Global Health Delivery & UHC: a quick overview

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Approaches to healthcare delivery

• Health as a human right (rights model)
• Development will result in health improvement (development model)
• Investing in health will improve the economy & bring societal benefits (investment model)
The “enjoyment of the highest attainable standard of health” has been recognised as a “fundamental right” since the adoption of the World Health Organisation (WHO) Constitution in 1946 and since then it has been recognised by various international human rights treaties.
40 years ago, countries pledged ‘Health for All’

Alma Ata, 1978

The International Conference on Primary Health Care calls for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world by the year 2000.
40 years after promising ‘health for all’…

AT LEAST HALF THE WORLD’S POPULATION STILL LACKS ACCESS TO ESSENTIAL HEALTH SERVICES.

http://www.who.int/sdg/infographics/en/
40 years since Alma Ata: It's back to the future for Health for All

20 February 2018

Quite a lot has changed in the last 40 years, right? And yet, four decades since the 1978 signing of the international Alma Ata declaration in Almaty, Kazakhstan, meeting the essential health needs of people through primary health care has once again been highlighted as the key to the attainment of Health for All by a ‘new’ global movement.
SDG 3—“Ensure healthy lives and promote well-being for all at all ages”—is a broad health goal, and calls for achieving universal health coverage (UHC), which is defined as access for all people and communities to services that they need without financial hardship.

Many countries are still far from UHC as measured by an index of access to 16 essential services.
The United Nations Sustainable Development Goals that all UN Member States have agreed to try to achieve Universal Health Coverage by 2030.

This includes financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
UHC coverage index

Fig. 1: Calculation of universal health coverage service coverage index on the basis of national levels of coverage

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<tr>
<th>Number</th>
<th>Intervention name</th>
<th>DCP3 package</th>
<th>HPP</th>
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<tbody>
<tr>
<td>C2</td>
<td>Counselling of mothers on providing thermal care for preterm newborns (delayed bath and skin-to-skin contact)</td>
<td>Maternal and newborn health</td>
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<td>C3</td>
<td>Management of labour and delivery in low-risk women by skilled attendants, including basic neonatal resuscitation following delivery</td>
<td>Maternal and newborn health</td>
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<td>C8</td>
<td>Detection and management of severe acute malnutrition and referral in the presence of complications</td>
<td>Child health</td>
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<td>C9</td>
<td>Detection and treatment of childhood infections (ICCM), including referral if danger signs</td>
<td>Child health</td>
<td>✓</td>
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<tr>
<td>C33</td>
<td>For malaria due to Plasmodium vivax, test for G6PD deficiency; if normal, add chloroquine or chloroquine plus 14-day course of primaquine</td>
<td>Adult febrile illness</td>
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<td>C35</td>
<td>In all malaria-endemic countries, diagnosis with rapid test or microscopy (including speciation) followed by treatment with ACTs (or current first-line combination)</td>
<td>Adult febrile illness</td>
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<td>C36</td>
<td>In high malaria transmission settings where rapid tests and microscopy are unavailable, presumptive treatment of febrile illness with ACTs (non-severe cases) or ACTs plus antibiotics (severe cases)</td>
<td>Adult febrile illness</td>
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<td>C38</td>
<td>In low malaria transmission settings, addition of single low-dose primaquine to first-line treatment</td>
<td>Adult febrile illness</td>
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<td>C43</td>
<td>Early detection and treatment of Chagas disease, human African trypanosomiasis, leprosy, Neglected tropical diseases and leishmaniasis Identify and refer patients with high risk, including pregnant women, young children, and those with underlying medical conditions</td>
<td>Pandemics</td>
<td></td>
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DCP3- third edition of the Disease Control Priorities. C=community platform; HPP= highest priority package. ICCM=integrated community case management. ACTs=artesunate-based combination therapy.

