Ensuring health in universal health coverage

Health systems must transcend clinical medicine and emphasize public-health approaches aimed at the drivers of disease, argues **James D. Shelton**.

Our planet's staggering ocean of death and disability — from backache to cancer — was painstakingly detailed in the Global Burden of Disease 2010 analysis, filling nearly an entire issue of *The Lancet* in December. One approach to this overwhelming disease burden is universal health coverage (UHC), which has been broadly defined as universal access to needed health services without financial hardship in paying for them. Indeed, *Lancet* editor Richard Horton declared the findings to be so far-reaching that "we should use them as a platform to advocate ever more vigorously for the growing consensus that universal health coverage could be the third great global health transition". But faced with almost limitless need and finite resources, what form of UHC is best? Demand will only rise owing to ageing, growing populations and ever-more-sophisticated and expensive technologies. UHC must include all available options to improve health, but much of its language — coverage, access, payment — conveys clinical medical care, especially through insurance.

For UHC to have the impact it promises, we must approach it with a different mindset: one that is broader, is driven by impacts and goes beyond the conventional pay-per-procedure approach.

Look no farther than the United States to see huge sums spent on expensive medical services, yet little improvement in the key indicators of life expectancy and infant mortality. Clinical services clearly have benefits, but their cost-effectiveness and impact on population-level health are far from clear. That is partly because therapies are not always effective and some even harm. Also, many systems emphasize payment for procedures and not the overall health of the population. But most important is that medicine's curative arsenal tends to arrive too late to address the drivers of disease.

The Global Burden of Disease analysis is compelling. Of the top ten risk factors, only high blood pressure (which accounts for 7.0% of the overall burden) and high blood glucose (3.6%) can be readily addressed by the clinical, curative approaches that dominate medical services. The others almost entirely elude clinical intervention. And even blood pressure and glucose level are highly affected by lifestyle factors that the analysis couldn't completely tease out. Moreover, 29 of the remaining 33 risk factors listed, which include many dietary factors, are equally resistant to clinical tools. For developing countries, the balance shifts even more towards non-clinical causes, as conditions such as suboptimal breastfeeding and sanitation rise in importance.

Developing countries face particular challenges. They tend to have weak public-sector services, poor private-sector organization and large expenditures. Rapid economic advancement can offer a way to shift towards more-efficient, equitable systems and avoid financial hardship, but the pitfall is preoccupation with clinical services. For example, Ghana's health-insurance programme follows the familiar pattern: reimbursement for mainly curative procedures (especially provision of drugs). Family planning and immunization are not covered, despite their substantial health benefits and major downstream cost savings, under the assumption that they are addressed by overburdened government clinics.

UHC will best serve developing countries if five approaches are used.

First, promoting healthy behaviours, such as exclusive breastfeeding and hand washing. Building overall health literacy is a good foundation.

Second, introducing structural and regulatory approaches such as tobacco taxation, clean-air requirements and speed bumps.

Third, prioritizing the clinical services that have the most impact: immunization, family planning and antenatal care. And programmes should be oriented towards the overall health of the population, rather than just paying for procedures. Health reform in the United States in the past few years has moved in these directions by making high-priority services free, and promoting organizations that take overall responsibility for their clients' health.

Fourth, deploying community-based services for high-impact health interventions. Ethiopia's Health Extension Worker cadre, which effectively provides key services, including sanitation and family planning, is a good example.

Finally, directing research and development less towards sophisticated technologies and more towards the strongest drivers such as nutrition and behaviour and towards low-cost, high-impact innovations, such as less-polluting cooking stoves.

Is it feasible? Yes. The economic extremes of Niger and New York City have shown this to be the case. Niger reduced child mortality by almost half between 2000 and 2009, emphasizing high-impact community-based and behavioural interventions. Almost half of the decline is attributed to improved nutrition and insecticide-treated bednets. New York City has seen life expectancy rise by 3.8 years and infant mortality fall by 23% in the past decade by emphasizing non-clinical approaches. Smoking has decreased markedly through increased taxes, decreased tobacco-product availability and hard-hitting public-health education programmes. Key community prevention-outreach programmes include HIV prevention and home visits to families with newborns. For true universal impact, other countries must follow suit. ■

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