WEEKLY EPIDEMIOLOGICAL REPORT

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The path to universal coverage (Part I)

This is the first in a series of two articles on Universal Coverage

Background

Promoting and protecting health is essential to human welfare, sustained economic and social development. This was recognized more than 30 years ago by the signatories to Alma-Ata Declaration, who noted that Health for All would contribute both to a better quality of life and also to global peace and security.

There are many ways to promote and sustain health. Some lie outside the confines of the health sector (e.g. education, housing, food and employment all impact on health). Redressing inequalities in these will reduce inequalities in health.

But timely access to health services– a mixture of promotion, prevention, treatment and rehabilitation – is also critical. This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system. It determines whether people can afford to use health services when they need them. It determines if the services exist. Recognizing this, Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardships paying for them. This goal was defined as universal coverage, sometimes called universal health coverage.

Current Situation

The world is still a long way from universal coverage. For example, on the service coverage side, the proportion of births attended by a skilled health worker can be as low as 10% in some countries, while it is close to 100% for countries with the lowest rates of maternal mortality. Within countries, similar variations exist.

Income is not the only factor influencing service coverage. In many settings, migrants, ethnic minorities and indigenous people use services less than other population groups, even though their needs are greater. The other side of the coin is that when people do use services, they often incur high, sometimes catastrophic costs in paying for their care. In some countries, up to 11% of the population suffers this type of severe financial hardship each year and up to 5% is forced into poverty. Globally, about 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line. The other financial penalty imposed on the ill (and often their carers) is lost income. Only one in five people in the world has broad-based social security protection that also includes cover for lost wages in the event of illness, and more than half the world's population lacks any type of formal social protection, according to the International Labour Organization (ILO).

Obstacles to Universal coverage

Three fundamental, interrelated problems restrict countries from moving closer to universal coverage.

The first is the availability of resources. No country, no matter how rich, has been able to ensure that everyone has immediate access to every technology and intervention that may improve their health or prolong their lives. At the other end of the scale, in the poorest countries, few services are available to all.

The second barrier to universal coverage is an overreliance on direct payments at the time people need care. These include over-the-counter payments for medicines and fees for consultations and procedures. Even if people have some form of health insurance, they may need to contribute in the form of co-payments, co-insurance or deductibles. The obligation to pay directly for services at the moment of need – whether that payment is made on a formal or informal (under the table) basis – prevents millions of people receiving health care when they need it. For those who do seek treatment, it can result in severe financial hardship, even impoverishment.

The third impediment to a more rapid movement towards universal coverage is the inefficient and inequitable use of resources. At a conservative estimate, 20–40% of health resources are being wasted. Reducing this waste would greatly improve the ability of health systems to provide quality services and improve health.

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Raising sufficient resources for health

Although domestic financial support for universal coverage will be crucial to its sustainability, it is unrealistic to expect most low-income countries to achieve universal coverage without help in the short term. The international community will need to financially support domestic efforts in the poorest countries to rapidly expand access to services. The first step to universal coverage, therefore, is to ensure that the poorest countries have these funds and that funding increases consistently over the coming years to enable the necessary scale-up. But even countries currently spending more than the estimated minimum required cannot relax. As the system improves, demands for more services, greater quality and/or higher levels of financial risk protection will inevitably follow. All countries have scope to raise more money for health domestically, provided governments and the people commit to doing so. There are three broad ways to do this, plus a fourth option for increasing development aid and making it work better for health.

1. Increase the efficiency of revenue collection

Even in some high-income countries, tax avoidance and inefficient tax and insurance premium collection can be serious problems. The practical difficulties in collecting tax and health insurance contributions, particularly in countries with a large informal sector, are well documented. Improving the efficiency of revenue collection will increase the funds that can be used to provide services or buy them on behalf of the population.

2. Reprioritize government budgets

Governments sometimes give health a relatively low priority when allocating their budgets. This has to be corrected.

