Achieving universal health coverage in low-income settings

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See **Editorial** page 859

See **Comment** pages 861, 862, and 864

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The goal of universal health coverage is deeply embedded in politics, ethics, and international law. Article 25 of the 1948 Universal Declaration of Human Rights states that everyone has the right to a standard of living adequate for health, including medical care, and the right to security in the event of sickness or disability.[1] Motherhood and childhood are to be afforded special care and assistance. In the same year, the Constitution of the World Health Organization came into force, declaring that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[2]

There are two related motivations for the commitment to universal health coverage. The first is that every individual has the right to health, and hence to some measure of health care. The second is that poor health has negative spillovers (externalities), from individuals to the community, and from poor countries to rich countries. Society at large therefore has a vested interest in ensuring that poor individuals have access to health coverage.

Despite the commitment to universal coverage, in practice effective access to health care and outcomes depends strongly on economic and social conditions. For example, people in the least developed countries have a life expectancy at birth of 59 years and under-5 mortality of 112 per 1000, compared with a life expectancy at birth of 78 years and under-5 mortality of eight per 1000 in the more developed (high-income) countries.[3] In high-income countries with high inequality of income and status, the socially deprived also fare much worse than the rich.[4] Being a member of an ethnic minority or indigenous population can also lead to a lack of access to health care and adverse health outcomes more generally. In this article I will focus on achieving universal health coverage for poor populations, especially people living in low-income countries rather than those living amidst prosperity in middle-income and high-income countries.[5]

Health outcomes are the result of many complex factors inside and outside the health system. Poverty affects health outcomes not only through access to the formal health sector but through nutritional adequacy, safety of the home environment, quality of water and sanitation, environmental exposure to toxic substances, limitations of knowledge about health-seeking behaviours (eg, because of a lack of literacy and schooling), and the direct effect of low social status on physiological stress and psychosocial wellbeing.

Even with such multidimensional linkages from poverty to poor health, the health care system can make a major difference,[6] especially if public provision is also made for basic infrastructure including safe drinking water, sanitation, electricity, and local environmental protection. The health sector is particularly important because a substantial portion of the excess disease burden of poor households results from a limited category of diseases, known as group I diseases: communicable, nutrition, maternal, and perinatal conditions.[7] The importance of this fact is that for most of the group I diseases there are powerful, low-cost health sector interventions to prevent, treat, or cure the disease.[8] Thus, even in the midst of poverty, much of the excess disease burden can be controlled at fairly low cost, even before poverty itself is relieved.

Universal health coverage should be defined partly in terms of coverage of a minimum basic package of health needs that prioritises effective low-cost interventions for the excess disease burden of the local population, typically group I diseases and a subset of group II (non-communicable) and group III (trauma) diseases that can also be addressed with high effectiveness at low cost. Assessments of cost-effectiveness (such as dollars per disability-adjusted life-year saved) can be helpful in this prioritisation. Health policy should also remain alert to interventions outside of the health sector that can have a large effect on health outcomes (eg, regulation of tobacco trade and use, promotion of smallholder agricultural production, school meal programmes, and basic infrastructure).

Given a minimum package of health interventions, two major considerations arise: health financing and the organisation of health-care delivery. Health financing can be through the national budget, private payments, or direct service provision by non-governmental agencies such as church-run clinics. Public financing can be sourced through earmarked revenues (eg, payroll taxation for public health provision), general revenues, or donor supported outlays. Private payments can be out of pocket at point of service or pre-paid (eg, through private health insurance). Of course, countless variations and gradations exist among the government, private, and NGO sectors, as described in the recent World Health Report on health financing.[9]

Many analysts and policy makers neglect two basic aspects of poverty that impede health-care coverage in low-income settings. The first is that in a low-income economy, many households do not have the means to pay for any health care at all. This is especially true for out-of-pocket costs at point of service. Some poor households have no cash whatsoever at many points of the year, for example just before harvest. The cultural and economic division of labour within the household can leave the mother, typically the caregiver, without any access to money even if the husband has cash available.

