Is Universal Health Coverage Always the Best Solution to Health Challenges?

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Margaret Chan, the director-general of the World Health Organisation from 2007 to 2017 posited that 'striving for universal health coverage is an admirable goal and a feasible one—everywhere.' (WHO, 2010: 5). Universal Health Coverage (UHC) itself is a rights-based aspiration seeking to establish affordable access to healthcare for everyone, based on their health needs rather than their ability to pay (Savedoff et al, 2012: 925; Holmes, 2012; WHO, 2005: 1). It has to be clear that UHC itself is a conceptual goal that upholds equitable access to healthcare through some form of risk pooling, rather than a specific set of prescribed policy instruments (Kutzin and Sparkes, 2016: 2).

While UHC may be an admirable goal, this essay will highlight three main challenges that determine the extent of UHC's effectiveness in responding to health challenges. Firstly, UHC requires comprehensive administrative and medical infrastructure, demanding for resources that certain countries may not necessarily have in the context of global wealth and health inequalities. In addition, striving for greater health coverage does not necessarily lead to a greater *depth* of coverage, which refers to the extent of insurance coverage that minimises out-of-pocket costs, as observed in China. Lastly, the quality and range of services provided by UHC also needs to be expanded to meet specific health challenges, a particular challenge in Mexico. This essay will demonstrate that while UHC is an admirable pursuit of health rights, it should not be exaggerated as the best solution for all contexts without first considering and articulating the factors discussed.

UHC is an admirable goal

UHC is an admirable goal that seeks to extend healthcare access to everyone, based on actual health needs rather than the ability to pay for a service (McKee et al, 2013: 39). Diseases such as tuberculosis drive people into poverty, taking up to 40 percent of annual family income in low and middle-income countries; placing an immense financial burden on families (WHO, 2013: 10). Globally, up to 100 million people are pushed below poverty lines because of healthcare costs, and only about five to ten percent of people in sub-Saharan Africa and South Asia have any insurance coverage at all (WHO, 2010: 8). The Congo for example, relies on out-of-pocket payments to fund about 90 percent of healthcare costs, with many payees resorting to risky borrowing or liquidating assets to pay for catastrophic and unexpected health issues (Lieve and Xu, 2008; WHO, 2007; Niessen and Khan, 2016: 9). This is compared to 11.3 percent of healthcare costs attributed to out-of-pocket payments in Germany (WHO, 2007). These figures reflect the inequalities in healthcare financing and the harsh realities of those living without UHC, where healthcare services are highly commodified.

The goal of UHC is to provide access to healthcare for everyone, without having to face financial hardship in paying for it (Savedoff et al, 2012: 925). Thailand for example, even allows irregular migrants to enrol in a national insurance scheme, covering curative and preventive care on top of primary care as part of an affordable package (Onarheim et al, 2018: 3). The inclusivity sought by UHC improves collective health security, strengthening society's resilience to health problems that spread across borders; a pertinent concern in the context of globalisation and migration (Kutzin and Sparkes, 2016: 2). Gwatkin and Ergo (2011: 2160) argue that UHC empowers the marginalised, such as the undocumented migrants, by removing the stigma surrounding differentiated services, allowing access to all regardless of race or religion or other social categories. Thus, UHC is an admirable goal in upholding normative

values of equity and non-discrimination; providing access to healthcare based on needs rather than financial capacity (Reid, 2017: 115; Kutzin and Sparkes, 2016: 2; McKee et al, 2013: 40). In 2005, all WHO member states committed to UHC, underscoring the importance and priority of this goal to many countries across the world (WHO, 2013: 4; WHO, 2010: 7). However, despite this overt display of commitment, austerity measures and anti-welfare rhetoric threaten to reverse efforts towards UHC, even in developed countries such as in Spain and Greece (McKee et al, 2013: 43). In developing countries, the inverse care law continues to be observed where countries with the greatest health burdens receive the least in financial aid, depriving some countries of the very resources they need to establish UHC (McKee et al, 2013: 43).

Infrastructural demands of UHC

UHC requires comprehensive infrastructure that may not necessarily be readily available or attainable in poorer countries. Without legitimate and strong administrative structures, even having formal policies promoting the right to healthcare does not necessarily translate to effective implementation (Savedoff et al, 2012: 925). Certain low-income countries, such as Ghana have an unstable tax base to begin with, as its weak tax identification systems and information processing units inhibit the collection of tax contributions and premium payments (WHO, 2010: 10; Ohemeng and Owusu, 2015: 353). Even if taxation systems are well-established, high unemployment continues to be a problem in generating revenue and sustaining insurance payments in low-income countries (WHO, 2005: 5). Despite this, Savedoff et al (2012: 930) insists that Indonesia's advances towards UHC demonstrates that UHC goals can be achieved without the need for large wealth.

