DEMYSTIFYING THE CONCEPT OF UNIVERSAL HEALTH CARE: A REVIEW

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ABSTRACT

Background: The concept of Universal Health Care (UHC) has become of late a common password, within the political circles without explicitly defining the meaning. There is a need to shed some light on the origin and meaning of this important philosophy.
Objective: To define and demystify what UHC is all about.
Data source: Published literature and other articles.
Data selection and extraction: Relevant material as to give clarity to the primary philosophy and understanding of the basic and practical steps to implementation.
Conclusions: The UHC envisages equalization of the quality of health provision to the citizenly of a country, utilising the available resources.

Key words: Equitable, Access, Efficiency, Quality, Availability

INTRODUCTION

The concept of Universal Health Care (UHC) has of late become a common password, with politicians, technocrats, medical specialists and even patients beholding the virtues. UHC grandiose as it sounds is shrouded in the mystery of its actual meaning and practicability. The concept creates high hopes in the populace yet in the majority, it is all baffling. What is Universal Health Care? Health is one of the legacy goals of the current administration with UHC bundled as an attainable goal. This article is meant to demystify the genesis and philosophy behind UHC. Consider a healthy 30-year-old technocrat with an unlimited health facility (including medical check-ups and treatment abroad) while his sickly 60 year old mother in the village cannot afford quality medicine even for flu. The UHC envisages equalization of the quality of health provision for the two, which lifts the care of the latter without necessarily interfering with the care of the former.

The eight Millennium Development Goals (MDGs) focused attention from 2000 to 2015 and were succeeded by Sustainable Development Goals (SDGs) in 2015 (1). The spirit of 2030 Agenda for Sustainable Development, which was adopted by all United Nations Member States in 2015, was to provide a common pathway to sustained peace and prosperity in the planet. This pathway was elaborated in the form of itemized goals, the seventeen Sustainable Development Goals (SDGs), which were deemed achievable by all nations, in collaboration (2). The SDGs covered all possible areas of basic human requirement, attempting to elevate and equalize man while maintaining the environment. The first goal addressed poverty, "end poverty in all its forms everywhere", the second addressed hunger, "end hunger, achieve food security and improved nutrition, and promote sustainable agriculture" and the third covered good health and well-being for people "ensure healthy lives and promote well-being for all at all ages". The third SDG is what is commonly referred to as Universal Health Care.

Primary tenets of UHC

Most nations in the world embraced UHC, although implementation became challenging to the countries that most needed it – the low-income countries (3). In many of them the UHC became a campaign tool with promises of delivery of essential medicines. But UHC is not only about delivery of essential medicines, but also accessibility, affordability and quality care. The care must be accessible in both distance and time; affordability implies lack of cost restraint (preferably internally contained within the institution). Finally, quality care requires skilled manpower (with elimination of quacks and impostors), quality medicines, quality management and administration, and a quality environment. Delivery of essential medicines is important, but these medicines must meet the quality threshold, something quite difficult to ascertain in the midst of all sorts of generics importation into countries where corruption and fraud is the order of the day. Eight key principle components anchor UHC, namely: Equitable access, efficiency, quality, inclusiveness, availability, adaptability, choice and innovation (4). These are cogs in a wheel that must drive and be driven by other wheels (SDGs). We will briefly discuss each one of them shortly. Political scientists will argue that these are tenets borrowed from socialist dogma with a tendency to equalize opportunity. A healthy body is universally equal, irrespective of economic opportunity and the reverse is true of disease, it does not respect the king or the servant.

(i) *Equitable access:* Equitable access underscores universal equity without discrimination by any form, political, social, economic, religious or sectional; all must have equal access to quality health care. Different health care packages hinged on the economic class of the individual should be discouraged and evened out so that the CEO and the messenger have equal access to the same quality care. The same applies to the pastoralist in Ngaremara (rural area) and the tycoon in Lavington (urban area), both should be able to access quality care closer to where they are. Packages offered by government (e.g. National Health Insurance Fund (NHIF)) should be equal for all, everywhere. The approach should be patient centred; how best to deal with the patient's problem and not provider centred whether this provider is an individual or an institution.

