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Sustaining Universal Health Coverage: The Interaction of Social, Political, and Economic Sustainability

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ABSTRACT

The sustainability of health care systems, particularly those supporting universal health care, is a matter of current discussion among policymakers and scholars. In this article, we summarize the controversies around the economic sustainability of health care. We attempt to extend the debate by including a more comprehensive conceptualization of sustainability in relation to health care systems and by examining the dimensions of social and political sustainability. In conclusion, we argue that policymakers when taking

decisions around universal health care should carefully consider issues of social, political, and economic sustainability, their interaction, and often their inherent trade-offs.

Keywords: social, political, economic, sustainability, trade-offs, universal health coverage.

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Introduction

The issues of how to move health care systems to universal health care and how to sustain and improve them in the long term are a matter of debate for most countries [1]. Universal health care (UHC) is prominent on the political agenda of fast developing countries, such as Brazil, Russia, China, and India, that face a growing demand for health care and other welfare services in a complex context that combines rapid economic growth, an increasing population, and socially and economically polarized societies [2,3]. UHC is also on the political agenda of most industrialized countries, albeit in different ways. In the case of the United States, UHC has become a source of continuous political conflicts and controversies on the very nature of the country's welfare system [4]. In Europe, UHC is similarly under attack. The idea, fuelled by the current economic crisis, that the vast range of benefits accumulated over the decades by European health care systems should now be considered privileges that cannot be guaranteed to the entire population permeates the discourse on health care.

UHC also features in the policies and recommendations of international organizations. UHC is part of the Millennium Development Goals (also in their redefinition by the United Nations), was the main topic of the World Health Report in 2010 and, implicitly, of several earlier reports (e.g., the World Report 2008 on primary care), and was one of the main items for discussion in the Tallinn Charter on health systems for health and wealth in 2008. Previous contributions on this issue identify

and discuss a variety of elements, including actors, competences, processes, and instruments, that can reinforce UHC and that, when lacking or not well implemented, threaten principles of equity and solidarity that are at the basis of UHC.

Most of the current debate on UHC centers on its sustainability, but, despite this high degree of attention, the discourse remains almost exclusively focused on the *economic* sustainability of UHC. Can we, and future generations, afford UHC? Can we, and future generations, afford health care systems that guarantee this principle?

In this study, we attempt to widen the debate surrounding UHC by reframing and expanding the conceptualization of sustainability to include its additional facets, particularly its social and political dimensions. We embrace the broader definition of sustainability offered by the Hawke Research Institute in Australia [4] and adapt it to the case of health care systems. According to this perspective, sustainable systems are "equitable, diverse, connected and democratic and provide a good quality of life" [5]. In addition, their formal and informal processes, structures, and relationships make systems durable over time such that both current and future generations can collectively benefit from their features.

In the case of health care, we argue that *social* and *political* sustainability are equally fundamental and desirable features of a health care system. Therefore, in our view, the discussion around the viability of UHC can only benefit from examining, on the one hand, how and to what extent UHC affects the social and political

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sustainability of health care and, on the other hand, the social and political conditions that might be facilitating or hindering factors for achieving UHC. In addition, it might be helpful to the debate to foresee potential trade-offs among these objectives.

In the following sections, we consider in detail these three dimensions of sustainability and provide a brief summary of the theoretical approaches and evidence that have emerged in the scholarly literature concerning each concept. Next, we conclude with several suggestions for policymakers.

Economic Sustainability

The current focus on the economic dimension of sustainability of UHC likely derives from the long-standing debate on the relationship between health care spending, health, and wealth that has been the focus of the scholarly discussion for decades.

After World War II, most advanced capitalist economies invested heavily in providing welfare services, such as health care, leading to a rapid expansion of coverage and insurance and to a concomitant increase in public expenditure [6,7]. At that time, the trend was considered an indicator of progress and a sign of the capacity of states and the public sector to promote development. Since the 1960s and 1970s, however, empirical studies have shown that across most Organization for Economic Cooperation and Development countries, and most notably in the United States, the growth rate of total health care expenditure outpaced the increase in the gross domestic product [8]. These findings started to raise concerns about the affordability of health care in the end and the potentially high opportunity costs of investing in health care instead of other sectors and activities [7,8]. In the 1990s, the advent of a neoliberal political ideology and of a “market” paradigm in public policy put health care spending under further scrutiny and often equated it with the inefficiencies of an excessively “big government” [9,10].

