Universal Health Coverage - A Tool to Fight Health Inequity Battles: The Need from Aspiration to Decisive Action in African Countries

Eshetu Bekle Worku¹, Selamawit Alemu Woldesenbet²

¹Northern Cape Department of Health, Kimberley, South Africa
²Communicable Diseases Control Section, US Embassy Pretoria, South Africa

Correspondence to: Eshetu B. Worku, Northern Cape Department of Health, Kimberley, South Africa. Email: eworku@ncpg.gov.za

ABSTRACT

Background: Universal Health Coverage (UHC) is considered an effective tool to reduce the current healthcare provision inequities observed both within and across countries. UHC helps by creating dynamic systems for health that usher access to good quality healthcare for all. It holds the center stage in the post-2015 Sustainable Development Goals (SDGs) agenda. Advancing towards UHC in African countries requires simplified actions in the three broad dimensions of UHC: population coverage, quality and type of services covered, and proportion of the costs covered.

Methods: We reviewed data from 51 African countries on their: current health status, healthcare expenditure on public and private health, budgets, out of pocket payments as a percentage of total expenditure on health, government total healthcare expenditure on public health services as a percentage of GDP, and population health status indicators required to assess progress towards achieving UHC. World Bank (2015) and UNDP (2015) datasets that measure the well-being of a nation and are available online were used for the analyses.

Results: We found high health inequities and poor population health status, high out-of-pocket payment (>75% of private healthcare expenditure), and low government healthcare expenditure on public health (<4% of GDP) for the majority of African countries. This shows the low commitments of the countries to promoting and achieving health equity.

Conclusions: The three dimensions of UHC are broad and complex, but justifiable for people at the centre health systems. In African countries, implementing UHC need innovative workable strategies to demystify and simplify the dimensions based on the each country’s context. One-size-fits-all philosophy may not work.
INTRODUCTION

Health agenda in the post-2015 era witnessed significant milestone foundation and countries’ commitment on far-reaching changes in the global, national, individual, and population health over the next fifteen years [1-4]. Related to health, the 2016-2030 Agenda for the United Nations Sustainable Development Goals (SDGs) launched in 2015 calls for all member states to ensure healthy lives and promote well-being for all at all ages and reduce inequalities [4,5]. Universal Health Coverage (UHC) principles are encouraged as an effective means to reducing the current health provision inequities and realization of the SDGs [3,5,6]. According to the WHO Director General, UHC is the single most powerful concept that public health has to offer [7]. Doing so not only ensures that utilization of health services does not expose marginalised poor to further financial hardship, but also not to leave anyone behind.

There are strong reasons to accelerate moving towards UHC principles, particularly in African countries where poor health status is pervasive and health inequalities are increasing [7,8]. The health status indicators measured by maternal mortality ratio, infant and child mortality rates, life expectancy at birth, and the number or people living under absolute and relative poverty lines endorse the importance of implementing UHC [7,8]. These health indicators have been central to monitoring progress towards the Millennium Development Goals (MDGs) and are now important indicators among the SDGs [9,10]. Unsurprisingly, over most of the targets, the MDG ended with sub-optimal outcomes in many African countries [11]. Although this negative relationship may not always hold true, the fact implies that to attain the SDGs targets there is a need to make concentrated efforts with major reforms in certain areas as well as setting relevant performance indicators and monitoring of progress thereafter.

Despite the UHC strategic benefits, many speculate that it may be more relevant for higher income countries who have better capacity and developed health systems [12]. In many of African countries where health systems are poorly functioning, capacity limitations and pervasive existence of the social determinants of health (SDH), to pledge and then fast-track the UHCs revolution within the context of its three dimensions seems challenging [12,13]. Further, unfortunately the concerns are not limited to the health systems reorientation and the subsequent funding requirements to provide a range of good quality health services to all, but also lack of clarity on the prior and subsequent reforms and their magnitude that have to be taken at different levels to step forward to the UHC [10,14,15]. Indeed, the positive association between higher levels of economic resources and better population health outcomes or lower socioeconomically caused inequalities is one of well-documented connotation in public health literature [3]. Given that in many African countries, where the magnitude and complexity of the challenges are not only due to limited resources and capacity constraints, translating pro-poor commitment within all-inclusive growth into practice may not be easy.

