Universal Health Coverage
A background document developed for the Belgian Development Cooperation

An Appelmans & Luc Van Leemput

September 2011

Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium Department of Public Health

Working paper N° 3
In the Studies in Health Services Organisation and Policy, the Department of Public Health, Institute of Tropical Medicine, Antwerp (ITM-A) publishes a series of monographs and a series of working papers.

The editors are Guy Kegels, Vincent De Brouwere and Bart Criel.

The Working Paper Series of the Studies in Health Services Organisation and Policy aims to present innovative work in the domain of policy, management and organisation of health services and systems in low- and middle-income countries. It provides a platform to publish and disseminate empirical research and conceptual work that is not constrained by journal formats. All papers are peer reviewed.

The editorial team includes Kristof Decoster, Bruno Marchal, Werner Soors, Josefien van Olmen and Wim Van Damme. Please contact Rita Verlinden (verlinden@itg.be) for more information.

Nr. 3, 2011

Universal Health Coverage
A background document developed for the Belgian Development Cooperation

September 2011

Luc Van Leemput, Department of Public Health, Institute of Tropical Medicine, Antwerp (Belgium). Nationalestraat 155, 2000 Antwerpen, Belgium, (lvanleemput@itg.be).

An Appelmans, International Health Policy Support, Institute of Tropical Medicine, Antwerp (Belgium). Nationalestraat 155, 2000 Antwerpen, Belgium.

The views expressed by the authors of this document do not necessarily reflect the views of their institutions or the ITM-A.

This paper can be downloaded at www.itg.be/WPshsop
Table of Contents

Table of Contents ............................................................................................................. 3

Acknowledgements ........................................................................................................ 4

List of abbreviations ...................................................................................................... 5

Executive Summary ........................................................................................................ 6

Introduction ..................................................................................................................... 8

PART I: Overview of the current thinking about UHC ...................................................... 9
  UHC Milestones 1946-2010 ........................................................................................ 9
  Definitions ..................................................................................................................... 11
  UHC in Belgium .......................................................................................................... 12
  Paths towards UHC ..................................................................................................... 13
    UHC: bottom-up and top-down .............................................................................. 14
  Time perspective of UHC actions and multi-sector collaboration ......................... 14
    A few broader theoretical frameworks and concepts related to UHC .................... 15
  Choices and trade-offs when moving towards UHC .................................................. 20

PART II: Discussion - From theory to practice: the main challenges ............................. 21
  Governance ................................................................................................................ 22
    National level ........................................................................................................... 22
    International level .................................................................................................. 23
  A global social contract ......................................................................................... 24
  Additional funding ..................................................................................................... 25
  Bridges between local, national and global levels .................................................... 27

Recommendations on the role of Belgium ..................................................................... 29

References ..................................................................................................................... 30

Annexes ......................................................................................................................... 33
  Annex 1: Feedback Emerging Voices on Global Health ............................................ 33
  Annex 2: List of landmark documents on UHC ......................................................... 37
  Annex 3: Recent literature reviews ........................................................................... 37
Acknowledgements

This ITM background note on Universal Health Coverage (UHC) is produced upon the request of DGD to provide a technical background summary of current best practices in the move towards UHC and possible roles for the Belgian government in its development policy.

The paper is inspired by landmark literature\(^1\) about UHC and by observations at recent international conferences on the subject in Montreux (Switzerland), Brasilia (Brazil), Cape Town (South Africa) and Dakar (Senegal). It also builds on the field experience of ITM staff. The note was coordinated and written by An Appelmans and Luc Van Leemput, with inputs from (in alphabetical order): Raoul Bermejo, Bart Criel, Kristof Decoster, Rachel Hammonds, Bruno Meessen, Gorik Ooms, Mit Philips, Wim Van Damme (academic promoter), Dirk Van der Roost and Bea Vuylstekte.

An advanced draft of this note was sent to the winners of the ITM Emerging Voices essay Competition, as a first attempt to consult “the south” on the document. Jean-Patrick Alfred, Theophane Bukele, Taufique Joarder, Seye Abimbola, Isidore Sieleunou, Walter Flores, N.S. Prashanth, Vincent Okungu, Anar Ulikpan and Mauricio Torres individually replied to our request. Part of their feedback has been incorporated in this note. However, in order to do justice to their rich comments, and avoid interpretation of the comments through a “western lens”, a separate document summarizing the main elements is also attached as an annex to this note. This attachment is compiled by Seye Abimbola. The drive for UHC requires long term attention and commitment. This background note thus needs to be updated regularly.\(^2\)

\(^1\) A list of key documents is available at the end of this paper

\(^2\) The (sub)case of Burundi will complement the chapter on fragile states whereas the note under preparation in the Be-cause health Social Protection working group will dwell more in-depth on a role for health mutual organisations.
List of abbreviations

CHI  Community Health Insurance
CoP  Community of Practice
EU   European Union
GDP  Gross Domestic Product
GFATM The Global Fund to fight AIDS, Tuberculosis and Malaria
HHA  Harmonization for Health in Africa
IHP+ International Health Partnership Plus
ILO  International Labour Organization
ITM  Institute of Tropical Medicine, Antwerp
LIC  Low Income Countries
ODA  Overseas Development Aid
OECD-DAC Organization for Economic Co-operation and Development - Development Assistance Committee
TRIPS Trade Related aspects of Intellectual Property Rights
UHC  Universal Health Coverage
UN   United Nations
WHA  World Health Assembly
WHO  World Health Organization
WTO  World Trade Organization
Executive Summary

Universal Health Coverage (UHC) has sparked a lot of debate over the years, both conceptually and in terms of directions on how to move towards achieving it. It continues to do so. Nevertheless, there is now a broad consensus on the objective of UHC in line with previous milestone targets as health and health care for all. UHC entails access to a package of essential qualitative health services for all.

The first part of the note gives an overview of current thinking on UHC. Health was endorsed as a human right in 1948. Ever since UHC has been at the core of a whole range of discussions: health as a human right versus health as a commodity; integrated versus targeted health approaches; health as a country matter versus shared responsibility of health and thus health as an international and transnational issue.

In Belgium the path towards UHC was long and winding, and characterized by a phased approach. For some decades now, the system nearly covers everybody. However, current challenges such as reaching illegal migrants (les ‘Sans papiers’) or keeping health care affordable with an increasingly ageing population show that UHC is not a one-time achievement but rather a “work in progress”, even in developed countries.

As resources are limited, choices and trade-offs need to be made during the UHC journey. WHO’s three-dimensional framework offers a valuable tool to analyse a country’s current situation, and allows planning of targeted interventions towards UHC. Some countries will immediately go for blanket population coverage but for a limited number of health services whereas others first target formal employees or vulnerable populations but provide deeper cover. The Belgian example shows that UHC is both a bottom-up and top-down process that requires careful planning and adjustment in the short, medium and long term. Quick wins should be compatible with long-term targets. In fact, UHC and health itself obviously go beyond health care and require a multi-sector approach involving other domains such as agriculture, education and housing (the social determinants of health). UHC is more likely to be attained in a more equitable society and a more equitable world. A key challenge is to get UHC on the political agenda in the different settings at the global, regional, national and sub-national levels.

The second part of the note discusses the role Belgium can play in the current drive for UHC in fragile states and stable low income countries. We opted for a focus on fragile states for a number of reasons: Belgian development aid puts them centre stage, challenges towards UHC are typically huge and potential “quick wins” are substantial in these countries. Taking a policy perspective, we focus on four priority areas that will need to be addressed to make significant progress towards reaching UHC.

First, we highlight the crucial role of governance on national and international level. We argue that in fragile states new governance mechanisms should be found involving different stakeholders in health mirroring the pluralistic reality of the supply side of health systems and involving representatives of the demand side also. Equally, at the international level, new governance mechanisms involving representatives from different backgrounds should be identified, in line with the increasingly complex (health) aid architecture and proliferation of relevant actors in health.

Second, we argue that in a world of increasing interdependence, where a shift can be observed from the previously dominant assistance paradigm that focused on international health towards a focus on global health, the development of a global social contract for health is essential. This
contract should clarify the roles and responsibilities of independent nation states in the definition, contribution and implementation of a defined package of basic health services for all. To move forward, UHC needs monitoring, evaluation and additional funding. Building bridges between the different actions on local, national and global level is key to move further towards UHC.

Thirdly, we argue that there remains an urgent need for additional domestic and international funding for health, if one is serious about reaching UHC. This is especially true for fragile states which receive disproportionately low shares of overseas development aid for health. Additionally, innovative funding channels need to be explored and/or expanded. In particular, a Financial Transaction Tax seems a promising mechanism to pool additional resources for UHC. Both existing and increased funding should primarily be used to boost Primary Health Care and UHC and channelled in ways to replace out-of-pocket health expenditures of patients, especially of the most vulnerable.

