

Original Paper

Universal Health Coverage

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Abstract

Universal Health Coverage has attracted global attention as an ideal vehicle that will drive health care services to the individuals, families, and communities globally. Good health systems are capable of serving the needs of entire populations, including the availability of infrastructure, human resources, health technologies, and medicines. This study seeks to identify the barriers and challenges which have hindered the provision of basic health care to communities and suggest ways of addressing some of them. Literature search reviewed 40 materials which were more relevant. Results revealed that there have been disparities in the provision of healthcare. Challenges in service provision include; lack of political commitment, weak health system resulting from limited financial allocation and poor leadership, lack of adequate number of skilled human resources, equipment and supplies and poor infrastructures. For UHC to be successful, an effective and well-functioning Primary Health Care (PHC) system is essential. Thus health systems can be strengthened through financial allocation; training of skilled and well-motivated healthcare workers. Also provision of right equipment and supplies, equity in resource distribution, improvement of infrastructures to meet the needs of the people is fundamental.

Keywords

universal health coverage, primary health care and skilled human resources

1. Introduction

Universal Health Coverage is a concept which has gained prominence in the recent past as it promises to deliver highly needed care to individuals, families and communities globally.

A vibrant economy of a country can be driven by health people who can actively be involved in socio-economic development of a country and not the sick. Public Health Association of Americas and World Health Organization (PAHO/WHO, 2019) states that health systems are capable of serving the needs of entire populations, including the availability of infrastructure, human resources, health technologies, and medicines. It likewise stresses the values of equity, solidarity, and access to reasonable health care.

Taking into consideration that healthcare is a fundamental human right that gives men and women a sense of dignity and justice, many low-income and middle-income countries are struggling to achieve universal health coverage amidst many barriers. We shouldn't be discussing about "Universal health coverage" (UHC) if we had handled Primary Health Care (PHC) and Millennium Development Goals (MDGs) and the recent Sustainable Development Goals (SDGs) in a much more rational way. That is by strengthening basic health care system through allocation of adequate financial resources, well trained and motivated human resource, and good leadership and governance, adequate equipments and supplies of commodities and essential drug supplies, as well as unwavering political commitment. It is important that we painfully re-look at the barriers that negated the process of achieving the earlier targets so that we do not fall into the same pitfall. Universal Health Coverage (UHC) is a concept that refers to the ability of individuals, families and communities to access quality health care without suffering undue financial hardships. This is a noble idea, which by all means is achievable if health system can be revolutionized and barriers addressed.

Most countries support the aspirations of UHC and have committed to its principles (Chan, 2015). Less has been articulated about how to deliver this goal. In many low-income and middle-income countries, health-care systems are inadequate and providers rely on patients' out-of-pocket payments. Those who are poor and sick cannot access care or avoid seeking care because they are unable to pay. This situation contributes to unacceptably high burdens of preventable diseases and deaths. Some countries, including Ethiopia and Rwanda, are undertaking reforms to upgrade health systems and develop sustainable financing towards UHC (UN Gen. Assembly. working group, 2015; WHO; World Bank, 2013). There are some steps which governments can apply to define their pathway to UHC and align stakeholders around these reforms. First, governments should define a cost-effective package of essential health benefits available to all its citizens. This priority setting process should be transparent, inclusive, and evidence-based. Governments should politically commit to equitably deliver these services to the entire population, irrespective of their ability to pay. The initial benefits package should include affordable, quality primary care and prevention, including comprehensive care for women, children, and vulnerable

