UNIVERSAL HEALTH COVERAGE I - The World Health Organization on UHC and South Africa

The first brief in a five part series contributed to by both Andrew Barlow and Charles Simkins. This brief plays a general and introductory role; as well as considering the conditions needed for UHC success.

The World Health Organization and UHC

The generally accepted definition of UHC is that of the World Health Organisation, which lists the following four components for UHC implementation:

1. "A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care (including services for HIV, tuberculosis, malaria, non-communicable diseases, maternal and child health) by:

• Informing and encouraging people to stay healthy and prevent illness;

• Detecting health conditions early;

• Having the capacity to treat disease; and

• Helping patients with rehabilitation.

2. Affordability – a system for financing health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways.

3. Access to essential medicines and technologies to diagnose and treat medical problems.

4. A sufficient capacity of well-trained, motivated health works to provide the services to meet patients' needs based on the best available evidence." [1]

Every UHC system shares a commitment to providing a specified package of benefits to all citizens of a particular country, as well as a degree of financial risk protection. But each system can vary in terms of who is covered, what is covered, and the extent of the cost that is covered. In other words, UHC does not equate to free and total coverage for everyone for everything. Rather, UHC is a concerted attempt at ensuring that everyone can "obtain the health services they need without suffering financial hardship when paying for them". [2]

Out of pocket payments can deny access to the health services that the poor need, and those who are able to afford them can be forced into poverty by severe or long-term illness. Pooling funds through tax, insurance

contributions and government spending can spread the financial risk across the population, thus allowing for cross subsidisation of rich to poor and healthy to ill.

The principles motivating UHC implementation are both morally grounded and socially desirable – everyone deserves access to adequate equitable health service provision, regardless of income. It is, after all, a constitutional right. Moreover, UHC implementation is attainable, even in low and middle income countries. The extent and quality of UHC is an indicator of a country's level of human development; the United States aside, every developed nation has a UHC system in place.

South Africa and UHC

The National Health Insurance White Paper, released on 10 December 2015, contains the government's plans for rolling out Universal Health Coverage (UHC) in South Africa. It envisages a single-payer system, with a comprehensive list of benefits provided – including, for example, palliative care, rehabilitation, and mental health care necessitated as a result of substance abuse. Simply put, everyone will have access to a wide and varied number of health services that are free at the point of delivery, as the government's prepared to foot the bill.

Yet, after reading the White Paper, it is not at all clear whether the government understands that UHC can take many forms. The number of proposed benefits covered, the hostility toward the private sector, and particularly the chosen single payer funding mechanism, all close out consideration of alternative systems. But given the large financial implications of the White Paper's proposals, it is a mistake by the government to rule out a priori alternative routes to UHC.

A single payer system is a possible way of achieving UHC. It is not a necessary one. Alternative UHC systems exist, and in this series of briefs – of which this is the first – to consider them. I will present some of the alternatives, successfully adopted by a number of countries, to realise and improve UHC.

Moreover, given South Africa's specific political, economic and geographic realities, the highly centralised and inevitably bureaucratised nature of single payer funded system seems – if we're being generous – to fly in the face of common sense. South Africa and Scandinavia, for instance, are simply worlds apart, despite what the government may think. In fact, private sector involvement in health care financing through an equitable and socially responsible two-tier system, or an open, competitive insurance mandate system, is increasingly common worldwide.

This brief considers UHC in general. Subsequent briefs will consider:

• The insurance mandate structure used by Austria and Germany to fund their respective UHC systems.

• The two-tier funding mechanisms in place in Israel and Netherlands. These are equitable and efficient systems – they ensure that everyone has access to at least a basic but sufficient package of benefits.

• The single payer systems of Canada and Scandinavia – the 'poster-boys' of the government's own plans, if you will – paying particular attention to the many issues that they have encountered.

In the final brief, themes will be pulled together and analysed by Charles Simkins.

The conditions for UHC success

The most important element underwriting successful implementation of UHC is the success of the financing mechanism the system is built upon. Sufficient funds must be raised in a manner that minimizes ruinous out of pocket payments, providing financial risk protection to users, whilst using "available funds (including donor funding where relevant) efficiently and equitably". [3] Clearly, the specific economic, political, geographical, social and historical realities of a country must all be considered when choosing the financing mechanism.

But a UHC system is also fluid, and looks to progressively expand the number of services covered and the amount of financial risk protection provided as resources become available. [4] In order to free up resources, the UHC system needs far more than just a workable financing mechanism. Steps must be taken towards reaching equity and development goals, towards consolidating social inclusion and cohesion priorities, and towards implementing all the subsidiary components that underwrite the success of a health care system: an able and willing workforce; the necessary facilities and infrastructure; communications networks; technologies and information system; quality assurance mechanisms; sound systems of procurement and supply of medicines; and governance and legislation.

The WHO assesses and evaluates country specific UHC systems on the basis of three overall indicators: [5]

• Health service coverage;

• Financial risk protection; and

• Equity or coverage for the entire population.

The government should keep these indicators at the forefront during any process of implementation – for

only by achieving these, concurrently, will it truly be progressively achieving UHC. If the government finds that the current White Paper proposals do not lead towards progressive joint realisation of these three indicators, then it must alter its plans. As the saying goes: there's more than one way to skin a cat.

Conclusion

The WHO has said: "UHC cannot be achieved in all countries overnight, but all countries can take actions to move more rapidly towards it, or to maintain the gains they have already made." [6] Ambition is one thing, arrogance quite another. The government must make sure that it is considering options without prejudice, that it is moving along the most efficient path to UHC, and that it is not over-reaching itself. New thinking is needed.

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Bibliography:
[1] http://www.who.int/mediacentre/factsheets/fs395/en/
[2] ibid.
[3] ibid.
[4] ibid.
[5] ibid.
[6] ibid.