Last but not least, important efforts should be made to identify mechanisms to build effective bridges between local, national and global levels to overcome the gap between the current global rhetoric on universal health coverage and what is actually happening in the field. Communities of practice or initiatives like “Switching the Poles” could provide interesting ways forward.

In conclusion, we argue that Belgium has several roles to play in the UHC era: the role of a national steward (UHC in Belgium itself), a donor, a provider of technical assistance and a global actor. Crucially, the Belgian government should further investigate and continue the focus on UHC within a multi-sectoral perspective. It should also emphasize and advocate for national and global social contracts as it has an obvious watchdog and actor position in both.
Introduction

The note has been compiled in two parts. The first part provides an overview of recent thinking on Universal Health Coverage (UHC). It starts with UHC milestones between 1946 and today and looks into wider theoretical principles and core concepts to put the term UHC in perspective. As there is no single way to achieve UHC, countries will need to make choices and trade-offs in their path towards UHC. The WHO framework is used to show what options are available.

The second part focuses on some of the main challenges around UHC in stable and fragile developing countries, trying to provide added value from a policy support point of view. We highlight the crucial role of governance on national and international level. In a world of increasing interdependence, in which no country alone can protect its own inhabitants from the challenges of global health pandemics, a global social contract could help mitigate against risks. To move on, UHC needs monitoring, evaluation and additional funding. Building bridges between the different actors on local, national and global level is key to move further towards UHC. In our opinion, these topics are crucial and often underrated in the current discourse on UHC.

Throughout the note, we kept the Belgian government in mind and the different roles it could play in the current UHC momentum: as a national steward (UHC in Belgium itself), as a donor, as a technical assistance provider and as a global actor. The conclusion lists the areas where Belgian actors can make a difference.
PART I : Overview of the current thinking about UHC

**UHC Milestones 1946-2010**

- 1946: In the Constitution of the World Health Organisation (WHO) health was defined as *a state of complete physical, mental and social well-being and not merely the absence of disease*. The objective of WHO was expressed as *the attainment by all peoples of the highest possible level of health*.

- 1948: The *Universal Declaration of Human Rights* put health and UHC (without explicit mention of the term) again on the agenda. The *right to the highest attainable standard of health* covers both health care and the underlying determinants of health, and includes the following interrelated and essential elements: health goods, services and facilities must be available, accessible to everyone (including being affordable and geographically accessible), acceptable (including culturally), and of good quality. States must respect, protect and fulfil the right to health (UN CESC 1966).

- 1978: The *Alma Ata Conference* advocated ‘Health for All’, with health being defined as a status of complete mental, physical and social well-being with a focus on primary health care and equity.


- 2000: Three of the eight anti-poverty *Millennium Development Goals* focus on health whereas the other five mostly concern social determinants of health. The MDGs clearly indicate that health is increasingly considered a global public good.

- 2001: The Belgian Development Cooperation and ITM reinvigorated *Health care for all* under the Belgian presidency of the European Union. Ten years later, the conference conclusions have lost nothing of their relevance. They fit nicely into the current UHC discussions. A well-functioning health system remains vital and certain factors are important in the quest for better access to quality health care services. Those factors include: financial accessibility, methods and incentives to improve quality of care, sufficient and motivated staff and smooth integration of disease control programmes and basic health care services. A cross-cutting theme is the human factor: how can providers and community members improve access to quality services, and what are the social dynamics that go with it?

- 2001: In its report, the Commission on Macroeconomics and Health (Sachs et al. 2001) estimated 35-40 USD per person per year to be the benchmark amount for realisation of essential health services for all.

- 2005: The *58th World Health Assembly* endorsed a resolution urging member states to work towards sustainable health system financing to achieve UHC, with the latter defined as ‘access to key promotive, preventive, curative and rehabilitative interventions for all at an affordable cost, thereby achieving equity in access’.

---

• 2005: The Paris Declaration on Aid Effectiveness represented a broader consensus among the international community about how to make aid more effective. At its core was the commitment of donors to help developing-country governments formulate and implement their own national development plans, according to their own national priorities, using, wherever possible, their own planning and implementation systems. The Declaration focused on five mutually reinforcing principles: ownership, alignment, harmonisation, managing for results and mutual accountability.

• 2008: The Accra Agenda for Action was drawn up to accelerate progress of the commitments agreed in the Paris Declaration. It mainly focused on predictability of donor commitment (3-5 years), country ownership and accountability.

• 2008: 30 years after Alma Ata the World Health Report Primary Health Care Now More Than Ever reiterated that ‘No one should be denied access to life-saving or health promoting interventions for unfair reasons, including those with economic or social causes’ (WHR 2008). UHC was mentioned as the way to achieve this.

• 2008: The Report of the Commission on Social Determinants of Health focused more on factors outside the health sector for improving health and achieving UHC. This report re-emphasized the need for multi-sectoral efforts, as ‘health for all’ obviously goes beyond the health sector.

• 2009: To cope with the global crisis the UN Chief Executives Board (UN CEB 2009) launched the Social Protection Floor (UN CEB 2009). This initiative builds on the human right for social protection (cf. the Universal Declaration of Human Rights 1948) and aims at ensuring a basic level of social protection and a decent life for all people i.e. including financial risk protection and the broader aspects of income protection and social support in the event of illness.

• 2010: The World Health Report Health Systems Financing: the path towards universal coverage recognised that there is no “one-size-fits-all” solution to reach UHC. The report listed what countries can do to adapt their financing systems in order to move more quickly towards UHC. It provided best practices for countries at all stages of development but remained more focused on the financing aspect.

• 2010: The First Global Symposium on Health Systems Research is organised in Montreux, Switzerland. The Symposium focuses on science to accelerate UHC.

• 2010: ILO’s World Security Report 2010/2011 launched an appeal for comprehensive social security systems (which included ‘access to health’).
Definitions

UHC is ubiquitous nowadays in international literature and at global health conferences. An abundance of terms is used to refer to it: universal health care, universal coverage, universal health coverage, universal health care coverage, health for all, health care for all and the often broader notions social (health) protection and social security\(^4\).

This mishmash of terms corresponds with a broad interpretation of UHC: it evolved from a strategy to an objective, which still creates confusion. Initially the concept was intended to differentiate between state interventions for all, and state interventions for those who would not have access otherwise (targeting the poor). Now, it is more often seen as an objective (all should have access) and targeted interventions are not excluded as possible strategies.

Furthermore, some now seem to understand ‘universal’ as international or transnational (all people should have access, no matter where they live), while others see it as a country-per-country strategy. The result is that we now have a more or less consensual objective, UHC, but still many different opinions on what it means and how it should be operationalized.

In what follows we will define the terms UHC, Social Health Protection, Social Security, and Social Determinants of Health. We argue that UHC cannot be seen in isolation but needs to be seen as part of a wider national and global social contract with solidarity at its core, if it is to be effective.

- **Universal Health Coverage (UHC)** (WHO 2008; Criel & Soors 2009) can be defined as ‘Access for all to quality health services if need be, with social health protection. Universal coverage is not by itself sufficient to ensure health for all and health equity. The roots of health inequities lie in social conditions outside the health system’s direct control and need to be tackled through inter-sectorial collaboration. Universal health coverage however is the necessary foundation within the health sector on the road to health for all and health equity’.

- **Social Health Protection** (ILO 2008) comprises ‘protective, preventive and promotional objectives (the so-called ILO framework). Promotional measures aim to stabilise or enhance income (eg micro-credits); preventive measures directly seek to avert deprivation (informal and formal insurance mechanisms, and other forms of risk pooling); protective measures in the strict sense aim to provide relief from deprivation (social assistance) to the extent that promotional and preventive measures have failed to do so’.

- **Social Security** (ILO 2010-2011) refers to ‘all measures providing benefits, whether in cash or in kind, to secure protection from

  - Lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;
  - Lack of access or unaffordable access to health care;
  - Insufficient family support, particularly for children and adult dependants;
  - General poverty and social exclusion’.

\(^4\) Annex 2 gives two recent literature reviews on the diversity of definitions of Universal Coverage and Social Protection
• The Social Determinants of Health are ‘the conditions in which people are born, grow, live, work and age, including the health system’ (WHO 2008). They are related to the development model of a society. The Commission considers health care a common good, not a market commodity. ‘Universal coverage requires that everyone within a country can access the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are empowered to use these services’. The determinants will be certainly addressed at the UN High-Level-Meeting on Non-Communicable Diseases in New York (September 2011).

Most countries subscribed to the UN Universal Declaration of Human Rights (1948). The idea of UHC is thus not new. The recent wave of attention builds on previous milestones that focused on health and health care for all, but is now embedded within the more encompassing objectives of social protection, social security and human rights. In the past 60 years numerous efforts and remarkable progress have been made. Yet, the outcome remains far from satisfactory: ILO (2010) estimates that globally 72% of the world population still has no access to comprehensive social security systems and one third has no access to any health services at all. Globally, every year, 44 million households or more than 150 million individuals are estimated to face catastrophic health expenditure and 25 million are believed to fall into chronic poverty because of that (Xu et al. 2007).

