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Commentary

Will Universal Health Coverage (UHC) lead to the freedom to lead flourishing and healthy lives?

Comment on "Inequities in the freedom to lead a flourishing and healthy life: issues for healthy public policy"

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Abstract
The focus on public policy and health equity is discussed in reference to the current global health policy discussion on Universal Health Coverage (UHC). This initiative has strong commitment from the leadership of the international organizations involved, but a lack of policy clarity outside of the health financing component may limit the initiative's impact on health inequity. In order to address health inequities there needs to be greater focus on the most vulnerable communities, subnational health systems, and attention paid to how communities, civil society and the private sector engage and participate in health systems.
Keywords: Health Equity, Universal Health Coverage (UHC), Complexity, Participatory Action Research, Healthy Public Policy

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The article "*Inequities in the freedom to lead a flourishing and healthy life: issues for public policy*" lays out both the causes and the complexities of inequities and makes a strong case for the issue of inequity to be taken up in any consideration of healthy public policy (1). To make this happen the paper asserts that tackling health inequities is a political issue that requires leadership, political courage, progressive public policy, social struggle and action, and a sound evidence base.

The global health policy on Universal Health Coverage (UHC) is currently taking centre stage in discussions leading to the health component of the Sustainable Development Goals (SDGs) (2). This commentary will explore Friel's framing of effective action to address health inequities as it applies to the UHC initiative.

The goal of UHC is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them (3). This is of course not the first time there has been an attempt to deliver on such an aspirational objective. The previous attempt was "Health For All by the Year 2000" (4). It was led by World Health Organization (WHO) and launched in 1978 following the Alma Ata Declaration with a 22 year time horizon, and shared some of the components of UHC. UHC places greater emphasis on service coverage and financial protection, while "Health For All" put greater emphasis beyond the health sector. In the words of its architect, Halfdan Mahler (5):

"*Health For All implies the removal of the obstacles to health – that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines*".

The "Health For All" approach was not backed by other development partners including the World Bank, who supported instead specific disease and interventions model (6), beginning what one commentator at the time called the counter revolution (7) against primary healthcare. This divergence of view, based on both the practicalities of the approach and the underlying opposing development paradigms shaped the relationship between the organisations and the health development agenda for more than a decade (8).

The structural challenges both organisations face at the governance level add to the risks of policy divergence. WHO's structural problem is the disconnect between its policy positions and the resources the organisation controls to support implementation of its own agenda. Assessed contributions as a percentage of total income have halved in the last two decades (9) and now represent only 24% of income. The remaining 76% comes from voluntary contributions from a small group of state and non-state donors, who choose directly how their money is spent. So although primary healthcare has had strong member country backing for three decades (10) full scale implementation has fallen short (11).

The World Bank's structural problem is the ongoing lack of legitimacy in the eyes of developing countries (12). Its governance arrangements have not kept pace with changes in the global political and economic order. WHO has the legitimacy but not the money, the World Bank has some money but not the legitimacy.

Given that there are no quick fixes to either of these

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structural problems, and both legitimacy and resources are required to tackle global health policy problems, it is heartening to see the leaders of the two organisations speaking from the one page on UHC. The Director General of WHO, Margaret Chan is strongly emphasising its importance, and is explicitly linking it back to primary healthcare (13):

"I regard universal health coverage as the single most powerful concept that public health has to offer. It is inclusive. It unifies services and delivers them in a comprehensive and integrated way, based on primary healthcare".

World Bank group President Jim Kim (14) sees UHC as a core plank to poverty reduction and also includes "resilient primary healthcare systems" in his recipe for effective implementation:

"Countries need to invest in a resilient primary healthcare system to improve access and manage healthcare costs".

The other significant change since "Health For All", is the mounting evidence of the negative impact of inequity, on both society and the economy. It was inconceivable thirty years ago that the Organisation for Economic Cooperation and Development (OECD) (15) would declare inequality as negatively impacting on growth in developed economies, or that the president of the World Bank would be complaining about wealth accumulation of the super-rich (16) and observe;

"The national income gains from growth tend not to be shared among a population in anything close to equal measure".

The coherency seen from the leadership is less reflected in the policy analysis being undertaken to implement UHC. A review of existing evidence (17) for UHC by the World Bank states:

"The UHC concept does not imply—or advocate for—a particular health system organization".

This lack of clarity about what UHC means in terms of service delivery is understandable given the troubled history, but it will threaten effective implementation unless some guidance is provided (18).

The two organisations are attempting to fill this policy vacuum by publishing potential indicators (19) for UHC. A recent review of the indicators points to the risks they run of potentially making equity worse (20). This concern echoes the experience with the Millennium Development Goals (MDGs) (21) where countries could achieve global goals without paying attention to hard and expensive to reach communities.

An alternative approach would build on the experience of those countries who have been effective in reducing health inequities as they have moved towards UHC. In both Brazil and Mexico, they started with the most deprived communities first, and did not rely on 'trickle down' (22) mechanisms to address the issue for the poor. There is also a call to place more emphasis on subnational health systems (23,24), to better focus on the delivery of services to the poorest communities in each country, be they rural or urban. This would require a response of building effective district level institutions, capable of preventive, curative, rehabilitative activity (be it public, private, NGO or faith based) at the local level. It would place the main emphasis on building local (rather than global) health information systems and information priorities. Without such an approach, the chances of UHC failing to live up to its equity promise is considerable.

