No magic pill

*Pursuing **universal health coverage** through equitable health systems*

For more than 10 years, researchers supported by IDRC have been working with health reformers in low- and middle-income countries. Focusing on governance, equity, and the effective integration of health systems, they have much to contribute to current efforts to extend universal health coverage.

It is a dream shared the world over: access to health care, delivered by competent professionals, without fear of financial ruin. In 1978, signatories to the Alma-Ata Declaration defined state responsibility for ensuring strong health systems. But for too many, these remain just words. In 2010, the World Health Organization estimated more than 100 million people fall into poverty each year due to catastrophic health expenditures.

Despite the challenges, a growing number of low- and middle-income countries are taking steps to implement universal health coverage (UHC). All are wrestling with what universal means – who is covered, what services are provided, and how they are funded. While there is no simple formula to guarantee health for all, a strong and well-governed health system is essential.

Beyond global targets and vertical efforts

Some $US5.3 trillion is invested annually in achieving global health goals. But there is a wide gap between rich and poor countries, and aid efforts are fragmented, with a large pool of donors backing vertical, disease-specific programs and funds. Success is measured according to quantifiable outputs, such as vaccines delivered and bed nets distributed.

Core messages

- Strong health systems are fundamental to UHC.
- Local evidence and participation are key to responsive health planning.
- Root causes of inequity must be addressed for truly universal access.
- Even low-income countries have viable options for financing UHC.

IDRC: S. MHATRE

Through NEHSI, surveys have been one way to give communities a voice in primary healthcare reform.

This approach does little to build the underlying systems that deliver health care. Rather than combatting single diseases, IDRC's Governance for Equity in Health Systems (GEHS) program funds researchers who work with health providers, civil society, and policymakers to strengthen health systems. They focus on technical and organizational capacities that improve system governance – increasing community input and responsiveness to local needs. Rather than ask "How do we best combat this illness?" the research responds to a more nuanced challenge: What are the health priorities this system must respond to, and how can it do so equitably and effectively?

Strengthening capacity for evidence-based decisions

With one of the highest infant, child, and maternal death rates in the world, Nigeria has put primary health care at the top of its priorities. In 2004, the Government of Nigeria, IDRC, and the Canadian International Development Agency formed a partnership to support primary health-care reform. Following extensive consultations and assessments, the Nigeria Evidence-based Health System Initiative (NEHSI) was launched in two states, Bauchi and Cross River. NEHSI is strengthening health information systems and working with health institutions to make better use of local evidence to plan, budget, and deliver services.

According to project leader Neil Andersson, globally set targets have driven some poor choices for maternal health care in Nigeria. In a push to meet the Millennium Development Goals, for example, families have been urged to seek clinic or hospital births. But too often these centres are distant, under-resourced, and lack water. In some areas, evidence suggests they pose a greater risk to women than home births attended by traditional midwives.

In Nigeria, community surveys have shown that men play a key role in maternal health outcomes.

Getting at the root of the maternal health problem, community surveys have also shown that men are a decisive factor in women's health outcomes. "When you ask women and look at data on who has survived," says Dr Andersson, "you clearly see the role men play. Women are beaten during pregnancy. They are lifting heavy loads. They are working far too much. So we need to work with men to change this."

As part of this effort to shift maternal health care to an evidence-based model, NEHSI and the Bauchi State government have set up a pilot surveillance system. Mothers' actual health risks are documented, and, through mobile technology, community health workers are able to take informed action based on real-time data analysis. Involving users, planners, and providers of health services — those at the interface of supply and demand — is crucial to strengthening the use of health information systems as a means to improve women's health.

With IDRC support, China is carefully monitoring progress toward its "Healthy China 2020" reform goals.

China has also embarked on ambitious reforms, aimed at achieving universal health coverage by 2020. Recognizing the need for an effective monitoring system, China's Ministry of Health approached IDRC for support in 2009. Together with a consortium of Canadian health research and evaluation centres, the newly established China National Health Development Research Center is strengthening its abilities to measure progress toward the "Healthy China 2020" reform goals. Their assessment will focus not just on service delivery, but on the equity of access.

These and other GEHS-supported efforts underscore the need to monitor health service provision systematically, and document needs and experiences from the bottom up. As most health systems are decentralized, these abilities must be built at the local level.

COURTESY OF CEGSS/ PAWEENA PRACHANRONARONG

A citizen's health council in Guatemala discussing the legal framework for their right to health.

