How to move towards universal health coverage in crisis-affected settings: lessons from research

Brief prepared by **Sophie Witter** and **Benjamin Hunter**

June 2017

In the last ten years universal health coverage (UHC) has become one of the leading aspirational features in health policy and research. This is demonstrated by its inclusion as a target in the Sustainable Development Goals: to 'achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all'. This policy brief reviews the meaning of UHC and summarises lessons for achieving UHC in crisis-affected settings.

What is universal health coverage?

UHC is commonly presented as the provision of healthcare to everyone in society in ways that protect users from financial hardship.[1] Concerns regarding the cost of healthcare reflect growing evidence of the role of healthcare costs in preventing access, especially for poorer social groups, and perpetuating poverty.[2] International recommendations for achieving UHC focus on beginning with provision of a 'basic package' of health services that can be provided universally and free-of-charge, and then subsequently expanded to include a wider set of services (see figure 1)[3]

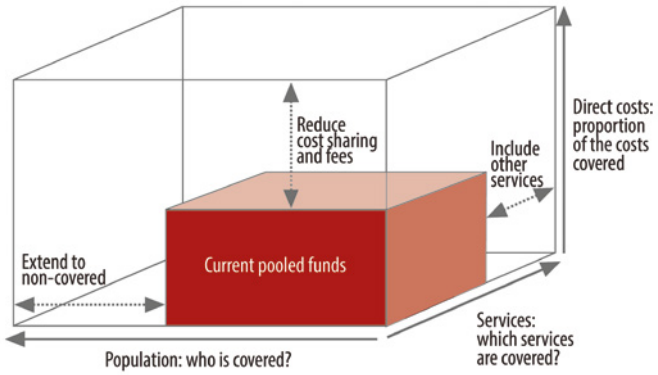

Figure 1. The three dimension of progression to universal health coverage. Source: World Health Organization, 2014. Available at: http://bit.ly/SHboRo

Key messages

- **UHC is a normative goal for crisis-affected countries, as for all others; indeed, its importance is even greater in these contexts where typically needs are higher and gaps in coverage and equity are often more extreme**
- **Given limited resources, UHC presents particularly acute trade-offs in many crisis-affected settings, though there may be some windows of opportunity, including external resource 'windfalls' and policy space for more structural reforms**
- **While managing crises, it is important to develop a longer term plan and vision for progress towards UHC which is locally owned and tailored**
- **Successful examples emphasise the importance of increased risk pooling, especially for vulnerable groups; of developing service packages which reflect high priority services in these contexts (such as treatment for trauma, addressing psychosocial needs, services for victims of sexual violence and mental health care); and increasing the capacity to regulate diverse health providers and systems (see accompanying brief on the different types of providers in crisis-affected settings).**

A stepwise expansion based on estimated cost-effectiveness, equity and financial risk protection can ensure that highest priority services are expanded first. There is however a risk that this prioritises easily-defined interventions with readily measurable effects, such as vaccination, rather than more complex multi-factoral issues, such as mental health.

Though seemingly supported by consensus, each of UHC's three constituent terms–universal, health and coverage–remain open to interpretation and contestation.[4] To date, significant research and policy attention on achieving universal health coverage has focused

This briefing paper series has been developed by the ReBUILD Research Programme Consortium to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a research agenda-setting study carried out by the Health Systems in Fragile and Conflict Affected States Thematic Working Group of Health Systems Global.

on expanding access to healthcare using models of social health insurance.[5, 6] This fits with the original conceptualisation of universal health coverage endorsed by the World Health Organization in 2005. There are however concerns that a narrow focus on expanding insurance coverage will divert attention from preventative and other public health interventions.[7] Further, the emphasis on financing arrangements based predominantly on social health insurance may exclude many of the poorest groups who have informal employment and/or cannot afford insurance contributions.[8] Moreover, insurance 'coverage' does not equate necessarily to financial protection – it is well documented that in some schemes users are exposed to high out-of-pocket payments, for example in Rwanda.[9]

What are the particular challenges for achieving UHC in crisis-affected settings?

Crises are often accompanied by falls in formal employment, and the reduced ability of people to pay for healthcare is compounded by decreased government income and a drop in government spending on health. Conflict-affected settings in particular may experience the destruction of health facilities, disruption of systems processes such as procurement and health information, and the emigration or deaths of health workers.[10, 11] Any destruction or militarisation of transport infrastructure further exacerbates problems for ensuring geographical coverage of health services.

