



# Universal Health Coverage: Supporting Country Needs



World Health  
Organization

# Contents

<b>Introduction</b>	<b>3</b>
<b>Strategies for Moving Towards Universal Health Coverage</b>	<b>4</b>
What is Universal Health Coverage (UHC)?	4
Moving forward: identifying and addressing health system obstacles	6
Dispelling myths about UHC	10
Tracking progress	10
<b>Conclusion</b>	<b>12</b>

# Introduction

“Universal health coverage is the single most powerful concept that public health has to offer. Universal coverage is relevant to every person on this planet. It is a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men. Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness. This is the anchor for the work of WHO as we move forward.”

***Dr Margaret Chan, address to the World Health Assembly, May 2012***

Universal health coverage (UHC), defined as all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them, has never been higher on the international health agenda. In 2012 alone four high-level international events, held in Bangkok, Kigali, Mexico and Tunis, focused on the importance for national governments of working towards UHC, while UHC was the core topic of a Ministerial-level meeting convened by WHO and the World Bank in February 2013, which brought together representatives from ministries of health and finance to share lessons learnt and challenges faced. It is increasingly seen as important to the post-2015 development agenda and the sustainable development goals that are being debated in the United Nations.

All this activity reflects the increasing interest at country level where low- and middle-income countries as diverse as Brazil, China, Georgia, Ghana, India, Indonesia, Kyrgyzstan, Moldova, Morocco, Rwanda, Sierra Leone, Thailand and Uruguay are among those that have taken steps to move closer to the goal of UHC. At the same time high-income countries, faced with rapidly ageing populations, new and more costly health technologies, increasing population expectations and recent fiscal austerity, have been struggling to continue to assure high levels of coverage with quality health services and with financial risk protection.

This document clarifies what UHC is and is not, and how countries can take steps to move closer and monitor their own progress.

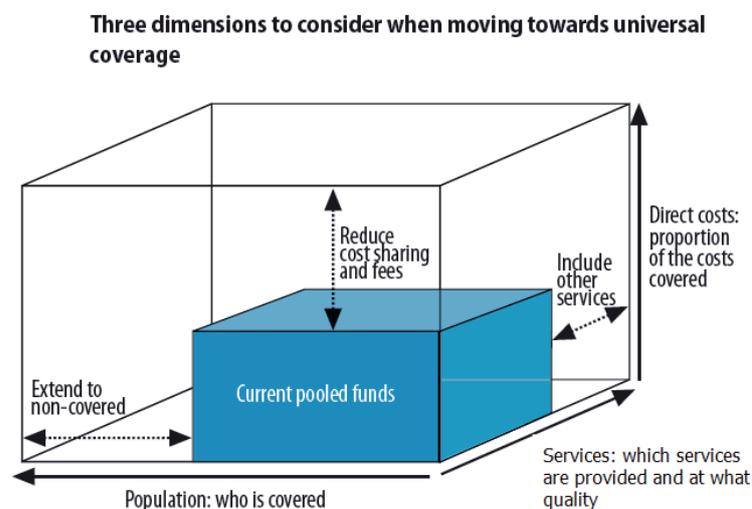
# Strategies for Moving Towards Universal Health Coverage

## What is Universal Health Coverage (UHC)?

Conceptually, UHC requires that all people receive the health services - which should be of appropriate quality - they need without exposing them to financial hardship. It encompasses three critical coverage dimensions – population (who is covered?), services (which services are covered and at what quality?), and cost (how much of the cost is covered?).<sup>1</sup>

These three dimensions are depicted on the axes of the cube in Figure 1. The population axis represents the population, the people who need health services. The services axis depicts the quality health services they need across the major causes of ill health – including the unfinished agenda of the MDGs, non-communicable diseases, mental health and injuries. This is not solely treatment. UHC must also include prevention, promotion (personal and non-personal), rehabilitation and palliative services, so population-based interventions designed to reduce tobacco consumption, for example, are required. Clearly, the services must also be of good quality. Moreover, universal coverage of needed services is not possible without universal access to essential medicines and other health technologies, sufficient motivated health workers located in the right places, and information systems that allow informed decision making, something to which we return subsequently.

Figure 1: The three dimensions of UHC



The vertical axis is the total cost of assuring the population obtains all the services they need.

