Being Fair in Universal Health Coverage: Prioritize Public Health Services for Low- and Middle-Income Countries

Universal health coverage (UHC) is attaining greater significance because of the importance attributed to it by leading global health agencies at the global level and its potential to improve population health across nations. UHC is achieved when "all people receive quality health services that meet their needs without exposing them to financial hardship in paying for them."[1] The needs are relative and can mean different things for different nations. The scope of UHC is its authority to (1) expand services, (2) increase coverage, and (3) ensure financial protection for those accessing services, popularly known as the depth, breadth, and height, respectively, of the "UHC box."[1(p4)] The challenge is to decide the basis by which services are prioritized among these three aspects as well as within each aspect, because UHC can be truly universal only if it caters to the real needs of nations. This is because the social, economic, cultural, epidemiological, and political context of nations should be considered while prioritizing the contents of UHC. By interpreting the needs as they pertain to low- and middle-income countries (LMICs), public health services must be prioritized over ensuring financial risk protection for exclusive inpatient services.

POTENTIAL COMPONENTS OF UHC

The World Health Organization (WHO) consultative group on equity and UHC envisages that services should extend beyond clinical and curative services to include preventive, promotive, and rehabilitative services. Furthermore, nations should respond to the need for intersectoral coordination because it is essential to achieve population health.[1(p5)] Besides, the report cautions against the overemphasis on financial risk protection by stating that it can be a central concern in UHC but not an exclusive one. Therefore, the range of services that can potentially form the package of UHC for LMICs includes (1) services related to hospitalization (inpatient services), (2) all other forms of curative care (outpatient services), (3) public health services, and (4) those services that address social determinants of health. The first two are curative in nature, whereas the third and fourth are preventive and promotive in intent. These services directly impact population health and cannot survive in isolation, and hence have to form a continuum for a country's health system to be equitable and sustainable. Public health services are those that fall under the primary responsibility of the state, which is to improve population health by implementing essential public health functions.[2]

THE INDIAN SCENARIO

In India, the annual hospitalization rate (inpatient) is around five percent, which ranges from two percent to more than 10% reported across states.[3] The popularity of various publicly financed insurance schemes in the country, all of which are only meant for reimbursement of hospitalization expenses and hence not comprehensive, reveal the overemphasis on financial risk protection within the UHC discourse.[4] However, the gross failures of public health services—reflected in the pervasiveness of preventable public health problems like undernutrition—are attributable to a multidimensional interaction of factors like inadequate food, poor access to water and sanitation leading to recurrent infection, and poor availability of timely curative care. In other words, the country fails to offer comprehensive public health services that reduce most of the major public health problems the country faces. Notwithstanding this, there is a grossly inadequate provisioning of outpatient curative care and an inequitable distribution of inpatient care services. The "dangerous neglect"[5] of public health services in countries like India should become a major priority in the context of UHC because there is ample opportunity to address it.

The criteria for prioritizing services according to WHO is based on cost-effectiveness; those that benefit the worst off and those that offer substantial financial protection.[1(p11–23)] In an Indian context, it is obvious that those services that address the social determinants of child health will be of higher priority than providing insurance coverage for hospitalization care. This is because the services that can improve child health are more cost-effective than those inpatient services. The former also

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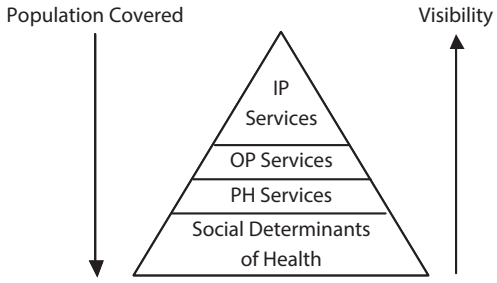

Note. IP = inpatient; OP = outpatient; PH = public health.

FIGURE 1—Potential Components of Universal Health Coverage

covers a larger population and is a priority among the worst off, as compared with the latter. Cost-effectiveness implies the effective improvements that can be achieved for every rupee spent on a population, which is furthermore dependent on the nature of problems the population are suffering and the feasibility of reversing them. Hence, it is necessary to use an ethical (health egalitarian) criterion rather than a mere economic (health maximizers) one to judge cost-effectiveness.[6] Additionally, WHO cautions that health systems should first expand coverage for services in high-priority categories and should generally not expand low- or medium-priority services before near universal coverage for high-priority services are achieved. This could be true for a range of LMICs wherein those services that cater to inpatient care will be of low priority whereas public health services will be of high priority. On the contrary, the inpatient services will have maximum visibility compared with the public health services, the outcomes of which may not be as visible (Figure 1). Visibility here implies those services that are appealing both to policymakers and to people at large, possibly because of the tangible nature of outcomes and the greater focus on individual health versus population health.

BEING FAIR

Being fair in UHC evinces reducing out-of-pocket payments through financial risk protection, either through prepayment or taxation. The challenge here, as well, is the prioritization of services for financial protection. According to WHO, out-of-pocket payments should be eliminated first for high-priority services.[1(p35)] Yet another complex prioritization is between services for "expansion" versus those for "financial protection"—the selection of services for increasing the depth and height of the UHC box. In other words, what shall be the criteria for prioritization in situations where public health services are present only minimally or almost nonexistent and inpatient services are distributed inequitably? This situation is characteristic of most LMICs wherein the majority of population health is hampered by the unavailability of public health services and inpatient services remain inaccessible because of people's limited capacity to pay. It is in this situation that policy communities overemphasize measures of financial protection for selected services at the cost of neglecting those high-priority services like public health services. The popularity and acceptance of an insurance-based system for exclusive inpatient services under UHC across LMIC nations is an obvious case that demonstrate the overemphasis on financial protection measures.[7]

One of the unintended consequences is that, because of overemphasis to ensure financial protection for those services already available, those services that are not currently covered by the health systems get overlooked. This is true with public health services, as in countries like India and other LMICs, because the various services provided under public health still remain inadequate or nonexistent. The contextual application of prioritization should be based on the ethics of public health, which calls for maximizing population health. This is accomplished through achieving equity in health, for which ensuring social justice becomes the necessary precondition. Instead, any form of prioritization driven by interchangeable[1(p7)] use of concepts like equity and fairness can result in domination of financial protection efforts for few selected services, leaving core public health services neglected. This, then, becomes an unacceptable trade-off under UHC that jeopardizes the equity concern of national health systems. AJPH

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