Because of the dynamics of globalization, there has been a heightened concern about the increase in health care expenditure and its potential to hinder economic growth. First, the increased mobility of people and the rapid diffusion of information about new opportunities for treatment and medical technologies have amplified the demand for health care services and made it difficult to reach an efficient equilibrium between demand and offer. Second, technological progress and the introduction of costly medical technologies (drugs and devices) in health care systems have been shown to drive a conspicuous part of the growth in expenditure with very limited means to control this increase [11–13]. Note that the development of most evidence on the contribution of technology to health care expenditure growth has been with data from the United States and might therefore be peculiar to this case. It is known that both demand for and prices of medical technologies are on average higher in the United States in comparison to Europe. For instance, high-tech care is more likely to be considered synonymous with better-quality care by US citizens than by their European counterparts [14]. In addition, unlike in Europe, policymakers in the United States have long refrained from adopting measures of price control over drugs and devices and from applying criteria of cost-effectiveness to reimbursement decisions [8,15].

Independently from the factors that determine the growth of health care costs, current forecasts for health care spending in many industrialized countries, regardless of whether they have implemented UHC, are alarming [16,17]. It is not surprising, therefore, that present proposals on the issue of the economic sustainability of health care, particularly UHC, devise progressively more refined financing structures to meet the requirement for long-term sustainability. Mixing public and private approaches to health financing and contribution-based health care with tax-financed inputs are some of the solutions available

to policymakers [18]. Attention appears to be focused on how to collect sufficient resources to sustain health care systems and, where it exists, UHC. If we consider that the middle class in industrialized countries are squeezed between higher taxation and unemployment rates and that employers struggle to be competitive in the global scenario, higher private spending appears not only infeasible but also unacceptably harsh on those whom the health care system serves.

Although health care has been portrayed as draining wealth, evidence has progressively accumulated to show that, on the contrary, investments in health (and health care) are effective strategies in both developing and developed countries not only to reduce poverty but also to pursue economic growth through increased productivity and higher household income [19–21]. Currently, and with the sole exception of the United States, countries that are actively pursuing UHC, such as South Korea, Mexico, and Turkey [22], are at the lower end of the income threshold, indicating that investments in health care for all are still deemed not only desirable but also feasible. The recent experiences of Taiwan and Thailand, despite their difficulties, show that introducing UHC has not necessarily meant unaffordability or an inconsiderate rise in health care expenditure [23,24]. Even if they are affordable, however, will these investments in UHC translate into health benefits?

The link between spending and health outcomes has been as controversial as the relationship between health care and economic growth. This issue is of particular relevance in the debate over consolidated universalist health systems, in which achieving further health gains appears to require unaffordable new investments. In the past, the literature has provided inconclusive results regarding the contribution of health care expenditure to health outcomes [25]. The case of the United States has often been proposed as the clearest example of a health care system that, if compared with other Organization for Economic Cooperation and Development countries, displays “more-than-expected spending” with “less-than-expected life expectancy” [26]. More recently, however, evidence of a positive relationship between spending and health outcomes has begun to emerge in studies that compare either health care systems at the macro level [e.g., 27–30] or local health authorities/organizations and their processes of care at more meso- and micro levels [e.g., 26,31,32]. Macro-level studies have shown that total health care costs or investments in human capital for health (e.g., number of doctors and nurses) contribute to reducing overall and infant mortality and, more rarely, to increasing life expectancy. Several methodological challenges, however, remain in this type of analyses, given the difficulty in isolating the impact of spending from all other determinants and the potential endogeneity of several of the explanatory variables utilized in the studies [25].