Advancing towards UHC calls for extending the three broad dimensions, namely population coverage to ensure equitable access of services; quality and type of services that are covered to be accessed; and the proportion of costs covered to reduce the direct payments needed for each service. The six main building blocks of the health system, include human resources (to provide quality healthcare services); financing of the health systems (to adequately allocate financial resources to needed services); good quality health services (that are accessible across all levels of care); governance of the health sector (implementation of national guidelines, policy and regulatory mechanisms, and partnerships with the private sector); infrastructure and technologies are essential components of effectively functioning health systems [18,19]. While the SDH are the conditions in which people are born, grow up, live, work and age, these circumstances are shaped by the distribution of money, power and resources at global, national and local levels [20].

This fact provides the necessary rationale that for designing, planning and implementing UHC, countries must choose innovative strategies based on context of each country. While unequivocally supporting the principles of the UHC, alignment of the resources of the
country - both public and private healthcare sectors, is an essential step towards achieving UHC. Thus, we argue in this paper that the UHC framework in many African countries should not necessarily be framed to rapidly expand in its three dimensions. African countries must systematically design innovative ways and plan a set of economically, socially and politically practical and feasible actions to move towards the UHC. Further, given the current capacity constraints in the key capability areas, prioritization of activities is imperative so that UHC is not to be an ambitious goal. Doing so will allow countries to address the significant challenges faced by the majority as there is no one single approach.

This study hypothesised that adequate funding coupled with capacitated dynamic public health systems at national, provincial, district and health facility levels to manage UHC processes, other sectors collaborations, active engagement with civil societies, global co-operations, and government commitments is critical to overcome the said obstacles and accelerate the effective move towards UHC. Based on this, 51 African countries’ current health expenditure and population health status indicators were systematically reviewed.

**MATERIALS AND METHODS**

This Datasets obtained online from the World Bank (2015) [16] and UNDP (2015) [17] were used for systematic review of 51 African countries’ health budgets for 2014 using different indicators which included: percentage of out-of-pocket spending on health, government’s share of spending on public health as percentage of GDP, as well as population health status indicators. Primarily descriptive statistics were used for data analysis. Where appropriate, data were disaggregated by different attributable characteristics of population health status outcomes by using indicators like: infant mortality rates; maternal mortality ratios; life expectancy at birth; and health expenditure in each of the 51 African nations. Furthermore, graphical analysis is used to show the interaction among the three dimensions of UHC, the six building blocks of health systems, and the SDH frameworks to establish the link and to indicate areas that require reforms to consider when moving towards UHC.

**RESULTS**

According to the recent World Bank (2015) and UNDP (2015) datasets that measure the well-being of a nation, poor population health status indicators still remain high in many African countries. As shown in Table 1, public health expenditure required to provide access to health care services that are both needed and are of sufficient quality continues to be very small. The majority of African countries allocated less than 4%, whilst only four countries were able to allocate greater than 6% of their GDP to health during the study period.

On the other hand, out-of-pocket (OOP) health expenditure was the major health expenditure (Table 2). In more than 90% of the African countries OOP expenditure was more than 75% of the total health expenditure. Furthermore, trends analysis of public health budgets allocation as percentage of GDP between 2011 and 2014 showed that many African countries continued to allocate the same low level or increased minimally in their public health budget. The envisaged reform of the health system towards UHC to achieve its purpose, African countries need careful planning and with sufficient attention to improving the financing mechanisms.

