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Sustaining Universal Health Coverage: The Interaction of Social, Political, and Economic Sustainability

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ABSTRACT

The sustainability of health care systems, particularly those supporting universal health care, is a matter of current discussion among policymakers and scholars. In this article, we summarize the controversies around the economic sustainability of health care. We attempt to extend the debate by including a more comprehensive conceptualization of sustainability in relation to health care systems and by examining the dimensions of social and political sustainability. In conclusion, we argue that policymakers when taking decisions around universal health care should carefully consider issues of social, political, and economic sustainability, their interaction, and often their inherent trade-offs.

Keywords: social, political, economic, sustainability, trade-offs, universal health coverage.

Introduction

The issues of how to move health care systems to universal health care and how to sustain and improve them in the long term are a matter of debate for most countries [1]. Universal health care (UHC) is prominent on the political agenda of fast developing countries, such as Brazil, Russia, China, and India, that face a growing demand for health care and other welfare services in a complex context that combines rapid economic growth, an increasing population, and socially and economically polarized societies [2,3]. UHC is also on the political agenda of most industrialized countries, albeit in different ways. In the case of the United States, UHC has become a source of continuous political conflicts and controversies on the very nature of the country's welfare system [4]. In Europe, UHC is similarly under attack. The idea, fuelled by the current economic crisis, that the vast range of benefits accumulated over the decades by European health care systems should now be considered privileges that cannot be guaranteed to the entire population permeates the discourse on health care.

UHC also features in the policies and recommendations of international organizations. UHC is part of the Millennium Development Goals (also in their redefinition by the United Nations), was the main topic of the World Health Report in 2010 and, implicitly, of several earlier reports (e.g., the World Report 2008 on primary care), and was one of the main items for discussion in the Tallinn Charter on health systems for health and wealth in 2008. Previous contributions on this issue identify and discuss a variety of elements, including actors, competences, processes, and instruments, that can reinforce UHC and that, when lacking or not well implemented, threaten principles of equity and solidarity that are at the basis of UHC.

Most of the current debate on UHC centers on its sustainability, but, despite this high degree of attention, the discourse remains almost exclusively focused on the *economic* sustainability of UHC. Can we, and future generations, afford UHC? Can we, and future generations, afford health care systems that guarantee this principle?

In this study, we attempt to widen the debate surrounding UHC by reframing and expanding the conceptualization of sustainability to include its additional facets, particularly its social and political dimensions. We embrace the broader definition of sustainability offered by the Hawke Research Institute in Australia [4] and adapt it to the case of health care systems. According to this perspective, sustainable systems are "equitable, diverse, connected and democratic and provide a good quality of life" [5]. In addition, their formal and informal processes, structures, and relationships make systems durable over time such that both current and future generations can collectively benefit from their features.

In the case of health care, we argue that *social* and *political* sustainability are equally fundamental and desirable features of a health care system. Therefore, in our view, the discussion around the viability of UHC can only benefit from examining, on the one hand, how and to what extent UHC affects the social and political

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sustainability of health care and, on the other hand, the social and political conditions that might be facilitating or hindering factors for achieving UHC. In addition, it might be helpful to the debate to foresee potential trade-offs among these objectives.

In the following sections, we consider in detail these three dimensions of sustainability and provide a brief summary of the theoretical approaches and evidence that have emerged in the scholarly literature concerning each concept. Next, we conclude with several suggestions for policymakers.

Economic Sustainability

The current focus on the economic dimension of sustainability of UHC likely derives from the long-standing debate on the relationship between health care spending, health, and wealth that has been the focus of the scholarly discussion for decades.

After World War II, most advanced capitalist economies invested heavily in providing welfare services, such as health care, leading to a rapid expansion of coverage and insurance and to a concomitant increase in public expenditure [6,7]. At that time, the trend was considered an indicator of progress and a sign of the capacity of states and the public sector to promote development. Since the 1960s and 1970s, however, empirical studies have shown that across most Organization for Economic Cooperation and Development countries, and most notably in the United States, the growth rate of total health care expenditure outpaced the increase in the gross domestic product [8]. These findings started to raise concerns about the affordability of health care in the end and the potentially high opportunity costs of investing in health care instead of other sectors and activities [7,8]. In the 1990s, the advent of a neoliberal political ideology and of a "market" paradigm in public policy put health care spending under further scrutiny and often equated it with the inefficiencies of an excessively "big government" [9,10].

