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Commentary

UHC Presents Universal Challenges

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“Universal health coverage” (UHC) is the current global rallying call in an ongoing movement aimed at strengthening national health systems to extend their reach and promote equity. The conceptualization of access to health care as a human right has developed over the past half century, but it was only in 2005 that the World Health Assembly endorsed UHC in connection with sustainable health financing. As with all slogans, the details of what UHC encompasses are complicated. UHC was defined as “access to key promotion, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access” (World Health Assembly Resolution 58.33). Subsequent World Health Reports (notably 2008, 2010, and 2013) promoted UHC to spread the risk of catastrophic expenditures for illness, through increasing prepayments and pooling financing systems. In 2012, the United Nations adopted a resolution naming UHC as a tool to promote overall human development and as a component of the post-2015 development agenda. Table 1 lists these and other selected landmarks in the movement for UHC.

Some global health leaders, notably David de Ferranti, have recently proposed that UHC represents the third grand transition in health. The first transition is the epidemiologic transition of disease profiles in a population; the second is the subsequent demographic transition toward low fertility and mortality with an aging population age structure. Considering UHC to be the driver of a third transition recognizes that national health systems aim to achieve three core goals: (1) reducing unnecessary mortality/morbidity, (2) ensuring patient satisfaction, and (3) preventing financial impoverishment from catastrophic costs of illness; they propose to achieve their goals through financial risk pooling.

UHC is always presented as a national responsibility. Yet, in an increasingly globalized world, what is the relevance of national boundaries? Why should the “global health community” promoting UHC not aim for true universality? How might those who advocate for UHC by nation-states begin to further conceptualize a genuinely global UHC in...
which every human being has financial protection against catastrophic costs of illness and access to at least a minimum set of services? One major challenge to the concept of globalized UHC is also, in fact, an argument against it. Many global processes and documents have steadily built up consensus that health coverage ought to be universal. This then begs the question: What is appropriate to cover universally? Thus, *priority setting* becomes an essential aspect of UHC. Priority-setting processes must be central to UHC, which, despite its name, cannot in fact include all services. Priority setting presents both methodological and political challenges. Methodologically, one common approach to priority setting is using cost-effectiveness analysis (of drugs, vaccines, and other interventions). This allows health systems to justify discarding coverage of interventions deemed ineffective or excessively expensive. Indeed, many countries with UHC use cost-effectiveness to compile a ranking of technologies and interventions.

Cost-effectiveness analysis is one approach in priority setting. Some systems use comparative burdens of diseases (generally quantified as magnitude of disability-adjusted life years) to rank priority intervention and diseases. In other situations, comparative analysis is used to go beyond categorical analyses, allowing health systems to account for related approaches such as female education, water sanitation, clean
environment, public health prevention, etc. All methods face the problem that holistic health interventions cannot be broken down easily according to their subcomponents, such as specific technologies. Moreover, it is virtually impossible to assign costs of entire health systems infrastructure to the interventions’ subcomponents.

Beyond questions of which methodologies to use to determine priorities looms another key question: Who should undertake the prioritization? National policy makers often take it upon themselves, frequently employing both technical and political analyses and needing to respond to special interest groups (including providers) that bring political pressure to bear on specific priorities. Patients’ and the general public’s perspectives are increasingly being taken into account, thanks to the expansion of democratic processes in countries around the world and in light of increasing adherence to human rights principles promoting local self-determination.

Context-specific priorities exist that must be taken into account. Many countries have a unique history of traditional medical practices that are still active. For example, traditional medicine practitioners remain the primary health care provider for millions of people in some rural Southeast Asia regions. In China, access to traditional medicine and its rich heritage might be culturally necessary. A drug for treatable childhood leukemia, Huangdai tablet (Realgar–Indigo naturalis formula), is derived from traditional Chinese medicine.

Successful implementation of UHC at the national level depends on compromises on the parts of various stakeholders, including policy makers, providers, payers, insurance companies, product manufacturers, and patients. The need for local engagement in the process of setting priorities limits the feasibility—and desirability—of a global approach to health coverage. Similarly, the core concept of UHC is securing adequate and effective financing and ensuring risk protection through pooling of funds. Financing necessarily comes from different sources in different countries, and no country has achieved complete coverage relying solely on one single financing strategy. This further demonstrates the relevance of the specific context to meeting the requirements of UHC. Finally, proper monitoring must be conducted of both private and public inputs that go into a mixed pooling financing system, and this requires on-the-spot local engagement.

The movement for UHC faces important questions about how to relate to targeted health initiatives. How do the various vertical disease movements link to financing, structure, and service delivery in a horizontal health system? Following the example set by the AIDS treatment movement, in recent years several major global initiatives have been proposed—on noncommunicable diseases, maternal health, child health, cancer, surgery, and pain control, among others. Although these movements utilize the terminology of universality, few cite UHC, much less articulate how they interact with the UHC movement. Do these individual initiatives reinforce or compete with UHC? Should the UHC movement develop explicit alliances with each? This remains to be seen.

A final observation: a fundamental assumption of the UHC movement is that an effective health care delivery system exists, which can then be complemented by health care financing and insurance coverage. Ultimately, modalities of setting coverage priorities and financing are meaningless without a health care system that is capable of providing services to prevent and treat diseases. Legitimate questions have been raised about whether, and how much, the UHC movement acknowledges this aspect of universal health coverage. For UHC to meet its goals, the components of the health care delivery system, including health workforce, technologies, and information systems, also require attention.

Achieving UHC is not easy. The wealthy United States, for example, only began to move toward covering large segments of its uninsured population with the Patient Protection and Affordable Care Act of 2010 (also known as Obamacare). But the political and priority-setting processes that enabled the policy to come into force required major compromises. In particular, President Obama’s administration had to make significant concessions to the pharmaceutical and insurance industries. Arguably, the Obamacare negotiations demonstrated that UHC advancement could jeopardize the interests of pharmaceuticals and private for-profit insurance. Compromises and concessions from various stakeholders are necessary to realize UHC.

Despite all of these complexities, UHC is the latest manifestation of a recurring motif in a social justice–inspired approach to global health. Universalism in health was a theme throughout much of the 20th century, and it clearly continues to resonate in the 21st century. Ultimately, the true achievement of UHC across the globe will represent the fulfillment of a basic human right, most especially for those who have the least political voice and the greatest need for access to health care. To ensure their true involvement in the processes of priority setting, for now UHC needs to retain some local aspects. But perhaps that can ultimately prove to be just one milestone in a longer-term movement toward truly global universal health care.
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