If people have to pay the entire costs out of their own pockets, the poor will be unable to obtain most of the services they need and even the rich will be exposed to financial hardship in the event of severe or long term illness. Forms of financial risk protection that pool funds (through tax, other government revenues, and/or insurance contributions) to spread the financial risks of illness across the population, and allow for cross subsidy from rich to poor and from healthy to ill, increase access to both needed services and financial risk protection.

<sup>1</sup> Health systems financing: the path to universal coverage. *The world health report 2010*. World Health Organization, Geneva, 2010.

This is shown in Figure 1 as the box labelled “current pooled funds”. In this hypothetical country, about half the population is covered for about half of the possible services they need,<sup>2</sup> but only half the cost of these services is met from pooled funds. The rest is paid out-of-pocket. Some people will not get the health services they need because they cannot afford to pay, and others that choose to pay for the health services they need will suffer severe financial hardship as a result. To get closer to UHC, the country would need to extend coverage to more people, offer more health services of good quality, and pay a greater part of the cost from pooled funds.

Each country “fills the box” as best it can, trading off the proportion of services, the proportion of the costs and the proportion of the population to be covered with the available pooled funds. As such, UHC is the ultimate objective or goal with countries starting from different places, with very different health problems, health systems and resources. They all need to find their own paths.

UHC is also a dynamic rather than static concept. New health technologies and medical products are developed continually, as are new ways of improving the quality of care. The health service axis in Figure 1, therefore, expands over time. Many of the new innovations come at higher costs, while population demands for new and better technologies also increase, expanding the cost axis. That is why the search to attain and maintain UHC concerns even the richest countries, particularly at times of financial crises where their ability to maintain high standards of service coverage and low household out-of-pocket payments is put under considerable strain.

This vision of UHC embodies principles of equity in access to and use of services, quality of the services people obtain, and financial protection for people needing health services. These principles have been a major priority for WHO since its founding, reflected in the Organization’s constitutional commitment to “ensuring the highest attainable level of health”<sup>3</sup> for all. The principles are also fundamental to the objective of Health for All developed at the Alma Ata conference of 1978 with its focus on primary health care. “Health for All” required universal access to needed health services, which, combined with intersectoral action on the social determinants of health, allows people to achieve the highest attainable standard of health.

### **Box 1: What does UHC mean for people and for governments?**

1. UHC means that everyone can get the health services they need, at good quality.
2. UHC requires coverage with key interventions that address the most important causes of morbidity and mortality. This includes the unfinished agenda of the MDGs where they are important, and an effective response to NCDs, mental disorders and injuries.
3. UHC includes promotion, prevention, rehabilitation and palliative care in addition to treatment.
4. UHC means that nobody suffers financial hardship as a result of paying for the health services they need.
5. UHC is about getting more health for the money as much as getting more money for health, and it is possible for all countries to move closer to UHC regardless of their income level.

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<sup>2</sup> It is difficult to fully incorporate the quality component of services in a three dimensional space, but we emphasize that countries need to work not just on the volume of health services but their quality. This is discussed subsequently.

<sup>3</sup> World Health Organization Constitution. 1948.

Because of its overarching significance as a concept, aspects of UHC are ubiquitous in the prevailing public health discourse at global and national levels. For example, the need to ensure coverage with essential health services of different types at an affordable cost was reinforced by the United Nations Every Woman Every Child initiative in September 2010, and the United Nations High-level Meeting on Prevention and Control of Noncommunicable Diseases the following year. UHC is also a key issue for disease and health programmes, including global health initiatives such as the Global Fund and the GAVI Alliance. UHC is a key goal in strategies designed to reach the Millennium Development Goals (MDG).

UHC is also a multi-sectoral issue, requiring multi-sectoral solutions. This was made explicit in the Rio de Janeiro Political Declaration on the Social Determinants of Health of 2012, which emphasized the interrelation between addressing social determinants and strengthening health systems to achieve UHC.