The implementation of UHC as part of the ‘Declaration of Human rights’ to ensure the well-being of all citizens seems far from universally accepted. Where most European countries see UHC as a strategic objective of the European social model, resistance towards the health care reform in the US shows that visions favouring private interests often prevail. In other OECD countries you also have conflicting visions: ‘health as a human right’ versus ‘health as a commodity’.

**UHC in Belgium**

At first sight the Belgian UHC experience may appear only remotely relevant to the reality of developing countries but a closer look at Belgium’s historical move towards UHC and the governance and management of its complex and pluralistic health and social security system quickly reveals a number of lessons that our country can share to promote and help boost UHC in LICs.

The Belgian case shows that the move towards UHC often is gradual, at times even incremental: the roots of Belgian UHC go back to the 19th century when voluntary mutual organisation and sickness funds were organised according to employment type without state subsidies. In 1944 social security (including protection against sickness) became compulsory by law for formally employed Belgians. The National Institute for Health and Disability Insurance (NIHDI) supervises the social health insurance organised in six schemes that merged from the voluntary schemes according to ideological background. They are responsible for reimbursement of health expenses according to the Belgian Nomenclature. After 1960 coverage was expanded to self-employed workers, civil servants and eventually the unemployed. It took until 2008 before over 99% of Belgian citizens were covered for major and minor risks with access to a broad range of health services (Gerbens et al. 2010).

The Belgian system started off as a Bismarckian one. It then gradually adopted some elements from the Beveridge system and evolved into a very mixed model: it is financed by means of (direct and indirect) taxation, social security contributions proportional to household income, and out-of-pocket payments (about 20% of total health care expenditure). The most vulnerable
are exempted from user fees, and catastrophic expenditure is avoided through the exemption of all fees if one has reached an annual fixed ceiling (maximum billing) (Gerken et al. 2010).

Belgium has a complex and pluralistic health system that is characterised by a complex regulatory framework involving government agencies, the medical and health profession councils, the social security system, the mutualities and other actors whose interests have to be balanced to ensure accountability and alignment of all stakeholders towards UHC. That encompasses certain trade-offs e.g. the prices of branded drugs from the big pharmaceutical companies remain very high as these have very powerful industry and lobbying groups in Belgium, and attempts to introduce alternative models to enhance price competition e.g. the kiwi system have not succeeded so far. Political choices clearly determine how technical challenges are met. Other challenges exist e.g. how to optimally reach marginalised and vulnerable groups like the so called ‘sans papiers’, how to deal with issues related to an ageing population, to only mention two. Moreover it is not yet clear how the EC/EU drive for privatisation of services will affect the Belgian health system.

Besides providing technical experience on how to run a pluralistic health system, Belgium can also offer some advice in the broader debate on social inclusion. Improving people’s financial access to health care is crucial but insufficient if other social barriers to quality health care are not addressed (stigma, lack of information, lack of voice, etc.). UHC needs to have a transformative social dimension (Michielsen et al. 2010) tackling societies’ power imbalances and social exclusion mechanisms to make sure that the health system becomes a place where inequities are overcome and empowerment is pushed for at micro (household, communities), meso (i.e. the interaction of individuals and groups with service providers and local institutions) and macro (i.e. regional, national and international policymaking circles) level.

All EU countries have policies in place that imply the acceptance of UHC and most do relatively well in implementing UHC (Mckee et al. 2008). However the EU countries show that there is no single path towards UHC. Like Belgium most of them started off with one of the classic approaches:

- the Bismarck model: it uses an insurance system usually financed jointly by employers and employees through payroll deduction, i.e. mandatory social insurance.
- the Beveridge model: health care is provided and financed by the government through tax payments.

Depending on context and path-dependence (Van Damme et al, 2010), countries adopted health system reforms that have increasingly blurred the distinction between the two models. The European social model currently faces some challenges due to globalisation and geopolitical and economic shifts but it has certainly proven its merit so far. It is by far preferable to a model with limited or no solidarity, like the US social contract (Hill 2010). Together with other European countries (Scandinavia, Germany, Benelux, France, UK) Belgium should thus take up an important advocacy role in the UHC debate.

**Paths towards UHC**

The European experiences show that UHC is not a one size-fits-all package nor is it a one-time achievement. Instead, realising, advancing and sustaining UHC is a complex and constant challenge that can only be effectively addressed when short, medium and long-term thinking,
planning and investments are combined and aligned. It is a bottom-up and top-down process in which timing is crucial. We will introduce WHO’s theoretical framework as a means to analyse the UHC status of a country. Depending on political choices and available resources, choices and trade-offs are made in the path towards UHC.

**UHC: bottom-up and top-down**

Recent conferences and symposia in Montreux (Nov 2010) and Cape Town (Dec 2010) highlighted political will as a key driver of UHC. Research can be an important player through the provision of evidence on best practices and on how to exert most influence on the political UHC agenda. The World Social Security forum in Brazil (Dec 2010) and the IV World Social Forum on Health and Social Security in Dakar (Feb 2011) showed the growing public demand and the powerful voice and role of civil society in the debate. Besides change instigated by the top, change should also emerge bottom-up, via political action from the basis.

The Belgian example illustrates this typical mix of bottom-up and top-down dynamics very well. Labour unions grew almost organically, eventually also operating at the national level. Over time they were subsidised, scaled-up, regulated and institutionalised in the health mutualities and social security system.

**Time perspective of UHC actions and multi-sector collaboration**

The understanding of possible paths towards UHC has matured through evidence and best practices of countries that have reached UHC. Classic examples are countries in Western Europe (a.o. Belgium), Thailand, Sri Lanka, Costa Rica and the Republic of Korea. They show that initial planning is important to dedicate sufficient resources to short, medium and long term interventions towards UHC and to make sure that the different actions build upon one another rather than jeopardise each other’s chances of success (Richard et al. 2007). The following are just a few examples to illustrate the different time perspective of actions towards UHC:

- A long-term objective to reach and sustain UHC could be the creation of a national insurance system. Evidently, setting up such a system is a stepwise process. Therefore, while keeping in mind the long-term objective of UHC, intermediary interventions such as the abolishment of user fees for certain targeted vulnerable groups e.g. pregnant women and children can be realised in the short term.
- Human resources efforts to improve health access show that “quick wins” can be achieved by task-shifting. Additionally, a more structural solution focuses on long-term investment in skills training of health professionals.

Important is the awareness that UHC does not suffice to ensure health for all and health equity. Indeed, the roots of health inequalities lie in social conditions outside the health system’s direct control. These need to be tackled through inter-sectoral collaboration (WHO 2008). Hence, more systemic change is needed. Change will only occur by tackling health policy at the national level to influence resource allocation for improving healthy living in general, and health service delivery in particular. Rights-based approaches highlight the need to address policy and law in sectors other than the health sector. This includes thus, among others, education, housing and equity in power relations. In its rights-based approach WHO endorsed the enormous value of the multi-sectoral approach. However, that approach also requires careful attention to prioritizing
the allocation of limited resources, especially in countries where national policies tend to overlook health.

UHC can only be achieved if a long-term vision is in place. Mentioning UHC in health policy documents is one thing, sustainable implementation is quite another. Quick wins are no doubt useful to have immediate outcomes. Yet, they will only be sustainable if they are integrated in a long-term strategy towards UHC.

**A few broader theoretical frameworks and concepts related to UHC**

As a direct consequence of complexity and path dependence, strategic planning towards UHC requires countries to first take stock of their current situation. It is highly recommended to start from a **situational analysis** to know where a country stands in the UHC process and to identify ways forward. Such an analysis entails:

- In-depth knowledge of the context-specific situation and the context reality.
- A stakeholder analysis taking into account all actors involved in the process.
- A clear view on the available financial resources.

The following frameworks can be used to arrive at this ‘status of affairs’ analysis:

*Composition and interaction of the health system framework towards UHC*

Building on WHO’s building blocks (2007) and other frameworks, Van Olmen et al (2010) developed their Health Systems Strengthening Framework. The framework consists of 10 elements (see figure 1) which mutually interact and need to be taken into account when one analyses the health system of a country. Health systems are context-specific and path-dependent.