3. Innovative financing

Attention has until now been focused largely on helping rich countries raise more funds for health in poor settings. The high-level Taskforce on Innovative International Financing for Health Systems included increasing taxes on air tickets, foreign exchange transactions and tobacco in its list of ways to raise an additional US$ 10 billion annually for global health. High, middle and low-income countries should all consider some of these mechanisms for domestic fundraising. Other options include diaspora bonds (sold to expatriates) and solidarity levies on a range of products and services, such as mobile phone calls. Taxes on products that are harmful to health have the dual benefit of improving the health of the population through reduced consumption while raising more funds. For example, raising taxes on alcohol to 40% of the retail price would cause consumption levels to fall by more than 10%, while generating substantial tax revenues. The potential to increase taxation on tobacco and alcohol exists in many countries and some countries are also considering taxes on other harmful products, such as sugary drinks and foods high in salt or transfats

4. Development assistance for health.

While all countries, rich or poor, could do more to increase health funding or diversify their funding sources, only some low-income countries have any chance of generating adequate funds from domestic sources alone. Global solidarity is required. The funding shortfall faced by these low-income countries highlights the need for high-income countries to honour their commitments on official development assistance (ODA) and to back it up with greater efforts to improve aid effectiveness.

Removing financial risks and barriers to access

While having sufficient funding is important, it will be impossible to get close to universal coverage if people suffer financial hardship or are deterred from using services because they have to pay on the spot. When this happens, the sick bear all of the financial risks associated with paying for care. They must decide if they can afford to receive care, and often this means choosing between paying for health services and paying for other essentials, such as food or children's education. Where fees are charged, everyone pays the same price regardless of their economic status. There is no formal expression of solidarity between the sick and the healthy, or between the rich and the poor. Such systems make it impossible to spread costs over the life-cycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life. Consequently, the risk of financial catastrophe and impoverishment is high and achievement of universal coverage impossible. Almost all countries impose some form of direct payment, sometimes called cost sharing; poorer the country, the higher the proportion of total expenditure that is financed in this way. The only way to reduce reliance on direct payments is for governments to encourage the risk-pooling, prepayment approach- the path chosen by most of the countries that have come closest to universal coverage. When a population has access to prepayment and pooling mechanisms, the goal of universal health coverage becomes more realistic. These are based on payments made in advance of an illness, pooled in some way and used to fund health services for everyone who is covered – treatment and rehabilitation for the sick and disabled and prevention and promotion for everyone. It is only when direct payments fall to 15–20% of total health expenditures that the incidence of financial catastrophe and impoverishment falls to negligible levels. The funds can come from a variety of sources and sources matters less than the policies developed to administer prepayment systems. Country experiences reveal three broad lessons to be considered when formulating such policies.

First, in every country, a proportion of the population is too poor to contribute via income taxes or insurance premiums. They will need to be subsidized from pooled funds, generally government revenues (e.g. direct access to government-financed services/subsidies) Those countries whose entire populations have access to a set of services usually have relatively high levels of pooled funds – in the order of 5–6% of gross domestic product (GDP).

Second, contributions need to be compulsory, otherwise the rich and healthy will opt out and there will be insufficient funding to cover the needs of the poor and sick. Voluntary insurance schemes might not be feasible for populations too poor to pay premiums. Longer-term plans for expanding prepayment and incorporating community and micro-insurance into the broader pool are important.

Third, pools that protect the health needs of a small number of people are not viable in the long run. A few episodes of expensive illness will wipe them out. Multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer, less healthy people. Cross-subsidization is possible where there are multiple funds, but this requires political will and technical and administrative capacities. Even where funding is largely prepaid and pooled, there will need to be tradeoffs between the proportions of the population to be covered, the range of services to be made available and the proportion of the total costs to be met.

Source -The World Health Report -Health System Financing, The path to universal coverage,

available from *http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf*

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

to be continued

Table 1: Vaccine-preventable Diseases & AFP

16th – 22nd February 2013 (08th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2013	Number of cases during same week in 2012	Total number of cases to date in 2013	Total number of cases to date in 2012	Difference between the number of cases to date in 2013 & 2012
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	00	00	00	00	01	10	12	- 16.7 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	06	01	02	00	00	00	00	00	00	09	02	46	08	+ 475.0 %
Tetanus	00	00	00	00	00	01	00	00	00	01	00	03	02	50.0 %
Whooping Cough	00	01	00	00	00	00	00	00	01	02	03	09	15	- 13.0 %
Tuberculosis	89	34	09	06	23	00	00	04	22	187	96	1440	1391	- 03.2 %