(ii) *Efficiency:* The principle of efficiency encompasses effective use of resources by the health systems. This can be achieved by employing best practices in preventive primary health care such as immunizations, antenatal care, sanitation, clean water, good nutrition, health education etc. The health systems should also employ qualified personnel for quick, efficient delivery of services. These workers must be adequately remunerated to avoid migratory and predatory tendencies. There should also be efficient distribution of equipment particularly the expensive ones that can be shared by communities and neighbouring regions (MRI, SPECT and PET scans, radiotherapy equipment etc.), avoiding unnecessary duplication.

(iii) *Quality:* Quality cuts across all aspects of patient care, nursing care, diagnostics, and various forms of treatment. There must be quality infrastructure, adequate information that is patient-centred, and a quality safe environment. There must be adequate guard against dangerous substandard medicines, counterfeit drugs, quacks and thieves. Quality encompasses policy on evaluation of care, inspection and quality control mechanisms.

(iv) *Inclusiveness:* The principle of inclusiveness allows efficient decision making about funding, infrastructure, cost distribution etc. It also includes all stakeholders including patients, health professionals, health managers, care givers, insurance companies, and governments. Inclusiveness creates transparency, social accountability and quick decision making and dispute resolution. Universal Health Care must be readily available to the citizenry without shortages and outages with clear information detailing what is available and where and who pays for it.

(v) *Availability:* This concept envisages not only availability of an adequate health facility but also of equipment, and necessary tools for diagnosis and treatment. This of course include availability of drugs, clean water, and clean environment (particularly from noise and other pollutants). There must be availability of adequate staffing, including key specialists for emergency situations.

(vi) *Adaptability:* Strategies should be in place to make care more adaptable to mitigate for diverse situations, population peculiarities, and geographical locations. Diverse approaches for collaborative financing by County and National governments transfer of funds where there are public - private engagements and so on. There may be need to upgrade and strengthen existing mission or community facilities to a capacity able to deliver UHC.

(vii) *Choice:* The other tenet of UHC is choice. The patient has a right to choose which facility to go to and the specialist of their choice. This choice is guided by adequate information on how the programme works and therefore, the relevant choices within this limitation. However, in a well-functioning system, the patient or guardians should have the ability to select health care options of their choice without hindrance by fraudulent, incompetent or corrupt intermediaries.

(viii) *Innovation:* The last principle in this philosophy is innovation, which is investment in research and new modalities for prevention, diagnosis, treatment of diseases and the attendant care and support in various circumstances. These innovations are better community centred and relevant to various cultural and geographical settings achieving quality homemade solutions. Research requires adequate funding but must be encouraged to keep the system dynamic and sustainable.

Implementation of UHC

In shaping the future UHC system for Kenya, it is important that we create a model which meets the needs of the diverse population we have. There is a unique demographic, geographic, social, political and cultural difference that must be put into consideration. The starting point is our current health system, which must be appreciated and critiqued for improvement and transformation. Therefore, the design of the future

system must take cognizance of these differences, and move forward from where we are, keeping in mind the core values of UHC. Other important considerations include making evidence-based decisions, and appropriate sharing of knowledge and information.

To appreciate the current status of health care in the country, the Cabinet Secretary of Health requires to commission a group of experts for a comprehensive review of both public and private health care delivery facilities in Kenya. The information must come from both the users (general public), the health insurance companies, the medical and paramedical groups and the caregivers (hospitals and other health facilities). The report generated of the current status and the shortcomings therein will form the bases of transformation to the desired model. The existing facilities will also form the scaffolding on which to build the desired model.

The ideal health care model

An ideal health care model must be patient-centred; in other words, based on patient needs, must be timely, proactive, and continuous. There must be efficiency and effectiveness, with strict regulation on patient safety and adherence to internationally accepted Standard Operation Procedures (SOPs). Staff governance and remuneration structures should support the provision of safe, high quality, integrated patient care.

