Women and children first: an appropriate first step towards universal coverage

Rob Yates[a]

There is a growing consensus that achieving universal health coverage is an appropriate, feasible and important goal for all nations. Under a rallying cry of "All for universal coverage", Garrett et al. explain in a *Lancet* paper that attaining universal coverage will be vital if we are to reach health, poverty eradication and human rights goals.[1]

Since the World Health Assembly resolution WHA58.33 of 2005,[2] the World Health Organization (WHO) has been leading international efforts to achieve universal coverage. This was defined as "securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost". In particular, WHO has been keen to focus attention on perhaps the most important factor in determining levels of coverage: health financing.

When setting health financing policy, policy-makers have often treated equity as a lesser priority. As a result, many countries have inequitable coverage rates and wide differences in health outcomes across income groups.[3] If we are to achieve the United Nations Millennium Development Goals (MDGs) for health by 2015 we must scale up coverage rates quickly and equitably. The best way to do this is to target the least-covered and most-needy groups first. In particular, as the MDGs specifically target child and maternal mortality, we should focus on women and children first.

In recent months, the international community has been giving a much greater priority to improving the health of women and children. This effort has been encapsulated in the Consensus for Maternal, Newborn and Child Health (MNCH)[4] which is built on five pillars: (i) political leadership and community engagement; (ii) effective health systems; (iii) removing barriers to access; (iv) skilled and motivated health workers; and (v) accountability.

This consensus has been agreed by virtually all of the major health agencies and contains one policy recommendation that, if implemented properly, could accelerate effective health-care coverage for billions of women and children. Under the pillar of "removing barriers", it is recommended that countries should consider providing free health services for women and children at the point of use. This statement marks a compromise made among leading agencies following decades of debate over whether countries should charge user fees for health services. The evolution of this consensus can be traced through a series of consultations hosted by Save the Children,[5] the United Nations Children's Fund (UNICEF) and the European Commission. These events included representatives from multilateral and bilateral agencies, academic institutions and civil society organizations. In each case, the final policy recommendation was the same: that when phasing-out user fees, women and children should benefit first. This common position was fed into and adopted by the MNCH consensus discussions.

Already there has been high-level commitment to this position. On 23 September 2009, at a special meeting at the United Nations General Assembly, the British Prime Minister, the Director-General of WHO and the President of The World Bank all publicly supported the concept of free services at the point of delivery. In addition, the heads of state of five low-income countries (Ghana, Liberia, Malawi, Nepal and Sierra Leone) announced that they would extend the benefits of free public services in their countries. In her speech, WHO's Director-General explained the significance of the MNCH consensus and highlighted user fees as the biggest barrier to universal coverage. In addition, a taskforce set up by the Japanese Government in 2008 recommended that developing countries should remove user fees, starting first with services relevant to MDGs 4, 5 and 6.[6]

This policy recommendation is gaining traction because it appears to address several key political, economic and health-related issues. Specifically, it is an appropriate compromise for the following reasons:

- There is overwhelming research evidence that out-of-pocket payments (user fees) are an inefficient and inequitable health financing mechanism.[7]
- Whereas many governments seem reluctant to remove user fees for their entire population, most appear keen to exempt high-need groups.
- Whereas attempts to exempt people from fees on economic criteria have tended to fail, women and children are easily identifiable groups.
- There are historical precedents for prioritizing women and children for health-care coverage in the developed and developing world and some services (e.g. immunizations and antenatal consultations) are generally provided free of charge.
- These reforms have been implemented without opposition from men who tend to have more control over family income and therefore better access to private alternatives. There is therefore no reason to believe that this policy will have an adverse impact on men's health.
- This targeting makes sense for countries attempting to achieve MDGs 4 (reducing child mortality) and 5 (maternal mortality).
- As women and children tend to have less access to financial resources, removing fees for these groups will have a greater impact on their use of services.
- While providing free care for women and children, countries could continue to charge fees for lesser priority groups.
- Ensuring that a free option is available does not mean that all providers must not charge fees. Indeed, it could be more efficient to channel people

[a] Department for International Development, 1 Palace Street, London, SW1E 5HE, England.
Correspondence to Rob Yates (e-mail: rob-yates@dfid.gov.uk).
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who have a greater ability to pay into the private sector. This would make the benefit incidence of public health financing more equitable.

- Providing services free at the point of delivery is compatible with all other financing mechanisms that rely on pre-payment methods, for example tax financing, social health insurance, community and private insurance.
- Countries could decide themselves which health services will be provided free of charge, depending on their priorities and the resources they have at their disposal. These should include proven cost-effective interventions such as those outlined in the MNCH consensus.
- Several low-income countries have already launched free health services targeted at women and children and more are set to follow. Since fees were removed in 2006, Burundi has witnessed a trebling in outpatient consultations by children and deliveries in health units have increased 146%. Sierra Leone launched free health-care services for pregnant and lactating women and children in April 2010.
- Launching free health services has proved to be a very popular social policy in several countries and has therefore been an attractive intervention for political leaders.

For all these reasons, it makes sense for countries with poor health-care coverage to provide a package of essential health services free at the point of delivery for women and children. This policy is particularly relevant to most of the 98 low-income and lower-middle income countries that still charge user fees.

However for such a policy to be successful, it is imperative that other financing mechanisms replace fee income and that additional funds are found to increase the availability and quality of services. Political leaders must realize that free health services do not exist – somebody has to pay and, if they don't secure additional resources for health, populations will consider their pronouncements as political gimmicks.

Providing free public health services for large population groups in developing countries need not be prohibitively expensive. Many low-income countries (such as Nepal, Uganda and Zambia) have introduced free public services with public health expenditure of around 2% of gross domestic product. As lower-middle income countries such as Sri Lanka have shown, universal coverage can be achieved with public funding levels of US$ 23 per capita if public financing is used efficiently. In many developing countries there is a lot of scope to improve the efficiency of existing public funds.[8]

As well as finding additional domestic public funds, aid flows to health systems must increase. It is therefore very important that this policy of prioritizing free health care for women and children is rooted in the overall MNCH consensus. As well as addressing the removal of financial barriers, this stresses the importance of strengthening health systems. It will only be through dealing with demand-side and supply-side constraints simultaneously that women and children will be able to truly benefit from effective health-care coverage.

With the United Nations MDG summit approaching, 2010 is going to be an extremely important year if the world is going to step up progress towards the goals set for 2015. As the health-related MDGs are so far off track, it is essential that the international community provides coherent policy advice and additional resources to help countries achieve universal coverage. In this respect, it would be useful if global leaders could agree on a timetable for achieving universal coverage compatible with the timeline of the MDGs.

The world health report 2010 will demonstrate how health financing reforms can have a major impact in reaching universal coverage. But the MNCH consensus has already given us a practical policy recommendation for a first step towards this goal. If we can raise additional funds, allocate and manage them well and remove financial barriers, we really should be able to guarantee effective coverage for the world's women and children. Providing services free at the point of delivery for women and children makes sense from a technical, ethical and political perspective. Furthermore by phasing-in universal coverage this way, we would just be following the common practice of saving lives in other emergency settings where "women and children first" is seen as an appropriate response to limited life-saving resources. ■

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