ACHIEVING UNIVERSAL COVERAGE IN HEALTH SYSTEMS: STRATEGIES AND PRE-REQUISITES

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1. Introduction

One of the most striking differences in the health systems of countries at different levels of development is that of the population covered by a health system. High income countries - with the notable exception of the United States - have health systems that guarantee universal access to health care regardless of a person's income or social status. There is of course a difference in how successful countries are in achieving such an equitable system; nonetheless the principle of universal coverage is unquestioned.

In contrast, the health systems of poorer countries demonstrate both absolute lack of access, and very different degrees of access for different population groups. Where compulsory social insurance schemes exist, they tend to offer a much higher quantity and quality of care than that available to those not in formal employment. Thus dual or even triple health systems can co-exist, institutionalising inequity in access to health care.

The health systems of currently developed countries demonstrate various means of achieving universal coverage. In addition, some middle income countries have in recent years made substantial strides towards universal coverage. The purpose of this paper is to examine the means that countries have used to achieve universal coverage, the desirable qualities or attributes of a universal health system, and preferred strategies for moving towards universal coverage. Given the historical experience of developed countries such as the UK and other countries in Europe, a major sub-theme of the paper is the appropriate role of the state in health care. It should be noted that universal coverage is interpreted in the sense of similar rights to access to similar packages of health care for all population groups.

2. Historical experiences of countries with universal coverage

In Europe, hospitals were originally developed by religious and charitable bodies with a commitment to care for the sick (Abel-Smith 1994, Roemer 1994). During the nineteenth century, as the role of infectious agents was understood, public authorities established isolation hospitals for diseases such as smallpox and leprosy. In some countries such as Sweden, public authorities took the lead from the late nineteenth century in providing hospital care for the whole community. In addition, many religious hospitals over time (or suddenly as in France as a result of the French revolution) were transferred to public authority control. Since most of those who used public and charitable hospitals were poor, hospitals were generally free of charge. The United States is unusual in having a long tradition of small hospitals set up by physicians for their own patients, and not till the later twentieth century were hospitals established as purely commercial enterprises (Roemer 1994). Outside hospital, in a number of countries in Europe the poor law or social assistance paid doctors on a full or part time basis to look after the poor.

Collective financing of health care in Europe has its origins in a strong voluntary insurance movement dating back to the middle ages (Ron et al 1990). Organisations of working men banded together for mutual benefit, especially from the late eighteenth century as industry developed, wage employment increased and income protection became vital. They made regular contributions to provide benefits for members in need, and later to cover the cost of medical care. Employers also became involved not least because of their concern to minimise the consequences of ill health on production. In Northern European countries such as the UK, benefits were generally confined to out-of-hospital care since hospital care was already available; in Central and Southern Europe hospital care was more often included. The provision of services was organised in many different ways: through direct provision (salaried staff and own facilities); or through various forms of contract with existing providers. Paying doctors on a capitation basis was particularly common because of its administrative simplicity.

Compulsory health insurance built on these voluntary schemes (Abel-Smith 1994, Roemer 1994, Ron et al 1990). The first compulsory scheme was in Germany in 1883, though well before that employment-based schemes involving contributions by both employees and employers had existed. In the UK, compulsory health insurance built on the friendly societies that provided voluntary health insurance, and covered out-of hospital care only. Often voluntary schemes covered half of the population before compulsion was introduced (Ron et al 1990). The medical profession, which had often resented the voluntary schemes because of their power, were in many cases able to capitalise on the changes to introduce more palatable arrangements such as fee for service payment, free choice of doctor, and payment by the patient with retrospective reimbursement by the insurer. Capitation persisted in some countries such as the UK for primary care, and helped to develop the concept of a general practitioner who was the first contact point.

Once compulsory insurance covered most of those in regular employment, various approaches were adopted to cover the self-employed who often had low incomes and who had no employer to share contributions:

- the cost of insurance was kept low by providing highly subsidised public hospital care (eg Scandinavia)
- existing funds cross-subsidised the low income self-employed
- all compulsory health insurance contributions were subsidised by public funds, or only the contributions of the self-employed.

The remainder of the population consisted of the aged, unemployed and disabled. Again various means were used to bring them within a universal scheme

- the aged might be covered as dependents of the insured
- rights to health care were added to cash benefits given within social security schemes for sickness, disability, unemployment and old-age
- those on social assistance had their contributions paid for them.