**DISCUSSION**

The Throughout the world, the concept of UHC has been accepted as a powerful means to overcome inequity in healthcare and advance all-inclusive sustainable socio-economic development [4,6,21]. At a national level, many African countries accepted the principle of UHC and a few have already started, while the rest actively seek to embark on this journey. According to the WHO, there are three broad dimensions to consider when moving towards UHC if it is to achieve its noble goals [1,6]. What remains as a concern is how to transform African countries health systems capacity to support the
Table 1. Health and Economic Indicators for 51 African Countries

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Number of Countries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio per 100,000 births, 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;500</td>
<td>16</td>
<td>31.37</td>
</tr>
<tr>
<td>500-250</td>
<td>21</td>
<td>41.18</td>
</tr>
<tr>
<td>250-100</td>
<td>7</td>
<td>13.73</td>
</tr>
<tr>
<td>&lt;100</td>
<td>7</td>
<td>13.73</td>
</tr>
<tr>
<td>Infant mortality rate per 1,000 live births, 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;100</td>
<td>2</td>
<td>3.92</td>
</tr>
<tr>
<td>100-75</td>
<td>5</td>
<td>9.80</td>
</tr>
<tr>
<td>75-50</td>
<td>21</td>
<td>41.18</td>
</tr>
<tr>
<td>&lt;50</td>
<td>23</td>
<td>45.10</td>
</tr>
<tr>
<td>Life expectancy at birth, 2014 (years)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤55</td>
<td>8</td>
<td>16.67</td>
</tr>
<tr>
<td>55-65</td>
<td>29</td>
<td>60.42</td>
</tr>
<tr>
<td>65-75</td>
<td>10</td>
<td>20.83</td>
</tr>
<tr>
<td>&gt;75</td>
<td>1</td>
<td>2.08</td>
</tr>
<tr>
<td>GNI per capita, 2014 (USD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤5,000</td>
<td>42</td>
<td>82.35</td>
</tr>
<tr>
<td>5,000-10,000</td>
<td>6</td>
<td>11.76</td>
</tr>
<tr>
<td>10,000-15,000</td>
<td>2</td>
<td>3.92</td>
</tr>
<tr>
<td>&gt;15,000</td>
<td>1</td>
<td>1.96</td>
</tr>
<tr>
<td>Human Development Index, 2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤0.25</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>0.25-0.50</td>
<td>25</td>
<td>49.02</td>
</tr>
<tr>
<td>0.50-0.75</td>
<td>25</td>
<td>49.02</td>
</tr>
<tr>
<td>&gt;0.75</td>
<td>1</td>
<td>1.96</td>
</tr>
</tbody>
</table>

*Missing data

It is important to adequately address these concerns for widespread adoption of UHC through innovative strategies. The manner in which the UHC is designed will have greater impact on both in its implementation success or limitation [10]. The experience in various countries, where UHC schemes have been implemented or being implemented shows that regardless of the institutional arrangement chosen and how well countries are able to raise funds, commitment to cover 100% in the three dimensions of UHC will never be possible. For instance, countries such as Thailand, Brazil, Mexico, Malaysia and Keralla State in India have shown how pro-poor dynamic health financing systems and social solidarity can move forward the principles of UHC. In these countries, governments’ commitment in raising revenue and prioritising health spending is commendable and instrumentally suggest that UHC is an achievable goal even with limited resources with focused strategies to tackle main barriers to access to good quality health services.

The results from this study show that, in the majority African countries, OOP health spending is the dominant means of paying for healthcare. The proportion of public health expenditure is very low. Given that the direct OOP payment can constitute a major barrier to access and is often an important source of financial hardship and inequity in health, African countries need to design pro-poor dynamic systems for health. Healthcare consumption-based on OOP payment will disproportionately affect the poor more than the wealthy [31,32]. The study results show substantial variation in financial coverage among African countries. Public health
Table 2. Trends in Health Expenditure (Public and Out-of-Pocket) for 51 African Countries, 2011-2014*

