

Improving Universal Health Coverage: Optimism or Pessimism for Vulnerable Population in Emergency Crises?

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ABSTRACT

It has been recently revealed that Universal Health Coverage (UHC) has increased from 45% in 2000 to 66% in 2017, with commendable achievements, particularly, in increased life expectancies and a decreased maternal and child mortality rates. This follows the international community's renewed commitment to tackle the challenges countries face, through the Sustainable Development Goals. This includes UHC which is supposed to be achieved by 2030. UHC aims at ensuring equitable, quality, and affordable health services for everybody, in order not to suffer financial hardship. However, this paper raises concern on how effectively the progress has been attained so far, and serves the goal of financial risk protection and access to quality health services for the vulnerable in emergency crises. This is because they are often severely disadvantaged due to numerous conditions aggravated by the political, economic, social, structural, or geographical factors.

Keywords: Universal Health Coverage, Vulnerable Population, Health Equity, Sustainable Development Goals

Universal Health Coverage in Sustainable Development Goals

It has been five years since SDGs program was adopted on January 1st, 2016. Through SDG, the international community renewed its commitment, to tackle the challenges countries face, including access to, and delivery of effective health services. In this case, a similar commitment regarding SDGs 3.8 was made, to implement UHC, to ensure equitable, quality, and affordable health services for everyone by 2030 [1]. In the spirit of leaving no one behind, the basis of SDG, and equitable "health-for-all" (the cornerstone of UHC), some structural adjustments have been made in all the countries regarding user fees, social health insurance, private voluntary insurance, compulsory

pooled prepayment and other social health programs. So far, SDG 3.8 has registered significant progress and health outcomes, as reported recently in the UHC Global Monitoring Report 2019, at the United Nations high-level meeting on UHC [2]. A case in point is the improvement in the global health service coverage from 45% in 2000 to 66% in 2017, which subsequently, increased life expectancies and decreased maternal and child mortality rates.

Vulnerable groups

Notwithstanding UHC's progress as reported, the concern is whether UHC, targeting 1 billion more people to benefit from health services by 2030 is whether or not excessively ambitious? In spite of the Millennium Development Goals

(MDGs) plan [3], which greatly superseded the SDGs in saving more than 1 billion people from extreme poverty, its health related goals, targeting health coverage, were left unfinished. This was mainly attributed to the exclusiveness and ambitiousness of MDGs. Besides, how effectively does the recent improvement of UHC, serve the goal of financial risk protection and access to quality health services for vulnerable people and other underserved groups (such as individuals with disabilities, homeless people, minorities, immigrants, drug addicts, sex workers, refugees etc.)? This is because these groups are often severely disadvantaged in emergency crises, such as disasters, wars and conflicts, displacements, and pandemics due to the conditions aggravated by political, economic, social, structural, or geographical factors.

Are the concerns of the vulnerable groups who are most affected in emergencies, addressed in the improvement of Universal Health Coverage?

Probably, it is still too early to project what will happen regarding the concerns noted above, although a remark made by Michel Sidibé, the former Executive Director of UNAIDS, conveys a vital message to be borne in mind. He once stated that; “[Sic] ...the ultimate measure of success for UHC will be whether the poorest, the marginalized and the most vulnerable people are able to benefit” [4]. Apart from facing numerous barriers and social exclusion in accessing essential services in the community, including but not limited to health, the vulnerable and underserved groups have higher rates of disease, injury, and premature mortality than the general population. They, particularly, experience this during and in the aftermath of emergency crises. While there is considerable overlap between the vulnerable and underserved people, an individual may be vulnerable, but not underserved. However, both groups are often at higher risk of adverse health outcomes, such as disease outbreak and transmission, which is compounded by their limited access to health services during emergency crises. Accordingly, they deserve

special consideration in a quest for leaving no one behind, as encouraged by the SDGs.

Good health is one of the underlying drivers of sustainable development, which is the overall goal of SDGs. “Health-for-all” implies the removal of obstacles to health. Sadly enough, this may take time to be realized for the impoverished people facing persistent and systemic barriers in virtually every aspect of life, and particularly, in the Low- and Middle-Income Countries (LMICs) In such countries, health systems are weak to deliver a full spectrum of health services [5]. Moreover, only 40% of the poorest people in developing countries are reported to have access to basic health services, especially maternal and childcare [2]. Consequently, a vast majority (60%) of people do not have access.