Of Western European countries, Britain was the first to introduce universal services in 1948, with Scandinavia in the 1960s, and Italy in 1980. Other European countries retained the social insurance structure they had inherited, developing 100% or virtual 100% coverage on the basis of multiple sickness

funds (eg France, Germany, Belgium). A few countries such as the Netherlands fail to reach 100% compulsory coverage because higher income groups are allowed to opt out and purchase private insurance voluntarily (Hoffmeyer and McCarthy 1994).

Abel-Smith (1994) has emphasised three important points about the development of universal services:

- countries generally retained their previous arrangements for service provision (the UK was the exception, in nationalising virtually all hospitals in 1948)
- most countries retained health insurance contributions as one source of finance
- whether the universal system was called a 'national health service', or 'national health insurance', was simply a matter of political choice.

Table 1 lists a selection of countries providing social insurance or equivalent health care protection, classified by level of coverage and income level. It shows clearly that the richest countries (with the exception of the US) have the highest coverage. However, some of the higher income developing countries are approaching universal coverage: notably Brazil, Taiwan and Korea. The means they are using to expand coverage include the following:

- to integrate the separate health systems developed for the insured and uninsured, by putting together the social insurance income and the tax income and giving similar rights of access to both groups (eg Brazil)
- to encourage the development of health insurance programmes for the difficult-to-cover groups such as farmers and other self-employed groups, with the aim of eventually standardising contributions and benefits (eg South Korea, Taiwan)
- to require substantial co-payments, to control use and keep contributions affordable (South Korea, Taiwan)
- to provide a public assistance programme to the remaining households who cannot be insured (South Korea).

With the progress to universal coverage in mind, countries can be classified (based on Frenk and Donabedian 1987) according to the basis of eligibility to care of population groups and the form of state involvement (Figure 1).

Eligibility can be on the basis of poverty (ie special public assistance programmes), contribution or privilege (eg social insurance programmes for specific groups, health care for the military), or citizenship (access for all). State involvement can consist of centralised public finance and provision through either centrally organised public services or decentralised public services (eg using local government structures). Centralised public finance may also be used to purchase services from private providers. Finally the lowest degree of state involvement occurs where there are multiple financing agencies and private provision, as in national health insurance in Germany.

Many countries can be considered to have moved through time from eligibility based on poverty or contribution, to citizenship. This progression has generally been accompanied by an increase in state involvement. Frenk and Donabedian suggest the different historical experiences can be crudely typified as in Figure 2. Non-socialist underdeveloped countries have had high state control (as proxied by the share of expenditure on health care borne by the state) with fairly low coverage. In contrast, many Western industrialised countries have had high coverage with relatively low state involvement in provision - with the notable exceptions of the UK and Sweden. Although the paths are shown converging on high coverage and high control, recent reforms in Europe have been aimed at reducing the role of the state in provision, though not necessarily in finance.

A number of issues relevant to countries seeking to move towards universal coverage arise from this rapid historical overview.

1. Local factors have determined the precise form of financing and provision of the universal system. Few countries have made radical changes to the patterns of financing and provision in moving towards universal coverage.
2. The coverage of the population by insurance has been quite high before countries have felt able to incorporate the unemployed, elderly and disabled.
3. The relative importance of insurance and tax have differed; however once countries are approaching universal coverage and insurance is compulsory there is little conceptual difference between them, except that insurance systems are predominantly funded from an earmarked tax on

employment.

4. Different countries have different preferences for ways of paying doctors and hospitals. However, in the 1980s and 1990s cost containment has been a constant theme in systems with third-party payers. In particular fee-for-service payment systems have been amended, and global budgets introduced for hospitals (Abel-Smith 1992).

5. The role of the state has been key in the expansion of coverage. As countries have grow richer, the share of public finance for health has increased (World Bank 1993). However, this has not necessarily meant state ownership of services (see table 2) or salaried public employment. Many European countries have retained a high proportion of beds in private institutions, though their income comes almost entirely from the state. Many of these hospitals are not-for-profit. Publicly-funded primary care is provided in most countries by doctors who are private, independent contractors (Hoffmeyer and McCarthy 1994).

3. Desirable attributes of a system of universal coverage

Based on the European experience, it is possible to outline a number of desirable attributes of a system of universal coverage (OECD 1992).

