

# The seven sins and seven virtues of universal health coverage

Universal health coverage is likely to become the backbone on which the health development agenda beyond 2015 will be constructed. To avoid unintended effects, universal health coverage should keep away from committing seven sins and should try to practise seven virtues.

BACKED by most actors in the global health scene, universal health coverage (UHC) is likely to become the mantra that will drive health transformations for years to come and the backbone on which the health development agenda beyond 2015 will be constructed. There is now widespread agreement on the need to extend access to healthcare to all individuals and populations, as illustrated by UN statements,<sup>1</sup> World Health Organisation (WHO) reports<sup>2</sup> and a number of articles in medical journals, including a *Lancet* series.<sup>3</sup> The call for UHC comes at a time when, after decades of neoliberal policies, privatisation of healthcare services has reached a peak, leading in many countries to further exclusion and/or catastrophic expenditures. To help reverse this trend, however, and to avoid unintended effects, UHC should keep away from committing seven sins and try to practise seven virtues.

**1. Sloth (failure to do things that one should do and to make the most of one's talents and gifts) vs. Diligence (upholding one's convictions at all times, especially when no one else is watching)**

To many people, UHC may sound like Health for All.<sup>4</sup> However, what is currently proposed differs substantially from what was proposed in Alma Ata. Primary healthcare intended to transform health systems, as opposed to healthcare systems, within a broader social transformation. The signatories of the Alma Ata Declaration were aware of the importance of the social determinants of health well before the report of the WHO Commission on the issue.<sup>5</sup> Primary healthcare included education, nutrition, water and sanitation, in ad-

**Adriano Cattaneo, Giorgio Tamburlini, Angelo Stefanini, Eduardo Missoni, Gavino Maciocco, Gianni Tognoni, Carlo Resti, Claudio Beltramello, Chiara Bodini and Nicoletta Denticò**

dition to essential healthcare. Unless UHC is served with an extensive dressing of primary healthcare and social determinants of health, i.e., unless it is implemented within a framework of social and economic transformation, it will not transform health as profoundly as hoped. Paradoxically, an excessive focus on UHC could divert attention and resources from other sectors with a bearing on health.<sup>6</sup>

**2. Greed (inordinate desire to acquire or possess more than one needs) vs. Charity (benevolent giving and caring, solidarity)**

To some people, UHC may seem to be synonymous with health insurance schemes that would fund a limited package of services, with governments playing a range of different and often minimal roles. The equation of UHC with financial coverage is implied also in the title of WHO's World Health Report for 2010, *Health Systems Financing: The Path to Universal Coverage*.<sup>7</sup> Such an interpretation of UHC focuses on the mere element of affordability, or economic accessibility. It may pave the way to a massive infiltration of the private sector into healthcare systems that in some countries are still mostly public, and it may undermine the efforts of those countries that have undertaken reforms towards a stronger public sector.

To avoid this, UHC should aim at increasing the proportion of healthcare services that are mastered and managed by the public sector,<sup>8</sup> and financed by progressive taxation systems. In places where the private sector is prevalent and likely to remain so for a long time, governments should strongly regulate it, especially as far as quality of care and lucrative attraction for health professionals are concerned, while progressively investing to reinforce the public sector.<sup>9</sup> Also, UHC should be robust enough to accommodate new challenges, e.g., the new burden brought about by the changing epidemiology of non-communicable diseases,<sup>10</sup> and to resist the downward swings brought about by present and future economic and financial crises.<sup>11</sup> Ad hoc goals and targets on access to the public sector should be developed if UHC is included in the post-2015 development agenda.

**3. Gluttony (over-consumption of anything to the point of waste) vs. Temperance (self-control, abstinence, moderation)**

Trade mechanisms will keep influencing the delicate balance between demand for and supply of healthcare services. Given the well-known asymmetry of information between providers and users in this atypical market, UHC should include mechanisms aimed at moderating any inappropriate excess of supply that in turn may end up increasing demand. Historically, this point has been raised by Ivan Illich: 'Although physicians did pioneer antiseptics, immunisation, and dietary supplements, they were also involved in the switch [from breastmilk] to the bottle.'<sup>12</sup>

Currently, demand may be artifi-

cially inflated by the push for new pharmaceutical or technological solutions to real or presumed health needs, in what is known as disease mongering.<sup>13</sup> Moreover, due to the liberalisation of global trade, the associated dissemination of unhealthy lifestyles, the aggressive marketing of healthcare products, the drive towards increasing consumption and waste, the legal obligations brought about by global trade treaties, and the lack of public regulations to protect public health, demand may rise above the capacity of healthcare systems to respond, creating imbalances that are difficult to address and that would be an obstacle to UHC itself.<sup>14</sup>

**4. Pride (failure to acknowledge the good work of others) vs. Humility (thinking of oneself less in a spirit of self-examination)**

UHC will positively affect health only if due attention is paid to its quality. Quality care is the delivery of safe and effective interventions in ways that, by taking into account the needs and the background of users and their communities, ensure the best possible outcomes to all. Quality of care has only recently been recognised as a neglected issue in the international health agenda, particularly as far as care around childbirth is concerned.<sup>15</sup> Several studies and reports indicate that quality may be far from acceptable, thus jeopardising the ultimate aim of health services.