Table: Urgent interventions for essential universal health care

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**Essential Surgery**

**Reproductive, Maternal, Newborn, and Child Health**

**Cancer**

**Mental, Neurological, and Substance Use Disorders**

**Diarrheal Diseases, Respiratory Infections, and Nutritional Disorders**

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**Recent News**

- Latest Video Collaboration on Child and Adolescent Health is Out!
- Global Partnership for Education Webinar on Optimizing Education Outcomes
- DCP3 Volume 8 Education Edition Launched at Annual Comparative & International Education Society Conference

See all news

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http://dcp-3.org/
How well are countries doing on UHC?

• At least half of the world’s population still do not have full coverage of essential health services.
• About 100 million people are still being pushed into “extreme poverty” (living on 1.90 USD (1) or less a day) because they have to pay for health care.
• Over 800 million people (almost 12% of the world’s population) spent at least 10% of their household budgets to pay for health care.
How far are LMICs from UHC?

UHC

Essential UHC

Highest priority package

What many LMICs offer today
What will it cost?

What will a healthier world cost?
Increasing investments over 15 years up to
$371 billion
each year or $58 per person per year by 2030

Countries are facing a financing gap of up to
$54 billion a year
to achieve the SDG health targets

http://www.who.int/sdg/infographics/en/
UHC is a political issue

• “For me, universal coverage is an ethical issue. Do we want our fellow citizens to die because they are poor? Or millions of families to fall into poverty because they lack financial risk protection?
• As you know, today more than 400 million people lack access to essential health services and 40% of the world’s population lack social protection.
• These people are being denied a fundamental a human right.
• That’s why it’s so important that universal health coverage is included in the Sustainable Development Agenda. Indeed, it is the centrepiece of the Sustainable Development Goal health targets.
• If countries choose to invest in making progress towards universal health coverage, they lay the foundation for making progress towards all the other health targets and other goals - like ending poverty, improving gender equality, decent work and economic growth, and more.

Within reach

The case for universal health care is a powerful one—including in poor countries

BY MANY measures the world has never been in better health. Since 2000 the number of children who die before they are five has fallen by almost half, to 5.6m. Life expectancy has reached 71, a gain of five years. More children than ever are vaccinated. Malaria, TB and HIV/AIDS are in retreat.

Yet the gap between this progress and the still greater potential that medicine offers has perhaps never been wider. At least half the world is without access to what the World Health Organisation deems essential, including antenatal care, insecticide-treated bednets, screening for cervical cancer and vaccinations against diphtheria, tetanus and whooping cough. Safe, basic surgery is out of reach for 5bn people.

Those who can get to see a doctor often pay a crippling price. More than 800m people spend over 10% of their annual household income on medical expenses; nearly 180m spend over 25%. The quality of what they get in return is often woeful. In studies of consultations in rural Indian and Chinese clinics, just 12-26% of patients received a correct diagnosis.

That is a terrible waste. As this week’s special report shows, the goal of universal basic health care is sensible, affordable and practical, even in poor countries. Without it, the potential of modern medicine will be squandered.

Through stricter regulation of the health-care sector, and by focusing on primary care, many countries have made good progress. But many countries have been slow to do this, and health-care costs have grown through out-of-pocket payments. More services could be provided if that money—and the risk of falling ill—were pooled.

The evidence for the feasibility of universal health care goes beyond theories jotted on the back of prescription pads. It is supported by several pioneering examples. Chile and Costa Rica spend about an eighth of what America does per person on health and have similar life expectancies. Thailand spends $220 per person a year on health, and yet has outcomes nearly as good as in the OECD. Its rate of deaths related to pregnancy, for example, is just over half that of African-American mothers. Rwanda has introduced ultrabasic health insurance for more than 90% of its people; infant mortality has fallen from 120 per 1,000 live births in 2000 to under 30 last year.

And universal health care is practical. It is a way to prevent free-riders from passing on the costs of not being covered to others, for example by clogging up emergency rooms or by spreading contagious diseases. It does not have to mean big government. Private insurers and providers can still play an important role.