Table 2: Newly Introduced Notifiable Disease

16th – 22nd February 2013 (08th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2013	Number of cases during same week in 2012	Total number of cases to date in 2013	Total number of cases to date in 2012	Difference between the number of cases to date in 2013 & 2012
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	11	05	12	07	03	17	06	08	10	79	85	615	781	- 21.2 %
Meningitis	03 CB=2 KL=1	00	01 GL=1	00	00	00	01 AP=1	03 BD=1 MO=2	00	08	05	153	123	+ 24.4 %
Mumps	01	01	01	00	02	03	00	05	02	15	16	216	642	- 66.3 %
Leishmaniasis	00	00	15 HB=13 MT=2	03 VU=1 MU=2	00	01 PU=1	05 AP=5	00	00	24	17	181	149	+ 21.5 %

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

DPDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008. .

Dengue Prevention and Control Health Messages

Thoroughly clean the water collecting tanks bird baths, vases and other utensils once a week to prevent dengue mosquito breeding .

Table 4: Selected notifiable diseases reported by Medical Officers of Health

16th – 22nd February 2013 (08th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	102	1373	2	29	2	7	3	24	0	9	3	31	0	1	3	12	0	0	**54**
Gampaha	20	655	0	18	0	5	0	8	0	1	0	21	0	5	0	39	0	0	**20**
Kalutara	26	290	0	32	0	8	0	14	3	7	7	54	0	1	1	4	0	0	**69**
Kandy	34	321	0	12	0	2	1	2	0	0	3	9	5	17	1	8	0	0	**52**
Matale	9	73	2	20	0	0	0	0	0	0	0	5	0	1	0	10	0	0	**67**
NuwaraEliya	1	39	0	11	0	1	0	1	0	1	0	1	0	16	0	0	0	0	**31**
Galle	15	107	4	17	0	5	0	0	0	2	0	17	0	8	0	2	0	0	**74**
Hambantota	6	64	2	11	0	0	0	3	0	2	8	51	2	18	3	35	0	0	**83**
Matara	10	113	1	6	0	5	0	1	0	3	2	22	4	14	5	60	0	1	**65**
Jaffna	17	165	4	35	0	1	7	84	1	4	0	0	6	101	0	4	0	0	**67**
Kilinochchi	0	5	0	4	0	0	0	3	0	1	0	1	0	0	0	0	0	0	**0**
Mannar	0	32	0	12	0	1	0	20	0	11	0	4	0	3	0	0	0	0	**0**
Vavuniya	2	19	0	13	0	5	1	3	0	4	0	8	0	1	0	0	0	0	**100**
Mullaitivu	2	18	0	2	1	1	0	1	0	0	1	4	0	2	0	0	0	0	**60**
Batticaloa	22	114	3	22	1	2	0	0	2	2	0	5	0	0	0	3	0	0	**71**
Ampara	4	26	2	25	0	0	0	1	0	0	0	4	0	0	0	1	0	0	**29**
Trincomalee	5	58	2	10	0	1	0	0	0	0	1	14	0	1	0	1	0	0	**50**
Kurunegala	54	1097	2	38	0	12	1	13	0	3	2	16	0	7	1	14	0	0	**77**
Puttalam	34	294	0	10	0	2	0	3	0	1	1	4	0	0	0	0	0	0	**50**
Anuradhapu	24	130	2	14	0	6	0	0	1	1	5	35	0	4	0	4	0	0	**53**
Polonnaruw	5	67	0	23	0	0	2	5	0	0	2	45	0	0	1	5	0	0	**29**
Badulla	0	72	0	19	0	0	1	4	0	0	1	5	0	4	0	7	0	0	**41**
Monaragala	9	46	1	14	0	2	0	3	17	17	2	28	1	8	4	17	0	0	**82**
Ratnapura	39	260	10	79	7	60	1	8	0	7	5	50	3	8	3	67	0	1	**72**
Kegalle	21	227	1	11	0	9	0	2	0	2	3	13	2	14	8	54	0	0	**82**
Kalmune	43	212	1	16	0	1	0	0	0	6	0	4	0	1	1	3	0	0	**46**
SRI LANKA	**504**	**5877**	**39**	**503**	**11**	**136**	**17**	**203**	**24**	**84**	**46**	**451**	**23**	**235**	**31**	**350**	**00**	**02**	**58**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 22nd February, 2013 Total number of reporting units 336. Number of reporting units data provided for the current week: 193
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk.**

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