Universal Health Coverage

Addendum to the policy note “The right to health and healthcare”
Universal Health Coverage

Addendum to the policy note
“The right to health and healthcare”¹

¹ Referring to the right to health, the policy note mentions that “in the event of a serious health problem, costs of healthcare can quickly spiral upwards … which implies that the person suffering will not resort to care” and proposes to “set up a social security system” (see point 2.2 page 10). “A failing financing strategy has negative consequences on the sustainable development of the health sector (…) and on the possibilities to guarantee access to healthcare for the poor” (see point 5.1.4 page 18). But with regards to operationalising the Belgian Development Cooperation, point 6.3.3 needs a more concrete interpretation in light of the 2010 world health report on health systems financing.
1. Universal coverage as part of the right to health

In order to address inequities in health, it is crucial for everyone to have access to basic healthcare of high quality. Such access should not lead to catastrophic financial consequences and should be considered in the broader frame of social protection and socio-economic determinants.\(^2\),\(^3\) This is what is called "universal health coverage", an essential part of the right to health and healthcare.\(^4\)

Three dimensions of universal health coverage

While different frameworks of universal health coverage exist, the three-dimensional approach of the World Health Organization is often used to assess progress towards universal coverage.\(^5\)

- **The breadth** of the coverage, i.e. the proportion of the population having access to social protection. Exclusion of the poor should be avoided, for example by providing them free medical care or by asking for a minimal contribution. Moreover, combining existing systems and progressively extending coverage is a complex process.

- **The height** of the coverage, i.e. the proportion of the total cost that is covered through pre-financing. In the long term, the aim is to keep direct private spending under 15 to 20% of the total cost.

- **The depth** of the coverage, i.e. the range of services that are available to meet the health needs of the population.\(^4\)

II. Challenges

In order to achieve universal health coverage (and therefore wider social protection), a number of political and functional conditions must be fulfilled:

**Political will** is crucial for reaching universal coverage, e.g. in order to provide funds and promote good governance.

**Strategic choices** have to be made, e.g. to make a small number of basic health services widely available simultaneously or rather to extend a wide range of primary healthcare services

---

2 Health is influenced by a multitude of factors, e.g. nutrition, housing, working conditions, living conditions, education etc. These factors which have a direct or indirect impact on health are called “the social determinants of health”.\(^1\),\(^2\) All the political, socio-cultural and financial factors must be taken into account to give people equal access to health defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.\(^3\)

3 Social protection refers to the prevention and control of, and to the recovery from situations having a negative impact on the wellbeing of an individual. Social protection includes the policy and programmes aimed at reducing poverty and vulnerability by promoting an efficient labour market, restricting exposure to risks and reinforcing the capacity to manage economic and social risks such as unemployment, exclusion, sickness, incapacity and age. [www.unrisd.org/publications/cpl](http://www.unrisd.org/publications/cpl)

4 Inspired by the social determinants of health, the UN Human Rights Committee proposes this set of basic healthcare measures:
- Access to health facilities, goods and services, without discrimination;
- Essential medicines;
- Access to minimum essential food, nutritionally adequate and safe;
- Access to basic shelter, housing and sanitation, and an adequate supply of safe and drinkable water;
- Maternal, child and reproductive healthcare, including family planning and emergency obstetric care;
- Immunisations against major infectious diseases occurring in the community;
- Education on the main health problems occurring in the community;
- Access to measures to prevent, treat and control epidemic and endemic diseases.
gradually from district to district? Other choices concern the quality of services, or the relation between health services offered and the demand from individuals and communities.

An effective health financing system is essential to fund universal coverage (see also point 5.1.4 on page 18 of the policy note). The World Health Report 2010 focuses on this topic and outlines three axes: (6)

- **Availability of sufficient funds** to broaden the system’s coverage and to guarantee its sustainability. Public revenues and innovative sources of income might need to be complemented with additional resources.

- **Elimination of financial risks and other potential factors hampering access to the system.** A prepayment system on the basis of risk-sharing, adapted to the local context, reduces the barriers to access the most basic healthcare.

- **Efficient use of resources.** A local analysis is necessary to detect and address any spending inefficiencies.

### III. The role of the Belgian Development Cooperation in universal health coverage

Through an integrated and coherent approach, the Belgian Development Cooperation should support low-income countries on their path towards universal health coverage. This approach is based on the following pillars:

- **At the request of partner countries**

Belgium can support partner countries in making a strong **strategic plan** for the development of the health sector (sector-wide approach, see also point 5.1 on page 19-22 of the policy note), and monitor its implementation. Such a plan must take into account the social determinants of health and should be based on an inter-sectoral approach. New types of governance – adapted to the local context, especially in the so-called “fragile states” – can have a major impact on the path to universal health coverage. In this regard, local, provincial and district levels can play an important role.