Proposed implementation strategies

For successful implementation of UHC as a health policy, various approaches and strategies are crucial, and will be discussed in six core areas: legislation, establishment of a National Health Authority, spatial distribution of health facilities, purposeful clinical governance, funding and insurance and finally responsible financial management. These are the cogs in the big wheel that gives life and momentum to an organization. There are smaller wheels with smaller cogs that must also run for efficiency.

(i) *Legislation:* Although the philosophy behind UHC has been universally accepted, no concrete roadmap to implementation is yet to be established. There is a lot of talk. We must walk the talk. Implementation of UHC begins with legislation, which entrenches this right in the constitution (5, 6). The laws must include the right of every member of society to have an adequate array of core health care benefits established through an ethical process. The health care system must be sustainable and long-term and must ensure that the stakeholders have clear responsibilities for which they conform. Constitutional changes that recognize right to health not only helps to protect this right but also in laying down the necessary guidelines, strategies, plans and policies, as well as sourcing for implementation funds within and outside the government. This is a good starting point. Legislation must be preceded by public participation, public education, and political goodwill. Public participation on organizational structure, funding, cost sharing if any, insurance policy and so on. Public education will be on the meaning, expectation, depth of cover and public contribution to the success of the program. No development will succeed without political leadership and political goodwill. History has shown that if the politicians work against an idea, that idea fails. Politicians are able to influence the citizenry for and against anything good or bad; that is why political goodwill must emanate from the highest authority possible and supported by cheer-leaders. In Kenya we are lucky that health is a recognized developmental pillar, not only as a legacy pronouncement for the current administration but also cited as such since independence.

(ii) *Kenya Health Authority:* The future UHC landscape in Kenya requires a unifying regulatory statutory body at the national level. There are too many uncoordinated, semi-autonomous regulatory bodies in the health sector. These include regulators for doctors, nurses, clinical officers, pharmacists, radiographers etc. These groups require to be brought under one umbrella, here proposed as Kenya Health Authority (KHA) or whatever other name. The individual professional regulatory bodies will then be perhaps departments of the authority and subservient to that authority. The authority will be under the Ministry of Health and with some degree of autonomy akin to the Law Society of Kenya. The first duty of this authority will be to amalgamate all the subsidiary licencing and regulatory bodies to one mandatory system of licensure for both public and private health service providers.

The authority should also seek more legislation as desired in order to strengthen and protect its activities. Some of these subsidiary legislations should be designed to improve patient safety by ensuring that healthcare providers do not operate below core standards. Secondly, legislation in relation to regulation and monitoring of the health sector performance in timely intervals as necessary. The authority will regulate the quality of all health care delivery services, including private facilities and medical insurance providers. This will ensure that providers exercise good governance, provide quality, monitoring, and adherence to proper guidelines and procedures while maintaining

discipline and good ethics. The authority will also ensure the introduction of licensing legislation and a robust regulatory framework for healthcare providers; and reform of the private health care and insurance market. The authority will play a critical role in fostering linkages as well as convergence within health and related programs of the National and County Governments. The authority should lead the development of strategic partnerships and collaborations with civil society, financial and insurance agencies, academia, think tanks, national and international organizations, while providing technical advice and operational inputs, as relevant, to the National and County governments. This may involve formulating standards/SOPs/guidelines/manuals to guide implementation, identification of capacity gaps and related trainings, development of health information and IT systems, facilitating cross-learning's, documentation of best practices, research and evaluation.