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Years [Number of Countries (%)]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td><strong>Public health expenditure (% of GDP)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;2%</td>
<td>10 (19.61%)</td>
</tr>
<tr>
<td>2%-4%</td>
<td>32 (62.75%)</td>
</tr>
<tr>
<td>4%-6%</td>
<td>5 (9.8%)</td>
</tr>
<tr>
<td>&gt;6%</td>
<td>4 (7.84%)</td>
</tr>
<tr>
<td><strong>Out-of-Pocket health expenditure (% total health expenditure)</strong></td>
<td></td>
</tr>
<tr>
<td>&gt;75%</td>
<td>28 (54.9%)</td>
</tr>
<tr>
<td>75%-50%</td>
<td>14 (27.45%)</td>
</tr>
<tr>
<td>50%-25%</td>
<td>5 (9.8%)</td>
</tr>
<tr>
<td>&lt;25%</td>
<td>4 (7.8%)</td>
</tr>
</tbody>
</table>

*Numbers do not add up in some categories due to missing data

Expenditure as percentage of GDP is greater than 6% in only five countries, while the bulk of African countries’ expenditure is less than 4% of GDP. This fact shows not only governments’ commitment to reorient health sector towards equity is insignificant, but with this rate, to attain the potential for far-reaching reforms in health system to ensure UHC in the next fifteen years seems challenging for many reasons.

We argue in developing countries UHC may not need to advance in the same way as of developed countries. The latter can certainly afford to provide healthcare at quite high levels for all by extending the three UHC dimensions. However, developing countries can start the process with an innovative strategy with a demystifying and simple approach for advancing to UHC. For instance, at UHC initial stage the tackling main barriers of access to widespread adoption of UHC, and some proposed strategies to work around said obstacles may be critical. Hence, contracting private health service providers to provide high quality health services to public may be of limited importance for developing countries, compared to the available capacity to contract, appropriately monitor and manage the contracted service providers. Rather the focus should be on a public delivery system or a combination of public and private to improve the quality and range of curative services provided by primary level health professionals, an improvement in the referral and feedback loops between different levels of care hierarchy and addressing inefficiencies in service delivery, may be most important.

Although OOP funding needs to consider the depth of the pockets, that is, what such expenses represent for the general population of the specific countries, and how much that means in terms of general expenditure, as a fraction of the GDP, for instance, in many African countries, it does mean barrier to access. The OOP funding for healthcare is huge in the US, for instance, and it is a problem, but quite different from African countries, where the majority population is without health insurance. In most African countries, OOP payment constitutes usage fees in addition to government provided services. Then, setting a progressive increment in GDP for funding for public health sectors to improve access and quality of care, to boost service utilization as well as satisfaction of
clients with care, therefore may be the immediate need. There are examples from African countries, such as, Ghana, Rwanda, South Africa and Ethiopia that are successful in providing a reasonably good quality healthcare coverage to all. In these countries among the strategies to start towards UHC used more responsive, effective and cost-effective integrated strategy such as primary healthcare re-orientation, linked to formal health system, building home-grown health financing system.

Improving the current weak health systems capacity is important but may not be enough. Many factors outside the health systems, commonly called the SDH - the conditions, in which people are born, grow, work, live and age have significant impact on health and health inequalities [2,16]. Because the health inequalities are largely driven by the SDH unequal distribution among population groups and geographical settings, WHO calls action to tackle core of health inequity and promote inclusive growth with the economy is growing. This requires multi-sectoral efforts, using a “Health in All Policies” across sectors so that everyone should play their part, yet it is a widely neglected area in many African countries. We argue, while it is increasingly important to integrate SDH into future UHC reform strategies [2,31-35] monitoring of progress towards the national and international commitments on SDH is equally important. Figure 1 shows key factors that have an impact on the progress towards UHC and the influential links to population health outcomes. We argue that in many African countries, where resources are relatively scarce, the advance towards UHC through dynamic health systems with people at the centre should include:

(1) National economic growth: To facilitate more resources allocation to health sector reflected in wealth creation, employment, and new tax revenue bases through economically productive citizens.