**Figure 1. The Health System Framework in its generic form (Van Olmen et al. 2010)**

Although the financial resources are often - justifiably - highlighted as crucial for achieving UHC (WHO 2010a), one should not forget that they are only a means to an end. Availability and accessibility of qualitative health services are equally important. A situational analysis will
unravel gaps in the health system and show where a country’s health system can be improved. The set-up of an efficient and well-functioning health system will also result in less wastage of money earmarked for health (estimated at 20-40% by WHO 2010a):

- A lot of countries lack infrastructure or use the available infrastructure inefficiently. Often the latter results in inappropriate hospital admissions and hospital size (white elephant hospitals versus unequipped local hospitals) leading to a suboptimal quality of care. Strengthening of primary care networks, provision of admission protocols, integration of first and second line health services and alternative care (day care, rehabilitation,...) are only some of the possible ways forward.
- Medicines: while safe medicines are key to improved service delivery, problems like the underuse of generic drugs, overpricing of branded drugs, inadequate cost and quality controls on prescribers, lack of provision of drugs, irrational use of drugs, substandard or counterfeit drugs lead to a situation whereby many essential medicines are still not available in all health services or are of questionable quality. A strengthened national procurement and quality assurance process is needed that is acceptable both for donor and recipient countries. In 2008 a charter (Be-cause Health 2008) was signed to address this situation. Several Belgian NGOs, gathered in the Be-cause Health platform, vowed to guarantee the quality of medicines, vaccines, diagnostic products and small medical materials used in their programmes. Further work on the quality of medicines is ongoing. At the same time Belgium needs to put pressure on the EC, WHO and WTO, in order to make the application of TRIPS flexibilities and the import of cheaper but high quality drugs a reality. Belgium could e.g. actively support initiatives like the Health Impact Fund\(^5\) which aims to provide a market-based solution for research and development, production and marketing of medicines to treat “poverty disease”.
- Health personnel need to be sufficiently skilled by means of appropriate training. Correct remuneration is a prerequisite for staff retention and staff motivation. Where no health personnel is available alternative solutions need to be looked into in order to guarantee basic health services. WHO (World Health Statistics 2010) ranks 57 countries as having a critical shortage in health professionals and estimates there is a global need for 4.3 million extra skilled health professionals. While incremental increases in health worker-to-population ratios in developed countries may not lead to substantial improvements in population health, in developing countries such increases are likely to significantly improve health outcomes. Some countries, e.g. Ethiopia booked remarkable progress by task-shifting. Other countries found new technologies to have quite some potential to reduce the need for specialised health workers and to move chronic care from the hospital into the community. Donors can play a role in the internal and external brain drain by drafting (and respecting) good codes of conduct and promotion of local capacity building.

WHO’s quantifiable three-dimensional UHC framework is nowadays widely used to measure a country’s progress towards UHC:

---

\(^5\) For more information, see http://www.yale.edu/macmillan/igh/
In the process towards UHC countries need to take into account three dimensions:

1. **Breadth**: the proportion of the population enjoying coverage
2. **Depth**: the range of services made available. Access to an essential and well-defined benefits package and quality services is crucial
3. **Height**: the proportion of costs covered

Depending on the funds available, countries need to set priorities and choices will need to be made. We explore the three dimensions in some country experiences to explore their options towards UHC and the trade-offs that implies.

1. **Breadth (coverage)**

Ideally the backbone of UHC is a tax-based or social insurance-based system pooling funds to make access to health services affordable to all people. The examples of Belgium and other countries (Thailand, Costa Rica etc.) show that national pooling tends to be a stepwise process. It requires the right political mind-set, a critical contributing mass and fiscal administration system. As a consequence national pooling initiatives remain far from sufficient to cover the population in most low income countries. Moreover, in all countries a group of people will always be too poor to contribute and their coverage will need to be guaranteed through government revenues or donor funding as soon as possible.

There tend to be initial and intermediary stages in the process towards UHC: usually small proportions of the population are covered first (the wealthier, the employed) on a voluntary, or (usually later) on a mandatory basis; the informal sector and vulnerable groups are typically covered in separate or later stages.

- **Voluntary schemes** such as Community-based health insurance (CHI, micro-insurance) a.o. in Senegal can play a useful role where compulsory approaches (far preferable) provide only minimal levels of prepayment. If they are able to redirect some of their direct payments into prepaid pools, they can expand protection to some extent against the financial risks of ill health and help people understand the benefits of being insured. CHI is a means to an end, a possible facilitator on the road to UHC. These kinds of schemes are a stepping stone towards
bigger regional schemes. So far there are no blueprints on how CHI can best be integrated in a national policy towards UHC. The options at hand are context-specific. CHI involves more than just financing health care. It is also about organising and empowering the demand side in the health care system (Soors 2010). Once the government identifies UHC as a priority it can build on existing informal schemes (e.g. CHI or self-help groups) to set up a more formal system.

- Limited or no user fees or incentives targeting the most vulnerable are successful in some countries; in Brazil they use vouchers and conditional cash transfers for instance. These help to reduce the barriers to access health services or undertake some specific health services for poor people.
- Increased domestic revenues and/or sector and budget support mechanisms allow governments to gradually expand the health service network.

*In view of its rich expertise with national pooling and health mutualities, Belgium can certainly play an important role in technical capacity building in the south, and feeding the debate, obviously in mutual respect for each other’s views.*

### 2. Depth (benefit package)

If these pooled funds are to have the best outcome they should cover the most adequate benefit package. This package should be available at health services with skilled health professionals close to the homes of beneficiaries.

The UN Committee on Human Rights (WHO 2008) provided an important starting point for defining an essential package under the right to health:

- Access on a non-discriminatory basis to health facilities, goods and services;
- 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 potable water;
- Maternal, child, and reproductive health care, including family planning and emergency obstetric care;
- Immunizations 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.

Some of these components refer to the broader area of social determinants of health and will require a holistic and multi-sectoral approach as previously discussed.

A package of care has to be decided upon on a country level but globally there is also a need for consensus on the content of that package. A crucial question is what goods and services are necessary to ensure the conditions of health everywhere. Human needs and socioeconomic conditions differ according to region or country: in rural areas the lack of transport can already be a major barrier that delays timely access to care. If the transport problem is not solved, just including more services in the benefit package will be of little help.

---

6 For a more detailed overview of countries that applied CHI as a means towards UHC, we refer to the WHO background paper by Soors et al. 2010.
Consequently, the essential package of health goods and services will not be the same in all countries, requiring flexibility and governance to define priorities. The essential package needs to be adapted regularly to the shifting epidemiological and health demands. Making choices will result in trade-offs that will be far more significant in low income countries.

High priority interventions are identified and donor assistance often focuses on those interventions. However many other services, notably maternal health services are supplied through general health services. Planning is essential to guarantee that the broader health system benefits from disease-specific programme funding (Coulibaly et al. 2008) by developing the interventions in a balanced way. In line with Alma Ata, the Thai and Costa Rican case studies suggest that investment in primary care services with a gatekeeping role is efficient.

Belgium can play a role in promoting primary health care and health system strengthening by making sure that its initiatives are carefully monitored and evaluated in terms of their long-term efficiency and effectiveness. Synergies with the wider health system should be the aim. The Belgian cooperation should also promote multi-sectoral aspects of health and healthy societies.

3. Height (proportion of costs covered)

Traditionally low income countries implemented user fees to raise additional revenue to help finance basic packages of care. In many countries out-of-pocket expenditure is over 50%, even 80%, leading to catastrophic health expenditure. Evidence has shown that user fees and other direct out of pocket costs provide important barriers to financial access to care (Meessen et al. 2009). Out of pocket payments are not just regressive; they also deter people from utilising health services. Systems to exempt the poor from paying often do not work as they mean income loss for the providers and stigma for the user. Long term goals should be: to decrease the level of direct payments to below 15-20% of total health expenditure and to increase the proportion of GDP taken up by combined government and compulsory insurance expenditure to 5-6% (WHO 2010). Reaching these targets will obviously take time in some countries; meanwhile, they might set more achievable short-term and medium-term goals.

For those countries unable to generate the required funding or lacking the technical capacity to support the transition towards UHC, external financial support will be vital. It is important that this support is given in the spirit of the Paris Declaration, in a way that allows aid recipients to formulate and execute their own national plans according to their priorities. Local, national and international levels should be linked efficiently and smoothly. We will further elaborate on this in the discussion part as we believe that the Belgian government could play an important sensitizing role.

---

7 For a more detailed overview of case studies regarding user fees, we refer to the UNICEF study by Meessen et al. 2009.
Choices and trade-offs when moving towards UHC

Case study: Universal Coverage in Thailand

After the landslide electoral victory of Mr. Thaksin Shinawatra and his Thai Rak Rhai political party, Thailand introduced evidence-based universal coverage reforms in 2001. Coverage of the employed was expanded to include also the informal sector and vulnerable population groups (i.e. universal coverage). A fairly comprehensive package, including preventive and curative care, is completely financed from tax revenue. The Thai government was successful in expanding the benefit package: in 2003 antiretroviral drugs were included (Pachanee et al. 2006) and a cost benefit analysis led to the inclusion of flu vaccinations for high risk groups in 2008 (Damrongplasit & Melnick 2009). In the latter case no extra budgets were scheduled as evidence showed that the outcome of the flu prevention would decrease the costs for curative flu treatment. The initial 30 Baht (approximately 0,75 euro) contribution was removed and now the entire package is prepaid through taxes. Governance and timing are crucial in the realisation of universal coverage (Van Ginneken 2007)

The Thai example of UHC is often seen as one of those miracle stories where all factors were almost magically in place and collaborating towards the goal of near- UHC: wide population coverage (breadth), a comprehensive benefit package (depth) and abolition of the 30 baht user fee (height). For obvious reasons, the Thai success story is not easily copied: it proves that not one single determinant but all determinants a.o. governance and timing need to be in place if UHC is to be achieved.