Among the evidence emerging from meso- and micro-level studies, several cases are drawn from UHC systems, such as Canada and the United Kingdom. For instance, Martin et al. [25] assessed the benefits of program budgeting in England across primary care trusts and showed that health care expenditure had “a demonstrably positive effect” on mortality rates in five of the care programs investigated by the researchers. Similar results have been obtained by Crémieux et al. [31] who compared health outcomes and different cost items in health care spending across 10 Canadian provinces. Stukel et al. [32], instead, analyzed all Ontario hospitals and demonstrated that patients admitted to higher-spending hospitals had better outcomes in terms of mortality, readmission rates, and major cardiac events. The most interesting aspect of this work is that the authors managed to unpack the black box of “spending” and to uncover the “cost items” that contribute to the difference: the nursing staff ratios, the frequency of medical specialist visits, the type of interventional and medical cardiac therapies, and the nature of

preoperative specialty care and postdischarge collaborative care [32]. In other words, this work highlights how certain building blocks of health care systems (e.g., professional competence, evidence-based technologies and treatments, interprofessional collaboration, organization of processes of care) transform health care into health, and as such are a worthwhile investment.

This literature draws attention to the fact that UHC or health care spending per se is not economically unsustainable but rather the part that is poorly allocated and wasted without producing health. Dealing with economic sustainability means devising better ways to assess what are critical, defining priorities in the allocation of resources and, simply, getting the most out of health care systems. In principle, this is not very different from what has been done in other sectors that, when facing issues of long-term sustainability, have not revised their core principles but rather have redesigned their work processes to be more efficient and effective. Some prominent scholars have proposed that a more explicit analysis of health care costs might be a critical step in the understanding of how costs are generated and in solving the efficiency issue [33,34]. We suggest that the production of evidence on the economic sustainability of health care, particularly UHC, is a much wider research enterprise that entails an analysis of the processes, competences, and organizational models that make a difference for health. Researchers in health management and economics might be in a privileged position to work with both policymakers and managers in the analysis of data and information, including information on costs, with the explicit aim of supporting priority-setting decisions. These decisions have the potential to be based on justifiable and reasonable arguments about why some things are prioritized and others are not, grounded in the reality of health care organizations and systems.

Social Sustainability

The term “sustainability” emerged in the 1960s in the domain of environmental policy, prompted by concerns about the negative ecological consequences of economic growth and the dominant paradigm of development. A sustainable ecosystem was defined as one that could maintain “the capacity to support life in quantity and variety” [35], a system with an inherent resilience and regenerative capacity that must be respected and guaranteed by development. In the 1980s, consensus was achieved and sustainable development was defined as growth that “meets the needs of the present without compromising the ability of future generations to meet their own needs” [36]. Since then, the conceptualization of sustainability, especially through the discourse on the “triple bottom line” and corporate citizenship, has expanded to include social, in addition to environmental and economic, concerns. The meaning of being “socially sustainable” has not been completely clarified to date, but consensus is emerging on the fact that equality, diversity, democracy, and interconnectedness represent relevant features of social sustainability [5]. Keeping this consensus definition in mind and with reference to health care, we pose this question: did UHC take health care, our health care systems, and us closer to being socially sustainable? It is undeniable that health care, especially when provided universally, promotes equality. With the introduction of universal care, for instance, disparities in service utilization and access across socioeconomic classes tend to decrease [37,38], although the health status gradient never completely disappears [39,40]. Furthermore, UHC coverage implies a sense of solidarity and interconnectedness within a society as members agree to pool resources to guarantee at least an acceptable level of response to those in need. The effort to define essential levels of care and benefit packages that has accompanied most processes of UHC initiation testifies to the

need to define the basic right to health care and health that societies can guarantee to their members. Although it is difficult to measure the positive effects of the interconnectedness and solidarity at the basis of UHC, studies have shown the negative consequences, both at the individual level and at the community level, of the lack of UHC, especially in countries in which the comparison between the uninsured and those who enjoy coverage can be easily seen. In addition to impoverishment, individuals without coverage experience a sense of social exclusion, vulnerability, and distrust of public institutions [41]. The differences in opportunities and economic status typical of socially polarized countries only worsen these effects. For communities, the negative impacts are equally evident, with a lack of health care coverage leading to diminished levels of social capital and mutual respect [42]. In summary, we can say that health care systems, mainly through UHC, generate positive social spillovers (or social value) well beyond health that characterize health care systems as socially sustainable.

