Brief: Universal Health Coverage and Integrating SRHR

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1. Introduction

Universal Health Coverage is firmly embedded in the discourse and interventions that recognize health as a fundamental human right. This essentially means that ensuring health is a key component of wellbeing. To do so countries need to ensure that access is equitable and that a recognition of marginalization within the population is factored into the provision of health care.

In 2015, at least half of the world's 7.3 billion people did not receive the essential health services they needed, and with substantial unmet needs on many accounts, including sexual and reproductive health (SRH) such as contraception and maternal health services and child health services amongst others. In 2010, globally, 808 million people have catastrophic health spending (i.e. over 10% of household consumption or income towards out-of-pocket expenditure). Asia (12.8%), second to Latin America, accounts for the highest number of people having catastrophic health spending. Since 2000, these rates (+3.6% per year) and absolute numbers have been consistently on the increase, and the Asian region is second to Africa where the percentage and size have increased. It is estimated that 97 million people were impoverished by health care expenditures at the $1.90-a-day poverty line in 2010 (1.4% of the world's population and largely in Africa and Asia, where 97% of the world's population impoverished by out-of-pocket health spending lives) and in 2011 at the PPP $3.10-a-day poverty line, it was 122 million (1.8%). This is largely seen across low and lower middle income countries. While the data shows improvement, progress is uneven and in Asia, those who fall within the higher poverty line of PPP $3.10-a-day continue to be more impoverished because of health spending than others.[1]

In the case of sexual and reproductive health and rights (SRHR), the picture is also mixed globally and in the Asia-Pacific region. Despite the gains made in reducing maternal mortality (which declined by two thirds between 1990 and 2015), some countries still have high rates of maternal deaths and maternal morbidity. While the contraceptive prevalence rate at 87.4%, some groups are unable to access adequate information and services, including adolescents (adolescent birth rate of 35/1,000) and young unmarried women.[2] Access to safe abortion services is limited, even in countries where legislation is progressive. The annual abortion rate in Asia during 2010-2014 was around 36 per 1,000 (married women) and 24 per 1,000 (unmarried women) with 27% of pregnancies ending in abortion, including unsafe abortions.[3] The coverage of antiretroviral therapy for HIV was also lower than the global average (41% versus 46%) and the incidence of sexually transmitted infections is higher. HPV immunisation is not readily available as part of national immunisation programmes nor is screening for cervical cancer.[4]

This brief aims to present an introduction to UHC and discusses its relevance in the context of achieving universal access to SRHR as a means of furthering gender equality and women and girls' health.

2. What is universal health coverage?

UHC involves all people, including the most vulnerable and marginalised in society, having access to quality health services including preventive, promotion, treatment, rehabilitation and palliative care (pain control) and they have access without facing financial burden when having to pay for such

[1] WHO and WB 2017
[2] HERA 2017
[3] Guttmacher 2018
[4] HERA 2017

services. This considers ensuring that health systems function efficiently and is accessible by the entire population, ensuring services received are of good quality, skilled health workers, availability (and affordability) of medication and technologies. The goal should be to provide an increasing number of health services over time based on needs, cost and public opinion, and hence would vary depending on the country, specific needs of a population and groups within it, political will and cost implications. Thus, UHC also has to consider financing systems and financial risk and protection from such risk in order to prevent people from falling into poverty as a result of the inability to meet health related costs.[5]

Unexpected or long-term illness requires people to use life savings, sell assets, or borrow having implications on other aspects of wellbeing in the short and long term. Reducing out-of-pocket costs to patients is a key goal of UHC as the need to pay for care when people need to use it discourages usage, particularly if it is going to cause financial hardship.[6] It covers essential health services (including for HIV, tuberculosis, malaria, non-communicable diseases and mental health, sexual and reproductive health and child health), which should be made available to all who need them.[7] Key towards moving in the direction of UHC is to address barriers to care, and in addition to addressing out-of-pocket expenditure (not high so that it makes people not access services), includes the distance to services, conditions of facilities, and skilled health workers.[8] A WHO report in 2013, identifies pre-paid pooled funds as a means of reducing the burden of high out-of-pocket expenditure and can help reduce the impact of sudden unpredictable health costs.[9]

A focus on UHC includes an emphasis on "*what* services are covered and *how* they are funded, managed, and delivered", requiring a "fundamental shift in service delivery so that services are integrated and focused on needs of people and communities". This includes "reorienting health services to ensure that care is provided in the most appropriate setting, with the right balance between out- and in-patient care and strengthening the coordination of care." UHC includes all components of a health system, including "health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation."[10]

Box 1: Key factors that need to be in place for UHC

A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care by:

- informing and encouraging people to stay healthy and prevent illness;
- detecting health conditions early;
- having the capacity to treat disease; and
- helping patients with rehabilitation
- ensuring sensitive palliative care where needed.