However, Savedoff et al neglect the fact that Indonesia's strategies, such as its compliance tax law reform to increase tax yields is considered beyond the scope of the lowest income countries, given their lack of administrative capacity (WTO, 2010: 26). Low-income countries tend to lack both the financial resources, as well as physical and human resources to provide the resources needed to sustain the structures of a comprehensive healthcare system (Heredia et al, 2014: 36). Chan, then director-general of the WHO acknowledges that efficiency in the use of resources is required to improve health outcomes (WHO, 2010: 5). Efficiency itself can be linked to the wider structural determinants of health, such as the quality of governance, institutions and public infrastructure such as transport systems; all of which require large investments in order for the goals of UHC to be realised (WHO, 2010: 5, 14; Moreno-Serra and Smith, 2012: 920; Van de Pas et al, 2017: 56). Both the WTO (2010: 19) and WHO (2010: 9) acknowledge that many low-income countries will not be able to finance UHC through their own domestic resources and require official development assistance.

Yet, international funding often come with regressive conditions that undermines health, and the effects of SAPs endure for the poorest people despite the advent of poverty reduction strategies (Breman and Shelton, 2007: 222; Marmot, 2005: 1101). User fees introduced through cost-reduction measures were meant to generate additional resources and increase efficiency, but instead, it has undermined access for the poor with its high administration fees and inefficiencies (Kentikelenis, 2017: 298; Akin, Birdsall and De Ferranti, 1987: 32). This increases the reliance on direct payment mechanisms, clearly inhibiting the goals of UHC by exposing people to greater financial risk (WHO, 2010: 9). For example, between 1990 and 1993, maternal mortality rates in Zimbabwe increased from 90 to 168 deaths per 100,000 births, attributable to the high costs of delivery services which forced mothers to deliver babies under unsafe conditions (McGow, 1995). It is true that SAPs have been rebranded as 'poverty reduction and growth' programmes, and are purported to more sensitive to social development and wellbeing, but it still involves deregulatory conditionalities as did its predecessor (Kentikelenis, 2017: 296; Wamala et al, 2007: 248).

This includes neoliberal moves to reduce social subsidies, commodify social services through user fees and the use of means-testing, effectively linking social provisions with the ability to pay rather than need (Bond and Dor, 2003: 1). In addition, while these poverty reduction strategies often include policies targeting the poor, they do not address larger concerns about the costs of inpatient care and catastrophic illnesses (Wamala et al, 2007: 241). The director-general of the World Health Organisation (WHO), Chan, argued that prepayment mechanisms that pooled financial risks were a more effective financing system for healthcare as compared to direct payment mechanisms which placed the burden of payment solely onto the individual (WHO, 2010: 4). Yet, regressive programmes by the International Monetary Fund and World Bank undermine the objectives of the WHO, increasing the burdens of

healthcare costs for people in poorer countries (Kentikelenis, 2017).

Health costs of pharmaceutical and biomedical trade

Medical infrastructure and resources are crucial components of UHC, but is challenged by the global economic structures that work in the interests of corporations. The availability of generic medicines is crucial in supporting universal health coverage, as patented drugs are highly costly and inaccessible to those who need it most (Busfield, 2015: 152). Thus, in 2003, the WTO General Council articulated that patent protection under the agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) should not undermine public health, and outlined how developing countries can utilise TRIPS flexibility to secure the goods for public health (Flint and Payne, 2013: 508). However, bilateral agreements involving preferential trading areas and the utilisation of 'TRIPS Plus' enforced strict regulations on patent protection, securing profits for pharmaceutical companies at the expense of those in need of those drugs (Busfield, 2015: 156; Flint and Payne, 2013: 509). For example, anti-retrovirals (ARVs) were available in the 1990s at the height of the African HIV pandemic, but uptake and distribution were hampered by costs that were up to $10,000 per year, and was only brought down to a hundredth of that price by generic alternatives made in Brazil and India (Flint and Payne, 2013: 501, 507). However, access to cheaper generics produced by these countries can be delayed or blocked by patent obligations (Waning, Diedrichsen and Moon, 2010: 42). Thus, patent protection has a stranglehold over the trade and development of generic drugs that are needed in these countries, hampering the responsiveness of medical supplies to the dynamic nature of disease (Flint and Payne, 2013: 500, 506).