Addressing power inequities to ensure universal access

In Guatemala, centuries of exploitation and decades of civil war have entrenched a power imbalance weighted heavily against indigenous people. Seventy percent of indigenous children are malnourished, and their mothers are three times more likely to die in childbirth. Progressive laws recognize the right to health and encourage civic participation in developing public policy. But distance, lack of education, language barriers, and persistent discrimination prevent indigenous people from fully realizing their rights.

In 2007, a coalition led by Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud began to explore how power is exercised in the health system. In six rural areas, they engaged indigenous community-based organizations in assessing needs and barriers; in devising plans to increase access; and in monitoring the follow-through in services provided. The team worked to build people's awareness of their rights and improve their ability to advocate for change.

Through this empowerment, indigenous people gained improved health services — hours of service were extended, more staff was hired, and health workers who provided inferior treatment were sanctioned. A rigorous impact analysis is now being carried out to validate the approach, while it is being adapted for other municipalities.

Through gender and social analysis, and by facilitating community participation, other research teams are shedding light on coverage "blind spots" and working with affected groups to overcome them.

RICHARD LORD

Dr Rene Loewenson coordinates the secretariat of EQUINET. This long-standing network in East and Southern Africa promotes equity through many channels, working with communities and with regional and national decision-makers.

Equity is about much more than simply extending coverage to everyone, according to Dr Loewenson. "It's about ensuring that in the process we address differences in health status that are avoidable and unfair," she says. "And it's about the power that people have to influence their health systems."

Public engagement in defining and defending equitable health systems is essential not only for countries seeking to achieve universal health coverage, but in high-income countries as well. It is, Dr Loewenson says, a political choice: "Universal systems are achieved and protected through struggle."

EQUINET spearheaded the *Equity Watch* report series, which tracks regional progress. Country reports, undertaken by governments and technical and civil society organizations in Mozambique, Tanzania, Uganda, Zambia, and Zimbabwe, analyze 25 markers of progress within and beyond the health sector to improve equity. With this

COURTESY OF TARSC

"(Equity) is about the power that people have to influence their health systems."

— Dr Rene Loewenson, EQUINET Secretariat Coordinator and Director of the Training and Research Support Centre (TARSC)

COURTESY OF CONSORTIUM FOR RESEARCH ON EQUITABLE HEALTH SYSTEMS/ BRENDON GEACH

Queue outside a South African health clinic.

increased focus, health ministers of the East, Central, and Southern African Health Community resolved in 2010 to strengthen their monitoring of health inequities.

Who pays for and benefits from universal health coverage?

As low- and middle-income countries strive to extend coverage, financing is a crucial issue. In a period of soaring debts in the 1980s and 1990s, health service user fees were widely introduced under structural adjustment programs that cut deeply into public services. These fees have proven a huge barrier to the poor, for whom even small costs can effectively deny access.

Many countries are now experimenting with ways to eliminate user fees and reduce other out-of-pocket expenses while extending coverage. GEHS supports a number of regional research networks that have undertaken groundbreaking studies on financing models that aim to extend equity and access. They are shedding light on the costs and benefits of various options, and their impacts on equitable service delivery.

One such initiative is SHIELD (Strategies for health insurance for equity in less developed countries), which united country-based teams in Ghana, South Africa, and Tanzania. Researchers measured the regressive (pro-wealthy) or progressive (pro-poor) impacts of a variety of payment mechanisms, including different forms of taxation, insurance schemes, and out-of-pocket payment. Findings published in *The Lancet* in 2012 revealed that fragmented financing — covering different groups in society through different funding mechanisms — weakened overall income and limited the extent to which groups shared health benefits. This analysis also showed that taxes can be a progressive means to finance health coverage in low-income countries.
A second phase of research is applying SHIELD's approach to analyze health financing in Kenya, Uganda, and Zambia. In 2011, SHIELD joined forces with two other GEHS-supported networks to form the Global Network on Health Equity.

Achieving UHC through health system strengthening

There is no single route to achieving universal health coverage. But investing in local and regional capacity — so that health systems are fair, inclusive, and respond to citizens' needs — is fundamental. Since 2002, IDRC has supported pioneering research on health system reform that recognizes the importance of health information systems, financing, primary health care, locally generated evidence, and civic input in achieving good governance and equity. The result is a critical mass of Southern expertise working from the local to global level to reshape and extend health coverage in ways that address root problems.

STUART FREEDMAN / PANOS

Governance for Equity in Health Systems
International Development Research Centre
PO Box 8500, Ottawa, ON
Canada K1G 3H9
Phone: +1 613 236 6163
Fax: +1 613 563 0815
Email: health@idrc.ca
www.idrc.ca/gehs

idrc.ca