Universal health coverage and universal access

David B Evans,[a] Justine Hsu[a] & Ties Boerma[a]

Universal health coverage has been set as a possible umbrella goal for health in the post-2015 development agenda.[1] Whether it is a means to an end or an end in itself and whether it is measureable are subjects of heated debate.[2] In this issue of the *Bulletin*, Kutzin argues that universal health coverage not only leads to better health and to financial protection for households, but that it is valuable for its own sake.[3] More recently, attention has shifted to just what the goal should be: whether universal coverage or universal access. This editorial focuses on this question.

Universal health coverage is the goal that all people obtain the health services they need without risking financial hardship from unaffordable out-of-pocket payments.[4] It involves coverage with good health services – from health promotion to prevention, treatment, rehabilitation and palliation – as well as coverage with a form of financial risk protection. A third feature is universality – coverage should be for everyone. Although many countries are far from attaining universal health coverage, all countries can take steps in this direction.[3,4] Improving access is one such step.

Universal health coverage is attained when people actually obtain the health services they need and benefit from financial risk protection. Access, on the other hand, is the opportunity or ability to do both of these things. Hence, universal health coverage is not possible without universal access, but the two are not the same.

Access has three dimensions:[5-8]

- Physical accessibility. This is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them.
- Financial affordability. This is a measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work). Affordability is influenced by the wider health financing system and by household income.
- Acceptability. This captures people's willingness to seek services. Acceptability is low when patients perceive services to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services.

Services must be physically accessible, financially affordable and acceptable to patients if universal health coverage is to be attained.

The requirement that services be physically accessible is fulfilled when these are available, of good quality and located close to people. Service readiness is said to exist when the inputs required to produce the services (e.g. buildings, equipment, health personnel, health products, technologies) are also available and of good quality. Financial affordability can be improved by reducing direct, out-of-pocket payments through insurance prepayments and pooling – e.g. the collection of government revenues and/or health insurance contributions to fund health services – or through demand-side stimuli such as conditional cash transfers and vouchers. Social and cultural accessibility can be enhanced by ensuring that health workers and the health system more generally treat all patients and their families with dignity and respect.

Addressing the broader social determinants of health will also improve access to health services; differences in access in particular will be ameliorated by reducing poverty and income inequalities. Improvements in education will raise the average income, make health services more affordable and equip people with the awareness needed to demand and obtain the health services they need. Efforts to address these social determinants will help to reduce inequalities in income, service affordability and access to services, and this, in turn, will help to attenuate differences in health service coverage and in financial risk protection.

These actions alone, however, will not guarantee that all people obtain the health services they need. Even if the services exist and people have access to them, they might not use them. They may be unaware, for instance, of having a condition requiring treatment (e.g. hypertension), of how health promotion or preventive services can benefit them, or of the availability of different types of health services or financial risk protection plans. Or they might not recognize that others' health may be affected by their health-care decisions (e.g. if they fail to get treated for a communicable disease).

In essence, universal health coverage is the obtainment of good health services de facto without fear of financial hardship. It cannot be attained unless both health services and financial risk protection systems are accessible, affordable and acceptable. Yet universal access, although necessary, is not sufficient. Coverage builds on access by ensuring actual receipt of services. Thus, universal health coverage and universal access to health services are complementary ideas. Without universal access, universal health coverage becomes an unreachable goal. ■

References

Available at: http://www.who.int/bulletin/volumes/91/8/13-125450

[a] World Health Organization, 20 avenue Appia, CH-1211 Geneva 27, Switzerland.
Correspondence to David B Evans (e-mail: evansd@who.int).

References

1. Vega J. Universal health coverage: the post-2015 development agenda. *Lancet* 2013;381:179–80. doi: http://dx.doi.org/10.1016/S0140-6736(13)60062-8 PMID:23332947
2. McManus J for the Task Team for the Global Thematic Consultation on Health in the Post-2015 Development Agenda. *Health in the post-2015 agenda: report of the global thematic consultation on health*. Gaborone: World Health Organization, United Nations Children's Fund, Government of Sweden & Government of Botswana; 2013. Available from: www.worldwewant2015.org/file/337378/download/366802 [accessed 2 June 2013]
3. Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. *Bull World Health Organ* 2013;91:602–611.
4. *The world health report 2010 – Health systems financing: the path to universal coverage*. Geneva: World Health Organization; 2010. Available from: http://www.who.int/whr/2010/whr10_en.pdf [accessed 2 June 2013]
5. Tanahashi T. Health service coverage and its evaluation. *Bull World Health Organ* 1978;56:295–303. PMID:96953
6. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care* 1981;19:127–40. doi: http://dx.doi.org/10.1097/00005650-198102000-00001 PMID:7206846
7. Shengelia B, Tandon A, Adams OB, Murray CJL. Access, utilization, quality, and effective coverage: an integrated conceptual framework and measurement strategy. *Soc Sci Med* 2005;61:97–109. doi: http://dx.doi.org/10.1016/j.socscimed.2004.11.055 PMID:15847965
8. Thiede M, Akweongo P, McIntyre D. Exploring the dimensions of access. In: McIntyre D, Mooney G, editors. *The economics of health equity*. Cambridge: Cambridge University Press; 2007.