the potential to unify a somewhat fragmented health agenda and ensure adequate attention to equity and human

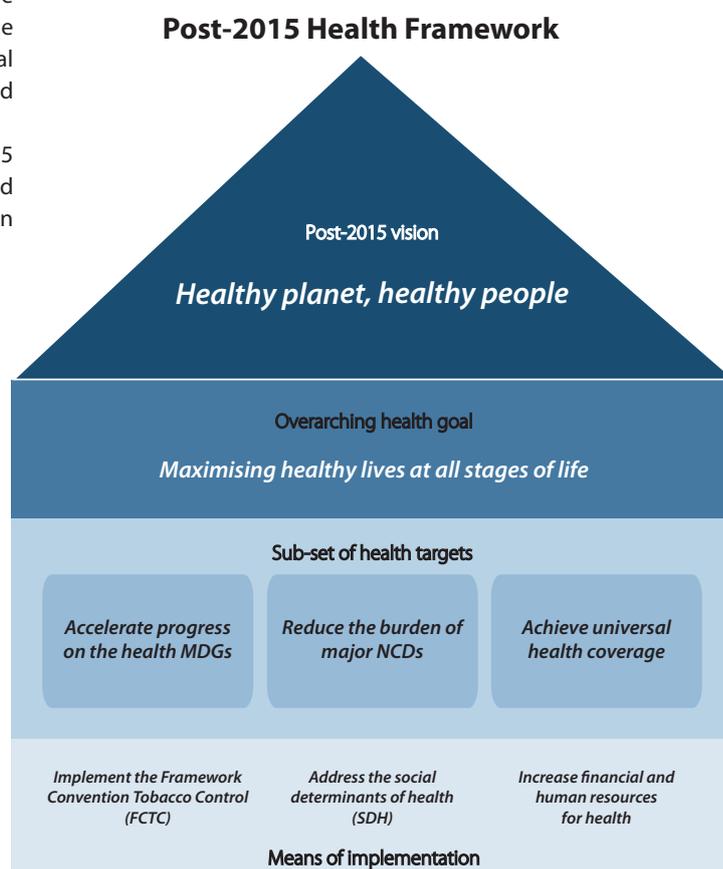
rights. But from a NCD perspective, it will be equally important to ensure continued political priority for addressing the underlying social determinants that shape health and NCDs more profoundly. Action on a much broader front than the health sector is required to meet the "25 by 25" NCD mortality target, and improve other health outcomes for the post-2015 era.

The diagram below illustrates the NCD Alliance's proposed framework for health in the post-2015 development agenda.

"Universal health coverage...will not in itself deliver higher health status. Action on a much broader front is needed, including on tackling the socio-economic determinants of health"

— **Helen Clark**

Administrator, UN Development Programme, Launch of the *Lancet Series on NCDs and Development*, Feb 2013



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