Indeed such a practical approach is just what the low-cost revolution needs. Take, for instance, the design of health-insurance schemes. Many countries start by making a small group of people eligible for a large number of benefits, in the expectation that other groups will be added later. (Civil servants are, mysteriously, common beneficiaries.) This is not only unfair and inefficient, but also risks creating a constituency opposed to further reform.
India as a case study
State of India’s health
Key findings

• Life expectancy is increasing but 6 out of 10 deaths now due to NCDs
• Under-5 mortality rate is improving nationwide, but there is a four-fold difference between states
• Even in states of similar development levels, there are major differences in the burden of leading diseases, highlighting vast health inequalities
• The rate of premature death and disability for ischaemic heart disease is 9 times higher in some states compared to others; and 6 times higher for stroke
• Overall burden of tuberculosis in India is highest in the world and its rate varies 9-fold between states
• Child and maternal malnutrition still leading risk factor for premature death and poor health, and is highest in the poorer states of north India
• Air pollution, diet, and obesity an increasing threat to health across many states
Infectious and associated diseases reducing, but still high in many states
Rising burden of non-communicable diseases
Rising risks for cardiovascular diseases and diabetes
Increasing but variable burden of injuries
Unacceptably high risk of child and maternal malnutrition
Major inequalities between states
India’s progress towards health-related SDGs...

Punching Below Its Weight: India’s Progress Towards Health-Related SDG Goals

It is time for India to fully fund and implement its ambitious health policies, and translate them into better health outcomes for its millions. Without health, little else matters.
• This is an analysis from the Global Burden of Disease (GBD) Study 2016, which measured 37 health-related indicators from 1990 to 2016. The researchers then transformed each indicator on a scale of 0-100 (with higher values indicating good progress), and computed an overall index representing all 37 indicators. These were then used to rank all 188 countries in the analysis.

• The results showed that, globally, the median health-related SDG index was 56.7 in 2016 and country-level performance markedly varied...
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<th>Latin America</th>
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India did very poorly in this analysis, ranking 127th, with a SDG index value of 39. Countries making good progress toward SDG goals will have most bars reaching the end of the ring (i.e. index values reaching 100).

https://vizhub.healthdata.org/sdg/
Comparison of India with Brazil

Every single BRICS country ranked ahead of India. Brazil ranked 67 (SDG index 63), China 74 (SDG index of 61), Russia 103 (SDG index 54) and South Africa 122 (SDG index 43).
India: punching well below its weight on health

1. India underperforms in health.
2. There is a huge and widening gap between India’s economic progress and the ground realities in health.
3. The prevalence of under-weight children in India is among the highest in the world.
4. TB kills nearly half a million Indians each year, with India leading the world in TB burden.
5. India has more people living in rural areas without access to clean water than any other country.
6. Nearly half of India’s rural population lacks access to toilets, and 240 million people live without electricity.
7. None of these statistics add up to good health.
What does India spend on health?

• The fact that India spends less than 1.5% of its GDP on health, as compared to the global average of about 6%, is one of the biggest reasons for India’s atrociously low ranking on the SDG index.

• India’s National Health Policy, approved in 2017, proposes to increase health expenditure by the government from the existing 1.15% to 2.5% of the GDP, by 2025.

• There are no signs this is actually happening!

India’s public expenditure on health is woefully low

Source: National Health Profile 2018, Indiaspend
Modicare: India launches world's biggest experiment in universal healthcare

Doctors and economists welcome the move to reform the country's neglected public healthcare system. But concerns remain over awareness and funding – and whether the scheme has been rushed out as an election crowd-pleaser.
Other countries have tried innovative models of delivery

• Ethiopia’s use of health extension workers
• Cuba’s healthcare system
• Costa Rica’s primary healthcare system
• Mexico’s Seguro Popular program
• Thailand’s Universal Health Coverage
• Rwanda’s UHC