As such, UHC is a key development issue.<sup>4,5</sup> Put simply, UHC contributes to a healthier work force, and thus, has a direct impact on labour productivity and economic growth. Similarly, healthy children do better at school; UHC can thus improve education outcomes which in turn affect economic productivity. At the societal level, UHC reduces inequalities by guaranteeing that everyone gets the good quality health services they need, regardless of who they are, thereby enhancing social cohesion. For this reason, UHC is increasingly seen as integral to the post-2015 development agenda, and essential to the achievement of the MDGs in the shorter term.

## Moving forward: identifying and addressing health system obstacles

The programmes designed to accelerate progress towards the health-related MDGs have achieved a great deal in terms of better health outcomes and increased survival rates in targeted populations. Nevertheless it has become apparent that their capacity to reach the desired targets has been hampered by weaknesses in health systems, weaknesses that particularly affect the poor. Health system strengthening is critical not just to attaining the MDGs but more generally to ensure progress towards UHC and sustain the levels of service coverage, quality and financial risk protection that countries have achieved. In doing this, special attention needs to be paid to the poorest and most vulnerable populations.

Obstacles to progress are encountered at all levels of health systems, and include:

- **Suboptimal leadership and governance:** Governments need to set the vision and direction for the entire health system and the broad strategies for achieving the desired goals. It also requires strong leadership to address social determinants, health inequities, and gender differences and to ensure the right to health. Frequently this direction is lacking and specific examples of weak leadership and governance can be found in countries at all income levels. They include: limited control of quality in health facilities and across health providers, including regulation of the private sector; inadequate policies on medicines, other medical products and clinical care; poor accountability and transparency; an incoherent architecture for the health financing system; and lack of leadership to ensure health-in-all policies across all sectors.

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4 See United Nations General Assembly Resolution 66/288, *The Future We Want*, adopted 27 July 2012 <http://sustainabledevelopment.un.org/futurewewant.html>

5 See United Nations General Assembly Resolution 67/L.36, *Global Health and Foreign Policy*, adopted December 6, 2012 [http://www.un.org/ga/search/viewm\\_doc.asp?symbol=A/67/L.36](http://www.un.org/ga/search/viewm_doc.asp?symbol=A/67/L.36)

- ***Inadequate financing systems:*** In many countries, limited financial resources have a significant impact on the availability and accessibility of health services and their quality; while high out-of-pocket payments, which are not infrequent even in high-income countries, prevent some people from seeking the care they need and result in financial hardship for many who use the available services. Perverse incentives resulting from the way in which health service providers are paid in many countries contribute greatly to system inefficiencies, while resources are frequently allocated to high cost, low value interventions when low cost, high impact options are not fully funded. An example is the disproportionately high proportion of government budgets allocated to hospitals when primary level and preventive care receive inadequate support.
- ***Poor quality or inadequate health services:*** Services are often in short supply and located too far from the places where people live, especially in rural areas. They are frequently of poor quality and are sometimes unsafe. Prevention, promotion, rehabilitation and palliation are often neglected because of the overwhelming need and demand for treatment and limited resources.
- ***Inadequate or mismanaged evidence and information:*** Disaggregated data at population and service provision levels are necessary to make evidence-based decisions at local and national levels, and are often lacking or of poor quality. Where they are available, they are sometimes under-exploited or not used at all. Moreover, locally-relevant evidence on how best to use scarce resources to strengthen health systems and move towards UHC is often missing, due to lack of investment in research.
- ***Inadequate, misallocated and mismanaged human resources:*** The critical lack of sufficient numbers of adequately trained and motivated personnel constitutes a major barrier to the availability of appropriate services in many countries. Distribution of health workforce within countries is highly skewed towards urban and higher-income areas. In addition, high staff attrition results from poor pay, and working conditions. There is not enough continuing education programmes that allow staff to maintain and update their skills, and cope with emerging health challenges.
- ***Lack of essential medicines and other health technologies:*** In many countries, essential medicines and other health technologies are not available, available only intermittently, of poor quality, or not affordable to the population. People frequently need to pay out-of-pocket for the medicines and diagnostic services they receive, often at high prices made worse by taxes, tariffs and margins on these health technologies. This means many people do not obtain the medicines and other technologies they need while others suffer financial hardship, even impoverishment, because of the purchases they make.
- ***Poor infrastructure:*** lack of investment - in buildings, equipment and other forms of infrastructure like information and auditing systems – reduces the availability of the health services people need close to them. It also reduces the quality and effectiveness of the available services, affecting patient safety.

