

Universal health coverage: the third global health transition?

As the world's nations gather for the UN meetings in September, 2012, real momentum on achievement of universal health coverage—aimed at giving everyone the health services they need without causing financial hardship—is no longer a distant dream. The 25 wealthiest nations all now have some form of universal coverage (apart from the USA, where political opposition remains strong, despite a recent supportive Supreme Court decision).¹ Several middle-income countries, including Brazil, Mexico, and Thailand do as well. Lower-income nations, such as the Philippines, Vietnam, Rwanda, and Ghana are working towards it; India, South Africa, and China are making progress too. According to WHO Director-General Margaret Chan, universal health coverage “is the single most powerful concept that public health has to offer”.²

This global movement follows two other great transitions in health. The first was the demographic transition that began in the late 18th century, and changed the planet in the 20th century through public health improvements, including basic sewerage and sanitation, which helped to reduce premature deaths greatly. Then came the epidemiological transition that began in the 20th century and eventually reached even the most challenged countries in the 21st century. Communicable diseases, from smallpox to poliomyelitis, were vanquished or controlled on a scale never imagined, opening the way for contemporary action to tackle non-communicable diseases.

Now a third great transition seems to be sweeping the globe, changing how health care is financed and how health systems are organised.³⁻⁶ For a long time, getting health care has meant first paying a fee to the provider—a practice that effectively burdens sick and needy people, a small and vulnerable segment of the population, with most of the health-care costs. For many poor people, that has meant choosing between going without needed services or facing financial ruin. Paying out of pocket is still dominant worldwide. In India, for example, patient fees account for more than 60% of health expenditure.

Countries moving towards universal health coverage, including India,⁷ are seeking to change this situation. By spreading the costs across the whole population, everyone would pay less in times of ill health and those in need of treatment for serious illnesses would be

spared from crushingly high costs. Illness would no longer regularly bring financial catastrophe.

This third transition in health is not the first time that humankind has jettisoned ill-functioning traditional practices when newer solutions, based on collective action, became feasible. First, the rule of law and systems of justice were adopted when formerly brute power prevailed. Then police and fire protection, initially purely private responsibilities, were found to be more efficiently handled communally. In the 19th and 20th centuries, country after country invested in the education of their children. Worldwide evidence shows that overwhelming majorities want health care too to be regarded as a collective good.⁸

Universal health coverage can be achieved in many different ways, as the diversity of approaches around the world shows. Until recently, disagreements about alternative paths threatened to obscure the shared goal. However, that every country will develop its own path, reflecting its own culture and legacy from existing health systems, is increasingly being recognised. Mechanisms to encourage cross-country learning have developed, such as the Joint Learning Network of countries that currently includes Ghana, Mali, Nigeria, Kenya, Vietnam, Thailand, India, Indonesia, the Philippines, and Malaysia. Adapting rather than adopting what others do makes all the more sense in a world where countries' domestic

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Women wait to be examined at a chest clinic in Srinagar, India, March, 2012

finances are vastly more important than what outsiders bring through development aid.

The papers in the accompanying Series in *The Lancet* investigate the evidence for universal health coverage. Rodrigo Moreno-Serra and Peter Smith⁹ explore the effects of progress towards universal health coverage on population health, while William Savedoff and colleagues¹⁰ delve into the political and economic dimensions of the story. A third paper, by Gina Lagomarsino and colleagues,¹¹ examines the structure and progress of some health insurance reforms in low-income and lower-middle-income countries. Finally, in an accompanying Viewpoint,¹² Jeffrey Sachs calls for continued progress and argues for a large role for the public sector.

Among the many important messages are these two. First, since so many countries are moving so strongly towards universal health coverage, attention should now focus not on whether but on how to make the most of this transition. Second, universal health coverage is an opportunity but not a guarantee for progress: getting things right now can have big payoffs later, but letting things go wrong initially can be highly problematic and costly. The precise contours of what will emerge in the decades ahead in each country undertaking reform is not entirely clear, but, as this Series and many country examples suggest, we are getting closer to a time when this third transition will be achieved and families will no longer be at risk of having the cost of sickness ruin their lives.

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Universal health coverage: good health, good economics

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Underpinning the trends examined in *The Lancet's* Series on universal health coverage are several points that deserve deeper appreciation. Call them EPIC—a fitting acronym, in view of the epic transition now underway as the world moves towards universal coverage.

The E in EPIC is for economics. Good health is not only a consequence of economic development, but also a driver of it, since healthier people can do more (greater productivity, more entrepreneurialism, improved educational performance, and reduced poverty). Good health systems not only enhance these benefits by improving health but also yield additional economic benefits. In particular, improved financial protection for families against large medical bills reduces their risk of financial

ruin and makes assets and savings more secure, enabling them to save more; when many families benefit, their increased economic activity can stimulate improved economic development. The 1993 World Development Report, *Investing in Health*,¹ emphasised this idea of health as an investment rather than an expenditure. The 2001 report of the Commission on Macroeconomics and Health² took this idea further, showing that a 10% improvement in life expectancy at birth is associated with annual economic growth increases of 0.3–0.4%.

P is for policies and politics. The importance of good policies and good management of the political challenges is compellingly evident from the huge differences in health achievements between countries with similar