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Health for All, All for Health

LESSONS FROM THE UNIVERSALIZATION OF HEALTH CARE IN EMERGING ECONOMIES

Achieving universal health coverage is integral to the central pledge of the 2030 Agenda for Sustainable Development to "leave no one behind". Meeting this target is about more than just having enough resources to incrementally expand health coverage to the entire population. This Brief provides policy makers with evidence-based advice on how to design and implement balanced and integrated policy solutions for universalism in the health sector and beyond, in the context of the Sustainable Development Goals.

Leaving no one behind and reaching the furthest behind first are key principles framing the 2030 Agenda for Sustainable Development. Goal 3, "Ensure healthy lives and promote well-being for all at all ages", illustrates the commitment of United Nations member states to realizing this principle in the health sector. Target 3.8, which aims to achieve universal health coverage, signals a departure from the preference for targeted interventions that characterized many health systems and drove reforms for more than three decades, and whose ad-hoc and reactive nature has proved insufficient, inefficient and unsustainable for dealing with complex health problems in the 21st century.

This global commitment to health for all at all ages reflects a shift in national discourse and practice that is bringing universalism to the fore. This Research and Policy Brief draws lessons from the experiences of eight emerging economies to assist policy makers, advocates and others seeking to expand and universalize health care systems.

Box 1: UNRISD Research on Universalism

This Research and Policy Brief summarizes key findings from the UNRISD research project ***Towards Universal Social Security in Emerging Economies.*** The project analyses the efforts of selected emerging economies to move towards universal provision of health care. It provides a comparative analysis of the political, economic and social drivers of, and constraints on, the extension of health care service for all and draws out the implications for poverty reduction, equity, growth and democracy.

Case study countries: Brazil, China, India, Indonesia, Russia, South Africa, Thailand and Venezuela.

The edited volume that presents the findings from this project (Yi 2017) is organized around groupings of countries based on their experiences with universalization of health care, as well as an analysis of the forces, factors and ideologies that have impacted this development.

- Part I: Analyzing Common Pressures and Diverse Social Policy Responses
- Part II: Moving Towards Universal Health Care: Opportunities and Challenges
- Part III: Obstacles to Moving Towards Universal Health Care

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For more information about the research project, please visit **http://www.unrisd.org/tussee**

Universalism in the context of health care

As a guiding principle for social policy, universalism implies that the entire population has the right to benefit from social services (Mkandawire 2005). With regard to health care, this means access to quality, affordable, adequate health services, and protection from the economic and social consequences of illness, for all members of society.

One of the most distinctive features of the 2030 Agenda for Sustainable Development is its emphasis on equity and inclusion as framing principles for global development. Yet while leaving no one behind is its pledge, and an underlying principle of all goals and targets, universal approaches to poverty reduction are not new. Universalism has been a fundamental

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principle of welfare systems in many countries. It underpins the Scandinavian welfare model; and beyond Europe, universalism has been key to state-centered policy and planning in many postcolonial governments.

The principle of universalism and various forms of universal social service provision took a strong hit from the beginning of the 1980s, when neoliberalism and its policies reshaped social services in many countries through market-driven commercialization and so-called managed competition. In the health sector, targeted, disease-specific programmes gained prominence, at the expense of overall health systems.

But even in the midst of the neoliberal swing in public policy, a range of international and national-level health initiatives, policies and plans emphasized the right to health and the importance of strong, inclusive health systems. The Alma-Ata Declaration, the result of a 1978 intergovernmental conference on primary health care, for example, recognized health as a basic human right, a social goal and an economic imperative. Indeed, despite their strong influence, neoliberal reforms of health care systems were not in fact adopted everywhere. Twenty low- and middle-income countries managed to maintain health coverage and in some cases made significant progress expanding it to 90 percent or more of their populations despite pressures to commercialize their health care systems.

The UNRISD research project Towards Universal Social Security in Emerging Economies has analysed the cases of eight selected emerging economies that have sought to maintain or expand their health care systems (see Box 1). The pathways these countries have followed are different from those of industrially advanced economies that pursued universalization in the middle of the last century. The challenges and opportunities that these countries have faced in this process are also different from each other. Based on the analysis of diverse trajectories of national efforts to move towards universal health care systems, this Brief identifies six enabling factors which have facilitated progress towards universalism, providing useful lessons for policy makers seeking to maintain or expand their health care systems.