populations. Benefits will be context specific, but must give priority to the most common and recurrent health needs. This package must be a realistic commitment and not promise people more than what is possible to deliver or finance. Second, governments should develop investment plans for the physical and human infrastructure needed to deliver benefits. This plan should include training and retraining for a sufficient number of health workers and the construction of health facilities and hospitals with clean water and power, medical equipment, laboratories, and management and information systems. Governments must strengthen supply chains and planning to procure the types and amounts of drugs, vaccines, and equipment needed, and to reach remote areas. The investment plan must be based on evaluation and costing of the needs of every local district. Third, governments should develop a national health financing system, such as insurance, to fund health service delivery. To be universal, the domestic financing 2020 system must reduce reliance on out-of-pocket payments, shifting to prepaid funds including progressive taxes, insurance premiums, or a mix of both (WHO, 2014, 2015; Gideon, Alfonso, Díaz, World Bank, 2013). Resources should be pooled across large segments of the population to spread risk in any given year, with healthy people helping to subsidize sick people and wealthy people helping to subsidize poor people. National health financing systems should collect funds into special purpose vehicles, ring-fencing spending to ensure adequate levels of funding from year to year. Managed well, pooled, prepaid funds increase purchasing power. The costs of some drugs, vaccines, contraceptives, and other health products are coming down, and countries with consolidated purchasing power will be best able to benefit from price reductions. Increased purchasing power can also be used to contract public and private providers, controlling costs and improving quality. Fourth, governments should develop multispectral district transformation approaches to ensure macro-level policies, strategies, and resources to transform lives at the household level. Districts can have a unified plan, budget, and accountability for reform. In most countries, districts are programmatically manageable administrative units, close to communities. Socioeconomic determinants of health outcomes can be substantially addressed through decentralization and provision of essential health services (UN Gen. Assemb. working group, 2015; Boerma et al., 2014). This approach fosters inclusive growth by engaging relevant sectors in an integrated way. New technologies can enable these four steps, for example, there are many new drugs and point-of-care diagnostics that can reach remote areas (Maeda et al., 2014; World Bank; Duran, Kutzin, 2010; WHO, 2010). Mobile-based software can be used for insurance to collect premiums, pay providers, and record services delivered. Real-time, patient-level data from these payment systems can be analyzed and used for improving service delivery. Development partners and development banks can help governments finance the capital investments necessary to build the health system and other district interventions with the promise that once these investments are made in the health system, services can be sustained. Organizations managing special purpose vehicles can increasingly pool domestic and international funds, and raise debt for investments and working capital. Ethiopia and Rwanda have

started developing and implementing the plans necessary to achieve UHC (UN working group Gen. Assembly, 2015; Frenk, de Ferranti, 2012). The experience of countries around the world shows that the process will take a decade or more to complete and will require continued political will and international support (Marmot, 2013; Tantivess et al., 2013). No doubt that these efforts can lead to success, and mobilise commitment to the right of all people to access quality health care regardless of their ability to pay. That said, it is a time to take the first steps of turning an admirable aspiration into a successful action. Districts can have a unified plan, budget, and accountability for reform. In most countries, districts are programmatically manageable administrative units, close to communities. Fundamentally these efforts can lead to success. The UN High-Level Meeting on UHC can reaffirm and mobilise commitment to the right of all people to access quality health care regardless of their ability to pay. It is a time to take the first steps of turning an admirable aspiration into action (Amir et al., 2015).

2. Method

Literature search was conducted and reviewed using 40 most relevant materials and personal experiences of working in a developing country. Desk review research was conducted to collect data.

3. Result

The search resulted in 40 articles and journals which have discussed the barriers; they include the following:

There were merits and demerits of engaging individuals, families, communities as well as governments in teaming up to achieve sustainable healthcare.

Other researches documented disparities in provision of healthcare to communities and populations.

Challenges in service provision include; weak health system resulting from limited financial allocation and poor leadership and governance, pertaining to its administration.

Problem with access to health services and supply of drugs and vaccines,

Lack of skilled human resource, which is tasked to deliver the required healthcare to the population.

Lack of equipments and supplies in the health care facilities.

Poor infrastructures, such as communication network and debilitated healthcare facilities.

Lack of political will or commitment, in terms of leadership, governance and resource mobilization.

Lack of equity in resource distribution, among the populations.