Low-income countries also do not always independently have the financial capacity to purchase life-saving technology such as vaccines, or infrastructure to administer them safely, disincentivising the pharmaceutical industry from even manufacturing them as the quantity of production is not sufficiently profitable (Craddock, 2007: 1043; Busfield, 2015: 161). To improve health, health spending will have to double per capita in 49 low-income countries in order to enable access to critical services which include treatment for non-communicable diseases, but only eight even have any capacity to do so (WHO, 2010: 10). Instead, pharmaceutical companies have divergent interests in maximising profits in high-income countries, translating to the development of drugs that are meant to be taken in the long-term for chronic illnesses, over treatment for terminal illnesses more common in developing countries (Busfield, 2015: 160-163). GlaxoSmithKline's legal challenge against South Africa for providing compulsory licensing and parallel imports for HIV medicines demonstrates the conflict of interests between corporate entities and health interests, even though it was withdrawn in the end (Flint and Payne, 2013: 507). In light of these dominant interests, it is unhelpful that the Sustainable Development Goals (SDGs) do not clearly articulate the obligations of the producers of global public goods (Van de Pas et al, 2017: 53). Global pharmaceutical and biomedical industries are key players in realising the UHC goal, but SDG 3 only seems to place that responsibility onto the nation-state when there are many other actors involved, a responsibility that not all nations have the financial capacity to undertake alone (Van de Pas et al, 2017: 53). In response, the United Nations, World Bank and Rockefeller Foundation have acknowledged the unaffordability of UHC in some developing countries and suggested priority interventions in oral rehydration, breast-feeding and immunisation as a better interim goal (McKee et al, 2013: 43). Clearly, there are limits to UHC as a universally achievable goal, in light of the global inequalities in resources.

Depth of Coverage

UHC seeks to expand health coverage, but the *depth* of coverage will also need to be considered in achieving equity of service access. The depth of coverage refers to the extent to which people are shielded from out-of-pocket payments for health services (Kutzin, 2000: 3). The aspirations of UHC include limiting out of pocket payments to a level of affordability, and targeted coverage to eliminate costs borne by the poor (WHO, 2013: 6-7). The lack of depth is a particular challenge for China (Yu, 2015: 1149). China faced skyrocketing healthcare costs in the 1990s in line with the precipitous economic growth, while up to 80 percent of the rural population were left uninsured (Li et al, 2014: 1080). It is in this context where the 2003 SARS outbreak acted as a focusing event for China to mobilise its political support and economic resources in reshaping the health agenda and its outcomes (Yu, 2015: 1146; McKee et al, 2013: 40). By 2011, China has effectively expanded health coverage universally, having 95 percent of the Chinese population insured compared to just below half of the population in 2005; the largest expansion programme

in human history (Yu, 2015: 1146). The government was subsidising 75 percent of the New Rural Cooperative Medical Scheme (NRCMS) a huge achievement in extending coverage to the rural population and in moving towards UHC goals (Yu, 2015: 1148).

However, issues remain, such as the reimbursement of inpatient care, which still places a large proportion of the financial burden on the consumer, and out-of-pocket expenditures still remains higher than the average level of upper-middle-income countries at 35% as of 2011 (Yu, 2015: 1148). NRCMS was an attempt to expand coverage to rural populations, covering 62 percent of the population in 2011, but was lacking the depth offered by the other two programmes, namely Urban Employee Basic Medical Insurance (UEBMI) and Urban Resident Basic Medical Insurance (URBMI) (Yu, 2015: 1149). In addition, there is substantial benefit variation across the different insurance schemes linked to the premiums paid, leading to social stratification between urban and rural populations (Yu, 2015: 1150). For example, the reimbursement rate for inpatient care under NRCMS was only 44 percent, compared to 68 percent under UEBMI, even though the burden of health issues such as child cognitive disability and low infant mortality rates fall largely on the rural population (Meng et al, 2015: 1484; Yu, 2015: 1149). Additionally, out-of-pocket costs remain high under NRCMS, offering very limited financial protection, exposing the rural poor to catastrophic medical payments (Sun et al, 2009: 103). In 2011, the incidence of catastrophic medical payments even after NRCMS reimbursement was 11.6 percent in a study of 25 counties, (Zhang et al, 2016: 30). Wide variability exists across and even within the schemes (Meng et al, 2015: 1484). The risk of NRCMS is pooled at the smaller county-level, with unequal levels of provision across counties (Meng et al, 2015: 1484). In addition, UEBMI and URBMI are pooled at the wider municipal level, 333 of them as of 2012 (Meng et al, 2015: 1484). This means that there is a multiplicity of schemes in China which are administered differently and unequally from each other, based on the administrative region, and the type of scheme concerned (Meng et al, 2015: 1484).