Depending on the resources available and on the political priorities of a country, countries will opt to make progress in terms of breadth, depth and/or height:

- Some will start with population-wide coverage and a limited benefit package and will then build upon this basis.
- Others will initially offer a broad benefit package with somewhat lower geographical coverage; then they will try to expand it gradually to as many people as possible thereby trying to overcome physical, financial, geographical, cultural and political barriers.
- Some countries have different schemes for different groups, with different benefit packages; they will try to link or merge these schemes.

The situational analysis hence requires benchmarks. For instance, if a country provides half of what can be considered as essential to 80% of the population, with 70% covered by pooled resources, is that UHC? We would argue it is not. None of the high-income countries that is currently said to have achieved UHC covers 100% of the population for 100% of the services with costs covered at 100%. UHC requires a commitment and strategy to do so in the long run (WHO 2010).

It goes without saying that the most challenging situation appears in many of the so-called fragile states. Their situation is one of no/low breadth, no/low depth and no/low height, combined with poor governance and very limited resources. Nevertheless, we think that Belgium can play an extremely important role in these countries’ quest for UHC. This is obviously a very fragile and complex exercise that requires a strong commitment and solid bridges between the local, national and international development actors at all levels. Our discussion in the second part of the note will elaborate further on that.
PART II: Discussion - From theory to practice: the main challenges

We could classify developing countries and their challenges to achieve UHC as follows:

<table>
<thead>
<tr>
<th></th>
<th>Middle income countries</th>
<th>Low income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>There is enough wealth for UHC without external assistance, and a government to organize UHC. There may not be a democratic consensus on taking the steps needed.</td>
<td>There is not enough wealth for UHC without external assistance, but there is a government to organize UHC. There may not be a democratic consensus on taking the steps needed.</td>
</tr>
<tr>
<td>Fragile</td>
<td>There is enough wealth for UHC without external assistance, but no legitimate government to organise UHC.</td>
<td>There is not enough wealth for UHC without external assistance, and there is no legitimate government to organize UHC.</td>
</tr>
</tbody>
</table>

The appropriate assistance Belgium could offer to each of these categories will be different. In stable middle income countries it could be mainly technical assistance. In fragile middle income countries it may require temporary financial assistance, while focusing on democratic governance. In stable low income countries it may require long term reliable financial assistance, supporting ministries of health as much as possible. In fragile low income countries, it may require long-term reliable financial assistance to private non-profit providers.

This discussion part will focus on the role Belgium can play in the drive for UHC in fragile states although a lot of the examples and comments apply to stable low income countries too. There is no universally agreed definition of state fragility⁸ but depending on the source used, fragile countries represent a total population of an estimated 800 million to 1.3 billion people worldwide.

Contrary to most other countries and to current practices of other donors, Belgium’s bilateral development aid already tends to focus on fragile states. A 2010 OECD/DAC review paper on Belgium rightly mentioned: “One-third of Belgium’s partner countries are fragile states. Indeed, the Minister of Development Co-operation’s 2009 Policy Note to parliament makes adapting aid policies to fragile situations a priority, and puts this high on the agenda for Belgium’s presidency of the EU in 2010.” However, in the same report, it was acknowledged that “Belgium is struggling to translate this political priority into its operations, and to make consistent use of international good practice. A key challenge is to move beyond discussions about definitions of fragility, and establish the links between political, security and development objectives.” (Belgium DAC peer review 2010)

“To make consistent use of international good practice” seems easier said than done. Only limited good practice on improving access to UHC in fragile states is available. To stimulate policy and research in the field, the Health and Fragile States Network was created in 2007. In a 2009 report commissioned by the Network (2009), good practices were collected, with a focus on health systems strengthening however. The authors of the report argued that while several innovative and creative models are currently being implemented and tested, so far limited evaluation and operational research has been performed to study those pilot projects.

---

From a policy perspective, we will focus on four priority areas that need to be addressed to make significant progress towards reaching UHC (in fragile states):

1. Governance
2. A global social contract for health
3. Additional funding
4. Build bridges between local, national and global levels.

Afterwards, we will zoom in on the specific role Belgium can play.

The broader access to health agenda, which includes the social determinants of health, will not be dealt with in this discussion part.

**Governance**

**National level**

In relatively stable fragile states, governance in health should focus on the development of a national health compact to be implemented in the spirit of the aid effectiveness agenda of the Paris Declaration. However, most fragile states are far from stable and have weak government capacity and government legitimacy. It is increasingly acknowledged that the Paris Declaration principles and prevailing aid instruments, like general budget support, are difficult to apply in such fragile situations (Severino and Ray, 2010). Especially applying the principles of harmonisation and alignment is a tall order if governance capacity and state legitimacy are weak.

New governance mechanisms have to be identified, involving different stakeholders in health and mirroring the pluralistic reality of the supply side of health systems. Representatives of the demand side (civil society organisations, representatives of patient (groups)) should also be mobilized.

The GFATM has successfully piloted new governance approaches, involving the different levels of governance and stakeholders. With a primary focus on results and payments based on performance, the organisation has shown that vertical projects, if implemented well, can also make a real impact in fragile states. Moreover, even if it is only a beginning, it is reassuring the GFATM is increasingly engaging in health systems strengthening as well.

Within nation states, the sub-national level is also emerging as an important level at which to intervene for better health care provision. This is especially the case in large countries (e.g. India and Nigeria) where health is a “state” or “provincial” matter (as opposed to e.g. defence). Efforts to strengthen state/provincial and district level health planning and management become widespread. Increasingly state level policies are emerging while the central ministry merely acts as a top-up financier or as the steward of national vertical programmes. Indeed, sub-national levels are especially important in the UHC agenda: stronger districts and states/provinces are important for ensuring the “breadth” and “depth” of coverage. Good governance has a way of creeping in where grassroots activism and demand for accountability is stronger.
International level

The health aid architecture has expanded dramatically and there is no sign that this proliferation of actors will end any time soon. Even in the midst of the recent financial and global economic crisis, several new financing initiatives for health were launched. Severino and Ray (2010) argue that development aid in general is subject to the birth of “hypercollective action”, a term they use to describe a double trend of increasing proliferation in the number of actors and increasing fragmentation of donor activity. Clearly, in line with the increasing pluralistic reality of health systems at national level, also at the global level, the picture gets more and more fuzzy. This is especially the case in the health sector. There is increasing overlap between different donors and an intensifying call for efficiency gains and better global health governance.

National and international initiatives should obviously be inclusive. Mechanisms should be created to promote the participation of sectors and stakeholders traditionally not included in governance mechanisms, such as civil society, business, private foundations, and patient and survivor groups. This could initially be achieved through the creation of temporary mechanisms and coalitions, so called “mini-laterals” (Shafik 2011), around specific issues, such as confronting the escalating pandemic of non-communicable diseases, affordable pricing of vaccines and drugs, or the health workforce crisis – as proposed by some of the Global Agenda Councils (Piot et al. 2010).

In 2010 Belgium joined IHP+, the International Health Partnership that focused on improving coordination between country governments and development partners to improve health services and health outcomes. Their Global Compact represents the formal commitment to put the Paris principles on aid effectiveness – national ownership, alignment with national systems, harmonization between agencies, management for results, and mutual accountability – into practice in the health sector.

Belgium also recently subscribed to the Multilateral Organisation Performance Assessment Network (MOPAN)⁹, an organisation that bundles 16 donor countries to jointly assess the organisational effectiveness of the major multilateral organisations they fund.

At the WHO Executive Board (2011) Dr. Margareth Chan announced a new future for WHO whereby the (then reformed and modernized) organisation would once again take up a leading role and enable all actors to play an active and effective role in contributing to the health of all people in a coherent way. The programme reform to work out this vision has been presented at the World Health Assembly in May 2011. We strongly encourage the Belgian actors to follow up this ongoing reform and try to influence it. The reduced budget of WHO and staff cuts could seriously compromise the future leading role of WHO.

Last but not least, improved international governance should also establish links with the broad access to health agenda, and link health with education, food security, environment and trade related issues that all impact health.