While coping with the loss of available resources, people in crisis-affected settings must also cope with rapidly changing burdens of disease. These include injuries and illnesses associated with violence, reduced food availability, resurgent infectious diseases, the mental health problems that accompany crises, as well as the burden of chronic disease that is growing worldwide.[12] Governments are thus expected to do more with less, and it is health workers who bear the brunt of those pressures.

These problems are compounded by reduced legitimacy of the state if the state is perceived by some societal groups to be ineffective or unresponsive **(see accompanying brief on health systems and state-building)**.[13] This can further reduce state capacity to collect taxes and insurance contributions to fund the health system. Likewise crises may undermine social cohesion and lead to exclusion of particular social groups from the health system based on their ethnicity or religion.[14]

Managing trade-offs to achieve UHC in crisis-affected settings

Windows of opportunity

The aftermath of crises can offer windows of opportunity to accelerate progress towards UHC, just as it does for promoting health systems resilience **(see accompanying brief on health systems resilience)**. Commonly cited examples of crisis-induced momentum to achieve UHC include Germany, France and countries in Latin America.[15] Those windows of opportunity may take some time to emerge while the state re-builds capacity and legitimacy for health system governance, and are often part of long-term policy trajectories that rely on domestic political will to introduce and implement reforms **(see accompanying brief on the political economy of health system reform)**.[16] This was the case in Sierra Leone, where it took several years for the policy environment to be suitable for government- and donor-backed healthcare reforms that led to the Free Health Care Initiative,[17] however momentum for reform was soon lost.[18] Further, it is important to look beyond national-level actors, for example by training district-level managers,[19] in order to ensure better implementation of UHC policies.

Fiscal space and health financing arrangements

Governments in crisis-affected settings are limited in their ability to extend healthcare coverage due to fiscal and governance constraints, and may be reliant on donor support just to maintain current coverage. Post-conflict countries that have made good progress towards achieving universal coverage, at least for basic services, have done so by pursuing a combination of strategies and with significant donor financing. In Rwanda, community-based health insurance ameliorated user fees, primary healthcare was strengthened, and many systems that were put in place for the HIV response were expanded to include other drugs and information.[20, 21] In Cambodia, the removal of user fees was reinforced through provider reimbursements from health equity funds.[22, 23] In both cases donors have played a crucial role in financing healthcare provision through pooled funds, which raises separate questions about the sustainability of coverage in those settings.

It is important that people are protected as much as possible from financial hardship when seeking healthcare services,[24] however limited-scope, poorly designed or badly managed financing systems may in fact exacerbate out-of-pocket expenditure. For example, the Free Health Care Initiative in Sierra Leone did not reduce expenditure as anticipated because the increased availability of some services led to greater usage of other important services that were not free.[25] Gaps in implementation undermine policies for free care, such as problems with disbursement of government funds in Zimbabwe which led to the

growth of informal user fees.[26] In such circumstances, formalisation of user fees may actually reduce out-of-pocket expenditure if the formal fees are lower than informal fees.[27]

The package of services

Given the above resource constraints, governments face difficult decisions on which services to offer free through public health systems, and from there how to transition to UHC. In conflict-affected settings, emergency packages typically focus on primary healthcare interventions relating to maternal, newborn and child health, immunisation, nutrition, mental health services and the diagnosis and treatment for some communicable and non-communicable diseases. Services for trauma and for sexual and gender-based violence are important in conflict-affected settings and for example the emergency package in Liberia included counselling, treatment and referrals for survivors of sexual violence. Providers need to be adequately trained, resourced and incentivised to implement the chosen services, otherwise the package may have little resemblance to services actually provided. Those packages can then provide a basis for expansion of coverage to include other cost-effective, equitable and financially protective interventions.[3]

Non-governmental and private healthcare providers have been incorporated into public health systems (either by contracting or by informal arrangements) in order to increase geographical coverage of healthcare in a range of crisis-affected settings **(see accompanying brief on the role of different providers in expanding health coverage)**.[28] There are two key challenges for this approach. First, governments in settings suffering protracted crises may have limited capability to manage and regulate such providers, leading to implementation problems and the undermining of state legitimacy. This has been reported in Afghanistan and Democratic Republic of Congo.[29, 30] Second, the growth of non-public providers may create sectoral distortions in health system resources, for example workforce migration to NGOs and private providers. Indeed Pavignani recommends undertaking an analysis during crises to identify such distortions as they emerge in order to plan for corrective responses after the end of the crisis.[31]

Population coverage

The poorest should be given priority for coverage by healthcare services,[3] however the international emphasis on social health insurance models privileges formal sector workers. This is particularly inappropriate for crisis-affected settings, where formal employment is limited and where large, mobile populations rely on informal employment, savings and the sale of assets.[10] Possible pro-poor financing models for expanding healthcare coverage include wider fee exemptions and health equity funds,[23] and a targeted insurance scheme has been trialled with some success in South Sudan.[32]