Suggested methods of addressing the challenges and barriers

WHO Director-General Tedros Adhanom Ghebreyesus (2019) has said on many occasions that UHC is a political choice, and political choices require leadership and governance. However, governance, leadership, and accountability are lagging behind in many low and middle-income countries especially in Africa; this said, time has come for those visionary leaders of good standing, to be elected among the

political leaders to leadership position to articulated healthcare issues. Again, it is important to consider those donors who are chosen to partner with: they should be those who share a genuine vision of social justice such that no one is left behind. This concept of commitment was taken up by former Nigerian Minister of Health, Isaac Adowole. In speaking about investing in health, he said that it was not the much-touted political will that was lacking, but political commitment and action. Ministers needed to engage better with national assemblies or parliaments in order to put good intentions into practice. Many researchers have recommended and made extremely good case for investing in UHC. For instance, the Lancet Commission on Investing in Health has demonstrated that pathways that target the poorest first, such as publicly financed insurance, could provide financial protection and essential health-care interventions to everyone and that returns on these investments would far exceed the costs. Investing in leaders who are prepared to confront global economic realities would also undoubtedly yield returns (The Lancet Global Health, 2019).

Many countries face high demand for health care services, but unfortunately they have limited financial and human resources to meet those needs. As resources become even more scarce, the components of health system which is formed of people, institutions (public and private), and processes—need to operate more efficiently and effectively to produce effective and equitable healthcare that responds to consumer needs.

In order to meet financial obligation there is increasing need to mobilize additional tax revenues and this can be achieved by introducing new taxes or increasing existing tax levels. Imposing taxes on specific products and services to increase general government revenue has also gained attention through the World Health Report 2010 (Frenk & de Ferranti, 2012). Countries' interest in resource expansion for health is increasingly becoming important in the light of decreasing levels of funding by global health initiatives to low- and middle income countries (WHO, World Bank, 2013). Importantly, raising additional revenue for health needs to be examined within the context of overall government revenues, of which health is only one component. The objective to increase fiscal space for health does not necessarily require new revenues to be earmarked for the health sector, although some countries do so. Instead, the aim is to increase overall government revenues and augment the share going to health as recommended by UN working group of General Assembly (2015). One strategy is to mobilize additional government revenues through new taxes or increased tax rates on goods and services. An example on how countries can assess the feasibility and quantitative potential of different revenue-raising mechanisms can be demonstrated by reviewing and synthesizing the processes and results from country assessments in Benin, Mali, Mozambique and Togo. The studies analysed new taxes or increased taxes on airplane tickets, phone calls, alcoholic drinks, tourism services, financial transactions, lottery tickets, vehicles and the extractive industries. Study teams in each country assessed the feasibility of new revenue-raising mechanisms using six qualitative criteria. The quantitative

potential of these mechanisms was estimated by defining different scenarios and setting assumptions. Consultations with stakeholders at the start of the process served to select the revenue-raising mechanisms to study and later to discuss findings and options. Exploring feasibility was essential, as this helped rule out options that appeared promising from the quantitative assessment. Stakeholders rated stability and sustainability positive for most mechanisms, but political feasibility was a key issue throughout. The estimated additional revenues through new revenue-raising mechanisms ranged from 0.47-1.62% as a share of general government expenditure in the four countries. Overall, the revenue raised through these mechanisms was small. Countries are advised to consider multiple strategies to expand fiscal space for health (WHO, 2019).

With regard to financing, again, it is important that governments must provide adequate finances for the purchase of essential medicines. Health expenditures must be seen as an investment, and not a cost. In this regard the value for money delivered by medicines and vaccines is underplayed in the Commission's report. It is also fundamental that the out-of-pocket expenditure be minimised. This is a critical element in achieving UHC. In GSK's UHC policy principles recommend risk-pooling mechanisms over out-of-pocket payments (GlaxoSmithKline, 2016; Rubin, 2016). Advocating for UHC is a key pillar in partnership with Save the Children (Witty, 2016). As countries move towards universal health coverage, new global mechanisms are needed that ensure fair prices for medicines. Fair in that patients can get access to the medicines they need, health systems are sustainable, and industry can produce quality products with a reasonable return on investment.