Income protection Patients should be protected from payments which threaten their household finances, and their payment for health care should be related to ability to pay. This requires at least three types of transfer: insurance (to cope with the unpredictability of need for health care); saving (since the elderly need more care than the young); and income redistribution (to provide care for those on low incomes)

Macro-economic efficiency An appropriate proportion of national income should be absorbed by health care. Because of universal coverage and potentially unlimited demand for care, the incorporation of cost containment incentives is vital. Experience with cost containment measures in European health systems has generally been positive, and the most effective measures

have been those which operated on the supply-side. These include the introduction of global budgets and central regulation of fees and charges. The evidence is strong that the higher the proportion of public financing, the greater the success in cost containment (OECD 1992). In addition, systems with integrated models of provision (as in a publicly-provided health service) were more successful in containing costs than those which relied on contracts (between the state and arms-length providers), which in turn were more successful than those which relied on reimbursement of patients' expenses.

Micro-economic efficiency The mix of services provided should be cost-effective, and the costs of services delivered should be minimised. There is less consensus in Europe on how to achieve this than in the case of macro-efficiency. A number of European countries, and the UK in particular, are seeking to encourage the routine use of cost-effectiveness analysis to guide priority setting and investment decisions on new facilities and technologies (Henshall and Drummond 1994). A number of countries are also seeking to use competition to encourage efficiency through approaches such as internal markets within public systems, and expansion of contractual arrangements. More complex payment systems are also being developed, particularly combining an overall expenditure cap with rewards for the productivity of individual providers. These include global budgets and fee-for-service for physicians in Germany, and capitation and performance related payments for GPs in the UK.

Freedom of choice for consumers While this is a commonly stated objective, in practice complete freedom of choice may conflict with cost-effectiveness and cost-containment objectives. In the UK, for example, although there is choice of general practitioner, choice of hospital care is limited by the agreements made between the institutional purchasers (fund-holding GPs and district authorities) and hospitals. Appropriate autonomy for providers Doctors and other providers should be given the maximum freedom of decision compatible with the attainment of the other objectives.

4. Strategies to move towards universal coverage

Again on the basis of European (including UK) experience, it is possible to identify a number of important aspects of the design of health systems for countries wishing to move in the direction of universal coverage. These include the role of regulation, the relative merits of compulsory versus voluntary insurance and of state versus private insurance intermediaries, controls on the provision of services, and the role of the state.

A free market for health care cannot be left to regulate itself (OECD 1992). However, government regulation can take two, main forms. It can seek to promote markets and self-regulation; or it can be of a command and control type. Much experience has been of the latter type, involving specifying coverage, regulating premiums and benefits, and controlling quality, quantity and prices of services. In contrast, pro-market regulation is aimed at encouraging the local autonomy of consumers, insurers and providers, an appropriate balance of power between them, and incentives to consume, finance and provide care in a cost-effective way. Although there is currently much enthusiasm in Europe for the latter approach to regulation, there is little evidence as yet of its success. Moreover, the approach to regulation has relied heavily on allowing the medical profession to monitor its own professional standards of behaviour. In countries where the self-regulating power of the profession is weaker, governments may need to intervene more directly to ensure quality. This is especially likely to be required as payment mechanisms are increasingly designed to contain costs.

Compulsion is an important element of any strategy which seeks to move in the direction of universal coverage (Normand and Weber 1994). Nearly all developed countries use compulsory health insurance contributions in whole or part to finance their health services (Abel-Smith 1994). Compulsory schemes have a number of advantages including:

- low administrative costs
- cross-subsidy from the healthier to the less healthy
- cross subsidy from the rich to the poor.

The latter two advantages reflect the principles of social solidarity which underlie European health policy.

In contrast, voluntary schemes are always likely to suffer from adverse selection, especially if premiums are community-rated. The healthy will regard the policy as too expensive and will not enrol. Those with higher risks will enrol, thus raising the expenditure of the scheme, raising premiums, and further discouraging lower risks from enrolling. However, as European experience shows, voluntary insurance can be an important precursor to compulsory health insurance.

The issue of compulsion is distinct from the question of whether the insurance intermediary should be a state body or a private entity (Hoffmeyer and McCarthy 1994). Using private sector financial intermediaries is increasingly being considered, on the grounds of superior efficiency and the potential to introduce competition between them for clients. However, competition will lead them to seek to exclude high risk individuals unless they are compensated completely for their higher medical care costs. Thus a central risk adjustment mechanism is required to compensate insurance agencies for accepting higher risk clients (Hoffmeyer and McCarthy 1994). A similar adjustment is required when capitation payment is used to cover all health care costs, unless the population covered or care specified is relatively homogeneous. There is still much to learn about the feasibility of risk adjustment mechanisms, even in developed countries (Jones 1990, van Vleit and Van De Ven 1992). A further problem with private insurance intermediaries occurs when, as in Korea, they are very numerous and hence small (Yang 1991). In such a situation administrative costs tend to be high (in Korea up to 22%).

