



Evidence Summary

How can countries
accelerate progress
towards Universal Health
Coverage?

K2P Evidence summaries use global research evidence to provide insight on public health priority topics that are ambiguous and have important uncertainty. This 3–5 page document informs policymakers and other stakeholders by synthesizing the best available evidence and presenting its relevance to local contexts. Evidence summaries do not provide recommendations but rather articulate evidence in a clear, objective and factual manner.



Evidence Summary

+ Included



Synthesis of evidence on a priority question or topic



Local context

x Not Included



Does not provide **recommendations**



Faculty of Health Sciences
Knowledge to Policy | K2P | Center

K2P Evidence Summary

How can countries
accelerate progress
towards Universal
Health Coverage?

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Merit Review

The K2P Evidence Summary undergoes a merit review process. Reviewers assess the evidence summary based on merit review guidelines.

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Key Messages

Key Messages

Background or Context of the Topic:

- Universal health coverage (UHC) refers to the ability of a health system to provide quality services to the population regardless of their ability to pay.
- UHC can expand access to healthcare services, improve health outcomes, improve quality of care, and control the burden of disease.
- UHC is a process not a destination, all countries can progress towards UHC.

Summary of Evidence on the Topic:

- Requirements for progressing towards UHC are political stability, growth in country income, decrease in out of pocket (OOP) expenditures on health and developing a basic and essential health package.
- OOP should be between 15 to 20% of total health expenditure; when OOP exceeds 40% of household income, the result is catastrophic on the health system and on household income as well.
- Even if political stability and income growth cannot be attained, countries at all income levels can start progressing towards UHC by working on decreasing OOP, by raising compulsory prepaid funds organized through general taxation and/or contributions to health insurance and pooling them to spread financial risks across the population.
- Countries can start with increasing population covered which can help expand available services and reduce cost sharing and fees.
- UHC is not only about ensuring that 100% of the population are covered. It is about identifying health services that can be grouped within a package considered basic and essential.

Relevance of the evidence to Lebanon:

- There are different forms of healthcare coverage in Lebanon
- OOP expenditures in Lebanon exceed 55% which is considered catastrophic
- There is a need to develop a basic and essential healthcare package
- Political commitment for UHC in Lebanon is needed as part of a broader social policy

Content

Purpose

The purpose of this K2P Evidence Summary is to clarify what is meant by Universal Health Coverage and examine the preconditions for establishing it as a realistic goal.

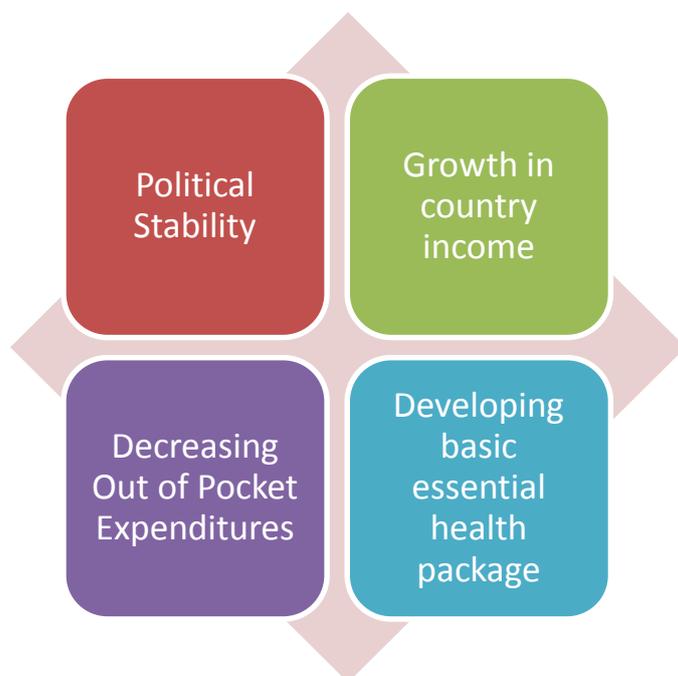
Defining Universal Health Coverage

Universal health coverage (UHC) refers to the ability of a country to provide equitable quality health services to its population without incurring additional cost or financial burden (1-4). It can prevent families from falling into poverty due to financial hardship and save households from financial catastrophes and impoverishment due to out-of-pocket (OOP) spending (3, 5). Broader health coverage leads to expanded access to necessary care, improved population health (4, 6-9), better quality of care and financial protection (10, 11).