Access to medicines has long been a potent flashpoint in global health, from antiretrovirals to drugs that cure hepatitis C. Indeed, as a new Lancet Commission report, "Essential Medicines for Universal Health Coverage" asserts, essential medicines should be at the centre of the vision for global health, affecting, as they do, the lives and dignity of people worldwide (Wirtz, Hogerzeil, Gray et al., 2016). Many medicines, old and new, remain unaffordable, and have been left to patients to purchase using out of pocket payments, and not all medicines have been of acceptable quality. Inappropriate medicines use has persisted. Development of new medicines has failed to address important global health needs. And national medicines policies have not always been fully implemented, let alone evaluated rigorously. Often, debates about access to medicines have mistakenly focused on low-income and middle-income countries only. But the Commission shows that access to medicines is a global concern. Think of antimicrobial resistance (WHO, 2015) opioid and tobacco misuse (Lancet, 2015) and the EpiPen price scandal (Rubin, 2016) and the truth of that proposition are readily apparent. The Commission identified five policy areas for all countries to address if equitable access to affordable, quality-assured essential medicines is to be achieved: paying for a basket of essential medicines, making those medicines affordable, ensuring quality and safety, promoting quality use, and developing missing essential medicines (Wirtz, Hogerzeil, Gray et al., 2016).

What is fundamental is to link essential medicines with other important concerns, such as financial sustainability for universal health coverage and the protection and promotion of human rights. However, most low-income countries spend far less and suffer from a structural lack of access to basic essential medicines. Urgent attention should therefore be paid to issues of equity and efficiency. Other key messages include strengthening the role of government (increased public funding for universal health coverage, pricing policies, better medicines regulation, promoting quality use, and stimulating innovation), the need for greater transparency, and a mechanism for effective accountability. This problem has been especially true for access to affordable antiretrovirals in middle-income countries. Most new essential medicines are under patent, and will be for many years to come. Although the number and proportion of essential medicines that are patent protected may seem low, the overall impact can be huge. It is worthwhile to note that high prices for cancer medicines and hepatitis C treatments affect all countries (Wirtz, Hogerzeil, Gray et al., 2016).

The recent UN High-Level Panel on Access to Medicines (UN, 2016) was tasked with proposing solutions to address access to medicines from the perspective of aligning human rights, trade, intellectual property, and public health objectives, whereas the Lancet Commission had a much broader mandate. It looked at access to medicines from a comprehensive health system perspective, covering all aspects of financing, affordability, quality, use, and essential innovation such as Health Technology Assessment (HTA). Thus health technology assessment is a method of evidence synthesis that considers evidence regarding clinical effectiveness, safety, cost-effectiveness and, when broadly applied, includes social, ethical, and legal aspects of the use of health technologies. The precise balance of these inputs depends on the purpose of each individual HTA (HTA, 2015).

A major use of HTAs is in informing reimbursement and coverage decisions, in which case HTAs should include benefit-harm assessment and economic evaluation (Luce et al., 2010) and “a multidisciplinary process that summarises information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, robust manner. Its aim is to inform the formulation of safe, effective, health policies that are patient focused and seek to achieve best value for money. Despite its policy goals, HTA must always be firmly rooted in research and the scientific method” (EUnetHTA, 2013). It is intended to provide a bridge between the world of research and the world of decision-making (Battista, 1996). Health policy decisions are becoming increasingly important as the opportunity costs from making wrong decisions continue to grow (Menon; Marshall, 1996). Any interventions that may be used to promote health, to prevent, diagnose or treat disease or for rehabilitation or long-term care can be beneficial. This includes the pharmaceuticals, devices, procedures and organizational systems used in health care (INAHTA; HTA, 2013).

However, the goal of achieving UHC will be undermined if concrete steps are not taken to protect, motivate, increase and retain adequate numbers of skilled, well-educated and trained health workers. A

robust public health workforce should be ensured. SDG's target 3c seeks to "increase substantially...recruitment, development, training and retention of the health workforce". As with UHC, there are risks, and opportunities. Specifically, capacity building must not narrowly centre on the clinical context, should promote the public health workforce development, and be implemented in ways that reduce brain-drain likelihood. Most low-income and even middle-income countries lack a sufficient number of well trained health-care workforce. And even if employment opportunities under UHC were scaled up equally in clinical and non-clinical sectors, clinical services are more attractive: compensation is typically higher, and clinical training generally makes physicians and nurses more marketable in high-income countries, further threatening workforce retention.