Delivering care which is not technically sound implies increasing the costs for the system and households without achieving health. Improving quality, however, implies no less difficulty than increasing access. A variety of approaches have been proposed, but reports of successful quality cycles are scant. Efforts to improve paediatric quality of care in district hospitals through systematic standard-based peer-review assessment have been successful, particularly when action at facility level is combined with action at national health system level, through introduction of national standards and improvement in all the building blocks of the health system.<sup>17</sup> The tool for paediatric care developed

by WHO, and the equivalent maternal and neonatal assessment tool, are able to identify quality gaps and prompt quality cycles at local level and systemic action at national level.<sup>18,19</sup> Market mechanisms alone, like those described by proponents of health insurance reforms,<sup>20</sup> are unlikely to have a sustained effect on quality of care.

**5. Envy (desire to deprive other people of their abilities or rewards) vs. Kindness (empathy and trust without prejudice or resentment)**

Health is a complex adaptive system within wider cultural, social and economic complex adaptive systems.<sup>21</sup> Changes in access to health brought about by UHC are likely to affect other building blocks within the health system, the training and distribution of the health workforce for example, or in other social sectors, the transport system for example.

Needless to say, the reverse is also true. A systems thinking approach is compulsory to try and predict the effects that modifications of the health system may have on other complex adaptive systems, and vice versa.<sup>22</sup> Parallel to UHC, capacity for a systems thinking approach should be built among policy and decision makers, as well as planners and researchers. This would be easier if UHC was integrated into a wider social protection framework.<sup>23</sup> To avoid increasing the gap between the better and the worse off, coverage and social protection should be preferentially provided to the latter group, at least initially.<sup>24</sup> This would be particularly important in places where financial risk protection and health insurance have proven to be difficult to implement and scale up, e.g., in remote contexts and poor, underserved communities.

**6. Wrath (impatience, revenge and vigilantism) vs. Patience (creating a sense of peaceful stability rather than hostility and antagonism)**

The implementation of UHC, with all its corollaries of principles, policies, activities and constraints, has

to be properly governed and monitored. Governments will obviously be in charge of it at national and local levels. But who will be in charge of its governance at global level? WHO is the natural candidate, but in recent years it has failed to provide an effective and coherent leadership based on the principles of the right to health for all. Critical budgetary and organisational constraints, including donor dependence, contradictions in the management of human resources, excessive decentralisation and lack of accountability to member states weaken the role of WHO in global health governance. The current process of reform suffers from many of the very problems that it is meant to address, and may fail to re-qualify WHO for the governance of global health.<sup>25</sup>

However, there are possibly no alternatives to a strengthened normative role of WHO as advocated by Chen and Berlinguer over a decade ago.<sup>26</sup> With patience and courage, WHO could lead the development of new ad hoc regulatory frameworks, modelled on the Framework Convention on Tobacco Control. A strong alliance with civil society organisations that look after the public interest and identify global health as a common good would be an asset. While the authority of WHO and its treaty-making power remain necessary, the potential role of bottom-up strategies involving community participation should also be acknowledged. By encouraging social empowerment, increasing the potential to strengthen health systems at local levels, organising demand for services prioritised by communities, and linking generation of knowledge to its use in action, strategies such as participatory action research and community-based monitoring are increasingly recognised as key elements towards UHC.<sup>27</sup>

**7. Lust (intense desire for money, fame or power) vs. Chastity (to be honest with oneself, one's family, one's friends and all of humanity)**

Finally, UHC should be spelled out and positioned within a human

rights framework. The Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights clearly state that the fulfilment of the human right to health relies on the fulfilment of other rights, e.g., food, housing, work, education, non-discrimination, participation and freedom of association. More specifically, the International Covenant states that while ‘the right to health is not to be understood as a right to be healthy’, it is ‘an inclusive right extending not only to timely and appropriate healthcare but also to the underlying determinants of health’. It adds that ‘a further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels’.<sup>28</sup> It states also that ‘The right to health [care] in all its forms and at all levels contains the following interrelated and essential elements’: (a) availability, (b) accessibility in its four overlapping dimensions: non-discrimination and physical, economic (affordability) and information accessibility, (c) acceptability, and (d) quality of services. Unless the international community pushes the right to health up in its scale of values and stops considering health as a dependent variable of the global economy, and unless it makes the respect of human rights mandatory and those who violate them legally accountable, UHC is unlikely to yield the expected results.

To conclude, the incorporation of the UHC concept in the post-2015 development agenda should aim at maximising benefits and minimising harm. This can be achieved only if all the above criteria are met and built into UHC, with enforceable mechanisms to hold governments accountable. In particular, UHC should be understood as a way to ensure the right to health. Only within a human rights framework would UHC benefit from a comprehensive approach, as opposed to the fragmented, vertical approach entrenched in the health (insurance) coverage approach with multiple actors either on the payer or on the provider side that focus on per-

sonal, mostly disease-centred and curative services. Addressing UHC in a human rights framework will help re-position the right to health in the context of the post-2015 development agenda. ♦

*Adriano Cattaneo, Giorgio Tamburlini, Angelo Stefanini, Eduardo Missoni, Gavino Maciocco, Gianni Tognoni, Carlo Resti, Claudio Beltramello, Chiara Bodini and Nicoletta Dentico are members of Italian Global Health Watch. This article is reproduced from the ‘Get involved in global health’ blog (getinvolvedinglobalhealth.blogspot.com).*

### Endnotes

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