This is a joint post with Ursula Giedion.

This week the World Health Organization held a major international meeting on universal health coverage (UHC), with Director General Margaret Chan reinforcing her regard for universal coverage “as the single most powerful concept that public health has to offer.” While the term “universal” signals that the entire population will be “covered,” an unanswered question is: covered with what? Another way to put the question: What health benefits or interventions would represent coverage, taking into account UHC’s implicit goals of improved health, equity and financial protection?

Many countries answer this question through the establishment of explicit health benefits plans. Better health benefits plans specify that at least a certain set of services and technologies will be financed and made available, and can sometimes indicate which services or technologies will not be funded and provided. Ideally, the selection of these services and technologies would be based on cost-effectiveness with respect to health outcomes, and would also take equity, financial protection and social values into account. Further, the design and adjustment of the plan would ideally utilize a transparent and fair deliberative process that considers evidence and social values in a systematic way.

By defining the “who” and the “what” more clearly via a benefits plan, many have suggested that an entitlement is created that allows governments and citizens to hold health systems to greater levels accountability and thus impact. There’s an evident gray area in between the positive and the negative list of benefits, but when the counterfactual is pro-wealthy, pro-urban, pro-tertiary public spending as is commonly the case in low- and middle-income countries, adequate funding and provision of at least the basic package for all could represent an improvement for health system outcomes.

In earlier work, we identified at least 63 low- and middle-income countries that use explicit health benefits plans or packages to set the scope of benefits to be provided, and structure at least a portion of public budgets (see here). Initially, we expected that explicit and detailed benefits plans would be found only in health systems relying on health insurance and a clear purchaser/provider split. Yet increasingly, countries with national health systems (public
funding, mostly budget-based public provision) are also using or considering adoption of explicit plans.

In the emblematic UK National Health Service (NHS), for example, policymakers and policy experts are debating whether the NHS should move towards defining clearly and explicitly what health benefits will be funded and provided through the system. Health economist Benedict Rumbold writes: “As the purchaser of health services for the British population, the NHS has always had to make hard choices about who is eligible for treatment, what services to cover and what criteria patients need to meet before treatment is administered. Yet recently, there have been extensive debates about who bears responsibility for making these decisions and the basis on which they should be made. These include questions about how the duties of the Secretary of State for Health should be framed, the extent to which the NHS Commissioning Board should intervene in the decisions of local commissioners, and... [whether and to what extent the system is] prepared to sacrifice equity for local autonomy.” And perhaps most interesting, according to a survey fielded by the Nuffield Trust, a health policy think tank, primary care providers in the UK NHS (GPs) overwhelmingly prefer that the NHS define clearly what should be made available for free at the point of service, rather than rely on the implicit rationing strategies currently used (waiting lists, variance in practice from one locality to another, potentially unfair subjectivity at the point of service in deciding who gets what, etc.) (see here).

In a recent paper, Rumbold and Peter Smith set out the pros and cons of an explicit benefits package in the context of this policy debate in the UK. It is well worth a read, particularly as policymakers consider what it really means to “do” UHC. Even in the US, it is a hot topic: the US Office of Management and Budget recently released new regulations on essential health benefits under the Patient Protection and Affordable Care Act soon (see here). I hope they’ll also take a look at our priority setting working group report that describes the achievements and shortcomings of benefits plans in developing countries thus far, and makes recommendations for better support from the global community.

I’ll also be mulling over what it really means to “do” UHC: Should an explicit positive or negative benefits list be a core part of the UHC concept? If so, how detailed should these packages be? How could the international community better support countries in their efforts to move in this direction? I’ll blog my views on this issue in the coming weeks, but would welcome readers’ feedback in the meantime.

**Possibly Related Posts**

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**3 Responses to “What Will Universal Health Coverage Actually Cover?”**

1. **Daniel Kress**:
   February 21st, 2013 at 2:36 pm
   
   Thanks Amanda and Ursula for a great commentary. UHC is a laudable goal but behind the UHC concept are very hard choices about how to allocate scarce resources to achieve health, equity and
financial risk protection goals. Too often, UHC expansion historically has fallen into the trap of the counterfactual you describe: ie public spending that ends up pro-wealthy, pro-urban and pro-tertiary care. Better defining the what and the who is a step in the right direction.

2. **Julia**

   February 23rd, 2013 at 3:19 pm

   Thank you for your post on an interesting subject. I agree that the specific design of UHC systems will impact the extent to which equity of health benefits (as well as financial burden) is achieved and that defining a minimum benefit package can improve the equity of benefits.

   One key consideration in the design a minimum benefits package is establishing a fair process for continuous modification. We can anticipate that population health, country financial resources, social values, and best practices in healthcare will change over time. We can also anticipate that it would benefit interest groups to gain undue influence on the priority-setting process. Establishing a fair and just process for making decisions over time can strengthen the equity of UHC.

   Countries will likely design their fair processes and minimum benefits packages based on their values and based on lessons learned from the experiences of other countries. The international community can support countries moving toward UHC by collecting, synthesizing, and communicating evidence about country health system experiences. Information on country successes and challenges establishing novel priority-setting processes and information on the successes and challenges of past and present priority-setting programs could help countries design such programs in their own contexts. Similarly, information on the level of detail of existing packages could inform countries as they make decisions for their populations.

3. **Jim Campbell**

   February 24th, 2013 at 3:05 am

   Dear Amanda and Ursula,

   Some excellent insights arising from your question, with increasing evidence available to guide systems and policy decisions. I particularly like the way you phrase this as the ‘benefits plan’, which is a necessary move away from the language of ‘interventions’. The latter has enabled health discourses and health programming to be seen in the traditional bio-medical model of clinical and vertical initiatives – to deliver certain interventions above others – detracting from a systems perspective in relation to population needs.

   I would though suggest that there is a further question that all countries need to ask, not only low- and middle-income countries. This is “How to achieve effective coverage?”

   Combining the dimensions of UHC (population, benefits, financing) with the availability, accessibility, acceptability and quality dimensions (AAAQ) of a) the right to health and b) the Tanahashi framework of effective coverage sheds new light on this issue.

   Central to effective coverage is the health workforce that responds to population access, delivers the benefits plan, and meets increasing demand if financial barriers are removed.

   New research on this question, including an effective coverage cube, was presented on the margins of the WB/WHO meeting on UHC in Geneva last week by the Global Health Workforce Alliance. The
Bulletin of the WHO has commissioned a paper on the same question.

Combining the question on what is covered and how effective that coverage will hopefully provide greater insights. Ensuring the workforce is fit for purpose to deliver is the challenge for all countries.

Would be happy to share more information with you.

Regards,

Jim Campbell
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