These are simply some of the many examples of the ways that health systems need to be strengthened to speed up progress towards UHC. Increased investment in health systems can mitigate many of these problems, but simply pouring more money into health is not enough to ensure progress towards UHC. Nor is progress towards UHC simply a question of removing the financial barriers to access through prepayment and pooling of resources with appropriate subsidies for the poor. For progress on UHC to be meaningful and sustainable, governments must ensure not only that adequate resources are committed, but that the resources available are used efficiently.

The World Health Report 2010 identified ten leading causes of inefficiency in health systems cutting across most of the specific areas listed above. Many relate to medicines and other health technologies. The underuse of generic medicines, paying too much for the medicines purchased, use of substandard or counterfeit medicines, inappropriate and ineffective use, and overuse/supply of equipment, investigations and procedures all contribute to health system inefficiencies. Improvements in this area alone could save countries around 5% of their total health expenditures.

Equally important are the inefficiencies in the delivery of health services, such as inappropriate hospital admissions and length of stay, inappropriate hospital size which can give rise to underuse of infrastructure, medical errors and suboptimal quality of care, inappropriate staff mix, and unmotivated workers. Finally, waste, corruption and fraud are important sources of inefficiencies in most health systems. Conservatively speaking, taking all of these causes of inefficiency together, about 20–40% of resources spent on health are wasted, resources that could be redirected towards achieving UHC.

Solutions to addressing health system obstacles and improving quality and efficiency include critically assessing what services are needed, getting the most out of the technologies and health services used; motivating health workers, improving hospital performance, reducing medical errors, and eliminating or minimizing waste and corruption.

Improved accountability and transparency at all levels of the health system will facilitate this. Information on decision-making processes, institutions and outcomes should be accessible in as transparent a form possible to allow the population understand how public funds are being used. Full accountability and transparency is unlikely in the absence of regular monitoring and evaluation, which is also important for helping policymakers make decisions based on the best available evidence and track their own progress in ensuring coverage with good quality, people-centred, and integrated health services<sup>6</sup> and with financial risk protection.

Because service delivery (cutting across all priority health conditions and including prevention, promotion, treatment, rehabilitation and palliative care) is seen by the population as the essence of the health system, ensuring an appropriate mix of needed services, with quality and safety, is a critical dimension of health system development designed to progress towards UHC. On the face of it this is obvious: population coverage with services that are unsafe or of low quality, or that do not represent value for money, reduces the potential impact of health services on population health and can even lead to harm. People are also deterred from using services they believe to be of poor quality or unsafe, undermining attempts to increase coverage. Expanding the range and availability of services and their affordability is critical to achieving UHC, but at the same time, quality enhancing efforts must also take place.<sup>7</sup> The principles for expanding coverage with needed health services, with quality, are described in Box 2.

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6 People-centred, integrated health services are defined as the organization, management and delivery of health services in which people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course.

7 Effective coverage is a term used to capture all aspects: it is defined as whether the people who need health services obtain them in a timely manner and at a level of quality necessary to obtain the desired health gains.

## Box 2: Principles for expanding coverage with needed health services with good quality

In terms of the cube in Figure 1, health service coverage is defined as the proportion of individuals needing a particular health service that received them, at good quality. Universal coverage of health services means that all people in need of quality health services receive them.

In order to expand coverage, the following principles need to be considered:

**Availability:** All the relevant resources (facilities, programmes, human resources, materials and products) required for the delivery of the health services should be available in sufficient quantity for the needs of the population, and be provided as close as possible to users (see accessibility).

**Accessibility:** Health services, covering the full continuum, should be accessible to everyone with an identified need. Accessibility encompasses physical accessibility (e.g. where services are located), information accessibility, non-discrimination and equity.

**Affordability:** Health services must be affordable; this is particularly important in low-income settings, where even minimal user fees can discourage use.

**Quality:** All relevant resources (health-care facilities, programmes and services, human resources, and materials and products) should be of an appropriate quality.

**Adaptability:** Health services need to be adaptable so as to meet the requirements of the individual, taking into account things like health condition, environment and personal factors (gender, age, race, physical fitness, lifestyle and habits).

