Universal health coverage can best be achieved by public systems

August 24, 2018,BMJ opinion

https://blogs.bmj.com/bmj/2018/08/24/universal-health-coverage-public-systems/

Expanding coverage by ushering in the private sector results in inequities in access, argue Ramya Kumar and Anne-Emanuelle Birn

This year the World Health Organization (WHO) observed its 70th birthday by holding World Health Day in Sri Lanka, where the theme was "Universal Health Coverage: Everyone, Everywhere." The high profile event focused on the access achievements of Sri Lanka's acclaimed low cost, publicly financed and delivered healthcare system.[1] Yet missing from the proceedings was any reference to the ongoing privatisation of this system, and its consequences and relevance to the goal of universal health coverage (UHC).

As WHO works towards achieving UHC through "financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all," it sidesteps the reality that expanding coverage by ushering in the private sector results in inequities in access and rising health expenditure.

Guided by a "Free Health" policy (1951) adopted in the aftermath of independence, Sri Lanka's public healthcare system comprises state owned healthcare facilities run by salaried healthcare workers. The system accounts for about 50% of outpatient visits, over 90% of inpatient admissions, the bulk of preventive service delivery, and remains free at the point of use. WHO is right to commend Sri Lanka's historical path of public, universal healthcare, yet the country is regrettably reversing direction. Investment in the public system has plunged since the 1980s, resulting in understaffed and overcrowded healthcare facilities, which are crippled by long waiting times and shortages of essential medical supplies and services.[2]

Today, a fast growing private health sector flourishes, incentivised by deregulation and provider subsidies, with a mushrooming of commercial hospitals, private clinics, and diagnostic centres.[2] At present, over 50% of total health expenditure transpires in the private sector, with two thirds of this financed by out-of-pocket payments, and the remainder covered by employers and individually purchased health insurance schemes.

Embracing WHO's mixed public-private UHC model, in 2017, the government introduced a publicly financed health insurance scheme to reimburse, within limits, the private healthcare expenses of students from age 5 to 19, draining much needed resources from the public sector.

Increasingly, health reforms advanced in the name of UHC in low and middle income countries (LMICs), many with World Bank involvement, favour the extension of coverage through publicly financed, means tested health insurance. The problem with health insurance is that it separates the purchasing and providing roles of a health system. The purchaser-provider split is typically justified in the name of improved cost effectiveness, although the effects are usually the opposite as governments entrust, albeit to varying degrees, purchasing and provision to private for-profit entities, facilitating market entry.

Moreover, while means tested schemes expand coverage, they often do so unevenly and inequitably. Different population groups are typically covered by different schemes with varying benefits in terms of quantity, quality, and comprehensiveness of services, leaving healthcare users with substantial out-of-pocket payments for the services that are not covered.[3][4] Without unifying coverage under a single payer system at a single level of care, these schemes inevitably result in inequitable access and comprehensiveness—as has long been the case in most of Latin America.[5]

Notably, when schemes to broaden health coverage are rolled out, there are differences in concomitant increases in health expenditure based on the extent of private sector involvement in purchasing and provision. In the Maldives, where since 2012 all citizens are covered at the same annual dollar limit (around US$6500) through a national health insurance scheme, which comprises a public-private partnership between the government and a private insurance company, national health expenditures rose from 8.1% of GDP to 11.5% between 2011 and 2015.

By contrast, Thailand's 2001 universal coverage scheme, which retains purchasing and much of the provision in the public sector, managed to universalise access to the country's urban and rural poor while maintaining health spending at below 4% of GDP.

Having promoted UHC as a platform to support mixed healthcare systems where "all providers, public and private," attend to users "cost effectively and efficiently," WHO today eschews conventional tax funded or social health insurance models, which are still operating in most high income countries. The "functional" (pragmatic) approach favoured by WHO assumes that all health financing systems, "regardless of the label attached," perform the same set of functions. Indeed, WHO's UHC monitoring indicators measure population coverage, out-of-pocket spending, and service comprehensiveness, but do not gauge private sector incursion and its consequences for healthcare systems in LMICs.

The advocacy of mixed healthcare systems in the guise of UHC will neither halt the dismantling of strong public healthcare systems, nor enable the building of new

equitable and comprehensive ones. WHO's symbolic showcasing of Sri Lanka's healthcare system overlooks the fact that its historic access achievements stemmed from crucial elements missing from UHC as touted by WHO: public financing *and* delivery. WHO must rethink its stance and advocate for truly universal and equitable healthcare—a goal that can best be achieved by maintaining healthcare in public hands.

Ramya Kumar *is a medical doctor and lecturer attached to the Department of Community and Family Medicine, Faculty of Medicine, University of Jaffna, Sri Lanka. She has authored various articles on health policy and health reform in Sri Lanka.*

Anne-Emanuelle Birn *is a historian and professor of critical development studies and global health at the University of Toronto, and has published widely on global health policy and politics. She is lead author of Oxford University Press's Textbook of Global Health (4th edition, 2017; 3rd edition 2009), and a member of the Independent Panel on Global Governance for Health.*

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following interests: None.

Acknowledgement

We thank Mariajosé Aguilera and Laura Nervi for their insightful suggestions.

References

[1] Halstead SB, Walsh JA, Warren KS, Eds. Good health at low cost. New York: The Rockefeller Foundation, 1985.
[2] Kumar R. The privatization imperative: women negotiating healthcare in Kandy, Sri Lanka. PhD [dissertation]. University of Toronto, 2018.

[3] Birn AE, Pillay Y, Holtz TH. *Textbook of global health*. 4th ed. Oxford University Press, 2017.
[4] Global Health Watch. *Global health watch 5*. Zed Books, 2017.
[5] Birn AE, Nervi L, Siqueira E. Neoliberalism redux: the global health policy agenda and the politics of cooptation in Latin America and beyond. *Dev Change* 2016;47(4):734-59.