- **Affordability** – a system for financing health services so people do not suffer financial hardship when using them.
- **Availability of essential medicines and technologies** to diagnose and treat medical problems.
- A sufficient capacity of **well-trained, motivated health workers** to provide the services to meet patients' needs based on the best available evidence.
- Actions to **address social determinants** of health such as education, living conditions and household income which affect people's health and their access to services.

Source: WHOa, undated, pp1

[5] WHO and WB 2017
[6] WHOa, undated, WHO 2013, and WHO 2018
[7] WHO and WB 2017
[8] WHOa, undated, and WHO 2018
[9] WHO. 2013.
[10] WHO 2018

Box 2: A case for UHC in Thailand

Thailand's Universal Health Coverage Scheme is considered a good example of making UHC available to the poorest, thereby significantly reducing out-of-pocket expenditure and encouraging the use of essential health services from 2003-2010. The programme is financed by general taxes, social health insurance contributions and private insurance premiums.

SRH is included as a key element to the essential services package and has improved utilisation of SRH services by all income groups.

Source: WHO 2013 and MSH, undated

The WHO resources on UHC also point to aspects that may be more challenging to cover under UHC. It notes that UHC cannot always mean free coverage of all possible health interventions as this is not sustainable. Rather it is about ensuring a minimum package of health services while ensuring an expansion of health service coverage and financial protection in a progressive manner, which would also require more availability of resources. Thus, UHC is more than just health, "taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion."[11]

Table 1: Some countries in Asia that have adopted UHC

Country	Year	UHC Reform
Japan	1961	Nationwide universal coverage reforms
South Korea	1977	National health insurance launched
Thailand	2001	Universal coverage scheme extends coverage to the entire informal sector and funded by general tax revenue
Nepal	2008	Universal free health care up to district hospital level
China	2009	Huge increase in public spending to increase service coverage and financial protection

Source: WHO 2013 and WHO et.al. 2018

*Other sources used in this brief also note countries such as India, Vietnam and Cambodia as countries taking steps towards UHC.

UHC should integrate human rights and equity as key components. Article 25 of the Universal declaration of Human Rights[12] confirms health as a human right and reaffirmed in 2012 in a UN General Assembly (GA) resolution on UHC[13] in 2012. The resolution emphasises the importance of achieving universal *population* coverage where "all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population."[14]

3. Strong Primary Health Care for UHC

Strengthening primary health care is a critical aspect of achieving UHC and is considered the most efficient and effective way to achieve it. Improving coverage requires availability, accessibility and a capable force of healthcare workers to deliver people-centred care, particularly investing in the primary healthcare workforce. It has been considered the most cost effective way to ensure access to essential healthcare, in addition to ensuring good governance, technological advance, good procurement systems and sound health information systems. Primary healthcare also includes preventive and curative care as well as the promotion of good health.[15]

[11] WHO 2018
[12] See https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf
[13] See http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36
[14] WHO 2013, pp.18
[15] WHO 2018

4. SRH services as a key component of UHC

SRH services include a broad range of service to cover the needs of women and girls such as contraception, safe abortion, post-abortion care, maternal health care (antenatal, delivery and post-natal), prevention and treatment of infertility, reproductive tract infections, prevention and treatment of all sexually transmitted infections, including HIV, reproductive cancers, comprehensive sex education (CSE), and services to address sexual and gender-based violence.[16]

Box 3: Who could be the most marginalized in a country when considering SRHR? Some examples

- Women employed in the informal sector who have lower wages, lack access to health insurance and work in uncertain and sometimes dangerous conditions
- Women and girls living in poverty who are unable to meet costs associated to accessing health services and meeting health needs such as menstrual health needs, and including indirect costs
- Adolescent girls access to youth friendly SRH information and services because girls are valued less in society, and they lack agency and autonomy to demand services
- Older women's SRH needs are deprioritized within the health system
- Migrant women who may be unable to access health services due to their undocumented or temporary status within a country or who may be required to spend more on health services
- Women with disabilities
- Indigenous women, who may be living in remote region where health services are minimal or non-existent