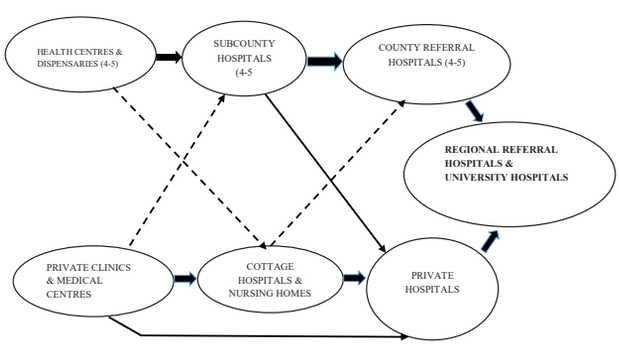
(iii) *Spatial distribution of health facilities:* In the past, health coverage has been viewed in terms of structural capacity, manpower, and local access (distance, language etc.). The health coverage has been organized in a hierarchical fashion of progressive complexity in terms of health delivery (so called levels I-VI) or in simpler terms health posts, dispensaries, health centres, sub-county hospitals, county hospitals and national referral hospitals. A careful look at the spatial distribution of the existing health facilities, vis-à-vis population distribution and density, there is a disparity. The facilities are far apart, unequal in every way (most are substandard), inaccessible, and ill-manned. This gives rise to delivery segmentations that are unequal, inadequate, and ineffective. The medical workers have increasingly become accustomed to ineptitude and are ill-motivated. This gives scenarios like the son and mother referred to earlier.

In retrospect, the segmentation of the health system was a negative design, imposed by convenience; a legacy inherited from the colonial administration. A good health structure must be organized after proper survey and planning, akin to the national road system where modern highways and thoroughfares are designed in near equidistant and well connected, fed by feeder-roads that originate directly from major population centres. In consideration to vast social inequalities between rich and poor, different levels of education, urban and rural populations, and nomadic and farming populations, careful spatial distribution of health facilities is paramount.

In my opinion, the country requires ten national referral hospitals, one for every 4-5 million people. These national referral hospitals should be under the national government. They must be purely referral (no walk-ins) and centres of excellence, fully equipped and manned, and strategically positioned so that they can be shared by clusters of neighbouring counties. These national referral centres will receive referrals from the corresponding county hospitals. Referral systems will be according to the laid down procedures and guidelines to avoid overcrowding. In turn, the county hospitals will receive referrals from the sub-county hospitals, health centres and dispensaries. This public referral system will run parallel with the private health providers (Figure 1).

Figure 1

Spatial distribution of health facilities



(iv) *Clinical governance:* This is a very important concept of medical care, particularly at the hospital level. Clinical governance enforces the principle of patient-centred care, the key of which is to meet patients' needs rather than the needs of the provider. Hospitals that place the patient at the centre of their efforts are likely to succeed better than those that put patients as beneficiaries. Patient focus results in good outcomes with patient satisfaction. To achieve this, population-based needs assessments, service planning, structuring, and information management are essential. This will ensure internal processes allow the patient to receive the right care at the right place at the right time; in other words, appropriate and adequate care. It should be easy for patients to navigate between various levels of care, without undue hindrance, congestion and any form of frustration. To achieve this, governance structures must be put in place and adhered to. It may be more challenging for large set-ups to retain a patient focus; this has prompted some experts to recommend multiple smaller manageable facilities which may have better chances at success.

Each facility should be able to form standardized care delivery through interprofessional teams (7). Standardized care delivered by such teams promotes continuity of the care process. Within these teams, all professionals are considered equal members with professional autonomy. The roles and responsibilities of all team members are clearly stated to ensure smooth transitions of patients from one type of care to another. The professionals should be well remunerated and offered incentives in order to maintain performance and efficiency standards. Shared protocols based on evidence, such as best practice guidelines, clinical care pathways and decision-making tools, are essential to the functioning of interprofessional teams and help to standardize care across services and sites, thus enhancing quality of care.

While an interprofessional team approach is considered a basic tenet of patient centred care, there are barriers to function team integration; which include, lack of role clarity leading to confusion, self-interest, competing values, lack of trust and conflicting views. These will be managed by creating hierarchical command system within various related groups; some form of authority with responsibility in form of team leaders, supervisors, managers, etc. titled appropriately. Communication in diverse manner of ways including memos, frequent team meetings and the use of electronic information systems is encouraged.