Factors enabling universalization

1. Empowered civil society, working together with government

Social movements play an important role in the drive for universal health care. Interactions between social movements and governments often contribute to moving universal health care policies up the policy agenda. The experiences of Brazil and Thailand demonstrate that the expansion of health coverage cannot be explained solely by elections, courts, legislatures or political parties. Empowered civil society, which was not separate from the institutions of the state, but rather worked in dialogue with the government, played a significant role in the process of reform towards a universal health care system in both countries.

2. Political will, institutional capacity and political support for reform to create fiscal space for universal health care

The experience of many emerging economies challenges the conventional wisdom that universal health care provision is not implementable when resources are limited. The availability of financial resources to pursue universal health care reforms is often subjective and dependent on political will, institutional capacity and the politics of reform. Thailand achieved universal health coverage on the heels of the Asian financial crisis of 1997, which damaged the Thai economy and reduced the government's fiscal capacity. Despite these financial constraints, it was still possible to progress towards universal health care thanks to administrative commitment and capacity, and support from civil society, which had been building for decades. In Venezuela, on the other hand, the country's oil wealth was not enough to overcome institutional and political challenges facing universalization. Failures to mobilize broad political support during Hugo Chávez's presidency made health care reform for universalization unsustainable.

3. Democratic mechanisms to build consensus between different interest groups and maintain reform momentum

Universalism does not mean the same thing to all stakeholders, nor are priorities always aligned about how to achieve universal health objectives. A lack of democratic mechanisms to achieve broad consensus on the meanings of and approaches to universal health care can entrench the divide within and between stakeholder groups and consequently stall the reform process. South Africa is a case in point. Supporters and opponents of the country's National Health Insurance could not reconcile their different positions on the meaning of universalism and the role of the state, which created bottlenecks in progress on health reform.

Differences exist between government institutions as well. Regardless of context, financial ministries tend to approach universal health care with caution, wary of financial implications, while welfare ministries are more proactive in advancing universal health care. But tensions exist even among welfare agencies, especially concerning the division of resources. In Thailand, for example, the drive to reallocate resources towards health care in underserved rural areas was met with opposition from stakeholders in the health sector in urban areas, who faced a reduction in their

own resources. In India, rights-based approaches to social policy have been advanced in areas such as education and income support, but there has not been a similar rallying around the right to health. This has resulted in a fragmented and residual health insurance system in the country, despite its focus on rights in other areas. Creating mechanisms for consensus building within the government and across policy sectors is therefore crucial to achieving and maintaining far-reaching reforms.

4. Strategies to reduce resistance in and from the private sector

Even those low- and middle-income countries that have sought to universalize their health care systems have not remained immune from the impact of neoliberalism. Market culture and commercialization are entrenched and deep-rooted in almost all emerging economies. As a result, the private sector has become firmly institutionalized and often functions as a source of resistance to health care reform towards universalization.

In Russia and China, for example, the privatization of health service providers has increased costs and generated resistance to the expansion of public health coverage. In South Africa, the expansion of private health provision in the 1990s strengthened commercial interests, which in turn intensified resistance to the expansion of public provision, generating concerns about remuneration, work-load, autonomy and quality of care. Given that the private sector remains a significant actor in health care systems, policy makers need to identify strategies to reduce the resistance of the private sector to reform towards universal health care.

5. Comprehensive and coherent national framework for health care, with mechanisms to ensure vertical coherence of policies between different levels of government

In all the cases studied in this UNRISD research, the expansion of health coverage was accompanied by decentralization, the drivers of which varied across contexts. In some countries, such as South Africa, Brazil and Indonesia, decentralization was part of the democratization process, while in Russia and China, it was part of the move from a centrally planned to a market-based economy. Decentralization by itself is not necessarily enough. In successful cases, such as Brazil, decentralization was accompanied by the provision of additional resources to local governments, for example strengthening local institutional capacity by creating sub-national health councils to implement federal policies for universal health care. In less successful cases, for example in Indonesia, decentralization was dominated by patrimonial, clientelistic politics where reform depended on connections with leaders rather than democratic principles, which resulted in a fragmented approach to health care. The lesson from these experiences is that a comprehensive and coherent national framework for health care must include mechanisms to ensure vertical coherence of policies between different levels of government.