Much remains to be done for health care systems to achieve or maintain social sustainability. Guaranteeing diversity, for instance, requires that policymakers, managers, and professionals in health care systems acknowledge and respect the sources of diversity in the societies they serve, including gender, race, and age. In the recent past, things may not have worked in this direction. For instance, the urge to achieve UHC may have led emerging countries to neglect the need for diversity in approaches to care, resulting in universal (i.e., one-size-fits-all) care.

The discourse on essential levels of care, mentioned above as a source of equality and solidarity provided by UHC, might be seen as contributing to the homogenization of approaches to care. In addition, a tendency toward standardization of care as an instrument to achieve efficiency has swept across most health care systems. The portrayal of standardization, in health care as in other sectors, has been in opposition to the wastefulness of diversification. As such, the diversification and the personalization of health care services have been limited to peripherals (e.g., technologies, hotel-like accessories and services in hospital rooms) instead of core activities. The respect for diversity that is implicit in the social sustainability of health care systems requires a different approach, which assumes biological diversity and focuses attention on developing services and, most importantly, relationships between patients and health care professionals that consider cultural and socioeconomic sources of diversity among individuals. Sufficient evidence has accumulated on the impacts of diversity (for instance ethnic and racial) on health and health care access to encourage the prompt consideration of the issue. For instance, a large presence of migrants within a society makes respect for cultural and socioeconomic diversity a matter of great social relevance.

As specified at the beginning of this paragraph, a socially sustainable health care system should also be “democratic,” or based on a high degree of participation by its societal members [5]. Once again, UHC may not have developed in parallel with this dimension of social sustainability. Not considering the case of authoritarian and centrally planned states such as the former Soviet Union, in most well-consolidated, universalist health care systems, civil society, through social movements and unions, has played a fundamental role in the demand for UHC, and this process has accompanied the development of modern liberal democracies. Once achieved, however, UHC has often been taken for granted, and its maintenance and implementation have been delegated to laws (e.g., constitutions) and states without much active participation by civil society. Recently, top-down reforms promoted by national-level policymakers, reforms that did not necessarily consider structured ways to guarantee involvement and ownership by citizens in their systems, introduced UHC.

Nevertheless, civil society has developed alternative, mainly horizontal, ways to have its say about health and health care services, as demonstrated by the intense flow of information on these issues on the Internet, the numerous patients' associations, and the level of their advocacy activities at both the domestic and international levels [43]. Achieving a socially sustainable (i.e., "democratic") health care system would require this activism to work for the benefit of the health care system. For this purpose, citizens should be more directly involved in determining priorities and their criteria, and in shaping a health care system that can better respond to collective expectations.

Attempts to include citizens and patients directly in priority setting exercises in several countries have met with mixed results [e.g., 44–46]. Despite the positive benefits of such experiences (i.e., empowerment, sense of belonging, and accountability of citizens), problems remain. For instance, it is unclear how the few individuals involved in this kind of exercise can be representative of the diversity of preferences and interests of society [46]. The appropriate channels and modalities for the participation of civil society in health care systems are probably still to be worked out, but it remains that they might be the only means to allow a health care system to renew itself by adapting and improving and are, therefore, critical for its resilience and sustainability.

Political Sustainability

The dimension of social sustainability that just discussed the level of democratic participation by citizens/patients within the health care system hints at a more political connotation of the concept of sustainability but does not exhaust it. With the term political sustainability, in fact, it is to be intended the development and maintenance of the political will necessary to sustain a major policy direction in the health care system [47]. Political sustainability is not a loose consensus concerning issues; rather, it is a long-lasting alignment of the interests and belief systems of the most important political forces shaping health policies and their implementation, namely, political parties, elected representatives, and different parts of government or different tiers of the public administration, such as central and state bodies. The literature has not explored much the concept of political sustainability of health care systems and UHC, and the negative effects of a lack of political sustainability have not been measured to date. We have no doubt, though, that the costs of persistent political conflict can only represent a burden for the development and viability of a health care system in the long run.

Universal health care reforms or active policies to sustain UHC are considered the testing ground for the type of political alignment that this dimension of sustainability entails. Debates among political forces over UHC often imply an explicit declaration of objectives and values and, as such, are critical to distinguish who is on board and who is not, who shares a similar vision of society and of how to guarantee the health of a population, and who has a different perspective. The cases of several countries (e.g., Italy and the United Kingdom) show how the political process leading to the establishment of UHC has been frequently characterized by the convergence on this specific point of parties that dramatically differ from an ideological standpoint [48,49].