The implication is profound. Even a tiny user charge imposed at point of service can drastically reduce the

access to health services by the poorest members of a poor community. Ending service fees can therefore lead to a surge in access of health services.[10] Of course, the services must still be financed in some way. Public revenues rather than private out-of-pocket outlays (or private prepayments) will generally be needed. The lesson, however, is to avoid the lazy thinking that small user fees (at point of service or even prepayments by community members) will usefully require households to avoid wasteful use of health services, or induce poor households to value the services more, or cover the operating costs of local clinics. Instead, even nominal copayments can lead to massive exclusion of the poor from life-saving health services.[11]

The second basic aspect of poverty is that the governments of low-income countries will often lack adequate domestic budget revenues to ensure universal access to a basic package of health services even if the government is disposed to guarantee universal access to health care. Some basic arithmetic is pertinent here. The minimum package for primary health services in 2012 is probably around US$50–60 per person.[12,13] This remarkably low sum, if properly deployed, can cover the main interventions at the primary level for most group I conditions: diarrhoea, pneumonia, vaccinations, malaria control, malnutrition, perinatal deaths, and maternal deaths (related to pregnancy and childbirth).

Yet even this low sum (compared with the several thousand dollars per person per year of public health spending in the high-income countries) is out of the reach of governments of the poorest countries. Consider a country with a gross domestic product at roughly $300 per capita, such as Mali or Ethiopia. Public revenues through taxes, royalties, and other means, can amount to around 20% of national income, or $60 per person per year. That sum must cover all public services, including education, infrastructure, and public administration, not only the health sector. One international norm known as the Abuja Declaration is that low-income governments promoting universal access to health care should devote 15% of their total budgets to health.[14] This amount is a stretch, but achievable. Yet it implies only $9 per person per year in the health sector (15% of $60) for these countries. There would be a health funding gap of some $40–50 per person per year that would have to be made up in large part through temporary international donor assistance, until those countries graduate from the need for aid through their long-term economic growth, enabled by a healthier population. The WHO report on financing for universal coverage concurs that for most of the least developed countries, domestic revenues cannot suffice for universal coverage: external assistance is needed.[12]

With around 800 million people in the least developed countries, and perhaps another 200 million in need in other low-income countries, total international aid should reach around 1 billion poor individuals, at around $40 per aid recipient per year. This cost suggests a total aid need of some $40 billion per year from the donor world, compared with roughly $27 billion in international health assistance in 2010.[15] Another $13 billion per year would reach the $40 billion annual mark. Note that $40 billion is only 0·1% of high-income annual gross product, so the need for international development aid can be summarised as roughly 10 cents per each $100 of donor national income.

Let us suppose that the financing is somehow brought into good order—that is, the combination of domestic budget revenues, earmarked levies on households (eg, to buy mandated health insurance), and foreign assistance for health covers the financing need of at least $50–60 per person per year in the poorest countries. The second great challenge, then, is the proper organisation of the primary health system. Should such a system be organised through public-sector provision (such as the UK National Health Service [NHS]), private-sector and NGO provision with public financing (such as contracts between the state payer and the private-sector health provider), or by a mix of public, private, and NGO providers? A national health system can of course include a mix of organisational types rather than one type of provider.

Private-sector health provision with public financing is commonly thought to offer the best combination to ensure efficient, high-quality, low-cost primary health care. The reasoning is that state providers are monopolistic (and highly unionised), technologically laggard, and perhaps corrupt as well; whereas the private sector offers the opportunity for competition, innovative delivery systems, and household choice. The World Bank, US Government, and market-oriented health economists have often argued for robust private-sector health provision as a result. They often state that private health provision accounts for a large proportion of existing health care in poor countries, so private provision is inevitable and should be championed.