As coverage expands, demand for services is likely to increase at an even faster rate since access to care will previously have been limited by cost or inadequate supply of services. Indeed, expansion in demand and cost inflation have been major problems for some countries nearing universal coverage such as Korea. If the cost of health care for the insured rises rapidly, this will make universal coverage even harder to achieve. One of the most important influences on cost inflation is the payment mechanism for providers. It is vital that uncapped fee-for-service payment systems be avoided. Alternatives include risk-adjusted

capitation systems such as those being tried in managed care experiments in the US (Kane 1995), and fee-for-service within a global budget.

A complementary approach to controlling costs and encouraging cost-effective care is to support the development of primary care and to establish the primary care physician as a 'gatekeeper' for hospital care. This principle has been long established in the UK, and is being introduced in managed care schemes in the US (Kane 1995).

A further element in controlling costs and encouraging cost-effective care is to define the health care package available to the insured, so that the commitment to care is not open-ended. In the past, definitions of care covered have tended to be vague and all-encompassing. As the costs of medical care continue to increase, discussion has intensified on how to define an essential package (Zwi and Mills 1995). While much attention has been paid to using the criteria of cost-effectiveness to define what should be included and excluded from such a package, there has been little discussion of the feasibility of applying such rules. In practice, a definition based on levels of care appears most feasible.

Given that some limitation of access to care is inevitable, the issue arises of whether to permit certain groups of the population, such as the wealthy, to opt out. The disadvantages are obvious: their contributions will be lost from the central pool of funds, and possibilities of cross subsidy from rich to poor reduced. Moreover, it makes it more likely that different services will be used by different population groups. The World Bank has argued that governments should try to ensure as far as possible that the same services are used by different population groups: 'services designed only for the poor will inevitably be low-quality services and will not get the political support to provide them adequately' (World Bank 1993). 'Private facilities' within facilities used by the general public are one means to ensure that standards do not diverge too greatly: better 'hotel' services can be provided for those who pay a supplementary fee, whilst standards of medical care provided can be similar.

Finally, the state has a key role in managing the process of moving towards universal coverage. It needs to ensure that the nature and cost of health services for different groups are converging rather than diverging. This will involve

seeking to influence payment mechanisms so that they encourage cost-effective provision of care, educating consumers to be better judges of quality, and encouraging self-regulation of hospitals and the development of quality assurance programmes. The state also needs to encourage the sense of social solidarity and reciprocity that underlies the goal of universal coverage.

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Figure 1 Classification of health systems in terms of population eligibility and form of state involvement

Form of state involvement	Basis of eligibility		
	1. Citizenship	2. Contribution /privilege	3. Poverty
Centralised public provision, public finance	Former national health services of socialist countries, hospital care in UK pre recent reforms and in several other European countries	Social insurance in various Latin American countries, health care for military in many countries	Public assistance for poor provided by MOH in many poorer countries, eg South Africa, Latin America
Provision through multiple public agencies, public finance	Hospital care in UK NHS; health services in Finland and Denmark	Social insurance in Mexico	Public assistance provided by states and municipalities eg in Latin America, USA
Centralised public finance, private provision	GPs in UK; ambulatory care in many European countries; national health insurance in Canada	Former social insurance in Brazil	Medicaid in USA
Multiple financing agencies, private provision	National health insurance in Germany, Switzerland, Japan	Social insurance in Argentina; Medicare in USA	

Developed from Frenk and Donabedian (1987)