6. Tax-financed health care systems

Health care programmes that move away from employment-based contributory insurance play a game-changing role in better health outcomes for large segments of national populations, especially in contexts with high levels of informal employment. This has been the case in Brazil and Thailand, where informal workers were excluded from previous health insurance systems. The Thai Universal Coverage Scheme and the Brazilian Unified Health System, both of which are based on tax finance, have made health insurance accessible to all and have had direct and indirect impacts on other systems of health provision, with wide-ranging improvements in health outcomes.

Universal health care and the 2030 Agenda for Sustainable Development

Universalism is more than just one element of one target of the 2030 Agenda for Sustainable Development: achieving universalism is integral to the Agenda's central pledge to "leave no one behind". The meaning of universalism is, however, continuously redefined and contested, and universalization of social services is not a static, finite process but a long-term exercise involving dynamic interactions between progress and regress.

Box 2: Further UNRISD Reading on Universalism and Health Care

- Yi, Ilcheong (ed.). 2017. *Towards Universal Health Care in Emerging Economies.* London: UNRISD/Palgrave Macmillan.
- Mackintosh, Maureen and Meri Koivusalo (eds.). 2005. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses.* Basingstoke: UNRISD/Palgrave Macmillan.
- Mkandawire, Thandika. 2005. *Targeting and Universalism in Poverty Reduction.* UNRISD Programme Paper, Geneva.
- Leppo et al. (eds.). 2013. *Health in All Policies: Seizing Opportunities, Implementing Policies.* Helsinki: Ministry of Social Affairs and Health of Finland.

The availability of financial resources to pursue universal health care reforms is often subjective and dependent on political will, institutional capacity and the politics of reform.

Box 3: How Universal is my Social Service Provision?

Universalism in social service provision may look very different from one context to another, varying across six dimensions. Depending on which dimensions are stronger, the design, implementation and practices of social policy provision can differ significantly. These six criteria can be used to assess the universality of a given programme.

- **Entitlement:** the legal relationship between the beneficiary and the social service or benefit
- **Eligibility:** the qualifying conditions for beneficiaries
- **Access:** the extent to which beneficiaries can consume or use social services and benefits
- **Appropriateness:** the extent to which benefits and services are provided
- **Distributive rules:** how costs and benefits are distributed
- **Organizing principles:** the political values or ideologies around which social policies are constructed and framed

Programmes that are claimed to be universal may excel in some of these dimensions while failing in others. For example, a legal right to health care (entitlement) does not automatically mean that all people can access an appropriate health service facility or that the proper institutions are in place to provide affordable care. Alternatively, health care may be widely accessible, but public facilities may be underfunded and provide low-quality care, and primarily used by poor, rural communities, while middle and upper class communities benefit from parallel private systems.

An overarching finding emerges from the successful cases of the universalization of health care observed in this UNRISD research: they all adopted integrated approaches that can promote synergies between health and non-health sectors; equally the contestation and consensus that reforms for universal health care entailed were not limited to the health sector alone. Health is interconnected with other areas of social, economic and environmental well-being, so the expansion of health care systems must happen alongside efforts to address the determinants of health that lie beyond the health sector.

UNRISD research on emerging economies demonstrates that two elements underpin integrated and comprehensive approaches to health care reform:

- strong institutional capacity within and beyond the health system to work across silos;
- the political will and capacity to mobilize broader support for reforms within and beyond the health sector.

The significance of these findings goes far beyond health care reform in individual emerging economies. Policy makers know by now that achieving the Sustainable Development Goals requires an integrated and balanced approach, incorporating the social, economic and environmental dimensions of development. This research provides them with concrete evidence of integrated and balanced approaches to policy making and the conditions for success in pursuit of the 2030 Agenda for Sustainable Development.

The United Nations Research Institute for Social Development (UNRISD) is an autonomous research institute within the UN system that undertakes multidisciplinary research and policy analysis on the social dimensions of contemporary development issues.

Through our work, we aim to ensure that social equity, inclusion and justice are central to development thinking, policy and practice.

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