Debates on how to establish or maintain UHC also uncover the distribution of power across different parts of government (most often, the Ministry of Health vs. the Treasury) or across different tiers of the public administration. For instance, the recent health care reform in the United States, apparently enacted entirely at the federal level, had a strong catalyst in the state of Massachusetts's initiative for guaranteeing universal access to health care [50]. From several quarters, this initiative

has been recognized as the "political, rather than policy, blueprint" for the Obama reform, given the bipartisan and biideological support that it has received at the state level of government [50]. At the same time, the current state challenges to the Affordable Care Act dramatically weaken the overall reform and signal the misalignment between central and state governments.

Debates over UHC normally also disclose the influence that interest groups, such as health care professionals and technology manufacturers, manage to exercise on the health policy arena through lobbying and advocacy activities. The case of the establishment of Medicare in the United States is, in this sense, emblematic [51]. The lengthy political process leading to the approval of this universalist health insurance program for the elderly saw the strong involvement on opposite sides of powerful pressure groups, such as the American Medical Association, the American Federation of Unions, and national associations of retired workers [51]. The fierce battle they fought was a sign of a much deeper polarization in society over "redistributive" issues, a polarization that was simply mirrored at a political level [51]. That is, political sustainability is primarily the result of the action of traditional political actors, but broader constituencies and stakeholder groups most likely influence it.

Achieving political sustainability, on the one hand, requires the willingness of political forces to align, identify points of convergence, and put themselves into each other's shoes for the sake of health and health care. On the other hand, it might be facilitated by an appropriate governance structure able to create a platform for dialogue and consensus both among political parties and among different parts or tiers of government. In addition, this governance structure might benefit from transparent and structured processes to consult relevant stakeholders outside the political system, such as technology producers, health care professionals, and patients' associations. The governance arrangements to be explored for this purpose are numerous. One notable example is the US Federal Executive Steering Committee on Mental Health that gathers, besides high-level representatives of health care federal agencies, other departments (e.g., education, labor, justice, and housing) with policies that might affect the specific domain of mental health. Not only do these officials and policymakers sit at the same table, but they have also developed a common political agenda to make services for mental health more universally accessible in the United States through formal engagement with a number of external stakeholders, such as schools, universities, and patients' advocacy groups [52].

In summary, political sustainability appears to be an essential element, like economic and social sustainability, for a health care system to achieve UHC. At the same time, by keeping health care issues on the policy agenda of many countries for a long time and by stimulating an alignment among the most relevant political forces, UHC has also partly contributed to making health care systems more politically sustainable.

Conclusions

We have attempted to summarize and rephrase the arguments surrounding the economic, social, and political sustainability of health care systems and, in particular, of those supporting UHC. Instead of asking only whether UHC is economically sustainable, we have suggested that the real question to be posed is this: would health care systems be socially and politically sustainable without UHC? Our answer has been mostly negative, although we have recognized that UHC has not always been as achievable as each of the three dimensions of sustainability. We have also noted how current proposed solutions to the issue of economic sustainability of UHC and health care systems tend to undermine the importance of their social and political implications, and how

they might, in some cases, pose concrete trade-offs, for example, between financial viability and equality.

In our view, it remains the responsibility of policymakers to achieve the sustainability of UHC in this broader conceptualization. It would be far too ambitious from our side to suggest definitive solutions to this complex task. We propose, however, that health policymakers should devise policies that act on the dimensions that we have described and analyzed in the previous sections, namely, the level of equity, diversity, interconnectedness, democracy, and political alignment within their health care system. In treating each of these aspects, we have already highlighted some of the possible instruments at the disposal of policymakers and extant experiences with their implementation. The task ahead also implies the capability of policymakers to mobilize a variety of actors around these concepts, including various parts and tiers of government, the main political forces in a country, health care managers, professionals, technology producers, and citizens. Framing UHC as a matter of social and political sustainability of health care systems has the potential to focus the efforts of these actors as if part of an interrelated sociopolitical system, the development and viability of which should be assured to future generations.

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