**Acceptability:** People should be actively involved in all stages of service provision, having choice and control over the decisions that affect them. This also means that the service providers need to be responsive to the needs of the population, treating them with respect, for example.

**Equity:** If all people obtain the health services they need without suffering financial hardship, equity in access has been achieved. However, on the path to UHC, it is important to focus on equity, and to pay particular attention to ensuring access to those who can be discriminated against, for reasons of gender, geographic location, and cultural or socio-economic status.

Even if a country addresses all of these health systems constraints, the health system will not be able to achieve UHC by itself. Levels and inequalities in education, income, wealth, and power relationships in society have a bearing on the health resources available, the risk factors to which individuals are exposed, and whether or not people use the services that are available. This is why a health-in-all policies approach is so critical to the UHC agenda, and why national and local government public health authorities, and ministries of health need to be able to engage in *cross-sectoral policy dialogue* that results in actions that improve health and financial risk protection.

UHC cannot be achieved without evidence from research. Indeed, on the road to universal coverage, taking a methodical approach to formulating and answering questions is not a luxury but a necessity. No single research study can guarantee a new and useful health intervention, but no useful interventions can be discovered, developed and delivered without some form of research. In order to support UHC, the World Health Report 2013<sup>8</sup> argues that all nations should be producers of research as well as consumers, and that the creativity and skills of researchers should be used to strengthen investigations not only in academic centres but also in public health programmes, close to the supply of and demand for health services.

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8 Research for Universal Health Coverage. The world health report 2013. World Health Organization, Geneva, 2013.

This discussion allows us to clarify some of the myths about UHC, what UHC is not (see Box 3).

### Box 3: Dispelling myths about UHC

1. UHC is only about treatment. **FALSE:** UHC includes access to needed prevention, promotion, treatment, rehabilitation and palliative care. In terms of prevention and promotion, it includes both personal and non-personal health services including population-based interventions such as anti-smoking campaigns.
2. UHC is only about health financing. **FALSE:** all components of the health system must be involved; if there are no health technologies<sup>1</sup>, health workers, health facilities or communications networks, health service delivery systems, quality assurance mechanisms, systems of governance and legislation, or information, UHC cannot be achieved.
3. UHC is not a concern for priority health programmes or global health initiatives, **FALSE:** UHC requires coverage with key interventions that address the most important causes of morbidity and mortality. It is therefore critical to the unfinished agenda of the MDGs, and also offers an effective response to NCDs, mental disorders and injuries.
4. UHC is only about assuring a minimum package of health services. **FALSE:** assuring UHC requires the progressive expansion of coverage of health services and financial risk protection as more resources become available. As incomes grow, a country's ability to expand the range of services and the level of financial risk protection will also expand, in some cases aided by external financial support
5. UHC means free coverage for all possible health interventions, regardless of the cost. **FALSE:** no country can provide all services free of charge on a sustainable basis.
6. UHC means abandoning the health MDGs. **FALSE:** UHC incorporates all priority interventions to achieve MDG 4, 5 and 6.
7. UHC is only about health. **FALSE:** moving closer to UHC is also about equity, development priorities, social inclusion and cohesion, for example, requiring multi-sectoral action and political solutions in addition to technical inputs.

<sup>1</sup> Health technologies relate to devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve the quality of life (from WHA60.16).

## Tracking progress

As countries move forward, they will need to track their own progress and make adjustments to their strategies and plans as necessary. To show how this can be done, we begin with the three dimensions of the cube in Figure 1.

The *coverage of needed health services (intervention coverage)* is best measured using coverage indicators for a mix of health services delivered at the different levels of care, and including promotion, prevention, treatment, rehabilitation and palliation. The health services that are included should address the main causes of disease burden in a country and ideally the indicators should capture service quality, which is often referred to as effective coverage.

A set of coverage indicators has already been agreed for HIV/AIDS, tuberculosis, malaria, child health and maternal health for the current MDGs. A set has also been agreed for NCDs following the UN high level meeting on the topic, although its operationalization still needs further work. Work is currently being undertaken to develop indicators for rehabilitation and palliation, and for service quality.

*Coverage with financial risk protection* can be monitored through several widely-used measures such as the incidence of catastrophic health expenditure or impoverishment linked to out-of-pocket payments. They require household expenditure surveys at regular intervals.