---

⁹ http://www.mopanonline.org/
A global social contract

Within the human rights approach, the current assistance paradigm for health is shifting from a focus on international health to global health concerns (like UHC). Health is no longer perceived a national responsibility only. Infectious disease does not respect country borders. Not investing in family planning and maternal and child health will impact the world population and increase migration of people. Catastrophic health expenditure feeds anger and frustration. If widespread, it risks destabilizing local communities with a possible spill-over effect to other regions. Conversely, it is increasingly argued that the provision of health services in fragile states, especially the most vulnerable, contributes to state- and even peace-building (Kruk et al. 2010) and to state legitimacy. Increasingly, health is considered a basic human right and a global public good.

Because of those “globalisation concerns” linked to health, there is increasing interest for health in foreign policy debates. It has become a matter of national self-interest to invest in health in poorer countries, because failure to do so risks to affect the life and well-being of citizens in richer countries also.

With this paradigm shift (from international to global health), development assistance for health is likely to undergo important changes in the near future: away from a primary and temporary focus on health problems of poorer countries whereby the volume of aid was limited to what those countries could be expected to financially self-sustain; and towards a focus on health as a global public good.

At the same time, there is a general concern in the aid community that international funding for health risks diverting domestic resources for health to other areas (Lu et al. 2010). Shifts from sector budget support towards general budget support result in less money for social areas. While international assistance for health to LICs tripled during the first decade of the 21st century, domestic government resources for health hardly increased. Worse: the countries that benefited most of increased international assistance are on average the ones that increased domestic government resources for health the least. While there are many factors to explain this ‘crowding out’ (Ooms et al. 2010) phenomenon, one cannot deny that there are still sources of confusion under the new paradigm: some argue that international open-ended co-financing is now an option, or even a reality, but then we also have to investigate how it should relate to national financing.

Global health governance therefore urgently requires the development of a “global social contract for health” (Ooms 2011)10, an agreed multi-country social contract that would clarify the roles and responsibilities of independent nation states in the definition, contribution and implementation of a defined package of basic health care services for all. There is a need to develop such a contract, because rich countries are expected to only contribute their “fair share” if they have a relative level of certainty that their contributions will result in health benefits locally. Similarly, poor and middle-income countries will only commit to invest the received financial support in health if they are convinced that they receive “fair” volumes of financial support which enable them to afford and defend (disproportionate) investments in areas that contribute to health outcomes of rich countries also. Both rich and poor countries would have to find a balance and make hard commitments on how to move forward.

---

Some believe a Global Fund for Health should be created to operationalize a global social contract; others think the World Health Organisation should take the lead in pursuing such a contract. Even if the discussion on mechanisms to realise such a global social contract is far from over, Belgium should promote the international debate on a global social contract at relevant forums like the GFATM, WHA and the IHP+.

**Additional funding**

As mentioned earlier, the WHO Commission on Macroeconomics and Health estimated 35-40 US$ per capita per year to be the cost needed to establish a basic benefit package for health in low income countries. It is estimated that this average will increase to 60 US$ per capita by 2015 (WHO 2010a). Without these minimum funds, an essential package of health services cannot be provided nor are sufficient quality standards in service delivery likely to be met. The bulk of fragile states spend far less on health: the average per capita expenditure on health in LICs, of which most are considered fragile states also, was only US$27 in 2009. Of this amount, US$11 came from government funding and the remainder from private out of pocket expenses of patients and external funds (WHO 2010b).

For most fragile states, it will take decades to reach the average cost of the essential package, due to limited fiscal space (Hay and Williams 2005) which is in turn directly related to limited possibilities to expand domestic resources.

Moreover, regardless of the current chronic underfunding of health in fragile states, even in those places domestic funding remains the backbone of health care financing. According to WHO statistics, only 17.5% of total health care spending in LICs is currently funded from international sources (WHO 2010b). The bulk of domestic funding comes from direct out of pocket expenses of the patients, only 8.7% of total health expenditure originates from direct government contributions to health.

While we do agree that the promotion of domestic funding is important for accountability reasons, it is evident that if one is serious about reaching UHC in fragile states, it is not realistic to count on domestic self-reliance for health care financing only, at least not on the medium term. Fragile states typically receive far less aid than other LICs, and aid flows tend to be more volatile (Mc Loughlin 2010). Significant additional funding from existing and new sources will thus need to be mobilized at both national and international levels if significant progress towards UHC is to be made. Those increased funds should primarily be used to replace out of pocket health expenditures from patients (height dimension, cf. WHO dimensions), especially for the most vulnerable. They should thus extend financial access to basic services for people who are currently excluded (breadth dimension, cf. WHO dimensions).

Increasing funds for health at both national and international levels would be a piece of cake if all governments in developed and developing countries respected agreements made in the past. In 2001, in response to the rapidly expanding HIV/AIDS epidemic, heads of sub-Saharan African states for example pledged to make the health sector a priority sector and commit 15 % of their annual budget to improving the sector (Abuja Declaration 2001). Unfortunately, ten years later, there is still a long way to go. Only 2 of 46 countries have reached the target. 7 Countries have reduced (!) their relative contribution. In the remaining 37 countries, domestic health expenditure remained more or less the same. If the Abuja commitment is to materialize, more African politicians will need to show (increasing) political will to put health on the domestic political agenda. Ideally, this should be the result of endogenous processes and forces: pressure
from local civil society organisations for example can help to push health higher up the agenda and push local government towards treating the health sector as a priority sector. In addition, external donors can also play a positive role and influence local accountability processes through promoting the participation of a mix of stakeholders (public, private-for profit & not-for profit, civil society organisations, academics) in the development of health plans and health budgets.

Equally, at the international level, there is still plenty of room for further expanding international assistance, including for health, if one keeps in mind the decade-old international agreement made on Overseas Development Aid (ODA) of OECD countries. Admittedly, a substantial increase of international ODA for health has been observed in recent years. From 1990 to 2007, ODA for health grew from 5.6 to nearly 22 billion US$ (Ravishankar et al. 2009). However, still only a handful of OECD countries honour the agreement to spend 0.7% of their Gross National Income on ODA. Belgium made a firm commitment to honour its ODA commitment by the end of 2010, in spite of the financial and economic crisis. In other words, our country now seems well on track to (finally) start honouring its commitment. Many others, however, like the US and Japan, are lagging far behind. Moreover, it seems extremely unlikely they will honour the agreement in the medium term.

Countries that are not formal members of OECD-DAC have also become relevant actors. The Arab States and emerging economies like China, Brazil and India are increasingly investing in bilateral aid, including for health, for example. In addition, especially with the MDG agenda, a multitude of new multilateral donors, non-state and private actors have started mobilising important and increasing volumes of financial resources for health.

However, even if all OECD donor countries honoured ODA agreements made and African states honoured the Abuja agreement to invest 15% of domestic resources in their health systems, there would still remain a funding shortfall of an expected US$ 7 billion by the year 2015 (Taskforce on Innovative International Financing 2009) for the provision of essential health care packages in low income countries. Clearly, additional and innovative funding channels need to be explored and/or expanded to cover the funding gaps.

One recent initiative is the Taskforce on Innovative International Financing for Health Systems, a taskforce specifically launched to diagnose and overcome the funding gap to reach the health related MDGs. Members of the taskforce have reviewed and proposed several options for additional fundraising from the public and private sectors or a combination of both. Their final report provides a list of 24 possible innovative financing mechanisms that can be launched at national levels (e.g. sin taxes on tobacco, alcohol), international levels (e.g. international levy on financial transactions) or both (e.g. airline levies). A levy on financial transactions has by far the biggest potential to raise significant additional financial resources. Income from those innovative funding mechanisms should be additional and can thus not act as a substitute for countries not living up to earlier international aid commitments. Additional funds yielded by innovative mechanisms should effectively be targeted towards investments in global health, with a primary focus on Primary Health Care, UHC and avoiding out of pocket expenditures for health for the poor. The agenda of global health will need to be aligned with other global public goods that are equally important and also require additional funds (e.g. climate change, security).

Last but not least, international trade with Low Income Countries should promote the ability of governments to raise additional taxes for social purposes. We refer to the 2010 World Health Report (WHO) in which several mechanisms are described to enhance domestic funding for health.
**Bridges between local, national and global levels**

Efforts on the local and national scene cannot be seen in isolation from what is happening in the global policy environment and vice versa. The changing global policy environment encompasses sociological changes (a growing public demand and a more vocal civil society), changing epidemiological patterns (from communicable diseases to chronic diseases) and policy and political changes (donor harmonisation initiatives, new multi-stakeholder fora and increasing complexity of the aid architecture, the move from international to global health).

Direct observation in different low- and middle income countries shows a major gap between the current global rhetoric on universal health coverage and what is actually happening in the field. This is also known as the ‘know-do’ gap (WHO 2005). In terms of health financing, for example, a coherent overall health financing picture is often missing for countries. The government budget, donor funding, out of pocket health expenditures and local financing initiatives often work in parallel and limited coordination exists between different financing sources. This may lead to inefficiencies at best, but also to fungibility of domestic resources for health from the health sector to other sectors, given the uncertainty on the predictability and volatility of donor funds.

