

# Moving Universal Health Coverage from Ambition to Practice:

## Executive Summary



Universal Health Coverage (UHC) is one of the health targets within the sustainable development goals (SDGs). It means that everyone who needs healthcare services receives ones of sufficient quality without having to experience financial hardship. Reaching this goal is a task both large and urgent: currently more than a half of the world's population lack access to at least some essential element of healthcare.<sup>1</sup>

Nor is it easy. The move toward UHC requires far greater financial resources for healthcare than governments in middle- and low-income countries have previously committed. These funds typically come from increased general taxes or compulsory social insurance payments – both of which may be politically unpalatable. UHC also frequently requires that health care systems greatly improve their levels of organisational sophistication. Ideally, this should involve a shift away from traditional fee-for-service medicine to so-called value-based care. The latter involves getting the best outcomes on things which matter to the patient for the least cost.

Given the different moving parts involved, it is not surprising that no simple roadmap exists. Instead, UHC as a concept has a complex and diverse range of national roots, with the most prominent country examples dating back many decades. However, in the last 15 years, UHC has attracted growing international salience. Since 2005, for example, various World Health Assembly declarations and UN general assemblies have urged bold action.

In September 2019 the UN general assembly adopted a political declaration strongly recommitting to achieving UHC by 2030 with a “view to scaling up the global effort to build a healthier world for all”.<sup>2</sup>

This is therefore an appropriate time for the Economist Intelligence Unit to consider how far ten key countries at different levels of economic development have come in the implementation of UHC. The countries are: Brazil, Chile, China, Colombia, India, Indonesia, Mexico, Philippines, Russia and Rwanda.

Such a review requires a multifaceted approach because the idea itself has various

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<sup>1</sup> World Bank and World Health Organisation (WHO), *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report*, 2019, [https://www.who.int/healthinfo/universal\\_health\\_coverage/report/uhc\\_report\\_2019.pdf?ua=1](https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1); ILO, *Universal social protection for human dignity, social justice and sustainable development*, 2019, [https://www.ilo.org/wcmsp5/groups/public/---ed\\_norm/---relconf/documents/meetingdocument/wcms\\_673680.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_673680.pdf)

<sup>2</sup> UN General Assembly, seventy-fourth session, Agenda item 126, 2019 <https://undocs.org/en/A/RES/74/2>

inter-related elements. The World Health Organisation (WHO) defines UHC as a situation where “all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”.

Each country’s results, and health challenges, inevitably have specific features. Nevertheless, several overarching themes appear often. These include:

**In our study countries, UHC policies and formal coverage have become widespread.**

Nine of our ten countries get a green traffic light for the existence of such policy. In the same number, at least 85% of the population have formal access to healthcare. The exception is India. Its healthcare reforms should greatly boost the number covered in the coming years but, even if all goes to plan, roughly 30% of the population will still be uninsured.

**Financial and health system resources continue to lag behind.** The current consensus estimate is that government and compulsory spending on health needs to be at least 5% of GDP for effective UHC. By 2016, only one of our ten study countries, Chile, reached this level, and that was after rounding up from 4.98%. More worryingly, four of the ten countries (Colombia, Mexico, Russia, and Rwanda) saw a decline in this measure between 2012 and 2016. Meanwhile, those states experiencing the greatest relative increases—Indonesia and the Philippines—began from very low bases, 0.9% and 1.2% respectively in 2012. As a result, even after rapid growth in government and compulsory spending as a proportion of GDP, neither of the two topped 1.5% overall.

UHC also requires a sufficient healthcare workforce—a minimum of 4.5 doctors,

nurses and midwives per 1,000 population, according to WHO estimates. Only four study countries—Brazil, Mexico, Philippines and Russia—exceed that number, with the Philippines doing so just barely. Meanwhile, in only three—Chile, Colombia and the Philippines—can primary care facilities typically carry out and assess five basic tests that are important for the clinical management of certain key non-communicable conditions: diabetes, cardiovascular disease, chronic obstructive pulmonary disease and asthma. Finally, looking beyond the general to more advanced provision, no country has enough radiotherapy machines for its cancer burden.

Investing in health system resources may be the most difficult part of UHC, but there is no substitute.

**Access takes time to build in general, with patients from rural areas and lower socio-economic groups too often not being reached.** The WHO’s Index of Average Coverage of Essential Health Services measures the ability of countries to provide citizens with 14 key tracer health interventions. On average, OECD countries score 80 out of a possible 100, which is the geometric mean of the proportion of the relevant need being met by use of each intervention. None of those in our study reached that level. On the other hand, Brazil, Chile, China, Colombia, Mexico and Russia all fall between 70 and 80 on this scale, suggesting reasonable access to the very basic provision covered in the WHO Index. Most of these countries have been working to improve health access for some time. Clearly, even essential care does not get rolled out overnight.

The bigger worry is that most study countries are still trying to find ways to reach those groups which are often underserved worldwide. Eight of these states received red lights because of their very high ratios of urban to rural doctors. Only Chile and Mexico

earned yellow here, with both falling short of the OECD average.

Socio-economic differences are another area of concern. Five countries received yellow or red lights here. Even this range of results likely reflects bigger disparities than it might at first appear. The metric we used was the difference in the number of births attended by skilled professionals for mothers in the highest and lowest economic quintiles of the population. Although an important measure, this is much easier to provide for those with lower income than, for example, comprehensive cancer care. That only five of our ten countries could do so raises concerns about socioeconomic disparities for more expensive or complicated interventions.

**Decisions on deepening of what UHC provides often lack scientific or patient input.** We looked at how different national systems select which health interventions to

cover or, where all are ostensibly included, which drugs to either subsidise or provide free. Only three countries—Brazil, Colombia and Mexico—have strong Health Technology Assessment bodies, although India, Indonesia, Philippines and Russia are currently developing in this area. Meanwhile, Mexico and Colombia are the only states to avoid red for how much patient input goes into deepening decisions.

Related to these issues is the very slow progress towards value-based care in the study countries. Just Rwanda and Colombia finish better than red here. Amid the strong policy commitment toward UHC, governments should be sure to build the patient-centred, evidence-based systems that are essential for value-based care. Otherwise, they will likely need to engage in yet more fundamental and difficult reforms sooner rather than later.

## Methodology

This Economist Intelligence Unit study measures where 10 countries stand in five areas—which we call pillars—relevant to UHC. These were selected after an extensive literature review and consultation with an advisory board of experts in this field. The pillars are: policy, health system resources, access, deepening, and outcomes. Within each we look at a range of individual metrics, or “indicators”. For each of these, we assign one of three scores modelled on traffic lights: a green means that the country in question is doing well by global or regional standards; a yellow that some concerns exist; and a red that important issues require attention. The indicator scores are then aggregated into pillar scores. For more detailed information on scoring and results, please see the workbook and country reports also published as part of this project available at the EIU Perspectives website.

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