



Policy Document

Surgery and Anaesthesia as Essential Components of Universal Health Coverage

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Introduction

In the twenty first century there are still many inequalities in the world, a crucial one being the ability to access healthcare when needed. People living in countries and regions of the world where health systems provide free to the point of care access to health services have access regardless of their situation. However, in many other countries healthcare is not free and available to all, but is expensive and its delivery restricted by financial, social and economic barriers. For individuals in this situation, health can easily become a luxury and not a fundamental right. Many individuals still incur in financial hardship due to the costs associated with accessing health services, primarily due to out-of-pocket (OOP) payments (1). Achieving universal health coverage is essential to abolish these differences and ensure that all people around the world can have timely and affordable access to healthcare when in need. All services should come under the umbrella of 'universal coverage', including preventative services, medical treatment and surgical interventions to truly make health systems equitable.

InciSioN's position

The **International Student Surgical Network (InciSioN)** strongly believes that access to healthcare services is a universal right for all people. Surgery and anaesthesia are essential of healthcare, and therefore must be included as fundamental components to achieve universal health coverage. Therefore, access to safe and timely surgical and anaesthetic care must be considered when addressing challenges in accessing Universal Health Coverage (UHC).



Call for Action

Therefore, InciSioN calls for:

Governments to:

- Recognise access to universal health coverage as a fundamental right for all people
- Acknowledge that out of pocket payments for accessing health services are an important cause of financial hardship for people worldwide
- Provide funding to the healthcare and related sectors to ensure people do not suffer financial hardship when accessing health services, especially for poorer income members of society
- Incorporate and prioritise funding within health departments for essential surgeries that everyone should have access to when in need
- Strengthen existing mechanisms for internal financing of health care, to reduce reliance on funding which may change depending on external sources

Medical faculties and teaching institutions to:

- Educate their students on the importance of UHC and current challenges that exist for people to access health services
- Integrate education on health prevention, health promotion as well as health economics to enable a better understanding of their interplay

International institutions and Non-governmental organisations to:

- Collaborate with governments, hospitals and teaching institutions to develop strategies for progressing towards UHC
- Advocate for the need of achieving UHC, sharing their expertise in this field

Healthcare sector to:

- Devise cost-effective and people centred methods of healthcare delivery, taking into account local, regional and national needs
- Engage in discussions with other related sectors such as pharmaceutical, health technology to devise strategies for care delivery to that are safer, more cost-effective and sustainable
- Invest in human resource development and encourage retention of trained staff
- Engage in developing health information technology and data collection

InciSioN National Working Groups to:

- Advocate for and raise awareness around challenges and issues pertaining to UHC, especially among peers



- Raise awareness about the Sustainable Development Goals and how these interact with UHC
- Advocate at the local and regional levels to medical school and educational institutions to emphasise the need to educate current and future doctors on the importance of UHC

Background

Introduction

Universal health coverage is a fundamental concept, the definition of which is best described through explaining what it means to truly achieve UHC. Firstly, UHC means equity in access to health services, so that everyone in need of health services is able to get the appropriate treatment, regardless of their ability to pay for such services. Secondly, to fully achieve UHC the quality of health services should be of a good enough standard that the health of those receiving such services is improved. Finally, all individuals must be protected against financial risk or hardship arising from accessing healthcare, therefore ensuring that the cost of using health services is not prohibitive to the population using it (2).

Even if not formally expressed, the principles underlying UHC have been around for a long time. In the 1946 Constitution of the World Health Organisation, the enjoyment of the highest attainable standard of health was recognised as one of the “fundamental rights of every human being”. In 1948, the United Nations Universal Declaration of Human Rights declared that health is part of the human right to an adequate standard of living (3).

Since that time, international treaties have repeatedly acknowledged the right to health as a fundamental human right. Despite this international recognition, many individuals still incur financial hardship due to the costs associated with accessing health services. Described by the WHO as the “hallmark of a government’s commitment to improve the wellbeing of all its citizens”, Universal Health Coverage entails a network of health providers and institutions so that the vast majority of the population can access priority health services in relation to health promotion, and illness prevention, detection and treatment, without the barrier of financial hardship (4).