As such, a vital step to address this health inequity, faced by vulnerable groups in situations limited not only to emergency crises, would be to scale-up robust Primary Health Care (PHC) systems. Broad evidence attests to PHC being the main platform, through which a comprehensive (nearly 90%) package of health services (for example preventive, curative, rehabilitative or palliative) can be successfully provided [5, 6]. Moreover, the provision of a fair share of health services for vulnerable groups and other underserved people, rural or urban, can easily be delivered in emergencies through PHC facilities, instead of relying on tertiary and specialized expensive hospitals. Fortunately, the indispensable role of PHC was underscored in the UHC Global Monitoring Report 2019, as being an engine for UHC, which called on governments to devote at least 1% of their GDP to PHC [2]. Dr. Tedros Adhanom, the current Director General of WHO, went on to emphasize that, “[Sic]...UHC, with strong primary care and essential financial protection, is the key to achieving the ambitious health targets of SDGs, and to avoiding impoverishment from exorbitant out-of-pocket health expenses” [7]. However, it will be interesting to see how the governments heed this call of committing 1% of their GDP to PHC, bearing in mind many countries have not even

honored their commitment to the Abuja Declaration of spending at least 15% of their budget on health [8].

Apart from the traditional challenges, involving insufficient funding, shortage and brain-drain of health professionals, lack of infrastructure and equipment, which is a challenge for health systems in LMICs, implementing PHC programs may have to contend with pervasive market-oriented goals (e.g. high profits and market competition with public and private care providers). Unfortunately, the goals may be inconsiderate to the health needs of the vulnerable groups, especially in emergency crises or related situations. It is interesting that some of the market-oriented health reforms seem to have received a nod of approval from international players, like the World Bank. The sanctioning of these players, as discussed by Tichenor and Sridhar, aims to promote equal access to government-run health services [9]. But where does this leave the over one billion people of the world's population, estimated to be living in absolute poverty, and the most affected, during and in the aftermath of emergencies? Already, over 100 million people, especially in Sub Saharan Africa (SSA), are reported to be annually pushed to extreme poverty due to exorbitant out-of-pocket health expenses [2]. Of course, UHC does not mean free coverage for all possible health interventions, as no country can provide all services for free on a sustainable basis. Ideally, UHC should act as a social contract and safety net for the poor [2].

While reflecting on the experience of the 1978 Alma-Ata Declaration, which envisioned realizing "Health-for-All by the Year 2000" [6], and without any motive for spelling doom, it is unclear if the reported progress of UHC plan will accelerate without falling short of its expectation(s) by 2030. Beyond addressing the traditional barriers noted above affecting health systems, health-for-all often has to relentlessly deal with other challenges intertwined with financial conflicts of interest, especially those affecting the poor and vulnerable. This is particularly so, with corruption, a global governance problem that has been slowly

infiltrating the health sector in many countries through its adverse effects. This mostly afflicts the poor, given their limited ability to meet the demands imposed on them [10]. Moreover, though a number of health coverage plans, as mentioned, have been evolving, another worry is whether they are practical for most of vulnerable groups, both in developed and developing settings? Apart from being at high-risk of emergency crises, the vulnerable groups are often without formal employment, necessary technologies and permanent physical addresses, who suffer from illiteracy, isolation, negative cultural beliefs and other barriers. It is undeniable that implementation of various health coverage programs, for instance, is dependent on effective governance, administrative and financial arrangements, employment and income, education level, technology use, and user attitudes. Some of these factors, as revealed by one systematic review, influence the uptake and sustainability of community-based health insurance plans in LMICs [11].

Conclusion

Looking forward, similar to recommendation(s) presented in previous Lancet commentary, by participants at the Bellagio workshop on implementing pro-poor UHC [12], it can be assumed that the road to achieving "health-for-all" by 2030, will depend on how well UHC strategies ensure financial risk protection and delivery of high-quality and cost-effective health services. In providing services, the needs and expectations of vulnerable groups and other marginalized people should be considered, both in emergency and non-emergency situations. It is because, unlike other mainstream groups of society, they have limited access to them. Services should also entail commitments aimed at addressing the conditions, which accentuate the adverse effects and barriers to health, such as precarious housing, social isolation, education, place of residence, marital status, ethnicity, religion, economic status, age etc. This is required, especially in the resource-constrained settings like SSA and South Asia,

where the disadvantaged people and those in greatest need receive less or merely no attention. With less than ten years till 2030, time is still on the side of proponents of SDGs, including the activists of UHC, to carefully address the challenges in the way of their progress to benefit all, and not leave anyone behind. Particular attention ought to be accorded to the vulnerable and other indigent groups, who are often deprived of their inalienable right of health, whenever they fail to access even the basic healthcare services due to their financial hardships.

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