Because of the dynamics of globalization, there has been a heightened concern about the increase in health care expenditure and its potential to hinder economic growth. First, the increased mobility of people and the rapid diffusion of information about new opportunities for treatment and medical technologies have amplified the demand for health care services and made it difficult to reach an efficient equilibrium between demand and offer. Second, technological progress and the introduction of costly medical technologies (drugs and devices) in health care systems have been shown to drive a conspicuous part of the growth in expenditure with very limited means to control this increase [11–13]. Note that the development of most evidence on the contribution of technology to health care expenditure growth has been with data from the United States and might therefore be peculiar to this case. It is known that both demand for and prices of medical technologies are on average higher in the United States in comparison to Europe. For instance, high-tech care is more likely to be considered synonymous with better-quality care by US citizens than by their European counterparts [14]. In addition, unlike in Europe, policymakers in the United States have long refrained from adopting measures of price control over drugs and devices and from applying criteria of cost-effectiveness to reimbursement decisions [8,15].

Independently from the factors that determine the growth of health care costs, current forecasts for health care spending in many industrialized countries, regardless of whether they have implemented UHC, are alarming [16,17]. It is not surprising, therefore, that present proposals on the issue of the economic sustainability of health care, particularly UHC, devise progressively more refined financing structures to meet the requirement for long-term sustainability. Mixing public and private approaches to health financing and contribution-based health care with tax-financed inputs are some of the solutions available to policymakers [18]. Attention appears to be focused on how to collect sufficient resources to sustain health care systems and, where it exists, UHC. If we consider that the middle class in industrialized countries are squeezed between higher taxation and unemployment rates and that employers struggle to be competitive in the global scenario, higher private spending appears not only infeasible but also unacceptably harsh on those whom the health care system serves.

Although health care has been portrayed as draining wealth, evidence has progressively accumulated to show that, on the contrary, investments in health (and health care) are effective strategies in both developing and developed countries not only to reduce poverty but also to pursue economic growth through increased productivity and higher household income [19–21]. Currently, and with the sole exception of the United States, countries that are actively pursuing UHC, such as South Korea, Mexico, and Turkey [22], are at the lower end of the income threshold, indicating that investments in health care for all are still deemed not only desirable but also feasible. The recent experiences of Taiwan and Thailand, despite their difficulties, show that introducing UHC has not necessarily meant unaffordability or an inconsiderate rise in health care expenditure [23,24]. Even if they are affordable, however, will these investments in UHC translate into health benefits?

The link between spending and health outcomes has been as controversial as the relationship between health care and economic growth. This issue is of particular relevance in the debate over consolidated universalist health systems, in which achieving further health gains appears to require unaffordable new investments. In the past, the literature has provided inconclusive results regarding the contribution of health care expenditure to health outcomes [25]. The case of the United States has often been proposed as the clearest example of a health care system that, if compared with other Organization for Economic Cooperation and Development countries, displays "more-than-expected spending" with "less-than-expected life expectancy" [26]. More recently, however, evidence of a positive relationship between spending and health outcomes has begun to emerge in studies that compare either health care systems at the macro level [e.g., 27–30] or local health authorities/organizations and their processes of care at more meso- and micro levels [e.g., 26,31,32]. Macro-level studies have shown that total health care costs or investments in human capital for health (e.g., number of doctors and nurses) contribute to reducing overall and infant mortality and, more rarely, to increasing life expectancy. Several methodological challenges, however, remain in this type of analyses, given the difficulty in isolating the impact of spending from all other determinants and the potential endogeneity of several of the explanatory variables utilized in the studies [25].

Among the evidence emerging from meso- and micro-level studies, several cases are drawn from UHC systems, such as Canada and the United Kingdom. For instance, Martin et al. [25] assessed the benefits of program budgeting in England across primary care trusts and showed that health care expenditure had "a demonstrably positive effect" on mortality rates in five of the care programs investigated by the researchers. Similar results have been obtained by Crémieux et al. [31] who compared health outcomes and different cost items in health care spending across 10 Canadian provinces. Stukel et al. [32], instead, analyzed all Ontario hospitals and demonstrated that patients admitted to higher-spending hospitals had better outcomes in terms of mortality, readmission rates, and major cardiac events. The most interesting aspect of this work is that the authors managed to unpack the black box of "spending" and to uncover the "cost items" that contribute to the difference: the nursing staff ratios, the frequency of medical specialist visits, the type of interventional and medical cardiac therapies, and the nature of