

### Universal health coverage: A re-emerging paradigm?

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A number of articles in this issue (1-4) highlight the importance of providing essential basic health services for achieving and maintaining optimal health status within a given population. The Ethiopian health system is also striving to address the need for providing essential health services within the perspective of universal health coverage (UHC) through its health care financing strategy (5) which is a basis for different reforms that include community based health insurance (CBHI) and social health insurance (SHI) schemes for people in the informal and formal sectors respectively as its health insurance strategy (6).

As endorsed by member states of the World Health Organization (WHO), the concept of UHC is defined as a target in which “all people have access to services and do not suffer financial hardship paying for them” (7) and it is conserved as a central goal that health systems should achieve. The concept implies ensuring or guaranteeing that all people obtain the health services they need, of good quality, without suffering financial hardship when paying for them (8, 9). The United Nations General Assembly has also called for the urgent and significant acceleration of the move toward the universal access to quality and affordable health care services (10) and has indicated three dimensions through which progress can be advanced to UHC: expanding priority services, including more people, and reducing out of pocket payments (11).

Historically, universal health coverage is a re-emerging concept in the context of developing countries when looked at within the perspectives of earlier initiatives in global health that include the basic health services and the primary health care approaches (12). The basic health services approach within the sixties and the primary health care movement in the seventies advocated the availability, accessibility (geographic,

economic, cultural) and appropriateness (technological) of health services to underserved populations in developing countries (13). In addition, the primary health care approach, as a philosophy, reframed and shifted the issue of focus from medical facilities to health services and from diseases to health care (14, 15). The ideals in those periods were reflections of the overall development thinking at the time, in addition to the post-independence ambitions and zeal of the progressive nationals and the contributions of labor movements, socialism and central planning during the seventies. More recently, the increasing trends in globalization and enhanced communication between populations across countries and continents has created new dimensions in the externality and public good nature of health leading to new initiatives that are attempting to shift the agenda of health services delivery, and that of UHC, to obligations that need commitments at international levels (16-18). It is also to be noted that the global movement towards UHC is said to represent the third major shift in recent global health history that followed the demographic transition beginning in the 18th century that sparked major public health developments through the 20<sup>th</sup> century, as well as the epidemiological transition starting in the 20<sup>th</sup> century (19).

However, according to its contemporary definition (20), universal health care is not a one-size-fits-all concept and does not imply coverage for all people for everything. Universal health care can be determined by three critical dimensions: who is covered, what services are covered, and how much of the cost is covered. It is rather a broad concept that has been implemented in several ways. The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards (21). Furthermore, there are significant challenges in meeting the ambitions of

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universal health coverage in low income countries, particularly those in Africa in that (22): revenue mobilization is a problem in informal sector (that includes the majority of the population in these countries, as there is no tax base with stable employment or wage system. In addition, tax administration systems are also weak and inefficient with high rates of tax evasion by the private sector. The macroeconomic contexts and the very low income levels in these countries also makes high tax rates politically unacceptable and practically infeasible. Issues of governance also complicate the managerial as well as technical administration of UHC schemes in these countries.

Therefore, developing countries should move very cautiously in the adoption and implementation of the concept of universal health coverage (23). Innovative approaches are required for only partial UHC with progress at varying speeds and with mix of social or national health insurance. With some complementary mechanisms in some cases such as: vouchers and community based health insurance schemes. Some combination of taxes and public financing, not just premium income, are required for UHC and for pooling contributions across from formal to informal sectors. Eventually, such transformation from partial to full and sustainable UHC, at the same time addressing the three criteria set by the WHO (cost-effectiveness, financial protection and prioritizing the worse-off), will require sustained 'economic growth with equity.

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