Promising strategies include locally relevant training with a focus on endemic conditions, and practising of medicine within country-specific resource scarcity constraints. The health care workforce is a major building block of health systems. Healthcare workers are the main driving force of UHC and particularly Community Health Nurses (CHN). Community health nurses have the potential to make significant contributions to meet the health care needs of various population groups in a variety of community settings. In order to assess the extent to which CHNs are achieving this potential, WHO conducted a study between 2010 and 2014 that examined the status of community health nursing in 22 countries, 13 of which were experiencing a critical shortage of health care workers. The study revealed that the countries surveyed had the basic and operational framework for optimizing CHN in their health systems as evidenced by the availability of PHC structures to guide interventions. However, challenges identified related to the education, practice and management of CHNs in these countries. The major challenges identified were: Limited availability of career opportunities; poor worker retention; low recognition for CHNs; inadequate and unsupportive working conditions and environments; absence of educational standards; varying educational entry-level requirements for CHN programmes; and a lack of consensus on the scope of practice for CHNs. These challenges were derived from the five key areas of the study focus. They included; National strategies for the practice of nursing and the nursing profession, Educational preparation of nurses and CHNs, Regulation of CHN practice, CHN practice elements, Advocacy and support for CHNs.

The study data were obtained from nursing faculties, nurses in practice settings, representatives of nurses in ministries of health, and representatives of nurses professional associations. Primary data generated from the WHO study was complemented by secondary data.

The training of doctors is very demanding and critical in achieving UHC. Medical schools, should bear the primary responsibility to offer global health learning opportunities in which students gain competencies necessary to work in a multicultural, globalised society, and should equip future doctors with the ability to adapt to and work in different contexts. The provision of clinical or research internships is a crucial strategy to this end, if embedded within sustainable partnerships to reduce

commercialization, prevent medical tourism, and create reciprocity of benefits, rather than a unidirectional benefit solely for the student from a high-income country going on exchange program to a low-income country. This will be very beneficial and contribute substantially to UHC. Promising strategies include locally relevant training with a focus on endemic conditions, and practising of medicine within country-specific resource scarcity constraints. This approach promotes professional prestige of local practice, equips workers with realistic expectations, and reduces chances that clinical medicine training is chosen predominantly as a stepping stone to work in high-income countries (Eyal, Nir, & Samia Hurst, 2008). Externally sponsored training should generally take the form of so-called sandwich training, with most time spent in the sponsored not the sponsors' country (Lazarus, Wallace, & Liljestrand, 2010).

Equitable resource distribution among populations is essentially lacking in low and middle income countries particularly in Africa. Politicians have a tendency to neglect areas which did not support them during election period. Using the earlier Chinese experience in PHC, equity was critical in facilitating the success of PHC in the Mao Tse Tung leadership. Therefore political commitment, leadership, governance, accountability, transparency and openness should be a major ingredient in spearheading universal healthcare coverage, in resource allocation, strengthening weak healthcare system, rehabilitating infrastructure, and equipments and supplies.

4. Discussion

Health system strengthening framework is fundamental in achieving Universal Health Coverage (UHC) which lies at the centre of SDG 3 on health. Making progress towards UHC is an ongoing process for every country as they work to ensure that all people receive the health services they need without experiencing financial hardship. The health-related targets of the SDGs cannot be met without making substantial progress on UHC. Achieving UHC will, in turn, require health system strengthening to deliver effective and affordable services to prevent ill health and to provide health promotion, prevention, treatment, and rehabilitation and palliation services. Health system strengthening requires a coordinated approach involving improved health governance and financing to support the health workforce, and provide access to medicines and other health technologies, in order to ensure delivery of quality services at the community and individual levels. As part of this, health information systems will be vital in informing decision-making and monitoring progress. Investments in these areas, financial and otherwise, should seek to increase responsiveness, efficiency, fairness, quality and resilience, based on the principles of health service integration and people-centred care.