Requirements for progress towards UHC

The main requirements for successful UHC programs are political stability, growth in country income, decrease in OOP expenditures (1-3, 7) and developing a basic and essential healthcare package (12) (Figure 1).

Figure 1: **Determinants of successful UHC**



➔ **Political stability:** This can initiate system- wide changes that have social welfare at their core such as expanding access, increasing equity and pooling

Background to Evidence Summary

A K2P Evidence Summary uses global research evidence to provide insight on public health priority topics that are ambiguous and have important uncertainty. This 3–5 page document informs policymakers and other stakeholders by synthesizing the best available evidence and presenting its relevance to local contexts.

Evidence summaries do not provide recommendations but rather articulate evidence in a clear, objective and factual manner.

The preparation of this K2P Evidence Summary involved the following steps:

- 1) Identifying and selecting a relevant topic according to K2P criteria.
- 2) Appraising and synthesizing relevant research evidence about the problem.
- 3) Drafting the Evidence Summary in such a way as to present global and local research evidence concisely and in an accessible language.
- 4) Undergoing merit review.
- 5) Finalizing the Evidence Summary based on the input of merit reviewers.
- 6) Submitting finalized Evidence Summary for translation into Arabic, validating the translation and Dissemination

financial risk (2).

- **Growth in country economy:** A rise in health spending will allow the government to purchase more services for more people (2).
- **Decreasing OOP expenditures:** No country can achieve UHC as long as the health system relies pre-dominantly on OOP for costly medical treatments or basic preventive care (1, 2, 13). Countries planning to develop UHC schemes should reduce reliance on OOP spending and improve the management of pooled funds to address challenges in equity, efficiency and sustainability of health expenditures (2). Even the smallest user fees can reduce demand for services and lead to catastrophic health spending (1, 6) whereas reducing OOP payments can increase utilization of health services (10, 14, 15).
- **Developing basic essential healthcare package:** UHC is not simply about making sure that 100% of the population is covered under a health plan. It is about identifying essential services that can be grouped within a package of guaranteed comprehensive services (12). Essential health benefits such as those in Turkey and the United States include all aspects of the continuum of care such as personal preventive healthcare, inpatient and outpatient services, emergency services, maternity and new-born care (7, 16).

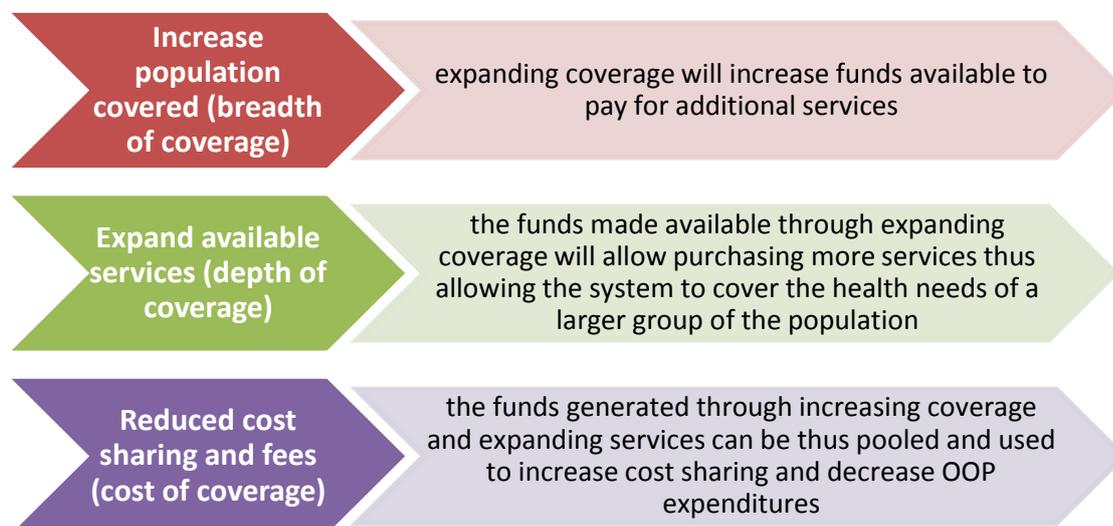
Dimensions and funding of Universal Health Coverage