Including SRH services into UHC needs to be comprehensive or else only some aspects and requirements of women and girls will be covered. While contraception and maternity care (usually antenatal care) tend to be included the service orientation has not been in line with population dynamics nor have they been considered on the basis of rights. This has resulted in other services being neglected, such as abortion care, including post-abortion care, CSE and youth friendly SRH services. Decisions and choices within households, even with regards to health, are affected by household income and women and girls health and wellbeing are deprioritised. As with other health services, access to SRH services is affected by costs, including associated costs, which drive out-of-pocket expenses high or result in an inability to access specific SRH services of women and girls. Women tend to experience a higher burden of out-of-pocket costs for health care services even when they have similar levels of insurance coverage as men. This can be due to non-coverage or limits on coverage for SRH services or the inability of women and girls to access the resources for such services, even if they are available, due to power relations and lack of agency.[17] Further, systemic weaknesses and barriers can also affect the quality of services received.[18]

Ensuring SRH services in UHC has to be done with a focus on availability, accessibility, quality and accountability. This should include universal access to rights- and context-based continuum of quality care (CQC) in the case of reproductive health, but also more broadly considering the lifecycle. Such an approach also takes into account diverse contexts that affect women and girl's access and the specific barriers to access that compromise their rights.[19]

5. Financing UHC

A system should aim to spread the risk of illness across a wide population. This can be done by collecting/pooling prepaid funds that people can draw from, even if they are unable to pay into the

[16] MSH, undated and IWCH, undated
[17] MSH, undated and IWCH, undated
[18] MSH, undated
[19] ARROW 2014

pool. Ensuring access to the marginalised is important requiring countries to monitor needs of populations as well as that of diverse groups.[20]

In terms of mechanisms to pay for health services, there is the voluntary (non-mandatory insurance and the out-of-pocket payment where people choose to use a service and pay for it) and compulsory (taxes, government charges of various sorts, and mandatory insurance). These mechanisms can be further broken down into subcategories, depending on whether the mechanism involves the pooling of financial resources or not. Pooling entails accumulation of pre-paid contributions from individuals into an overall pool or fund, which is used to pay for health services of members of that pool as needed. This can be specified for health, such as a health insurance pool or government revenue. Assessing which mechanism works best is dependent on assessing effectiveness, efficiency and equitability. With out-of-pocket spending health services become accessible depending on who can pay. Even when user fees are minimal poor people can be excluded so what works best needs to be factored in.[21]

Box 4: UHC in the SDGs

Goal 3: Ensure healthy lives and promote well-being for all at all ages

3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)

3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income

Source: https://sustainabledevelopment.un.org/sdg3

6. Recommendations

UHC should be tailored to each population at a national or sub-national level and its specific health needs, and that this should be monitored over time to meet the changing needs so that resources can be allocated accordingly. We have to ensure meeting a minimum standard of health services, especially ensuring that it is accessible to the most marginalised groups. Thus, there is no one-size-fits all model of UHC. It is a political process, with the involvement of a number of interest groups over what health benefits means and who should be paying for it.

On UHC[22]

- Advocate for higher public spending on health, including increase in government budgets and the allocation of a greater share of public funds for the health sector.
- Review health financing policies periodically to ensure that the needs of vulnerable groups are not left out.
- Prioritise the health needs of vulnerable groups, including women and girls in line with their needs along the life cycle as opposed to during specific times during their lifecycle.
- Integrate UHC, including SHR into national strategies and related health policies. Consider this approach as an interlinked and integrated strategy that has the potential to benefit development priorities and countries more broadly.

[20] WHO 2018
[21] WHO 2013, pp.24-28.
[22] WHO 2018

On SRHR in the context of UHC[23]

With regards to creating the environment that recognises SRHR as critical:

- Integrate a comprehensive definition of SRHR and include the broad range of issues within its scope when conceptualising and progressively implementing UHC as well as in building a collective health for all movement.
- Recognise that SRHR is an integral part of the discourse and actions to implement the right to health at the national, regional and international levels.
- Ensure that right to health and public health services remain state responsibilities and a part of social protection measures, which should be adequately prioritised, resources and sufficiently available at all levels in a country.
- Ensure that systemic barriers to access UHC that are perpetuated by patriarchy, social norms and practices that perpetuate gender inequality, the influence of socio-cultural beliefs and practices on women and girls on autonomy and agency, and the devaluing of girls are recognised and addressed as persistent barriers to UHC.
- Ensure women and girls who experience multiple and intersecting form of violence and discrimination, harmful traditional practices access social protection, public health services and sustainable infrastructure.
- Regulate the private health sector to provide acceptable, affordable, accessible, quality health services and ensure dignity and respect, privacy and confidentiality.
- Ensure strong social protection systems are in place, that they take into consideration gender and SRHR, and ensure coverage of SRHR in social protection systems.