The broad focus of the SDGs offers an opportunity to reset and refocus health strategies and programming to strengthen health systems. The MDGs provided an important impetus for making progress in a selected set of health areas—namely reproductive, maternal and child health, and

HIV/AIDS, malaria and tuberculosis. However, far less attention was given to the performance of whole health systems, including health services, with the result that the benefits of doing so were not sufficiently emphasized. Many countries lack sound health financing, leading to high Out-Of-Pocket (OOP) payments and financial catastrophe or impoverishment for families. Many countries also have major inadequacies in terms of their health workforce and infrastructure (especially in rural areas), medical products, service quality, information systems and accountability. Weak health systems also leave major gaps in national, regional and global defences against outbreaks of infectious diseases, such as Ebola virus disease and novel strains of influenza zika virus, and the most recent corona virus (Covid-19).

There is a dire need to strengthen healthcare system based on tested business strategies and innovative services to increase resource efficiency and make measurable impacts on health outcomes. This will be based on tested experience, tools, and methodologies in data analytics, performance management, and organizational capacity building so as to help leaders make smart decisions and investments in the health system to achieve performance targets and increase value for money. The hallmark is to ensure efficient and effective programs that fight infectious and non-communicable diseases, improve maternal and child health, and promote healthier behaviours.

When we optimize health service delivery and maximized value for money, then the result will be improved health outcomes. The government should be ready to seek and understand and make some tangible decision-making in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature, it is inter-disciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology, that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape- and be shaped by- health systems and the broader determinants of health (Alliance Deloitte, 2003). Health system can be defined either by what they seek to do and achieve, or by the elements of which they are comprised. The defining goal of health systems is generally seen as health improvement- achieved not only through the provision of curative and preventive health services but also through the protection and promotion of public health, emergency preparedness and intersectoral action (Mackintosh & Koivusalo, 2005).

However, health systems are also part of the local fabric in any country, offering value beyond health (Gilson, 2003; Mackintosh, 2001). Their wider goals include equity or fairness, in the distribution of health and the costs of financing the health system as well as protection for households from catastrophic costs associated with disease; responsiveness to the expectations of the population; and the promotion of respect for the dignity of persons (WHO, 2007). These last two goals specifically require: Ethical integrity, citizen's rights, participation and involvement of health system users in policy development, planning and accountability and respect of confidentiality as well as dignity in service provision

(Mackintosh & Koivusalo, 2005); Building and maintaining the social relations that support sustained resource redistribution, through strategies and activities that include, rather than exclude, socially marginalized population groups within all decision-making activities (Freedman et al., 2005).

Therefore, health systems, through both their service provision role and their influence over societal relations, are a critical field of action to address the social determinants of health and the related health inequities (Commission on Social Determinants of Health, 2008; Gilson et al., 2008).

The PAHO Equity Commission has stated that health is an end in itself. It is a worthwhile goal for individuals and for communities. Certainly, there are good instrumental reasons for improving health: good health may be a route to individuals enjoying flourishing and productive lives; a healthier population may make economic sense for a country. Health is more than a means to some other end. Health is a state that is much valued and cherished and is part of a world view; common in the Americas as elsewhere, that human well-being is an end in itself. Better health and greater health equity will come when life chances and human potential are freed, to create the conditions for all people to achieve their highest possible level of health and to lead dignified lives.

Unquestionably, UHC is timely and fundamentally important (Frenk, 2012; WHO, 2014).

However, its promotion also entails substantial risks. A narrow focus on UHC could emphasise expansion of access to health-care services over equitable improvement of health outcomes through action across all relevant sectors especially public health interventions, needed to effectively address Non Communicable Diseases (NCDs).

WHO first endorsed UHC in its 2005 resolution on sustainable health financing, calling on states to provide “access to (necessary) promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost” (WHO, 2005). The resolution and its UHC concept firmly and narrowly centre on health insurance packages financed through pre-payment. This narrow understanding is echoed in major recent reviews of 65 empirical studies on UHC progress (Giedion, 2014; Maeda, 2014). The proposed SDGs also separate population-level public health measures from UHC, addressing the former as distinct targets, not under UHC (UN working group Gen. Assembly, 2015). Yet, a broader understanding encompassing nonclinical measures can also be found in relevant WHO documents (Maeda, 2015; WHO, 2014). Independent of UHC’s conceptual indeterminacy, clinical health services are an essential part of UHC, and are likely to dominate post-2015 state health system improvements (WHO, 2013; WHO, 2014, O’Connell, Rasanathan, Chopra, 2014). In implementing UHC, how can we ensure continued emphasis on the full spectrum of public health interventions?

