UNIVERSAL HEALTH COVERAGE (UHC):
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Over 800 million people in this region still do not have full coverage of essential health services.

At least 65 million people are pushed into “extreme poverty” when they pay for health care.

What is UHC?

UHC means that everyone receives the health services they need without suffering financial hardship. It includes the full spectrum of essential services, from health promotion to prevention, treatment, rehabilitation and palliative care. UHC is about equity. This means increasing people’s access to quality frontline health care.

UHC means caring for people with life-long health problems

In Thailand, Universal Health Coverage eases the impact of diabetes. Thais who have diabetes have ready access to the medicines they need to survive, and to prevent complications. Local health centres routinely test and treat patients. If needed, they are referred to the district hospital. Under the national health care scheme, anyone who needs treatment is offered it free of charge.

UHC means reaching people in remote areas

In Solukhumbu, a remote area of Nepal, preventable maternal deaths were occurring at home. The District Health team took action. It raised awareness of health workers, established a maternity waiting home for the women who live in inaccessible places, and established a comprehensive emergency obstetric and neonatal care site to manage complications immediately.

What UHC is not

- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as this is not sustainable anywhere.
- UHC is not just about health financing. To achieve UHC you need health services and health workers; health facilities and medicines; information, and governance.
- UHC is not only about ensuring a minimum package of health services. It is also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.
- UHC is not only about individual care, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, and so on.

Achieving UHC is one of the targets in the Sustainable Development Goals. Countries that progress towards UHC will make progress towards other health-related targets, and towards the other goals. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

All SEAR countries are committed to achieve UHC, as part of the Sustainable Development Goals.
What is the current status of UHC in the South-East Asia Region?

Countries in the South-East Asia Region are at very different stages along the path towards UHC, but no country is starting from zero.

Coverage of essential health services: regional average*

- **essential services coverage index**
- **% health expenditure from pre-paid mechanisms**

- 57%
- 42%

How can countries make progress towards UHC? A lot is already happening but more intense efforts are needed.

A country does not need to be rich before making progress on UHC.

Countries in the South-East Asia Region are already making progress. Progress can be made from any starting point.

UHC can happen when political will is strong, even if a country is not rich

Thailand has gradually moved towards UHC over the last three decades, starting with the launch of free medical care for the poor in 1975, when the gross domestic product (GDP) per capita was only US$ 390. In 2002, only a few years after the 1997 Asian financial crisis, full population coverage was implemented, when the GDP per capita was still relatively low at US$ 1900.**

Health workers and medicines are critical for UHC

Health services depend on health workers. Investment in the primary health care workforce is a cost-effective way of improving access to essential health care services. Access to affordable, quality medicines and health technologies, good governance and well-functioning health information systems are other critical elements. In this Region, shortages of health workers and medicines have been judged as particularly big obstacles to progress on UHC.

Well-trained, motivated health workers are central to achieving UHC

Indonesia has taken steps to improve the quality of health professionals’ education. Accreditation of training institutions and programmes is mandatory. Since 2012, the Indonesia National Accreditation Agency for Higher Education has been responsible of accrediting training institutions. In 2015 the Indonesian Accreditation Agency for Higher Education in Health was created. It accredits health training programmes for seven types of health professionals: doctors, dentists, nurses, midwives, pharmacists, public health workers and nutritionists. By end 2017, over 1600 programmes had been accredited. Improving accreditation is judged to have had a positive impact on education standards and graduate competencies.

Improving access to medicines through improved procurement and better data

In 2011, the Rajasthan State government in India launched a programme to improve availability of essential medicines. It did three things. It increased public spending on medicines. It set up a State Medical Corporation, which improved processes for selection, quantification, procurement and quality assurance of medicines in the public health system. It introduced an electronic procurement platform, e-Aushadhi, which enhanced the efficiency of public procurement. In 2013, facilities reported fewer shortages and stockouts and increased use of services at public health facilities.
Frontline health care is the cornerstone for achieving UHC.

UHC emphasizes not only what services are covered, but also how they are organized and financed. Today’s health services are having to adapt in order to deal with increasing numbers of people over 65 years, who more commonly have chronic and often multiple health conditions. This includes ensuring the right balance between out- and in-patient care. Frontline health services are already beginning to change in many countries in the region.

Adapting frontline health services is essential for achieving UHC

Timor-Leste has made great gains in maternal and child health, and malaria, since 2000. Despite these gains, there remains a need to reduce inequities in health. In 2015, the Prime Minister launched Saúde na Família, a model of Primary Health Care that puts individuals and families at the center of health services, with the first step being home visits to detect health problems and give advice. By end 2016, over 90% of households had been covered.

The ways health services are financed is also key.

When people have to pay most of the cost for health services out of their own pockets, the poor are often unable to obtain many of the services they need. Even the rich may experience financial hardship if they have a severe or long-term illness. Reducing out-of-pocket payments for health care is a priority in SEAR, and there is growing experience on how to do this.

UHC means protecting people from financial hardship as a result of health care

The main driver of financial hardship as a result of health care in the South-East Asia Region is direct, out-of-pocket payment on medicines. The South-East Asia Region has historically had the highest share of health spending coming from out-of-pocket payment. Increasing public spending is a pre-condition for improved financial protection. Increasing government health budgets is possible even if it is challenging. Since 2000, five countries in the Region have managed to do so.

Can UHC be measured?

Yes. Monitoring progress towards UHC focuses on two things:

- The proportion of a population that can access essential quality health services.
- The proportion of the population that spends a large amount of household expenditure on health.

Countries are increasingly monitoring their progress towards UHC, and also giving attention to better equity monitoring.

Measuring UHC: who is not getting health care, and who is being impoverished by health care?

Sri Lanka is monitoring UHC and the health SDGs as part of their health sector monitoring framework. The Ministry of Health has consulted widely on data sources; has improved health service data through new surveys, and has increased health inequality monitoring. Better data on health, health services availability and readiness, and on equity, has led to improved capacity to target interventions towards the more vulnerable.

Who needs to be involved, to advance UHC?

Many different people and institutions need to be involved. Ministries of Health, and also Ministries of Finance and Planning; heads of state; health workers and their professional associations; regulatory bodies; public and private service providers; manufacturers, non-government, civil society organizations, and international development agencies all have a role to play.
WHO response in the South-East Asia Region

WHO, along with many partners, is supporting countries in their moves towards UHC. There is now a global commitment for 1 billion more people with UHC by 2023. Much of the additional service coverage needs to come from the South-East Asia Region: at least 300 million of the one billion live here. This gives a new impetus to efforts to advance UHC, and increases demands on accountability for progress.

• WHO will continue to track progress on UHC, by supporting national monitoring approaches, and by reporting on progress on UHC each year until 2030 to the South-East Asia Regional Committee.

• WHO’s regional UHC focus on strengthening the health workforce and access to medicines will continue. Recent developments include regional collaboration on regulation of medical products through the South-East Asia Regulatory Network (SEARN); regional collaboration on the procurement of antidotes, and a regional medicines price information sharing platform.

• WHO will encourage experimentation with new ways to organize, manage and pay for health services to tackle today’s health needs, and exchange of experience and evidence on how countries have made progress.

The potential benefits are great: by increasing coverage of health services, and by reducing the impoverishment associated with direct payment for health services, health outcomes and health security will be improved and poverty reduced.

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Image Credit: WHO Timor-Leste / Karen Reidy