Policy-makers need to respond to population movement during and after crises. Urban settings often attract displaced populations yet suffer from poor healthcare planning.[10] There needs to be investment to expand service coverage to slum areas and displacement camps on the assumption that populations will remain there for a significant period of time. Policy-makers need to react to changes once populations begin to return to their homes as people may then lose access to healthcare if similar services are not available in places of origin. For example refugees returning home from displacement camps in Uganda reportedly shifted from formal to informal healthcare providers due to impoverishment and the costs of care.[25]

Civil society provides an important mechanism for ensuring that health budgets are equitable and that socially excluded groups can access healthcare without risking financial hardship. However, the size and influence of civil society may be limited in crisis-affected settings as a legacy of crisis and by restrictive laws. In such settings, external support provides vital resources and training to develop the monitoring and advocacy roles of civil society. For example, civil society organisations in Uganda have received substantial international support, which has enabled them to campaign strongly for expansion of access to treatment for HIV in spite of a restrictive advocacy environment.[33]

Policy traps

There are policy traps that arise when pursuing UHC in crisis-affected settings, and it is vital to use consultations to incorporate the perspectives of national and local actors into UHC strategies. Extensive use of contracting can become entrenched if governments are bypassed by donor organisations due to lack of capacity to manage contracts and/or an unwillingness between different sectors to engage with one another.[23] Long-term contracting in Cambodia has led to a legacy of fragmentation in health workforce management and remuneration.[18] Further, the expansion and entrenchment of social health insurance programmes, as has been mooted in Uganda for some time,[34] can disproportionately benefit non-poor groups and divert public funds from preventative services towards curative care, as has been the case in Colombia.[7]

Many post-conflict plans focus on achieving scale-up of training and recruitment of health workers and managers, however the resources required to deliver such training equired to deliver such training are often lacking. This means training may be of limited value and may in fact increase costs once the need for subsequent re-training is considered.[35] There is also a risk that, without adequate remuneration packages to encourage working in less desirable geographical areas, workers will increasingly cluster in urban and better connected areas.[18]

References

1. World Health Organization, 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization http://bit.ly/1jt45Xr
2. Krishna, A., 2010. One Illness Away: Why People Become Poor and How They Escape Poverty. Oxford: Oxford University Press
3. World Health Organization, 2014. Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization http://bit.ly/SHboRo
4. O'Connell, T., Rasanathan, K. & Chopra, M., 2014. What does universal health coverage mean? The Lancet, 383(9913) http://bit.ly/2qn4MMl
5. Lagomarsino, G. et al., 2012. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. The Lancet, 380(9845) http://bit.ly/2qM8dha
6. Reich, M.R. et al., 2016. Moving towards universal health coverage: lessons from 11 country studies. The Lancet, 387(10020) http://bit.ly/2rlhp8h
7. Schmidt, H., Gostin, L.O. & Emanuel, E.J., 2015. Public Health, Universal Health Coverage, and Sustainable Development Goals: Can They Coexist? Lancet, 386(9996) http://bit.ly/2rbozQ3
8. Oxfam, 2013. Universal Health Coverage: Why health insurance schemes are leaving the poor behind. Oxford: Oxfam http://bit.ly/2rll5qU
9. Saksena, P. et al., 2011. Mutual health insurance in Rwanda: Evidence on access to care and financial risk protection. Health Policy, 99(3) http://bit.ly/2rboXOH
10. Pavignani, E. & Colombo, A., 2009. Analysing Disrupted Health Sectors: A Modular Manual, Geneva: WHO http://bit.ly/2qqhTuy
11. Ager, A.K. et al., 2015. Health service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency. Conflict and Health, 9(1) http://bit.ly/2rlIB7T
12. Spiegel, P.B. et al., 2010. Health-care needs of people affected by conflict: future trends and changing frameworks. The Lancet, 375(9711) http://bit.ly/2rlzLa2
13. Whaites, A., 2008. States in Development: Understanding State-building. London: DFID http://bit.ly/2rlZlpZ
14. Pearson, N., 2010. The Role of the Health Sector in Wider State-Building London: Save the Children http://bit.ly/2qMkG4l
15. Saleh, S.S. et al., 2014. The path towards universal health coverage in the Arab uprising countries Tunisia, Egypt, Libya, and Yemen. The Lancet, 383(9914) http://bit.ly/1jqHP1z
16. ReBUILD, 2016. Institutions for strong and equitable health systems after conflict and crisis: lessons from ReBUILD research. Liverpool: ReBUILD Consortium http://bit.ly/2hs1EJ4
17. Bertone, M. et al., 2014. A window of opportunity for reform in post-conflict settings? The case of Human Resources for Health policies in Sierra Leone, 2002–2012. Conflict and Health, 8(1) http://bit.ly/2pQ1C1a
18. Witter, S. et al., 2016. Evolution of policies on human resources for health: opportunities and constraints in four post-conflict and post-crisis settings. Conflict and Health, 10(1) http://bit.ly/2qqLvbb
19. Bertone, M.P. & Witter, S., 2015. An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone. Social Science & Medicine, 141 http://bit.ly/1E7P2dC
20. Schneider, P. & Hanson, K., 2006. The impact of micro health insurance on Rwandan health centre costs. Health Policy and Planning, 22(1) http://bit.ly/2pFBF8k
21. Jay, J. et al., 2016. Building from the HIV Response toward Universal Health Coverage. PLOS Medicine, 13(8) http://bit.ly/2aZTTsk
22. Tangcharoensathien, V. et al., 2011. Health-financing reforms in southeast Asia: challenges in achieving universal coverage. The Lancet, 377(9768) http://bit.ly/2rbprEv
23. Witter, S., 2012. Health financing in fragile and post-conflict states: What do we know and what are the gaps? Social Science & Medicine, 75(12) http://bit.ly/2rkzFi7