Many of the targets under SDG 3 need population-level health interventions. For instance, targets for maternal and newborn mortality, communicable diseases and NCDs, alcohol, and narcotics, sexual and reproductive health, and tobacco call for broader, largely non-clinical measures, including education, improved sanitation, hygiene, nutrition, bednets, taxation, and restrictions or bans on selling and

promoting alcohol, narcotics, and tobacco. Similarly, targets for road, and air, water, soil pollution fall entirely outside clinical services.

The global move towards UHC by ensuring affordable access to essential health benefits is urgent and long overdue. The current enthusiasm and momentum is encouraging. However, the ultimate challenge for policy makers is not merely to improve clinical services, but to achieve equitable health outcome improvements through genuine integration of individual and population-level health promotion and preventative efforts with curative services.

Looking ahead, policy makers must make complex prioritisations in moving towards UHC. This process includes striking the right balance between individual level curative services, and individual-level and population level health promotion and preventive measures. Three steps can help to ensure that increased attention to clinical services will not undermine, but support, robust action across the full range of public health measures and social determinants of health. Second, fixed and distinct budgets are important. As noted, political and societal pressures favouring curative services under UHC can harm health promotion.

Equity in resource distribution

There have been disparities in resource distribution, particularly in both low and mid-income countries. This is as a result of poor governance and nepotism. When resources are distributed well within the country taking into consideration- inclusion and engagement, the level of social economic status tends to be relatively stable. Population tends to be at a stage that they can also enjoy the country's wealth.

In terms of time, there is a tendency to make the health inequality situation for the poor and marginalized people more visible as well as based on more scientific quantitative evidence. Regarding the subjects addressed, there is also a tendency to highlight epidemiological and clinical studies, particularly on non-communicable diseases and external causes. Notwithstanding this tendency, the focus seems to have shift towards analyzing the problem from a social sciences perspective to provide a greater explanatory capacity. Such study findings also pinpoint the challenge of conducting studies with mixed methods that will allow a better understanding of the mechanisms that generate, transmit, and perpetuate health inequalities. Quantitative research has fundamentally focused on the social determinants of health, risk factors, and negative or positive health outcomes. Some authors have stressed the need for more research into the mechanisms whereby poverty, social injustice, and ethnic and cultural factors act as barriers to contribute to the generation and perpetuation of inequalities, especially as they pertain to negative outcomes.

Political commitment is fundamental in supporting decision making about health policies, programs, plans, and technical protocols with the aim of eliminating or reducing health inequalities among the poor and marginalized, in a manner consistent with the Sustainable Development Goals (SDGs) pledge of "leaving no one behind" (UN Committee on Dev. and policy, 2019). There is urgent need to

“mobilise the highest political support to package the entire health agenda under the umbrella of UHC and sustain health investments in a harmonised manner”.

In conclusion, as countries try to implement UHC, considerable challenges and barriers have emerged, which require urgent attention. Strengthening health system through financial allocation is fundamental; training of skilled and well motivated healthcare workers. Provision of right equipments and supplies, equity in resource distribution, improvement of infrastructures to meet the needs of the people is fundamental. A strong political commitment is required to mobilize resources. These challenges underscore the need to re-examine the principles of Primary Health Care (PHC) that is people- and community-centered thus designed with the participation of actors and based on their needs and acceptance of services and technology, intersectoral at the upstream policy level, and universally accessible at a cost that is affordable for both the health system and individuals and thus contributes to improving health for all. Health is more than a means to some other end. Health is a state that is much valued and cherished and is part of a world view; common to developing countries as well as developed ones, that human well-being is an end in itself. Better health and greater health equity will come when life chances and human potential are freed, to create the conditions for all people to achieve their highest possible level of health and to lead dignified lives.

Conflict of interest

I declare no conflict of interest

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