Universal health coverage

The Commonwealth People's Forum (CPF) is a biennial event held prior to the Commonwealth Heads of Government Meeting. CPF 2018 took place on 16-18 April in London and was jointly organised by the Government of the United Kingdom and the Commonwealth Foundation. CPF 2018 critically explored policy based actions under the theme of 'Inclusive Governance: The Challenge for a Contemporary Commonwealth'. It provided an innovative opportunity for civil society organisations to share knowledge and learn from each other as well as to interact with governance institutions on key policy issues. The CPF 2018 series elaborates on the issues covered in the London Declaration on Inclusive Governance for a Renewed Commonwealth.

Introduction

An extensive discussion at the Commonwealth People's Forum 2018 (CPF 2018) explored the provision of universal health coverage (UHC), defined by the World Health Organisation (WHO) as 'ensuring that everyone, everywhere can access essential quality health services without facing financial hardship' (World Health Organisation 2018).

Participants recognised that Commonwealth countries are often far from achieving UHC and that an alternate, people-centered concept of health is required to counteract the growing shift from public to private health provision. Participants also felt that governments need to be held to account; not only for providing health care as a basic human right, but also for the treaties they sign and commit to, such as the 2030 Agenda for Sustainable Development (SDGs).

The session highlighted the range of contemporary models and approaches to building health care systems that promote full coverage, including several country case studies. Requirements for an effective health workforce and challenges in achieving effective, qualified and motivated health workforces were also identified.

> 'Affordable and quality healthcare is a necessary foundation for the development of countries'

The challenges of the new demands on health systems such as non-communicable diseases (NCDs) including heart disease, various forms of cancer and mental health were explored. While there is increasing public and governmental focus on this challenge, in practice there has been a limited financial and policy response from governments. Participants proposed several recommendations for action by Commonwealth governments and civil society in the period to 2020.

Issues and strategies

Benefits and advantages of UHC

Affordable and quality health care is a necessary foundation for the development of countries and is desirable Commonwealth-wide. Recognised as SDG 3, it promotes social equality and cohesion and helps reduce disparities between rich and poor societies.

Models for UHC

Participants heard that while no perfect model exists in practice, effective models deliver high quality health care at the point of need, eliminate waste and remove inequalities in access to care and in quality of service. Systems such as these also address financial hardship and financial risk to already disadvantaged populations.

Countries have taken various routes to achieving UHC. Social health insurance (SHI) approaches are pursued mostly in middle and upper-income countries although these approaches have been shown not to cover the health care needs of poor and unsettled communities. Alternatively, national health system (NHS) models in these countries require government funding commitments of at least 3% of GDP, delivered predominately but not exclusively by the public sector. By contrast, lower income countries spend on average some 7% of GDP on health care (World Health Organisation 2017, page 10).

NHS and SHI models can prove unfeasible in developing countries due to the inequitable distribution of income and wealth. Delegates heard that a third model may provide a practical route towards UHC for many Commonwealth developing countries. This comprises a mixed public/private system, which recognises the economic and political constraints which prevent full public funding of, for example, a fully-developed NHS approach. Key characteristics of the mixed model are majority funding from government with exclusively tax-based publicly funded packages widely dispersed to the poor, and private financing provided as an 'add on' to meet consumer demand. The logic underpinning the model is that the poor can access public services while more affluent people can choose private health care services.

While the standards for both SHI and NHS models are hard to implement in most developing countries, mixed systems are not free from challenges: in developing countries health sectors are often poorly regulated, and vocal middle class demands for better consumer choice and higher quality private health services are often unable to be met. Yet mixed models demonstrate that high income status is not a necessary pre-condition for the achievement of UHC. Mixed models appear to provide a practical approach for countries with limited tax resources.

The cases of Sri Lanka and Hong Kong were presented as two examples of a mixed approach. Sri Lanka has been successful in achieving health outcomes with minimal annual public spending of just 1.4% of GDP. Hong Kong has also achieved health outcomes using this model; despite a relatively low government spending rate of 6% of GDP, those on income support are charged no fees.

In the discussion that followed, participants noted that efforts to create better health care models can be compromised by the adjusting priorities of donors. Use of GDP per capita as a basis to allocate official development assistance (ODA) ignores the extent of inequality in health coverage and the impact of changes in funding models on vulnerable groups. The adverse effects of this are particularly acute in recently graduated middle-income countries that have seen ODA cut, despite still being home to a large proportion of vulnerable people. In addition, poor planning and coordination with key stakeholders during the transition away from donor support has made the challenge of achieving UHC greater. As developing countries see funding reduced, technical assistance is required to support

access to health care as well as advocacy for community mobilisation. Systems for accountability need to be strengthened and global support is needed to ensure government actors are better able to allocate resources.

Mental health as a non-communicable disease

Mental health is now the third leading cause of disease and by 2030 it will represent the leading burden of disease (World Health Organisation 2011, page 1). While the challenge is not widely discussed, addressing mental health will be essential for achieving UHC. At present, persons with low income spend an average of 0.5% of annual income on mental health treatment, while high income earners spend far more, approximately 5.1% of earnings. Expenditure where it occurs is not efficient. The most effective way to address mental health is through primary care, but in low-income countries most costs are incurred through intensive in-house care.

Access to reliable data

Across the Commonwealth, health data is often unavailable and crucial information such as the numbers of active health care professionals remain unknown. A dearth of reliable data clearly effects a country's ability to plan and develop an agenda to address health care challenges. The World Health Organisation has developed a Mental Health Atlas to house data on mental health and address this problem. However, only six Commonwealth countries have submitted mental health data for the atlas.

