OPINION ARTICLE

A review of the universal health coverage strategy

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Universal health coverage (UHC) has been defined in terms of ensuring all people's access to needed promotive, preventive, curative and rehabilitative health services, of adequate quality to be effective, at the same time making it sure that people do not suffer from financial hardship due to buying the required services. Health coverage itself has been defined as "the capacity of the health system to serve the needs of the population, including the availability of infrastructure, human resources, health technologies (including medicines) and financing, while universal access to health care has been defined as the absence of geographical, economic, sociocultural, organizational or gender barriers" (1). To elaborate further, universal right to health must be seen as the core value of universal health coverage, without any distinction by age, sex, gender, race, ethnicity, gender, sexual orientation, language, culture, religion, political or other beliefs and opinions, national or social origin, economic position, birth, or any other status (CD53/5. Rev. 2.2 and CD53.R14 PAHO/WHO, 2014) (2). The 53rd Directing Council of the Pan American Health Organization, including the ministers of health or their representatives, of all countries in the Pan American Health Organization Region, approved Resolution CP53.14 on the "Strategy for universal access to health and universal health coverage" (3).

UHC has been set as an avenue for attaining SDG 3: Ensure healthy lives and promote wellbeing for all at all ages (4). Target 3.8 under the goal aims to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (5). UHC should ensure that all people obtain the health services they need without risking financial hardship from unaffordable out-of-pocket payments (6). UHC is expected to cover health promotion to prevention, treatment, rehabilitation and palliation ensuring financial risk protection. Universality of UHC should mean, assurance of health care of required quality and effect for everyone at affordable price.

Taking into view, the following objectives:

- Provide the reflection of the professional posture of caregiver, working their defense mechanisms, their resistances and their Esteem;
- Identify the stresses that affect the oncology nursing professionals, which are many, but that each professional You understand them, and you face them in a different way.

Of the three processes that UHC should ensure, one is prevention of catastrophic illnesses, which has been defined by Russell as costs of coping with an illness that force households to spend less on other basic needs (e.g., food, housing or school fees), incurs debts due to seeking the service, or that it compels one to sell productive resources to meet the health care needs (7).

In any health seeking, the demand side needs that must be considered are: accessibility to services (physical, financial, geographic, cultural and linguistic), availability of service (round the clock time-wise with continuity of the range of care including referral services), appropriateness of the services locally by type and depth, system-wide adequacy, affordability (equitably priced services), acceptability (psychologically and culturally) and of course the quality of services which would include client centeredness and client responsive service provision. These parameters necessitate that commitment of service providers is coupled with their technological and management and clinical skill. Efficient management of the health systems needs efficient, and skilled management, with stewardship and leadership capacity and trait. In many developing countries the health systems is managed and lead by public health physicians, who are hardly raised and trained to be managers. One of the weaknesses of the health systems in these countries is inefficient management of resources including management of human resources and the absence of leadership qualities among managers; more importantly, absence of non-materialistic resources, like commitment, honesty, empathy and humility. Managers and service providers alike hardly pay attention to fairness in their dealings with the service seekers and seldom think about justified approaches in service provision.

Skill and efficiency for buying and paying for health services are important qualities that are necessary for intelligently playing management roles in the health market, where information is asymmetric and therefore fraught with the danger of market failure. It needs no emphasis to appreciate that mere presence of hard core technologies is not enough, the technique and know-how of managing technologies efficiently are also necessary to utilize technology efficiently and release fund for more expanded and versatile use.

UHC requires that health care quality is assured. Information forms the basis for assessing quality. Management capacity should be able to assess the extent of technical consistency of health care delivery like identification of mistakes by service providers, service approach or responsiveness, and governance; consistent health worker motivation; service and technological prioritization; innovation; efficient price assessment and buying skill; and good leadership.

Pricing and insurance premiums including other health expenditures, such as co-payments should take cognizance of poverty, debility and disability conditions of beneficiaries, women headed families, the rate of literacy, social exclusion, urban-rural and hard to reach locations, occupation, and pre-service and post-service payments, cultural or linguistic and other marginalization, family size, (within a limit- not to encourage creating big families by poor parents) etc. The aim should be to ensure that equity is protected between pre-payment and post-payment states and also between pre-tax and post-tax states. So that poor's share of payment is proportionately less. If necessary payment for health care should redistribute equity in payment, both horizontally and vertically, to be measured by the post-payment equity or Gini coefficient (8). This may be better achieved if the health care payment rate is proportional to prepayment income. To this end the horizontal equity should be tightened and efficiently structured first for reaching better vertical equity, as this approach will enhance vertical redistribution of equity better, so that horizontal equity treats equals as equals, rather than un-equals as equals and vertical equity ensures treatment of un-equals as un-equals proportionately. If financing system is progressive payment rate should rise faster than income, i.e. if drawn, the payment concentration curve would lie outside the income share curve (Lorenz curve).

A progressive financing scheme/ UHC scheme should redistribute disposable income, which requires that payment for health is compulsory,

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not voluntary- not out of pocket (OOP), independent of utilization, at least partly financed from govt tax, that tax liability rises disproportionately with gross incomes (which will make the post-tax distribution of income more equal than the pre-tax distribution), i.e. it would reduce Gini coefficient gap (the lower the post-payment Gini coefficient gap the more the redistributive effect, provided other regressive factors remain static, e.g. OOP). UHC, as an avenue of dispensing social welfare should have standard of living enhancing effect, which is reduced if payment for health care is voluntary.

REFERENCES

1 http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=27312&Itemid=270&lang=en

2 http://www.paho.org/hq/index.php?option=com_content&view=article&id=9392&Itemid

3 https://nacoesunidas.org/oms-empresas-devem-promover-saude-mental-de-funcionarios-no-ambiente-trabalho/

4 PAHO-WHO. 53rd Directing Council 66th session of the regional committee of WHO for the Americas. Washington, D.C., USA. 2014.

5 http://www.who.int/sdg/targets/en

6 http://www.who.int/whr/2010/whr10_en.pdf

7 Russell S. The economic burden of illness for households in developing countries: a review of studies focusing on malaria, tuberculosis, and human immunodeficiency virus/acquired immunodeficiency syndrome. Am J Trop Med Hyg 2004;71:147-55.

8 Gini C. "Concentration and dependency ratios". 1997;769–89.