Another aspect of clinical governance is to have a well-developed performance monitoring system that includes indicators to measure outcomes at different levels (8,9). Protocols and procedures that help measure care processes, outcomes and cost-effectiveness must be developed. This evaluation system should be standardised and made mandatory. The results of evaluation should be the key instrument for promotion and termination of individual contracts. These processes are only possible with the support of quality computerized information systems that allow data management and effective tracking of utilization and outcomes. It is essential that information can be accessed from anywhere in the health system, even in remote locations, to facilitate seamless communication between care providers and regulatory authorities.

Caregivers need to be effectively integrated at all levels of the system and play leadership roles in the design, implementation and operation of an integrated health system. Integrating primary care physicians economically and ensuring recruitment and retention through compensation mechanisms, financial incentives and ways to improve quality of working life is also noted to be critical to success.

(v) *Funding and insurance:* Resource needs are largely dependent on the geography of a country, population distribution and diversity, risk profile of beneficiaries and their utilization rates. It will also largely depend on how the health system is organized and financed. Adequate resources for running UHC recurrent budgets are high. Medical insurance coverage is a form of contribution from the individual or employer in the provision of health care. A rough estimate has it that only 20% of Kenyans have access to some sort of medical coverage which means that approximately 40 million Kenyans are excluded from quality health care. This contrasts with the USA where in a 2010 commonwealth report 56% of residents received primary coverage through private insurers, while 27% was covered under federal and state programs while the remaining 16% lacked health insurance entirely. Only 21% of the hospitals in US are public. The rest are private and most of them profit making (10). Health financing, however, is not just about resource adequacy: it is also about the efficiency, equity, and effectiveness of the ways in which the available resources are used. In a nutshell, it's about policies to improve revenue collection, strategic purchasing, and dealing with labour costs.

Sources of capital funding include government funds, grants and other external sources. While sources of treatment funding include private sector insurance programs, which provide coverage to all their employees and their dependants; National Health Insurance Programs which should provide cover for the unemployed, the poor and the vulnerable such as students. The latter, which is tax-financed coverage should be mandatory to all, though the classes of contributors can be stratified according to ability and nature of cover required. All these funding groups and private establishments require some form of regulation. The bar of quality should be high, but cost effectiveness must be maintained. Charges must be regulated and maintained at reasonable and sustainable levels (11,12).

(vi) *Financial management:* Financial management is one of the major causes of success or failure of any scheme. Financial management is really about accountability, cost control, prevention of pilferage, wastage and corruption. Various measures to strengthen accountability have been suggested but in my view the most practical is the framework for accountability as developed by the

World Bank in the World Development Report (WDR): Making Services Work for Poor People (World Bank 2003)(13). The WDR framework conceptualizes accountability as a relationship between actors that has five components: delegation, finance, performance, information about performance, and enforceability.

This is a principal-agent relationship in which the principal delegates a task (or tasks) to an agent and provides financing for its execution. The agent then performs the task (well or badly) and provides information about what has been done. Finally, the principal holds the agent responsible for the agent's performance through various enforcement mechanisms, both positive (rewards) and negative (sanctions). Typically, the process is then repeated. Stronger accountability is achieved when each of these five elements is present and working well. They are mutually dependent in the sense that if one element fails, overall accountability can break down too. At the heart of these relationships is performance monitoring. The other four elements are the essential scaffolding that helps to support good performance. A good financial performance will be measured in terms of cost-effectiveness, prompt payments, sticking to a reasonable budget, purchasing power, and being able to meet required financial obligations.

CONCLUSION

In conclusion, it is the moral and civic duty of any government to provide UHC to its citizens. Health is a driver for human development and independence; healthy people make a wealthy nation. This effort is sustainable as healthy people are more economically active and wealth production increases. Failure to properly implement UHC in totality will leave various components of this goal to be used as campaign slogans during electioneering periods.

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