Ensuring SRHR is integrated into essential benefits package of UHC and include the marginalised:

- Ensure the specific needs and priorities of women, adolescents, and other underserved populations, including their SRH needs, are considered as a priority in the development and implementation of UHC policies, including resources allocation. This should include ensuring that essential benefits packages for UHC include comprehensive SRH services.
- Acknowledge the unique needs to population groups based on their circumstances, needs and lived realities. For instance ensuring CSE a key component of quality education and ensuring access and availability of menstrual hygiene products that would allow girls to stay in/complete school.
- Ensure that often neglected areas of SRHR are covered, such as safe abortion services, youth friendly SRH information and services, CSE, and addressing sexual and gender based violence. Provide additional support to more marginalised groups, such as in humanitarian contexts and people of diverse sexual orientations, gender identities and expression, and sex characteristics.
- As with the provision of quality health services overall, strengthen health systems to ensure that SRH services meet public health and medical ethics standards.
- Prioritise universality and marginalised groups who are deprioritised and ensure SRHR services are available, ensure health facilities are accessible physically and financially, such SRH services are gender sensitive, youth friendly and respect confidentiality.
- Ensure strengthened capacity of health workers at all levels, to include delivery of SRH services as well as recognition of the need to respect and human rights of women and girls and marginalized communities and provide services free of stigma, violence and discrimination.
- Ensure that laws and policies, including the criminalisation of abortion and homosexuality that discriminate women, girls and marginalised groups are repealed.

[23] Compiled from recommendations in MSH, undated, Guttmacher, Lancelet Commission. 2018, and PMNCH call to action March, 2018.

Prioritising SRHR as part of financing UHC:

- Ensure the allocation of resources, including technical support to incorporate SRHR into national UHC frameworks.
- Increase domestic financing to support UHC strategies, that include SRH and recognise intersectionality.
- Prioritise and invest in comprehensive SRH services and supplies and integrate it into the health system, including in the context of discussion, policies, programmes on UHC. These investments should ensure the integration of rights orientation to quality service provision, to provide services free of judgement, coercion and in a non-discriminatory manner.

Ensure strong evidence based monitoring, implementation and accountability to ensure SRHR is integral to UHC

- Ensure strong evidence bases that fill research gaps on SRHR that are used to inform decisions, policies and programmes on UHC.
- Form multi-stakeholder participations that would include civil society organisations, the broad range of community actors, marginalised and disadvantaged populations including young women, and professional associations providing sexual and reproductive health interventions and advocating for rights.
- Ensure accountability mechanisms are in place, are operational, regularly monitored and informed by evidence and outcomes so they are able to prioritise services according to the needs of women and girls, how they can access services, supply of services and health and equity outcomes.
- Integrate UHC in the follow up and review process of SDGs at the national, regional and international level.

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Annex 1: Indicators of measuring progress on UHC

According to WHO resources, monitoring progress towards UHC should focus on 2 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 income on health.

Together with the World Bank, WHO has developed a framework to track the progress of UHC by monitoring both categories, taking into account both the overall level and the extent to which UHC is equitable, offering service coverage and financial protection to all people within a population, such as the poor or those living in remote rural areas. WHO uses 16 essential health services in 4 categories as indicators of the level and equity of coverage in countries:[24]

1. Reproductive, maternal, newborn and child health:
    - family planning
    - antenatal and delivery care
    - full child immunization
    - health-seeking behaviour for pneumonia.
2. Infectious diseases:
    - tuberculosis treatment
    - HIV antiretroviral treatment
    - Hepatitis treatment
    - use of insecticide-treated bed nets for malaria prevention
    - adequate sanitation.
3. Noncommunicable diseases:
    - prevention and treatment of raised blood pressure
    - prevention and treatment of raised blood glucose
    - cervical cancer screening
    - tobacco (non-)smoking.
4. Service capacity and access:
    - basic hospital access
    - health worker density
    - access to essential medicines
    - health security: compliance with the International Health Regulations.

In addition, indicators on government spending on health as a proportion of total expenditure on health and government spending on health as a proportion of gross domestic product. To ascertain the burden of paying for health services, borne by households and individuals, out-of-pocket expenditure as a proportion of total health expenditure can be used.[25]

Indicators should be disaggregated by region, income, sex, age, race, ethnicity, disability, location and migratory status, depending on data availability.

[24] WHO 2018

[25] See https://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide_SRHR-Indicators_2013.pdf