Even if political stability and income growth cannot be attained, all countries can start progressing towards UHC by working on decreasing OOP to levels lower than 15 to 20% of total health expenditure. When OOP exceeds 40% of total health expenditure, the result is catastrophic on the health system and on households (1, 3).

Decreasing OOP can be done through raising prepaid funds from domestic sources and pooling them to spread financial risks across the population (2, 10, 17). There is strong evidence that raising funds through compulsory prepayment organized through general taxation and/or compulsory contributions to health insurance promotes progress towards UHC for countries of all income levels (1, 4, 10, 17). The challenge of raising funds through compulsory pre-payments from the informal sector has been recognized as a challenge in Low and Middle Income Countries (1). Governments of low- and middle- income countries sometimes cannot raise sufficient funds by pre-payment to eliminate OOP entirely (1, 3, 6). Nevertheless, the national

health insurance programs in several low- and middle- income countries such as Ghana and Indonesia have eliminated OOP for all covered services (1).

Countries can adopt three broad strategies in raising prepaid funds (3, 4, 11, 17):



Enabling factors and Barriers

Enabling Factors	Barriers
Political stability (1-3, 7)	Absence of an effective and comprehensive health system vision (11, 18)
Growth in country income (1-3, 7)	Poor coordination between providers and health system partners (11)
Ability to raise and effectively pool funds for prepayment schemes (5, 10, 11) and establish large risk pool (1, 4, 5)	Fragmented financing and service delivery systems and inadequate coordination among national stakeholders and international partners (11)
Reducing OOP expenditures (1-3, 7)	Challenges in collecting revenues for prepaid funds (11, 18)
Availability of a PHC package provided by a network of state owned facilities or ones contracted out to non-governmental organizations (11)	Limited ability for resource allocation and rational use of resources (11)
	High OOP expenditures (11)
	Complex health emergencies which hinder long term health planning (11)

Relevance of the Evidence to Lebanon

Lebanon has a primarily private delivery system and a pluralistic financing system. There are six public funds that have different contracts with private hospitals including tariffs (19) but half the population does not have formal health coverage. Many reform activities, particularly to health financing, are needed prior to the development of a UHC program. One issue to consider is that OOP expenditures on health in Lebanon have reached 56.5% which is considered catastrophic by WHO. There is also a need to lower reliance of the poor on private ambulatory services and secure funding for this component through taxation. Creating benefits packages that include essential health services should also be considered.

Progress towards UHC is not a “one size fits all journey” (5). The income-generating potential and political feasibility of options to raise additional funds for health vary depending on contextual features, such as political environment, culture, and inherited legacy (1, 17).

Even if political stability and income growth cannot be attained, evidence suggests several action items to guide countries in their path to UHC (17):

-➤ Identify who is covered from pooled funds, for what services and what proportion of cost, showing the gap between what is currently achieved and what the country would like to achieve.
-➤ Assess current and potential funding sources to create a comprehensive funding framework.
-➤ Develop a healthcare benefits package that includes the basic minimum health services the Lebanese population needs, which should include primary healthcare services.

These steps can help raise and pool funds in a more effective and targeted way. In addition, mapping areas of constraints inside and outside of health is important for identifying key stakeholders to consult with and securing political commitment. A national deliberative policy dialogue can help outline the country-specific steps and strategies for progressing towards UHC.

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Knowledge to Policy Center draws on an unparalleled breadth of synthesized evidence and context-specific knowledge to impact policy agendas and action. K2P does not restrict itself to research evidence but draws on and integrates multiple types and levels of knowledge to inform policy including grey literature, opinions and expertise of stakeholders.

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