(2) Government commitment and political will: To channel resources for all-inclusive growth. Government must be willing to allocate more resources on healthcare and determine to fight access obstacles such as inefficiencies, corruption, wastage and weak leadership.

(3) Effective citizens’ engagement and social solidarity: Social solidarity important to create financial pools through taxes or premiums where citizens commit to paying into this pool.

(4) Health systems: Developing capabilities in the six main building blocks of the health system.

(5) Other sectors and global cooperation: As many of the root cause of poor health are linked to SDH, to achieve UHC there must be engagement and support from other sectors in implementing health in all policy [36,37].

Figure 1 highlights that with strengthened health systems, economic growth, government and citizens’ commitment as well as global collaboration it is possible to extend the three dimensions of universal health coverage in Africa. This has been demonstrated by egalitarian societies who showed on average relatively better population health status than non-egalitarian countries [34,38]. A fully implemented UHC strategy in turn will facilitate more economic growth reflected in wealth creation, employment, and new tax revenue bases through economically productive citizens [39].

Thus, in the desire to support the implementation of the UHC and acknowledgement of the difficulties many African countries will face, we offer below our recommendations:

(1) Craft smarter and simpler approaches, particularly high focused interventions which are critical at initial steps to move forward UHC. Given the vagueness of the boundaries of the concept of UHC, it is critical in its early stage to promote primary healthcare approach.

(2) Creating awareness around the basic principles and benefits of UHC with broader marketing of the approach, with other sectors and communities at different levels for UHC policy formulation.

(3) Costing the delivery of envisaged health services and financial projections to combat capacity constraints to the strengthening health systems.

(4) Tackling the SDH through working pro-actively and collaboratively with other
Figure 1. Key Factors that Impact the Progress and Future of UHC and Health Outcomes
(Adapted from WHO’s SDH and Health system frameworks)

- Social and environmental conditions that ensure equity in health
  - Favourable early childhood
  - Good quality education
  - Employment
  - Good income level
  - Economic growth
  - Access to housing
  - Good eating habit & safe food
  - Healthy and safe environment
  - Gender equality
  - Healthy behaviour
  - Social support/security

- Health systems conditions that ensure efficiency and effectiveness
  - Leadership/governance
  - Workforce for Health
  - Health services
  - Pharmaceuticals
  - Health financing
  - Health information
  - Equipment & technology
  - Infrastructure

- Health outcomes
  - Morbidity
  - Disability
  - Mortality
  - Quality of life
  - Longer and healthy life

- Universal Health Coverage
  - Quality
  - Access
  - Cost

- Other sectors, Global Collaboration and Monitoring Actions
- National Socioeconomic Conditions
- Government Political Will and Policies
- Public Participation Social Solidarity

(1) Review the experiences of various high-performing developing countries, where UHC schemes have been pursued using different health policies and successful in providing basic quality healthcare at low cost to targeting the majority poor.
(2) Development of necessary supportive institutions, policies and legislation reforms desirable to move forward UHC.
(3) Strengthen co-operation within regional and international organizations to promote equity and distribution of resources, and

(4) Tackling inefficiency as well as corruption in the provision of healthcare.

CONCLUSIONS

The idea of achieving UHC in Africa is not a distant dream. It needs appropriate health systems reforms strategies to guide development efforts to move towards UHC with the help and support of political will, government, public and development partner’s commitment. Keeping individual country’s context in sight is imperative as there is no “one-size-fits-all” approach to start moving towards UHC, and therefore, each country must determine the
strategies and reforms that best meet their needs and different phase of UHC.

AUTHORS’ CONTRIBUTIONS

EBW conceived the idea, designed the study, analysed the data. SAW critically reviewed the paper for important intellectual contents. Both authors have read and approved the final manuscript.

CONFLICT OF INTEREST

Authors have declared that no competing interests exist.

REFERENCES