Yet at least three considerations point to the importance of public sector provision more akin to the NHS. First, public health financing with private provision of health services opens up a can of worms regarding contracting between the public and private sectors. To the extent that the public financing reimburses private sector costs (such as US Medicare payments), there are powerful incentives for the private providers to inflate costs, especially since patients themselves cannot effectively monitor the quality of care offered by their doctors and health facilities.[16]

Second, the presence of a large private sector may create not merely the incentive of individual providers to raise their costs, but also a relentless lobbying pressure to attend to the needs and wants of the middle-class rather than the poor. Mixed public-private systems usually entail a mix of payments by private middle-class and upper-class households that contract directly with private health providers, as well as public sector

financing of public clinics. In such a case, the public sector is likely to become the sector of last resort for the poor, whereas the private sector becomes the politically dominant sector in the society, able to reap large public outlays on behalf of the politically powerful middle and upper classes.

The third limitation of private provision is more intrinsic to health-sector systems design. Much good public health is based on systematic applications of best-practice technologies applied at population scale and systematic monitoring and data collection. Vaccine coverage should be applied comprehensively in order to achieve herd immunity in the community. Disease eradication, such as for smallpox and perhaps imminently for polio, depends on universal protection applied systematically and rigorously. Even the control of communicable diseases not currently close to eradication, such as malaria, will often be characterised by mass action benefits if coverage levels are very high.

These limitations imply that efficiency as well as equity calls for highly systematic and broad coverage of key intervention strategies. There are tremendous economies of scale and scope to ensure that health interventions reach a large proportion of the population. Malaria control began to work when donors finally abandoned social marketing of bednets and medicines, and agreed to support a model of mass free access to these control measures, roughly around 2007–08. Since then, coverage with freely distributed bednets has soared, and the number of malaria deaths has fallen substantially.[17]

In theory, the sum of private providers could offer comprehensive coverage, if each private provider is required by government to provide certain key public services, such as high levels of coverage of vaccines and immunisations among their clientele, community health outreach of preventive services (vaccines and bednets), emergency services, and the like. In practice, public goods such as mass coverage, mass public awareness, mass access to trained community outreach workers, and mass access to emergency services (such as ambulance transport), are more effectively provided through public programmes rather than the sum of highly regulated private programmes. Poor people may have formal access to health services, but unless there is outreach into their communities (eg, community health workers and ambulance services) they might in fact not be able to get access to life-saving services in a timely and reliable manner. In the rich countries, epidemics are always handled by the public sector, never the private sector, because of the need for comprehensive control (and hence economies of scale in service provision). The same should be true for poor countries as well, and for the same fundamental reasons.

The argument that we should build on private provision because it is the prevailing reality is also misplaced. If the public sector is nearly moribund because it is deeply under-funded, the private sector will loom large as a proportion of the total health sector. The large out-of-pocket expenditures and private provision in low-income countries is mainly a reflection of the paucity of public services, especially for the poor, forcing the middle and upper classes to go directly to private providers, while the poor are left without reliable basic services.[18] This reality is unfortunate, and not a case for private provision, but rather a call to action to bolster the deeply under-financed public sector as is being proposed in India.

Since the WHO Commission on Macroeconomics and Health (2000–01) and the adoption of the Millennium Development Goals (2000), there has been a major increase in primary health-care access in low-income countries. Donor aid increased from around $10 billion in 2000 to $27 billion in 2010,[19] which has closed over half of the financing gap of the poorest countries. New strategies for free access at the point of service (especially for women and children), and the mass deployment of effective disease control, have taken hold.

And the results are clear. Malaria mortality, maternal mortality, and child mortality have all fallen sharply as increased public spending on health has been put to good use by the low-income countries.[20] Sub-Saharan Africa has enjoyed a rapid decline in mortality in children younger than 5 years since the middle of the past decade, although there is still considerable ground to cover for the low-income African countries to achieve the Millennium Development Goals.[21] These are mainly gains in public health in the dual sense of public financing and public provision.

The world is getting closer than ever to universal health coverage, yet powerful headwinds have been gusting ever since the outbreak of the financial crisis in 2008. Most importantly, donor aid budgets are being cut.[22] The public should understand that small additions to aid for health could bring the world to universal coverage, whereas cuts in aid at this point could undo the great progress of the past decade. Universal coverage for health is within our reach—if we persevere.

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