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Driving Better NCDs Outcomes: What is the Role of Universal Health Coverage?

For photos of this event click here

With the UN high level review on NCD prevention and control taking place the next day, and the open working group discussions on post-2015 sustainable development goals in recent weeks, July 9 was auspicious timing for a discussion of NCDs and the role of Universal Health Coverage (UHC). Seventy representatives from UN permanent missions, UN agencies, civil society, and business gathered at UN headquarters for a panel luncheon hosted by the Business Council for the United Nations, with the support of Merck, joined by a view that NCDs and UHC are a priority that should be "high on the development agenda", as Secretary-General Ban Ki-moon has stated. The panel consisted of five experts: H.E. Dr. Mwaba P. Kasese-Bota – Permanent Representative of the Permanent Mission of the Republic of Zambia to the UN; Dr. Fabienne Bartoli, Counsellor at the Permanent Mission of France to the UN; Dr. Werner Obermeyer, Deputy Head of the WHO Office to the UN; Dr. Margaret Kruk, Assistant Professor at Columbia University Mailman School of Public Health; and Dr. Lori C. Stetz, Senior Medical Director at Aetna International. The discussion was moderated by Katie Dain, Executive Director of The NCD Alliance.

H.E. Dr. Mwaba P. Kasese-Bota, Permanent Mission of the Republic of Zambia to the UN
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Katie Dain, The NCD Alliance
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After opening remarks by Ambassador (ret.) John Lange, Senior Fellow for Global Health Diplomacy at the UN Foundation, Dain suggested that when translating the global traction of UHC at a national level, a tailor-made approach should be adopted as "there is no one-size-fits-all model". She posed three questions for the discussion: how the prominence of NCDs and UHC can combine and benefit from each other, how to ensure that UHC works for prevention as well as control and treatment while not overshadowing existing public health instruments, and what it means for the post-2015 development agenda.

Fabienne Bartoli, the first panelist at the podium, guided the audience through France's efforts in championing UHC and its financing strategies. Bartoli stressed the importance of meeting the growing demand for equitable access to health services without discrimination, as well as changing the perception of health care as a "last option".

Fabienne Bartoli, Permanent Mission of France to the UN
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Health care financing is crucial for a successful transition to universal health coverage, Bartoli said, and three important financing tools that she advised are tax collection, measures to ensure efficiency of health system financing, and a pooled insurance mechanism. Tax collection not only provides the resources to help finance the health system but also helps to reduce unhealthy consumption of tobacco, alcohol, and unhealthy foods, she said. Measures to ensure efficiency of health system financing include cost containment, targeted reimbursement, and health technology assessment. In France, Bartoli said, a special authority assesses the added value of each new health product before deciding on the level of reimbursement. Pooled insurance spreads the costs of NCD treatments and mixes the needs of the very sick with the youthful and healthy. In France, free medical coverage is provided for the poorest segment of the population as well as the vulnerable such as child migrants. Targeting the poorest means targeting chronic illness and premature deaths, which hinder development both economically and socially.

Finally, Bartoli said that France is keen to cooperate, through domestic funding and innovative development aid, with developing countries that are willing to move forward towards a UHC system. In 2014, Bartoli said, 30 million Euros of revenue from financial transaction tax was used towards transition to UHC in six western Africa countries. Bartoli reinforced Dain's statement about a tailor-made approach to health care across countries, referring to France's support towards a social health protection network hosted by WHO that helps countries develop a health strategy according to their "socioeconomic and epidemiological situation".

Ambassador Kasese-Bota carried on with Bartoli's point that chronic NCDs are a number one cause of death and disability worldwide and are no longer diseases of the affluent, but rather those that affect all countries regardless of socioeconomic status and thus undermine progress. She said Zambia takes a firm stand in fulfilling the commitments made by the General Assembly in September 2011 on the prevention and control of NCDs. Zambia has built an NCD strategic plan that includes strengthening physical activity in schools and communities, promoting healthy diets, enforcing regulation on tobacco and alcohol use, and constructing 650 health posts that provide services as close to the families as possible. Ambassador Kasese-Bota pointed out the challenges that her country faces despite its "noble ambition to cater to all" regardless of status. The high cost of treating NCDs as compared to that of treating infectious diseases is one important challenge. She offered an example – stabilizing an HIV infection costs less than $50 per month, while stabilizing an asthmatic costs around $400 per month. Thus, she highlighted the importance of cost-effective treatments. Another problem is the presence of silos, both in health services and health funding. Ambassador Kasese-Bota objected to the syndrome of analyzing a single patient into many different conditions that require treatment from many different doctors, for countries like Zambia may not be able to provide this. Donor funding is also often siloed and more often than not comes with conditions that target infectious diseases rather than NCDs.

Therefore, Ambassador Kasese-Bota said, Zambia as part of the open working group calls for a goal on health that addresses an individual as a whole and has a broader redefining of health care that includes prevention of NCDs that is not limited to hospitals but is also employed by primary health care providers. Another important necessity in achieving universal health care is enhanced diagnostic strategies that require expensive technology, something that many countries

like Zambia cannot afford. Thus, she called for technology transfer of health services: “We are not asking for the most sophisticated technology. We are asking for life-saving technology”. In order to fund the universalization of health care, she said, bilateral and multilateral partners are needed in both the public and private sector.