Thus, while wide coverage is achieved, the access to health provisions remains geographically, and therefore, socially determined (Marmot, 2005: 1101). Similarly, Mexico has a system of mixed and highly unequal packages, exacerbated by the unequal spatial distribution of resources that left 20% of the population uninsured (Heredia et al, 2015: 35). Thus, Waitzkin (2015: 93) criticises the UHC as being distinct from the aspiration for 'healthcare for all', where equal services are provided for an entire population, independent of the financial resources of the individual. Instead, UHC neglects the provision of equal services for all (Waitzkin, 2015: 93). Perhaps it is the broadness of UHC's definition that allows the space for such criticism on its intended outcomes. Nonetheless, this remains as a sobering warning that UHC is not achieving the very objectives it purports to support. UHC in practice can create a fragmented system that even undermines access, stratifying social groups into tiered benefits that leaves the poor with fragmented and inadequate health provision (Waitzkin, 2015: 93-94).

Scope of Services

UHC also needs to consider the access to quality services in order to respond effectively to contextual health needs. Gwatkin and Ergo (2011: 2160) highlight the grim possibility that the pursuit of UHC would lead to an opposite effect – to overlook the provisions that are most needed in the quest to extend coverage. The WHO (2013: 6) advocates that health service provisions should include a broad range of options, such as prevention, treatment, rehabilitation, promotion and palliative care and should be insulated from disasters and pandemics. There is a need to identify key diseases and their nature as well as targeted components of the health system that needs to be improved (WHO, 2013: 57). It has to be acknowledged that Mexico has expanded and improved the scope of services covered by Seguro Popular, more than tripling the number of interventions covered between 2004 and 2018 (Ruiz, Ratsch and Martinez, 2018: 197). 49 percent of the population who cannot afford private insurance or employment-based social security can rely on Seguro Popular, a government insurance programme, which effectively doubled the proportion of citizens having insurance coverage between 2002 and 2015 (Garcia-Garcia and Chavez-Iñiguez, 2018: 1027). The programme can be lauded for prioritising and targeting the uninsured, providing fully-subsidised coverage for the lowest-income groups found by means-testing (Gwatkin and Ergo, 2011: 2161).

However, challenges remain in incorporating high-cost interventions into this programme, particularly dialysis for chronic kidney failure, given the financial limitations (Ruiz, Ratsch and Martinez, 2018: 199; Garcia-Garcia and Chavez-Iñiguez, 2018: 1027). This is an especially pertinent issue as chronic kidney disease (CKD) in Mexico is

second-leading cause of death, with a prevalence rate of 1556 per million of the population, and the second-highest 'disability-adjusted life year' rate in the world (WHO, 2018; Garcia-Garcia and Chavez-Iñiguez, 2018: 1027). Thus, Mexico suffers a large share of the global burden of chronic kidney disease and yet, a large proportion of its citizens under Seguro Popular do not have access to dialysis for CKD (Garcia-Garcia and Chavez-Iñiguez, 2018: 1027). Therefore, access to dialysis and transplantation treatment remains based on whether one can afford it (Garcia-Garcia and Chavez-Iñiguez, 2018: 1027). Clearly, the provision of quality healthcare that is accessible to all can be expensive, especially if a country is suffering from a larger burden of disease, much unlike the assertions of Chan that UHC need not be expensive (WHO, 2010: 5; Ruiz, Ratsch and Martinez, 2018: 199).

Another notable gap between disease and treatment provision is cervical cancer. Cervical cancer is the second-leading cause of deaths due to cancer in Mexican women, with a crude rate of 6.21 out of 100,000 Mexican women (Mohar-Betancourt et al, 2017: 743). While pap smear diagnosis for cervical cancer is provided for under Seguro Popular, the treatment for cervical cancer itself is not necessarily covered and varies according to state programmes (Waitzkin, 2015: 94). It is in light of these realities that Waitzkin (2015: 94) accuses UHC of being yet another neoliberal policy that leaves the state to cover the residual uninsured through unstable programmes where quality hinges on budgetary allocations, while corporate actors dominate the rest of the system of healthcare provision. Thus, UHC, at least in practice, does not seem to be the panacea for all health challenges by focusing on coverage, but ignores the quality of services (Gwatkin and Ergo, 2011: 2160; Waitzkin, 2015: 94).

Conclusion

In conclusion, while UHC is a noble aspiration to improve the health of people, there are formidable challenges that need to be overcome. On a global scale, persistent health and wealth inequalities continue to keep developing countries from pursuing UHC goals. The global burden of disease falls disproportionately on poorer countries that lack the resources to cope with them, a problem exacerbated by the global economic structures that is purported to generate wealth. This calls for greater responsibility at the level of global governance. Even if health coverage is extended to all, the depth and scope of services must be calibrated to suit the needs of the population. This will require a greater responsibility at the level of state governance; in directing and managing resources efficiently. Ultimately, the issue of health is highly challenging and complex, requiring the various actors in the multifarious levels and networks of governance to act in the pursuit of better health outcomes for all. In light of these considerations, UHC should not be exaggerated as the panacea to all health challenges.

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