Clinic at Makara hospital in Preah Vihear, Cambodia.
Photo: Chhor Sokunthea / World Bank

24. Rothman, I. et al., (2011). Moving towards a sector-wide approach (SWAp) for health in fragile states: Lessons learned on the state of readiness in Timor Leste, Sierra Leone and Democratic Republic of Congo. Amsterdam: KIT http://bit.ly/2rlFRqS
25. ReBUILD, 2016. Health financing policy in conflict affected settings: lessons from ReBUILD research. Liverpool: ReBUILD Consortium http://bit.ly/2rkQvO1
26. ReBUILD, 2015. The challenge of retaining health workers in Zimbabwe: Implications for Universal Health Coverage. Liverpool: ReBUILD Consortium http://bit.ly/2rlTWF4
27. Akashi, H. et al., 2004. User fees at a public hospital in Cambodia: effects on hospital performance and provider attitudes. Social Science & Medicine, 58(3) http://bit.ly/2qmDmqi
28. Newbrander, W.et al., 2011. Rebuilding and strengthening health systems and providing basic health services in fragile states. Disasters, 35(4) http://bit.ly/2rlcsfV
29. Palmer, N. et al., 2006. Contracting out health services in fragile states. BMJ (Clinical Research ed), 332 (7543) http://bit.ly/2raMmjm
30. Waldman, R., 2007. Health Programming for Rebuilding States: A Briefing Paper. Arlington: USAID http://bit.ly/2rldA2W
31. Pavignani, E., 2005. Health Service Delivery in Post-Conflict States. In High Level Forum on the Health MDGs: Selected Papers 2003-2005. Geneva: WHO http://bit.ly/1KzYecB
32. Witter, S. and NHIF, 2015. Expanding access, utilisation and financial protection in a post-conflict setting: results of a pilot project with the NHIF in Darfur http://bit.ly/2qMhqWB
33. Rosenquist, R. et al., 2013. A critical player: The role of civil society in achieving universal health coverage, Global Health Governance, 6(2) http://bit.ly/2rm7uQH
34. Basaza, R.K. et al., 2013. Players and processes behind the national health insurance scheme: a case study of Uganda. BMC Health Services Research, 13(1) http://bit.ly/2qn5SrL
35. Roome, E., Raven, J. & Martineau, T., 2014. Human resource management in post-conflict health systems: review of research and knowledge gaps. Conflict and Health, 8(1) http://bit.ly/2qmiZd1

ReBUILD Consortium

The ReBUILD Consortium is an international research partnership working on health systems strengthening in settings affected by conflict or crisis.

For more on ReBUILD's research and outputs, visit the website at **www.rebuildconsortium.com** and follow us at **@ReBUILDRPC.**

For further information, contact:
Sophie Witter – switter@qmu.ac.uk or
Nick Hooton – nick.hooton@lstmed.ac.uk

ReBUILD Consortium
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool, L3 5QA
T: +44(0)151 705 3100
E: **rebuildconsortium@lstmed.ac.uk**

This is an output of a project funded by UK aid from the UK government. However the views expressed do not necessarily reflect the UK government's official policies.

UKaid from the British people