And yet, for initiatives like the implementation of Social Health Insurance to become effective, coordination of the different funding sources is key. To be able to reach the most vulnerable, and to sustain access to essential health care services for those groups on a longer term, a certain level of synergy between global, national and local funding sources will be required. Only then, financial sustainability of the insurance will be guaranteed as well as continued access to an essential package of care of good quality.

In order to overcome the know-do gap in operations, policy development and policy implementation, and in governance, there is a need to identify mechanisms to build effective bridges between the different levels and identify complementarities between local, national and international efforts. Health service providers and civil service organisations, which possess first-hand information on the field reality and the obstacles they face, should be involved in discussing strategic decision making to boost UHC. Peer learning and peer exchange should be promoted both within and between countries within specific geographical regions or globally. Exchanges on leadership experiences could be promoted between strong and weak performers.

A useful mechanism to build bridges between the different levels is the so-called “community of practice” (CoP). A community of practice is a tool to improve knowledge management among and between stakeholders working in a similar area of expertise. While traditionally applied in private enterprises, some experts are convinced it could also provide a way forward in public health, especially in low income countries facing important operational problems in public health (Meessen et al. 2010). The primary focus of the community of practice is to bring together policy makers, implementers and researchers active in the same field of expertise and to build effective communication channels on the topic. The CoP aims to identify knowledge gaps that exist in the specific area of expertise it focuses on, to collect and share evidence and to develop implementation strategies to overcome operational bottlenecks. Focus is to produce knowledge on how to move forward, as opposed to describing what the problem is. The exchanges both happen face to face and via virtual networks. Especially given the fast development of information and communication technology, it is becoming increasingly easy to set up such exchange networks and to bring local, national, regional and global actors together on a regular basis.
Different communities of practice with a focus on public health have recently been launched by Harmonization for Health in Africa (HHA), a collaborative initiative by the African Bank for Development, UNAIDS, UNFPA, UNICEF, USAID, WHO and WB to provide regional support to governments in Africa in strengthening their health systems¹¹, and considered an initiative related to IHP+. Amongst other initiatives, HHA has launched 22 communities of practice in areas such as health financing, human resources for health, pharmaceuticals and supply chains, governance and service delivery, infrastructure and ICT, all with a view to improve UHC. Most CoPs are still in an early stage of development, but it will definitely be interesting to follow them up in the coming years.

Building bridges is also possible through long term collaboration projects. One such collaboration initiative in which Belgium is heavily involved is the well-known “Switching the Poles” initiative. The initiative starts from the idea that, in order to meet the health needs of a country in a sustainable way, exchanges between north and south need to go further than just the simple transfer of expertise and resources to developing countries. The aim is to build sufficient professional skills, managerial expertise and analytical and sustainable capacity in the communities and countries to equip them for the move towards UHC. This obviously includes training of individuals through physical or virtual centres of technical expertise in the north. Yet, it should preferably happen through infrastructure, on the job-training and professional development for in-country staff or through setting up networks and institutional collaboration projects. It is hoped this approach will not only create a sustainable response but also increase financial and operational efficiency in the field. Ownership and leadership are promoted by putting the recipient country in the driver’s seat.

A successful way of building bridges, be it on a national or international level is the Best Brains Exchange initiatives practised in Canada (Flood 2010). It brings together experts of the research and policy spheres in a one day event, between four walls and in all confidentiality, to discuss research evidence on a high-priority, ministry-identified issue. As decision-makers within the ministry select the topics, the exchanges offer a tremendous opportunity for researchers to contribute directly to policy-making.

These opportunities for exchange on the specific topic of UHC potentially have an impact far beyond individual initiatives.

¹¹ For more information, see http://www.hha-online.org/hso/
Recommendations on the role of Belgium

Belgium can play several roles in the UHC debate.

1. The Belgian government, as a **steward**, regularly needs to monitor and assess UHC domestically, in line with its national social contract. So far, Belgium has managed to take the necessary actions to sustain and advance UHC, but reaching the most vulnerable people (e.g. the “sans papiers”), keeping care affordable for everybody in an ageing society and the unsecure outcome of the European push for privatisation remain constant challenges. It is vital that all stakeholders are heard and that health is dealt with in a wider multi-sectoral perspective.

2. Belgium also has an important role to **sensitize** other countries and global institutions on the need to develop a global social contract for global health with a mutual accountability for rich and poor countries to contribute to global health.

3. Furthermore, the Belgian government, as a **donor**, should endorse its commitment to allocate the equivalent of 0.7 per cent of its Gross Domestic Product to international assistance. The same goes for our country’s willingness to consider ‘mirroring’ the Abuja target, by allocating 15 per cent of its international assistance to health. The bulk of the funds for development aid in health should be invested in promoting PHC and UHC.

4. As a **technical assistant**, Belgium could strengthen its pole position in the exchange of best practices as well as in the support of knowledge management platforms and initiatives at all levels. Further capacity building initiatives with the recipient country in the driver’s seat are important. Belgian donor aid does not play its role in a vacuum: efforts to align donor and national country initiatives in networks such as IHP+ and MOPAN are crucial. Without any question, Belgium should continue investing in fragile states. The rationale is clear: it is exactly in these countries that external funding can have the biggest short and medium term impact in terms of improving UHC. UHC promoting experiences at decentralized levels should be valued at different policy levels.

5. Building on its local expertise acquired over decades in mutual health organisations, social security and the like, Belgium should actively **lobby** for more accountability towards relevant global and national stakeholders. More inclusive models of cooperation are necessary (Fryatt et al. 2010). Belgium can support the role of civil society in calling governments to account and in scaling up efforts on the ground.

6. Belgium should **support** initiatives that try to link local, national, regional and global efforts, such as the Taskforce for Innovative Financing for Health Systems (Fryatt & Mills 2010), and that aim to improve the long-term predictability of national and international funding for health and efficient use of the funds. Especially the Financial Transaction Tax could yield important additional funds for health.
References


Belgium (2010) DAC Peer Review - Main Findings and Recommendations, available at [http://www.oecd.org/document/17/0,3746,en_2649_34603_45415825_1_1_1_1,00&&en-USS_01DBC.html].


GFATM (2005) Global Fund Investments in Fragile States: Early Results, GFATM.


Meessen B et al. (2010) Communities of Practice: the missing link for knowledge management on implementation issues in low income countries? Submitted for publication to TMIH 2010.


Ooms G et al. (2010) Crowding out: are relations between international health aid and government health funding too complex to be captured in averages only? In: Lancet; Published online April 9, DOI:10.1016/S0140-6736(10)60207-3.


Stuckler et al. (2010) The political economy of universal health coverage. Background paper of the global symposium on health system research and the presentation of Martin McKee dd. 18 Nov 2010, Montreux, Switzerland.


Annexes

Annex 1: Feedback Emerging Voices on Global Health

Policy Note On Universal Health Coverage For DGDC: Feedback From Emerging Voices For Global Health
Compiled by Seye Abimbola

Feedback from Emerging Voices for Global health on the Policy Note on Universal Health Coverage (UHC) has been categorised under two headings: 1.) Request for clarification or further exploration of terminologies and 2.) Preference for other approaches or request for greater emphasis on specific areas of the policy note.

DEFINITION OF TERMS

Universal Access versus Coverage: The concept of "universal access" needs to be addressed in the policy note. For many years the preferred concept in the literature was "access" and not coverage. Access has traditionally been understood in a wider sense than coverage and thus coverage is part of effective access. The reason for this shift in emphasis from "universal access" to "universal coverage" needs to be discussed in the report. Possibly, it is due to the fact that historically “universal access” has been associated with the primary health care (PHC) movement and its principles leading to an interest to present universal access detached or distinct from PHC.

Universal Health Care versus Coverage: It remains controversial but some authors argue that there is a difference between universal health care and universal health coverage. The former is said to be more relevant to developed countries while the latter (i.e. a package of essential basic services) suits developing countries because of resource constraints. This is an area where terms are still developing so the controversies are healthy in refining what universal health coverage actually entails.

Governance: The policy note addresses governance as "good governance" but does not expand on what is understood by "good governance". There is no explicit discussion of the political processes that may lead to “good governance”. The literature from the World Bank and other donors stresses issues of corruption, respect of the rule of law, including respect of private property and others. It is much more appropriate to replace the expression by "democratic governance" as presented by UNDP.

Fragile State: There is little discussion on how to define a fragile state. Even developing countries with enough wealth but poor governance have several areas with indicators suggesting a fragile state. How does one decide to not apply Paris Declaration as proposed in the document, citing fragility even though fragility may not be a well understood concept?