The monitoring of *inequalities* in intervention coverage (and service quality) and financial risk protection will have to be a central and integrated component. This is the population coverage axis of Figure 1. Average levels of the indicators are important for tracking overall progress but must be supported by disaggregated measurements to identify if inequalities across different population groups are being redressed. This includes disaggregation by income/wealth, education, sex, age, place of residence (e.g. rural/urban), migrant status and ethnic origin (e.g. indigenous groups). A cross-cutting equity stratifier for all indicators, such as the poorest 40% of the population, can be helpful to monitor the general situation and trends.

While the overarching goal of UHC is the same everywhere, the relative importance of different health service coverage indicators will vary according to differences in epidemiology – e.g. the presence or not of malaria, type of HIV epidemic, relative importance of NCDs and risk factor patterns. Countries will choose a set of indicators and measurement approaches that are relevant to them for monitoring their own progress towards UHC. A global measure of progress could be synthesized from the country data, either using an index or a small set of tracer indicators common to all countries.

A concrete example is a set of coverage indicators that reflect the situation and trends for the MDG related intervention areas. This includes immunization (e.g. measles vaccination coverage), maternal and newborn care (e.g. skilled birth attendance and at least four antenatal care visits), family planning (e.g. need for family planning satisfied), treatment of childhood illnesses (e.g. coverage of antibiotic treatment of children with suspected pneumonia) and chronic conditions and injuries (such as not smoking, prevention of hypertension, treatment of diabetes). These indicators should be monitored for the population as a whole and for the poorest 40% on a regular basis. They can be combined into an index, although the individual performance of all health priority areas need to be monitored as well. In addition, the core indicators of financial risk protection should be monitored for the whole population and the poorest 40% of the population.

Measuring the three dimensions of UHC – coverage with quality health services, coverage with financial risk protection, and inequalities across the population – is, however, only the start of a policy process. Governments need to decide if progress is appropriate, what can be done to address problems that are identified, and whether progress towards UHC is having the desired impact on broader development outcomes.

To facilitate this, measurement of progress towards UHC needs to be embedded the context of health system performance assessment in countries. Performance monitoring includes a focus on critical health system inputs that make it easier, or more difficult, to progress towards UHC such as health workforce, essential medicines and other health technologies, infrastructure and financial resources. It requires evaluating the health system outputs that the inputs produce, notably service readiness, quality of care, the availability of financial risk protection mechanisms. It also requires assessing the impact of UHC on health (e.g. mortality and morbidity) in terms of averages and inequalities.

In addition the social and environmental determinants of health will need to be monitored; recognizing that they not only impact on progress towards UHC but also on health outcomes.

Of course, measurement is simply the first step. It identifies where a country stands compared to where it would like to be. It is, however, critical if countries are to be able to make evidence-based decisions on how to develop or revise the policies and strategies that would help them progress more rapidly.<sup>9</sup>

## Conclusion

UHC is increasingly being seen as an important objective for health policy and health system development at country and global levels. It is a concept that is fundamentally about equity – ensuring that all people can use the health services they need without facing financial ruin.

It is a journey that all countries will travel at their own pace given their own needs and capacities. It is important to all countries. Even the richest continually struggle with the need to meet the increasing health needs and demands of their populations in the face of constantly rising costs.

It is possible for all countries to make progress regardless of income. By frequently assessing and adjusting the various components of their health systems, by linking with priority health programs, and by addressing social determinants, progress towards UHC can be made and steps can be taken to protect past achievements during times of financial downturn.

Countries need to be at the centre of this process, taking the lead in setting the direction, developing plans and strategies, implementing them, then monitoring progress and making adjustments as necessary. The role of development assistance partners is to assist them to do this, recognizing that the different components of a health system need to move forward together if progress is to be made while at the same time addressing the interventions that address the unfinished agenda of the MDGs, non-communicable disease, mental health and injuries.

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<sup>9</sup> More detail of how countries can monitor their own progress towards UHC, how they can embed it within health system performance assessment, and how they can develop capacities to do this is available in a separate document being prepared jointly by WHO and the World Bank. It also describes how indicators and targets related to UHC are related to discussions about the post-2015 development agenda.