The Belgian expertise and experience in the field of mutual healthcare insurance and in reaching socio-political consensus can be used to promote and support national healthcare coverage.

---

5 It is clear that the situation in each country, province or district must be thoroughly analysed in order to determine the best suited strategy for universal health coverage: the specificity of the local context, who the stakeholders are and which are the resources available. Challenges such as a dysfunctional or even non-existent health infrastructure, the remoteness of some populations, or inequities that are ingrained in the existing health system, must be taken into account.

6 The mutual healthcare insurances focus on each of the three dimensions as outlined by the World Health Organisation (7):

1. the breadth, as a larger number of members means that more people are covered by a health insurance;
2. the depth, as the mutual healthcare insurances aim for a wide range of high-quality healthcare services;
3. the height, as the mutual healthcare insurances strive for the right to access to affordable and high-quality healthcare. There is no pursuit of profit and the proceeds are reinvested into services for the members.

7 In Belgium, the first initiatives which eventually gave rise to the current system of mutual healthcare insurance date from the 19th century. It is only since 2008 that more than 99% of the citizens benefit from a low-risk and high-risk coverage and have access to a wide range of healthcare services.
Indeed, active members’ participation and democratic management are at the heart of the mutual health insurances, resulting in a unique social proximity.8

- **Building bridges between local, national and international initiatives**

In addition to national initiatives for achieving universal access to healthcare, there often exist local initiatives, both large and small scale. These all need to be coordinated, requiring knowledge management and exchange between the different actors involved. Healthcare providers and civil society, both with their knowledge of field reality, are actively involved. The principle of “community of practice” enabling policy makers, operational staff and researchers to exchange knowledge and experience, is a nice illustration in this regard.9

- **On international level**

As health is more and more recognised as a right, it becomes increasingly important in international policy.(8) At the same time, less means are available for health in low income countries. Therefore, more political will is needed to maintain national budget allocations for health sufficiently high. There is also room for additional resources from international donors, e.g. if the OECD countries would keep their commitment to spend 0.7% of GDP on development aid. Belgium makes genuine efforts as to its contributions and encourages other donors to do the same.10

Moreover, innovative mechanisms and financing methods can help ensuring universal health coverage. One possible and promising mechanism, supported by Belgium, is the financial transactions tax.

---

8 The Belgian platforms Masmut (Community health insurance / Mutual health organisations) and Be-cause Health are a pool of non-governmen-ental organisations, mutual health organisations and the Belgian Development Cooperation. They want to share the long-term Belgian experience with low income countries, adapted to the local context.(7)

9 In Belgium, the Institute of Tropical Medicine set up the initiative “switching the poles” at the end of 2006. Countries on the path towards universal health coverage are provided support through the sustainable development of sufficient professional skills as well as management expertise and analytic capacity.

10 Belgium is committed to spend 0.7% of its GDP to development cooperation (0.64% in 2010). About 13% of this share (which corresponds to 0.1% of its GDP) is aimed at strengthening universal health coverage. If all OECD countries would make a similar effort, the gap between the current national health budgets in the low income countries (25$ per inhabitant) and the needs (54$ per inhabitant) can be bridged (on the basis of a GDP of 37 billion in 2010 for an OECD population of 1.2 billion inhabitants), (see [www.unicef.org/health/files/MBB_Techni-cal_Background_Global_Costing_HLTF_Final_Draft_30_July.pdf](http://www.unicef.org/health/files/MBB_Technical_Background_Global_Costing_HLTF_Final_Draft_30_July.pdf) and [www.tradingeconomics.com/high-income/population-total-wb-data.html](http://www.tradingeconomics.com/high-income/population-total-wb-data.html))
IV. Summary

Principles

• Universal health coverage is a key tool for the right to high quality health and healthcare.

• Universal health coverage must be considered in the broader framework of social protection.

• Political, socio-cultural and financial factors all contribute to the health of an individual/population; a multi-sectoral approach therefore is of paramount importance.

Universal health coverage in practice

• In-depth analysis of local context.

• Support the definition of long term vision and planning.

• Availability of necessary funds.

Role of the Belgian Development Cooperation

• Support to partner countries, both financially and through Belgian experience and expertise.

• Build bridges between international, national and local initiatives.

• Take up international responsibilities and further promote these in alliance with donor and partner countries, e.g. through innovative mechanisms.
References


Federal Public Service for Foreign Affairs, Foreign Trade and Development Cooperation

Rue des Petits Carmes 15
B-1000 Brussels
Belgium

Tel. +32 2 501 81 11

www.dg-d.be
www.diplomatie.belgium.be

Responsible publisher: Dirk Achten, Rue des Petits Carmes 15, 1000 Brussels

Legal registration : 0218/2012/022

The data in this publication are given for information purposes only, and do not legally commit the Federal Public Service in any way.

February 2012