Werner Obermeyer, WHO Office to the UN
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This multi-sector intervention was again emphasized by Werner Obermeyer – both public and private institutions engaged in transportation, education, agriculture, and many other industries must be incorporated in the effort to achieve UHC, although the effects are most acutely felt in the health sector. He also posed the question that resonated throughout the discussion: How can health systems be tailored to cope with the growing burden of mobility, mortality, and financial cost? The approach has been largely vertical, --that is disease-specific. This does not mean, Obermeyer said, stepping away from communicable diseases, but should rather mean inclusion of NCDs. He described the challenges we face as two-fold: the provision of services and financial risk protection. In terms of the latter, the premise should be that the entire population shares the cost rather than just the sick. The services should consist not only of promotion and prevention, but of frequent rehabilitation and palliation.

Countries should work for a progressive health system, Obermeyer said. This means starting from low-cost interventions – such as vaccinations targeting the poor, which would reduce risks of high-cost medical expenses later in their lives. Through financing methods such as taxation and insurance, instrumental strengthening of health systems could be achieved, especially focusing on primary health care facilities. Then, an increase in coverage, in terms of both intervention as well as the number of people of benefiting, should result in progress towards UHC. This progress can be measured, through the number of people that have access to the health care as well as the percentage covered by pre-payments. This is why, according to Obermeyer, health is considered a precondition, indicator, and outcome of sustainable development. Finally, WHO and the World Bank have proposed two targets that can also be measured: by 2030 there should be zero impoverishment due to health expenses, and zero catastrophic out-of-pocket expenses. It seems that UHC and NCD prevention and control would contribute greatly to achieving these goals. A key term that Obermeyer closed with, that lies at the heart of UHC, is equity – UHC does not make distinctions between NCDs and CDs and beyond the four main NCDs, the set of quality services covered must include mental health and disabilities.

Margaret Kruk also brought to attention the portrayal by some of a rivalry between NCDs and UHC or between other diseases, as has been the case to some extent, she says, during the MDG era. Kruk explained UHC as the key platform for expanding access to services, and closing the performance gaps that resulted from the MDGs. Some countries performed better than others in terms of health goals and she claimed that UHC would allow the global community to converge at the best performance level through UHC. An approach she suggested to get countries started towards achieving this was similar to that of Obermeyer and is called progressive universalism. This method would allow countries to take initiative in

Margaret Kruk, Columbia University Mailman School of Public Health
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prevention, treatment, and palliation by starting with the poor. First, the poor must be included without fees at the point of care in any UHC package and second, the diseases that are predominately suffered by the poor (many of which are NCDs) must be included. From Kruk's research, as economies grow, the countries' health packages also tended to grow and she gave Mexico as a case in point that went from 78 interventions to 230 as its GDP per capita grew.

Other than the progressive universalism strategy for delivering UHC, Kruk offered two methods of transformation to tackle NCDs. The first is an all-hands-on-deck public strategy. This entails expanding the circle of involvement to a higher level than covered by the Ministry of Health, that is, thinking outside the health sector. The suggestion of multi-sector interventions and policies have been a consistent topic for all speakers throughout the discussion. Specifically, such policies could include taxation (on 'sinned goods' such as tobacco), regulations (on seatbelts, helmets, smoking, drinking and driving), information and communication to the public, and improving the built environment (such as road safety). Kruk's second suggestion was the patient-first approach. Health care needs to be patient-centered in terms of location and service. Transitioning from a vertical disease-by-disease focus to a patient focus makes sense epidemiologically because many NCDs share common risk factors. Furthermore, health services need to be located at an accessible place – that is, where the patients are, not where the doctors want to be. "Don't try to bring patients in to a central location", Kruk said.

Lori Stetz, Aetna International
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Lori Stetz also dealt with the issue of the health care provider environment. The environment of the health care provider and the broader concept of health care coverage are interdependent, she said. A health insurance plan is irrelevant in an environment where there are no health care services or infrastructure. Likewise, if the cost to access that care is not manageable or spread-out across the population, those health care services would not serve their purpose. In any environment, health policies can have important impact. For example, they can shape actual practice by insisting on responsible diagnostics, prescribing, and treatment, or they can demand the use of evidence-based medicine. At the patient level, they can curb overutilization and encourage patients to seek primary care before seeking specialist care. Through these behavioral changes, Stetz said, a rising demand for critical and basic services may be established, which would contribute to the evolution of a strong primary care system.

Stetz described Aetna International's partnership with Qatar's national health system, begun last year, in which Aetna is engaged in the national health insurance company which will help provide care for 1.9 million residents within five years. Aetna International is charged with the coordination and integration of care, specifically in administration, case management, analytics, and disease management to address the burden of NCDs. This she believes will contribute to the establishment of a robust primary care system.

All the speakers at the panel luncheon were in unison that NCDs and UHC must be a priority in the development agenda at both the international level and the national level. The September 2011 resolution was a good start, but in a world where one billion people lack access to health care, it seems there are still many gaps from the Millennium Development Goals to be filled in the Post-2015 agenda.

By Sue-In Oh, BCUN Intern, United Nations Foundation

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