In conclusion, how does the global UHC policy compare with Friel's criteria of leadership, political courage, progressive public policy, social struggle and action, and a sound evidence base? It has certainly been established as a political issue of high importance in the context of the SDGs, and some courage is being demonstrated from the two leaders of the lead agencies. The policy itself is less well developed, and the risks of addressing global policy primarily through a global monitoring and targeting mechanisms have not been adequately addressed (25). Supporting social struggle and action is a weakness of the current approach, and the soundness of the evidence base remains a work in progress.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

DM is the single author of the manuscript.

References

1. Friel S. Inequities in the freedom to lead a flourishing and healthy life: issues for healthy public policy. *Int J Health Policy Manag* 2014; 3: 161-3. doi: 10.15171/ijhpm.2014.82
2. Open Working Group proposal for Sustainable Development Goals [internet]. Available from: http://sustainabledevelopment.un.org/focussdgs.html
3. World Health Organization (WHO). What is Universal Health Coverage [internet]. 2014. Available from: http://www.who.int/features/qa/universal_health_coverage/en/
4. World health report: Achieving health for all [internet]. Available from: http://www.who.int/whr/1998/media_centre/executive_summary6/en/
5. Mahler H. The Meaning of "Health for All by the Year 2000". *World Health Forum* 1981; 3: 5-22.
6. Walsh JA, Warren KS. Selective primary health care: An interim strategy for disease control in developing countries. *Social Science & Medicine. Part C: Medical Economics* 1981; 14: 145-63. doi: 10.1016/0160-7995(80)90034-9
7. Newell KW. Selective primary health care: the counter revolution. *Soc Sci Med* 1988; 26: 903-6.
8. Brown TM, Cueto M, Fee E. The World Health Organization and the Transition from "International" to "Global" Public Health. *Am J Public Health* 2006; 96: 62-72. doi: 10.2105/AJPH.2004.050831
9. World Health Organization (WHO). Financing of the World Health Organization. 2011. Available from: http://apps.who.int/gb/ebwha/pdf_files/EBSS/EBSS2_ID2-en.pdf
10. Chan M. Dr Margaret Chan Director-General elect: Speech to the First special session of the World Health Assembly Geneva. 2006. Available from: http://apps.who.int/gb/archive/pdf_files/WHASSA1/ssa1_div6-en.pdf
11. World Health Organisation (WHO). The World Health Report 2008 - Primary Health Care (Now More Than Ever) [internet]. Available from: http://www.who.int/whr/2008/en/
12. Vestergaard J, Wade RH. Protecting Power: How Western States Retain The Dominant Voice in The World Bank's Governance. *World Dev* 2013; 46: 153-64.
13. World Health Organization (WHO). Universal Health Coverage [internet]. Available from: http://www.who.int/universal_health_coverage/en/
14. Kim JY. Speech by World Bank Group President Jim Yong

Kim on Universal Health Coverage in Emerging Economies [internet]. Available from: http://www.worldbank.org/en/news/speech/2014/01/14/speech-world-bank-group-president-jim-yong-kim-health-emerging-economies
15. Cingano F. Trends in Income Inequality and its Impact on Economic Growth (No. 163). OECD; 2014. doi: 10.1787/5jxrjncwxv6j-en
16. Kim JY. Speech by World Bank Group President Jim Yong Kim at Council on Foreign Relations: "Count on Us." [internet]. 2014. Available from: http://www.worldbank.org/en/news/speech/2014/04/01/speech-world-bank-group-president-jim-yong-kim-council-on-foreign-relations
17. Giedion U, Alfonso EA, Diaz Y. The impact of universal coverage schemes in the developing world: a review of the existing evidence. The World Bank; 2013.
18. O'Connell T, Rasanathan K, Chopra M. What does universal health coverage mean? *Lancet* 2014; 383: 277-9. doi: 10.1016/S0140-6736(13)60955-1
19. World Health Organization (WHO), World Bank Group (WBG). *Monitoring Progress towards Universal Health Coverage at Country and Global Levels : Framework, measures and targets*. 2014. Available from: http://apps.who.int/iris/bitstream/10665/112824/1/WHO_HIS_HIA_14.1_eng.pdf
20. Rodney AM, Hill PS. Achieving equity within universal health coverage: a narrative review of progress and resources for measuring success. *Int J Equity Health* 2014; 13: 72. doi: 10.1186/s12939-014-0072-8
21. Moser KA, Leon DA, Gwatkin DR. How does progress towards the child mortality millennium development goal affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data. *BMJ* 2005; 331: 1180-2. doi: 10.1136/bmj.38659.588125.79
22. Gwatkin DR, Ergo A. Universal health coverage: friend or foe of health equity? *Lancet* 2011; 377: 2160-1. doi: 10.1016/S0140-6736(10)62058-2
23. Brixi H, Mu Y, Targa B, Hipgrave D. Engaging sub-national governments in addressing health equities: challenges and opportunities in China's health system reform. *Health Policy Plan* 2013; 28: 809-24. doi: 10.1093/heapol/czs120
24. Meessen B, Malanda B. No universal health coverage without strong local health systems. *Bull World Health Organ* 2014; 92: 78-A. doi: 10.2471/BLT.14.135228
25. Fehling M, Nelson BD, Venkatapuram S. Limitations of the Millennium Development Goals: a literature review. *Global Public Health* 2013; 8: 1109-22. doi: 10.1080/17441692.2013.845676