# EDITORIAL

## Universal health coverage: A re-emerging paradigm?

Damen Haile Mariam[1]

A number of articles in this issue (1-4) highlight the importance of providing essential basic health services for achieving and maintaining optimal health status within a given population. The Ethiopian health system is also striving to address the need for providing essential health services within the perspective of universal health coverage (UHC) through its health care financing strategy (5) which is a basis for different reforms that include community based health insurance (CBHI) and social health insurance (SHI) schemes for people in the informal and formal sectors respectively as its health insurance strategy (6).

As endorsed by member states of the World Health Organization (WHO), the concept of UHC is defined as a target in which "all people have access to services and do not suffer financial hardship paying for them" (7) and it is conserved as a central goal that health systems should achieve. The concept implies ensuring or guaranteeing that all people obtain the health services they need, of good quality, without suffering financial hardship when paying for them (8, 9). The United Nations General Assembly has also called for the urgent and significant acceleration of the move toward the universal access to quality and affordable health care services (10) and has indicated three dimensions through which progress can be advanced to UHC: expanding priority services, including more people, and reducing out of pocket payments (11).

Historically, universal health coverage is a re-emerging concept in the context of developing countries when looked at within the perspectives of earlier initiatives in global health that include the basic health services and the primary health care approaches (12). The basic health services approach within the sixties and the primary health care movement in the seventies advocated the availability, accessibility (geographic, economic, cultural) and appropriateness (technological) of health services to underserved populations in developing countries (13). In addtion, the primary health care approach, as a philsophy, reframed and shifted the issue of focus from medical faciilites to health services and from diseases to health care (14, 15). The ideals in those periods were reflections of the overall development thinking at the time, in addition to the post-independence ambitions and zeal of the progressive nationals and the contributions of labor movements, socialism and central planning during the seventies. More recently, the increasing trends in globalization and enhanced communication between populations across countries and continents has created new dimensions in the externality and public good nature of health leading to new initiatives that are attempting to shift the agenda of health services delivery, and that of UHC, to obligations that need commitments at international levels (16-18). It is also to be noted that the global movement towards UHC is said to represent the third major shift in recent global health history that followed the demographic transition beginning in the 18th century that sparked major public health developments through the 20$^{th}$ century, as well as the epidemiological transition starting in the 20$^{th}$ century (19).

However, according to its contemporary definition (20), universal health care is not a one-size-fits-all concept and does not imply coverage for all people for everything. Universal health care can be determined by three critical dimensions: who is covered, what services are covered, and how much of the cost is covered. It is rather a broad concept that has been implemented in several ways. The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards (21). Furthermore, there are significant challenges in meeting the ambitions of

[1]School of Public Health, Addis Ababa University, Addis Ababa, Ethiopia.

universal health coverage in low income countries, particularly those in Africa in that (22): revenue mobilization is a problem in informal sector (that includes the majority of the population in these countries, as there is no tax base with stable employment or wage system. In addition, tax administration systems are also weak and inefficient with high rates of tax evasion by the private sector. The macroeconoic contexts and the very low income levels in these countries also makes high tax rates poltically unacceptable and practically infeasible. Issues of governance also complicate the managerial as well as technical administration of UHC schemes in these countries.

Therefore, developing countries should move very cautiosly in the adoption and implementation of the concept of univeral health coverage (23). Innovative approaches are required for only partial UHC with progress at varying speeds and with mix of social or national health insurance With some complementary mechanisms in some cases such as: vouchers and community based health insurance schemes. Some combination of taxes and public financing, not just premium income, are required for UHC and for pooling contributions across from formal to informal sectors. Eventually, such transformation from partial to full and sustainable UHC, at the same time addressing the three criteria set by the WHO (cost-effectiveness, financical protection and prioritizing the worse-off), will require sustained 'economic growth with equity.

**References**


1. Wakgari N, Wencheko E. Risk factors for neonatal mortality in Ethiopia. *Ethiop J Health Dev* 2013; 27(3):192-199.
2. Dillu D, Haidar J. Iodine deficiency disorder and its correlates among antenatal care service users from Northwest Ethiopia. *Ethiop J Health Dev* 2013; 27(3):208-215.
3. Tefera B, Ahmed Y. Contribution of the anti-HIV/AIDS community conversation programs in preventing and controlling HIV/AIDS. *Ethiop J Health Dev* 2013; 27(3):216-229.
4. Degineh H, Tekle Giorgis A. Glaucoma awareness among ophthalmic patients in Menelik II Hospital. Addis Ababa, Ethiopia. *Ethiop J Health Dev* 2013; 27(3):230-234.
5. Federal Ministry of Health (FMOH), Ethiopia. Health care financing strategy. Addis Ababa; Planning and Programing Department (FMOH), 1998.
6. Federal Ministry of Health (FMOH), Ethiopia. Social health insuranc strategy. Addis Ababa; Planning and Programing Department (FMOH), 2008.
7. World Health Organization (WHO). The world health report 2013: research for universal coverage. Geneva; WHO, 2013.
8. World Health Organization (WHO). Sustainable health financing, universal coverage, and social health insurance. Geneva, WHO, 2005.
10 World Health Organization (WHO). Universal health coverage: Supporting country needs. Geneva; WHO, 2013.
11 United Nations (UN). UN global health and foreign strategy. New York; UN, 2012.
12 Ottersen T, Norheim OF, Chitah BM, Cookson R, Daniels N, Defaye FB, et al. Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage. Geneva;WHO, 2014.
13 Secretariat, WHO. International conference on primary health care, Alma-Ata: Twenty-fifth Anniversary. Report by the Secretariat. Geneva; WHO [cited 2013]; Available at: URL:http://apps.who.int/gb/archive/pdf_files/WHA56/ea5627.pdf
14 WHO. Declaration of Alma-Ata: Adopted at the international conference on primary health care. Alma-Ata; USSR, 6–12 September 1978.
15 King M. Medical care in developing countries: A primer on the medicine of poverty and a symposium from Makerere. Oxford University Press, 1967.
16 Starfield B. Politics, primary healthcare and health. *J Epidemiol Community Health* 2011;65:653–655.
17 WHO. Macroeconomics and health: Investing in health for economic development. Report of the commission on

macroeconomics and health. Geneva: WHO; 2001.

18 United Nations. Millennium Development Goals. Background [cited 2013]; Available at: URL: http://www.un.org/millenniumgoals.

19 Atim C. Mobilizing revenues for universal health coverage in African countries. Presentation at the Pan-African Congress on Universal Coverage. Accra: Ghana; 2011.

20 WHO. World Health Report 2010. Geneva: WHO; 2010.

21 Stuckler, David; Feigl, Andrea B.; Basu, Sanjay; McKee, Martin (November 2010). The political economy of universal health coverage. Background paper for the First Global Symposium on Health Systems Research, 16–19 November 2010, Montreaux, Switzerlan". *Pacific Health Summit*. Seattle: National Bureau of Asian Research. p. 16.

22 Giedion U, Alfonso EA, Diaz Y. The impact of uuniversal coverage schemes in the developing world: A review of the existing evidence. Universal Health Coverage Studies Series (UNICO). UNICO Studies Series No. 25. Washington DC: The World Bank; 2013.

23 McIntyre D, Garshong B, Mtei G, Meheus F, Thiede M, Akazili J, et al. Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic or Tanzania. *Bulletin of the World Health Organization* 2008;86:971-976.