PREFERENCE FOR OTHER APPROACH & DEMANDS FOR GREATER EMPHASIS

On Health Insurance

- Targeted Coverage and Phased Approaches: Targeted coverage beginning with certain population groups such as the formal sector is often discriminatory against the poor. The policy note will be richer if it contained some examples of countries that started UHC with blanket coverage for the entire population and those that started with targeted coverage,
and with examples of the consequences for each of these policy approaches and the circumstances surrounding each policy approach. It is also important to include examples on insurance initiatives in fragile low income countries working towards achieving UHC. Times have changed and countries aspiring to achieve UHC should not wait for several decades while taking phased approaches. Evidence suggests that, while achieving UHC took several years in pioneer countries such as Germany, it is increasingly taking shorter periods, for example in countries such as Rwanda and Thailand. In addition, a phased approach may lead to undue rationing and the emergence of a two tier UHC system. There is also a danger of becoming complacent and accepting poor quality of services for the poor.

- **The Context Matters:** Interventions must be context specific. For example in Bangladesh, a Muslim majority country, any form of insurance is considered by many people as unacceptable. However, this may not apply to health insurance per se. Hence the term ‘insurance’ may create confusion and antagonism among the people.

- **Community Health Insurance:** The incorporation of Community Health Insurance (CHI) schemes into a large government-managed scheme would depend on whether the establishment is trusted by members of such schemes. The south has a problem with political and health system governance, as such there is little trust, which erodes solidarity. Solidarity is a key component in universal coverage. Moreover, CHIs are not encouraged as a financing option because they are inequitable and discourage cross-subsidization. Often their members are people in similar socio-economic groups in the low-income category, which means that the poor subsidize the poor contrary to the principles of insurance. Furthermore, evidence indicates that CHI does not offer tangible financial protection to their members. However, good elements from the CHI can be borrowed and incorporated into a social health insurance arrangement, as is the case in Ghana.

- **Technical Assistance:** Many low and middle income countries have very low rates of formal employment. Therefore, it is a challenge to provide insurance coverage for the vast majority of the people in informal sector. These countries will require technical assistance as well as financial assistance to expand coverage to the informal sector.

- **Monitoring and Evaluation:** In relation to the three dimensions to assess UHC in terms of the population covered, services offered and their costs, it is necessary to incorporate a fourth one on the impact on population health. The reason for the UHC is to improve the health of the population, therefore health indicators should play a key role in the conceptual framework of health systems, especially in monitoring and evaluating the impact of insurance schemes on the population.

**On Governance**

- **Levels of Governance:** The sub-national level is emerging as an important level at which to intervene for better health care provision. This is especially the case in large countries (e.g. India and Nigeria) where health is a "state" or provincial subject (as opposed to federal subjects like defence). Efforts for strengthening state/provincial and district level health planning and management are increasing. Slowly and steadily, state level policies are emerging while the central ministry merely acts as a top-up financier or to steer national vertical programmes. The situation in smaller countries may be different. However, the sub-national level of planning must not be neglected. The sub-national levels are especially important in the UHC agenda; stronger districts and states/provinces are very important for ensuring the "breadth" and "length" of coverage. Governance at the national and
international level are mentioned but an important issue is local governance. Good governance has a way of creeping in where grassroots activism and demand for accountability is stronger. Conceiving UHC at global and national levels disconnects it from the communities it is supposed to cover and makes it merely technical in nature. However, in a globalized world it is necessary to build bridges between local, national and even global levels of governance and to recognise the important bridging role of national governments.

- **Engaging Politicians:** The governance of health care is particularly important in low-income countries where it often happens that politicians (from district to national levels) do not consider health issues as central to their roles as leaders. The activities being proposed in the policy note ought to include those aimed at authorities especially on the cross-sectoral importance of health, on how to implement and monitor programmes and also on how to 'infiltrate' UHC into existing agendas at national and district levels.

- **Human Rights:** The policy note needs to avoid a potential loophole that may allow for the argument that universal coverage of only a few basic services is the only thing that can be afforded and guaranteed to citizens. It is important to address UHC from an ethical and human rights perspective. The Commentary on the Right to Health by the Commission on Economic, Social and Cultural Rights describes the "core health care services" that demand immediate fulfilment, the principles of "progressive realisation" and "avoidance of retrogression" in the enjoyment of the right to health. These provisions are crucial to justify a health system that provides coverage to “its maximum capacity or available services.” In addition, a human rights approach to universal coverage would also be appealing for many NGOs.

- **Working with People and Communities:** It is imperative to include the people in the whole process of universal coverage, make the communities informed of their health rights and encourage them to raise their demands for UHC. It is important to work with people and communities to demand accountability from authorities, especially if a human rights approach is adopted as a strategy to demand UHC. In addition, there are various interest groups who may resist the initial attempts at universal coverage due to vested interest or lack of understanding.

**On Human Resource for Health**

- **Task Shifting:** Human Resources for Health (HRH) are in short supply and when available, they are highly concentrated in urban areas making it difficult to reach rural dwellers, a huge obstacle to achieving UHC. Therefore task shifting should be considered as a strategy to achieve universal coverage. There is great need for research in respect to HRH for universal coverage. The training and recruitment of community health workers (CHWs) should be put forward as part of the solutions to deliver basic care where there are HRH shortages.

- **Human Resource for Operational Research:** There should be a place of prime importance for building local capacity for operational research as there is no single way to achieve universal coverage. The challenge is to help countries find their own path to universal coverage.

**On How to Maximise Funding and Development Assistance**

- **Improve National Commitment:** External funding is fungible as highlighted in the policy note. However international funding can also require that the recipient governments commit a
certain percentage (equal to 35-40US$ per capita per year) of their national health budget to be channelled to provision of UHC as a condition for receiving external assistance towards UHC.

- **Through Non-Governmental Institutions**: The peculiar circumstances of working in fragile states needs to be stressed, especially the role of non-state actors i.e. NGOs, civil society et cetera, and how Belgium has channelled its ODA in the past in relation to working with and through these non-state actors with recommendations going forward.

- **New Governance Structures for UHC**: The example of the achievements of the Global Fund and GAVI in successfully piloting new governance approaches, involving different levels of government and stakeholders with a focus on results and payments based on performance, including in fragile states should be received with caution. Apart from the fact that these are mostly vertical projects, the amount of resources put in both financially and technically is enormous. Is it possible for the provision of UHC to afford this? Would there be the same amount of interest and investment by stakeholders for setting up new governance for UHC as was the case for GFATM and GAVI?

- **Preventive and Primary Health Care**: The policy note needs to state explicitly that the bulk of funding assistance for health has to go to primary health care instead of vertical programmes as money spent in vertical programs may be put to better use, potentially leading to increased overall health coverage. The Belgian Cooperation has chosen countries with very limited resources as development assistance focus. Therefore, there is a need to emphasise prevention as a cost-effective strategy for fragile states in the policy note.

- **Education and Agriculture**: The Belgian government could also contribute to efforts to improve education and agricultural productivity particularly among the poor in rural areas. A population that is able to feed itself, is well educated and has transparent governance is one that is on track to achieving its human potential. Although health outcomes for children and others have improved over the years in many developing countries, decreasing investment in agriculture has seen these gains eroded through rise in cases of famine, malnutrition and stunted growth, and a decreasing purchasing power among rural adults. Education on the other hand, helps create awareness about health insurance and acts a means to develop a critical mass of middle class that is capable of holding wayward regimes accountable.

**On Initiatives for Access to Health Technologies**

- **Health Impact Fund**: Many innovative pharmaceutical industries found very difficult to make money in poorer countries because the low prices required to generate substantial sales in those markets made it impossible to charge high prices to wealthier people in those and other markets. The new project called Health Impact Fund aim to eliminate this problem by requiring a uniformly low price worldwide, while offering innovative companies direct payment based on the health impact of their innovations, no matter where the health impact occurs. This ambitious project could help move towards UHC since UHC is also a matter of access to health technologies. It is important for Belgium to take a supportive stand on this project.

- **Free-Trade Agreements**: There is a need in the policy note to emphasise advocacy directed at the European Commission in aligning business goals of the EU with the UHC agenda. This is
an important role that countries like Belgium can play. For example, the furore over the EC seizure of low-cost Indian drugs en route to other countries in the global south, citing EC laws and the downstream drug shortage effects was a failure to understand the health implications of several general legislation and poor agenda setting of UHC and drug access within EC itself. The several "free-trade" agreements being forged with countries in the global south especially India also create imminent hindrances for the free flow of ideas and innovation.

Annex 2: List of landmark documents on UHC


Annex 3: Recent literature reviews

- Recent literature review of definitions of universal coverage:
  Stuckler et al. The political economy of universal health coverage. Background paper of the global symposium on health system research and the presentation of Martin McKee dd. 18 Nov 2010, Montreux, Switzerland.

- Recent literature review of definitions of social protection:
  Brunori, Paolo and O’Reilly, Marie (2010), Social Protection for Development: a Review of Definitions, Background paper to the European Report on Development 2010, European University Institute, Florence, Italy.