Figure 2 Paths of state intervention in medical care

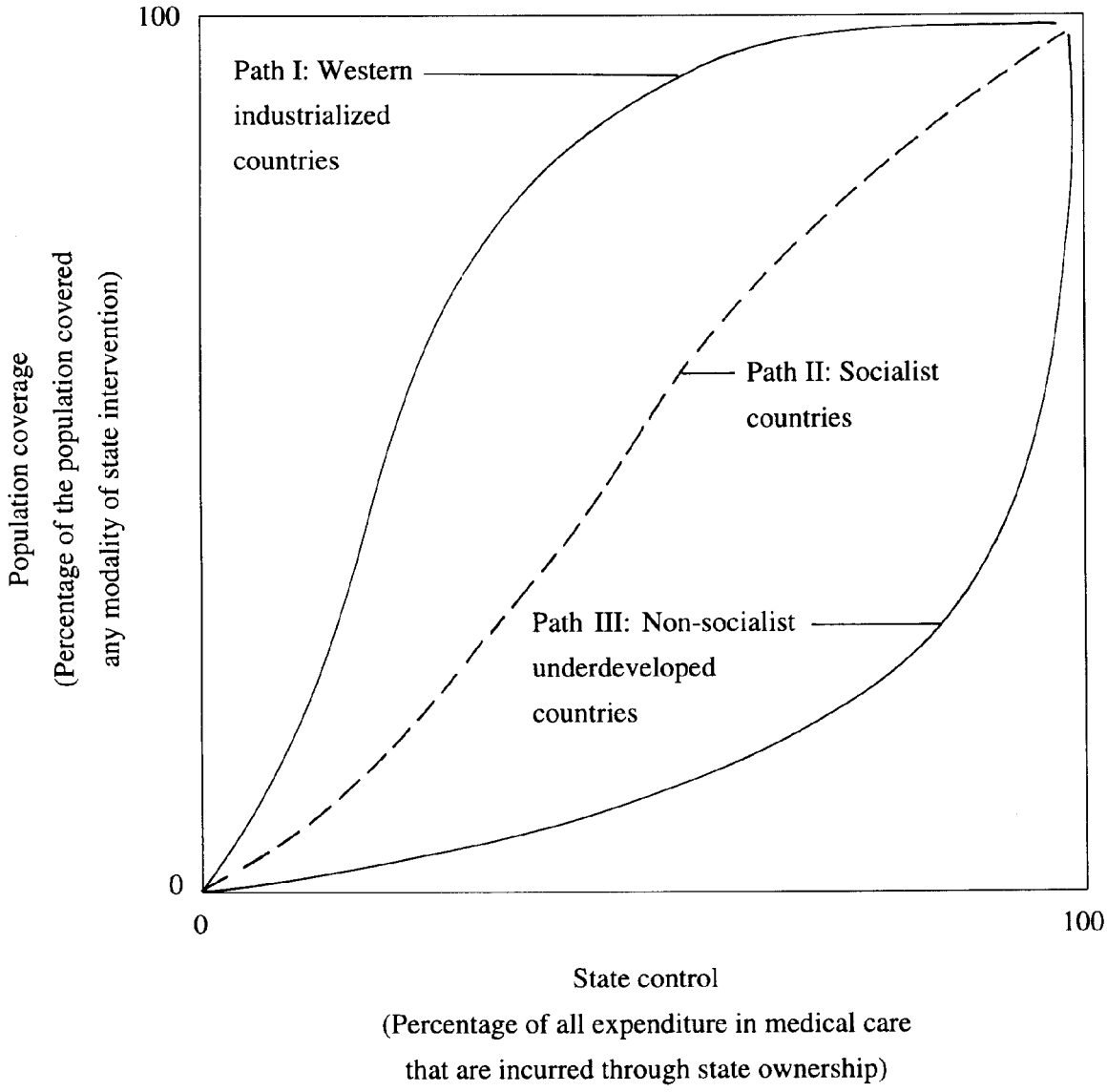

Table 1: Countries Listed According to Social Insurance Coverage (as Percent of National Population) for Medical Care and GNP per capita, 1986

Country	GNP per cap.
Coverage 90-100 percent	
Norway	15,109
Canada	14,124
Sweden	13,734
Denmark	12,907
Japan	12,809
Australia	12,454
West Germany	12,049
France	10,986
Belgium	9,298
Great Britain	9,009
Soviet Union	8,442
New Zealand	7,115
Israel	6,181
Spain	5,248
Coverage 25-89 percent	
Taiwan	3,611
Venezuela	2,922
Mexico	2,678
Korea, South	2,418
Brazil	1,809‹
Philippines	590
Coverage under 25 percent	
United States	17,148
South Africa	2,077
Colombia	1,290
Peru	1,153
Indonesia	491
Pakistan	331

Source: Ruth Leger Sivard, World Military and Social Expenditures 1989. Washington: World Priorities 1989.

Table 2: Hospital Sponsorship: Percentage of Hospital Beds under Governmental and Private Sponsorship, Industrialized Countries in the 1980s

Country	Government	Private
Japan	5.1	94.9
Canada	35	65
Belgium	37	63
United States	38.3	61.7
Israel	41.4	58.6
Germany	52.3	47.7
Spain	67	33
France	69	31
Australia	73.3	26.7
New Zealand	79	21
Denmark	90	10
Norway	90	10
Great Britain	92	8
Sweden	94.5	5.5
Soviet Union	100	0

Source: World Health Organization, World Health Statistics Annual. Geneva: WHO, 1983.