In developing countries, there are only five psychiatrists per one million of the population but no data is available for the numbers of active social workers. There is evidence that in Commonwealth countries, the average number of mental health professionals is generally higher than in non-member countries (World Health Organisation 2015); a strength that can be built on to establish a comprehensive database of the total health workforce in each member country.

Addressing gaps and improving efficiency in the health workforce

There are substantial gaps in the number of health care workers, in the efficiency of the existing workforce and incentives needed to retain and develop their skills and quality of care. It is thought that there is an existing shortfall of around 12.9 million health workers globally (World Health Organisation 2013). However, improved supply is not simply a question of increasing the numbers of existing health care workers, but also one of utilising current workers more efficiently by focussing on their ability to deliver more effective health care interventions. Participants pointed out that training nurses to work as practitioners, including as paramedics, can be a highly effective use of resources.

Key challenges for governments include developing a better understanding of how demand for health services is changing and how best these changes and new demands can be met by shifting the composition and skill sets of the workforce as well as how best to attract, recruit, motivate and retain new workers and how to ensure that services are provided in understaffed areas and across the various sectors of the health care system.

Many high-level professionals unfortunately leave rural and more poorly-served areas for the cities due to better career opportunities and peer networks, thereby reducing health care coverage and perpetuating inequality in access to care. This phenomenon can be seen across the Commonwealth, with the demand for health care professionals in developed countries draining developing countries of skilled personnel. This gave rise to the Commonwealth Code of Practice for the International Recruitment of Health Workers. This was adopted by 22 Commonwealth Health Ministers at an informal meeting in the wings of the World Health Assembly in May 2003.

In developing a model for UHC, challenges associated with improving access to education, training, peer and professional support and incentives for the health workforce need to be addressed. Focussing on local recruitment and training; providing health workers with mobile phones; enabling them to be paid through digital payment systems and keeping them connected to peer networks and to web-based health and medical information are some of the steps that can make a difference. Utilising distance learning technologies more efficiently and helping promote workforce rotation in remote areas can also improve accessibility. The World Health Organisation has developed useful evidence-based guidelines to support this process.

Qualitative improvements in the workforce

Several actions are needed to further strengthen the quality of the workforce, to ensure that both the existing and newly trained workforce have the necessary skills to provide primary care, and to address NCDs. This must include strengthening social policy to facilitate career path development. Current workforce planning, education and training are also often misaligned with the needs of employers, necessitating changes to education curricula for health, including greater emphasis on continuing professional development. In the presence of a large array of health education providers, there is also a need for a stronger regulatory and accreditation architecture to support improvements in workforce quality.

Aligning workforce policy, planning, regulation and management

Participants emphasised that there are neither simple, nor singular solutions to improve and establish an effective health workforce. To develop and scale up the workforce, an integrated approach to health planning, financing, policy, and the development of necessary legislation is needed and interventions need to be carefully sequenced. Changing the profile of the workforce is also a long-term endeavour and can take over a decade to achieve. Upskilling the existing workforce is therefore an effective and critical step to achieve results.

Integrating policy, planning, regulation and management raises multiple challenges for policy makers. As already highlighted, data and health workforce information is often incomplete. Yet rather than waiting for systems to improve, health services can use existing data as effectively as possible. As most health-related national workforce data is compiled from sources outside of Health Ministries, finding ways to assimilate and integrate existing relevant datasets is increasingly important. Likewise, the development of the health workforce is not the sole responsibility of health ministries. Other departments of government, regulators and legislators are also responsible, underpinning the need for an integrated response. Similarly, greater engagement with civil society and citizens in policy formulation is needed for more responsive and effective healthcare systems.

Reducing the risks of medicines

Reducing the risks of medicines is an essential stepping stone toward UHC, as medicines are a critical ingredient in prevention, diagnosis and treatment. This is particularly imperative as the cost of medicines can put them beyond the reach of populations in low-income countries, effectively denying access to health care. As populations age, demand for medicines increases.

Due to the shortfall in numbers of health workers, pharmacists play an important, often unrecognised role in the efficiency of health outcomes, improving the clinical use of medicines, helping reduce the length of patient's stay in hospitals, reducing morbidity and mortality and contributing to improved achievement of NCD targets.

Achieving equitable access and building a rights-affirming UHC

A participative, open and transparent system of governance is critical to achieving equitable access to health care and a rights affirming UHC system. A key component therefore is meaningful engagement with communities and civil society in developing and implementing policies, recognising that stakeholders are best placed to hold governments to account by monitoring progress and identifying gaps. National health plans and policies are needed that are capable of assessing which vulnerable groups and populations are most in need and that target these groups first with appropriate and inclusive policies.

Recent global and national approaches to tackling HIV and Malaria are instructive when attempting to map a path forward for UHC. A people-centred approach has built on the principle that patients living with disease are autonomous individuals possessing rights, not passive recipients of care. The approach has yielded results in treatment, positive health outcomes, and has reduced marginalisation and stigmatisation. There are now useful guidelines and good practice case studies which can be used in pursuing UHC.

Several initiatives have been taken to ensure that the institutional architecture that manages donor funding, at an international level and within recipient countries, involves people living with the disease in question. Efforts have also focussed on strengthening health systems in conjunction with community systems and delivering resources to community groups to respond to social determinants of health. Translating political commitment into action has been achieved through the use of indicators and measures of progress, with consistent reporting permitting greater accountability and visibility.

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