

Universal health coverage: how to mix concepts, confuse objectives, and abandon principles

Cobertura universal de saúde: como misturar conceitos, confundir objetivos, abandonar princípios

Cobertura universal de salud: cómo mezclar conceptos, confundir objetivos, abandonar principios

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The World Health Report 2010 of the World Health Organization (WHO), *Health Systems Financing: the Path to Universal Coverage* ¹, might have been one more declaratory report with a set of good intentions like others, if it were not for the expanded interest that the proposition “universal coverage” awakened in circles of conservative health thinking, defenders of the “market” in the provision of services, foundations acting in the Global Health arena, like the Rockefeller Foundation, and even the prestigious British medical journal *The Lancet*. The latter published a set of articles on the theme, one of which stated that “universal health coverage” meant a “third global health transition” ². In December 2012, the theme was submitted to the United Nations General Assembly and incorporated as one of the items in *Resolution A/RES/67/81 – Global Health and Foreign Policy*.

An in-depth debate on the right to health is beyond the scope of this paper. Emerging from the ashes of World War II, the creation of the United Nations, the World Health Organization, and the *Universal Declaration of Human Rights* were important signs of a collective will to renounce barbarianism and pursue standards of social life and cohesion in which the use of force could be minimized.

The right to health was clearly expressed in the WHO Constitution when it proclaimed, “*The enjoyment of the highest attainable standard of*

health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, or economic or social condition.”

The Brazilian National Constitution of 1988 incorporated the right to health as the right of all and considered its guarantee as the duty of the state “*by means of social and economic policies aimed at reducing the risk of disease and other health problems and universal access to actions and services for its promotion, protection, and recovery*”.

The proclamation of health as the right of all under the Brazilian National Constitution, or “without distinction” as enunciated by the WHO, introduces the issue of equity and justice both in the enjoyment of health and in access to health actions and services.

According to WHO Director General Margaret Chan, the 2010 report was elaborated “*in response to a need, expressed by rich and poor countries alike, for practical guidance on ways to finance health care. The objective was to transform the evidence, gathered from studies in a diversity of settings, into a menu of options for raising sufficient resources and removing financial barriers to access, especially for the poor*”. She further emphasizes the theme’s urgency “*... at a time characterized by both economic downturn and rising health-care costs, as populations age, chronic diseases increase, and new and more expensive*

treatments become available". And further, "At a time when money is tight, my advice to countries is this: before looking for places to cut spending on health care, look first for opportunities to increase efficiency"¹.

The first explicit reference to "universal coverage" by the WHO appears in one of the reports to the 58th General Assembly in 2005, entitled *Sustainable Health Financing, Universal Coverage, and Health Social Security*. This document launches the semiotic transformation of the right to health and universal and equal access to health care into the concept of "universal coverage", indelibly associated with "financial risk protection" and the search for alternative mechanisms for health sector financing.

In the 2010 report, the order of the expressions is finally inverted, and the central theme becomes the health sector's financing as the "path to universal coverage". And in the opening session of the 65th World Health Assembly, the Director-General of WHO proclaimed, "Universal health coverage is the single most powerful concept that public health has to offer."³

The message from WHO contained in the 2010 report proceeds, emphasizing the determinants of health status: "The 'circumstances in which people grow, live, work, and age heavily influence how people live and die. Redressing inequalities in these will reduce inequalities in health.'

And universal coverage: "... Member States of the World Health Organization committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. This goal was defined as universal coverage, sometimes called universal health coverage."

The first reference alludes to the report by the Commission on Social Determinants of Health⁴, which highlighted conditioning factors for health status that have greater health impact than those resulting from health care provision itself. To guarantee the right to health, it is necessary to examine the different processes under way in countries and that relate to employment and income, education, housing, sanitation and environment, food, agrarian reform, and social development, among others. As a general rule, investments and services in the collective interest are financed by taxes and other revenues that are part of the governments' budgets at different levels. The final destination of the funds from this pool of fiscal resources is described in the budgets and investment plans, in which the decisions are made explicit, both for defense, education, and health as well as interest payments and debt service. This digression aims to demonstrate the weakness of the argument that for a

specific policy to materialize, it requires a specific pooling mechanism. Government interventions take place through the pooling of taxes and other public revenues! We should also examine its expression both on the side of the appropriation of societal resources by fiscal mechanisms (fiscal justice) and the destination of these levied resources (distributive justice). If health services are in the public interest and are financed with public resources, they should not be subject to different rules and analyses.

Universal coverage

The term "coverage" classically expresses the reach of a given health intervention, such as the proportion of pregnant women that receive prenatal care. This involves an association between provision, access, and use. Another use of the term corresponds to the possibility of actually obtaining the provision. This possibility may or may not materialize, either because the individual abstains from the right to its use, or because he or she is unable to obtain the desired provision. In the case of health care, when one says that a given health unit "covers" a given number of individuals, it does not mean that that number of individuals is actually using the services or is able to use them when needed. Coverage thus differs from access and utilization. To discuss universal coverage without qualifying it is a major mistake, since one might assume that contributive "coverage" or paying-in to social or private insurance will always correspond to opportunities for access and use, which is not true. If we accept "coverage" as "access to and timely use of effective and quality services when necessary", the problem disappears. Coverage should mean access and use and not only entitlement, and should occur without barriers.

There are numerous barriers to access on both the demand side and supply side⁵. The "financial barrier" is definitely a significant barrier on the demand side, but not the only one, and not always the main one. It varies according to the service required to meet specific needs. Besides, why sell the idea of dedicated pools as the central idea for health care financing? If "social determinants of health" exist, why create specific pools or taxes for health care and not for each of the policies corresponding to the long list of "determinants"? Would payments to private insurance, which are known to be selective and subsidized, be part of these pools? Is there a "subtext" to this text?

Finally, a last reference to the report: why is the issue of equity launched as subordinate to

the idea of “financial protection” for the poor? Oddly, the postulators of the purportedly innovative concept of “universal coverage” gloss over the very serious problem of supply according to social class and the type of protection guaranteed by the different insurance modalities, public or private, i.e., segmentation in the “basket” and in the quality of care guaranteed by them.

The conclusions of the meeting at the Bellagio Center promoted by the Rockefeller Foundation and entitled *Future Health Markets* may help clarify the force of the proposal of “universal coverage” as opposed to “Universal Health Systems”: “Strong market players such as pharmaceutical

manufacturers, hospital organizations, provider associations, and insurance companies are likely to increase pressure to attract public and private financing, particularly as low and medium income countries adopt policies to finance health insurance as a means to Universal Health Coverage (UHC)” ⁶.

Do we have “the single most powerful concept public health has to offer”, moving quickly towards transforming human health into a commodity and liquidating the principle that health needs should determine access to and use of health services rather than the ability to pay for such services or to pay into specific funds?

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