

People-centered health systems for UHC

How to put people first while increasing health service access

As delegates gather in Cape Town, South Africa, on September 30th for the Third Global Symposium on Health Systems Research, the concept of people-centered health systems will be the theme running through all discussions. The multifaceted 'people-centered' agenda has emerged as a call to reframe our thinking on health systems by recognising that health services are uniquely entwined with social context and social justice. This reframing is directed explicitly at the movement for universal health coverage (UHC).

The vision of UHC is that everyone has access to the quality prevention and treatment services they need, without enduring financial hardship as a result of essential health expenditures. UHC programmes pursue this aim by mobilising all viable financial resources, with an emphasis on increasing public funding; by using these resources to strengthen health systems and ensure service quality; and by establishing financial protection mechanisms. Success in each of these three critical areas is far from assured.

Achieving the fundamental objectives of UHC and meeting the challenges of governing complex new systems will require people-centered schemes that include formal mechanisms to bring civil society and communities into the design and implementation of UHC programmes. This is especially true for addressing the emerging health needs of our time, such as the epidemic of non-communicable diseases whose roots are deeply entrenched in social issues.

The need for such an approach will only accelerate with UHC's likely adoption in the post-2015 United Nations development agenda. A people-centered approach should help ensure that UHC programmes are truly designed around users to provide the right services, remove barriers to access, reduce inequities, and improve quality.

Providing the right services

Every health system faces difficult decisions on how to allocate resources and prioritise services. Most UHC schemes identify an 'essential services package' to which every user receives access. Such decisions should not be made by government or health service officials alone, but should reflect a dialogue between the plan's beneficiaries, its administrators and other stakeholders.

In Brazil, for example, 'social control' is built into the national public UHC scheme's (known as Sistema Único de Saúde, or SUS) management and governance.^[1] Citizen-users occupy 50% of seats on health councils at the municipal, state and national levels.^[2] This model gives citizens a stake in the programme, bolstering its political credibility, and empowers a diverse range of groups. That empowerment can be an important public health tool: when the HIV epidemic appeared in Brazil, non-governmental organisations (NGOs) were the catalyst for what has been identified as one of the world's most impressive national HIV responses.^[3] Emerging from the grassroots and effected through collaboration between government and NGOs, the Brazilian HIV response addressed stigma and outperformed projections, substantially reducing HIV's anticipated impact on the country.

Removing barriers to access

By removing barriers to care – such as user fees – UHC enables more people to access services. This is especially true for women, who often have primary responsibility for their family's health care, but limited access to finances.^[3] In addition to influencing important decisions about what services are prioritised, a people-centered approach can help identify and remove these barriers, thereby improving the efficiency of service delivery.

This effect was apparent in Bolivia after the introduction of a government programme eliminating fees for certain maternal and child health services, representing an important step in extending primary health care to an important segment of the population. Despite the intentions of the programme, patients often found they had to make informal payments to receive services that should have been free.

Regulations put in place to control such payments had little effect. Community members, on the other hand, were able to significantly reduce overpayments.^[4] Through activism on local citizen health boards, they participated in hospital planning and oversight, and exposed inefficiencies. Together with subsequent reforms, Bolivia was successful in increasing utilisation of services such as skilled birth attendance, especially among low income families.^[5] In this case, community

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involvement was fundamental in successfully eliminating economic barriers to care and expanding access to vital maternal and child health services.

Reducing inequities

For a growing number of countries, one of the driving forces behind the UHC movement is a commitment to reverse widening health inequities. A decade or more of evidence from Brazil, Mexico and other countries demonstrates that well-conceived and effectively implemented UHC programmes can increase equity of access and reduce income-related disparities for in infant, child and maternal health, among other areas.^{16,71}

The power of civil society in making health care more equitable is perhaps best demonstrated by the Ghana Universal Access to Health Care Campaign – a campaign of over 200 groups advocating for health for all Ghanaians. Together, they brought to light several roadblocks toward reaching UHC. Not only had the government grossly overestimated the proportion of people covered under the national health insurance scheme at over 60% compared with the actual 34%, but the rich were benefiting in far greater numbers than the poor. Because of persistently high out-of-pocket payments, the richest women were three times as likely as the poorest to deliver at a health facility, contributing to huge inequities in health outcomes.⁸⁰ By exposing these weaknesses, and making concrete recommendations for reform, the campaign is working to make the health system more responsive to the people it serves.

Action for people-centered UHC

Throughout low- and middle-income countries, there is a promising trend to include user-representatives in national governing bodies. In Kenya and Estonia, for example, the supervisory boards of national health insurance agencies include substantial representation from civil society: in each, two-thirds of seats are held for representatives from outside government, including some designated for citizen-users.⁸¹ In South Africa, a newly developed agency for health care quality, which will help pave the way for a national insurance initiative, holds seats on its governing board for representatives from academia, the private sector, labour groups and activists. These approaches are poised to improve oversight and accountability as these countries expand efforts toward UHC, and offer a promising avenue for health systems research.

Empowering citizens through meaningful and formalised roles in UHC governance is the single most

important step toward people-centered UHC and ultimately for the success of country UHC efforts. At the national level, financing agencies should include civil society representation on governing boards and other priority-setting and oversight committees. The same holds true at local levels, where oversight of facilities is particularly critical.

Government officials and health leaders must work side-by-side with civil society and community groups to ensure a well-functioning system. For their part, academics, researchers and interest groups must organise themselves to deliver accurate information and concrete recommendations, as well as advocate for the right to health.

Citizen representation is essential in every level of the health system and at every step in the design and implementation of UHC. Putting people at the centre will ensure that health systems prioritise the right services and the populations most in need – so that UHC will achieve meaningful increases in equity and improvements in health outcomes for the people it is meant to serve.

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