In 2014, World Bank President Jim Kim stated, “surgery is an indivisible, indispensable part of health care and of progress towards universal health coverage.”(5). However, health systems in many countries fail to achieve this due to financial barriers in the form of high out of pocket



expenses, lack of trained staff and facilities, resulting in inadequate access to quality surgical care. In pursuing the goal as of universal health coverage as an international standard, it is important to recognise the essential role of surgical and anaesthetic care.

Timeline of UHC as a concept

The world's first national social health insurance system originated in Germany in 1883, when the Sickness Insurance Law implemented compulsory sickness insurance for workers. The Bismarck government of the time promoted health as the solution to social problems of industrialisation including alcoholism and STD's (6). Many European countries followed, and the first single-payer universal healthcare coverage policy was adopted by the Norwegian government in 1912 (7).

The WHO constitution of 1948 clearly declared that health is a fundamental human right (2), and the Health for All agenda set by the Alma Ata declaration in 1978 reaffirmed this concept, issuing a Declaration identifying a commitment to equitable systems of healthcare, providing universal access to primary health care (8). The First International Conference on Health Promotion in Ottawa in 1986 resulted in adoption of an international charter by United Nations agencies, national governments and civil organisations. The charter recognised access to health care and underlying determinants as a human right. (9)

These milestones highlight the concept of Universal Health Coverage has been embedded into goals, targets and interventions since early in the last century. However, progress towards the goal of UHC has been elusive. In the intervening period, recurring financial crises have resulted in disinvestment in the public sector. In many low-income countries, health systems still lack functioning infrastructure, logistical routes of transport, reliable supplies of medicines and equipment, and qualified health care workers. Many basic goals of primary health care, such as reducing child and maternal mortality, are not on track to be met (10). It was not until recent years that a number of events and initiatives brought the focus back on UHC.

In 2010, the First Global Symposium on Health System Research analysed 194 countries, finding that 75 countries had legislation that provided a mandate for UHC, and of these, 58 countries satisfied access, quality and outcome criteria for UHC in the years 2006 to 2008 (6). In 2015, the 'golden year' for global surgery, the connection was made between the importance of advocating for the provision of safe surgery and anaesthesia care worldwide, and UHC. UHC cannot exist if it does not include access to surgery and anaesthesia services, as data showed that about a third of the global burden of disease needs surgery as part of



their treatment (11-13). The WHA Declaration 68.15 clearly put into writing that strengthening emergency/essential surgery and anaesthesia must be a priority to achieve UHC (14).

Building on this international effort, the Health Ministers of the G20 forum for international economic cooperation met in Berlin in May 2017, calling for “strong, sustainable and resilient health systems”, recognising that health is one of the most valuable resources for sustainability (15)

The Tokyo Declaration of 2017 affirmed that UHC is technically and financially feasible, and recognised that UHC is a crucial cornerstone of sustainable development, driving employment and inclusive economic growth. The Principle of Leaving No One Behind prioritises the most vulnerable members of the world’s population, including children, refugees and those affected by emergencies. In advance of the 40th anniversary of the Alma Ata Declaration, an anniversary conference was planned, and December 12 designated as International UHC Day (16).

UHC in the context of SDGs

Sustainable Development Goals (SDGs) are a universal call to action to put a stop to poverty, protect all populations and the planet, ensuring people enjoy peace, prosperity and health (17). For this reason SDGs encompass multiple areas including climate change, economic inequality, health systems among others. All the goals are linked, highlighting that one cannot be fully achieved without the others and vice versa.

SDG number 3, namely “to ensure healthy lives and promote well-being at all ages”, consists of nine substantive targets and four additional targets, outlining its implementation. The commitment to achieve UHC is one of these, and it has been acknowledged as essential to the achievement of all other health targets. This is because UHC incorporates financial risk protection, access to quality, safe, effective and affordable essential health services and medicines.

There is no doubt that UHC spans across all the domains covered by the Sustainable Development Goals (SDGs), as it advocates for better health and protection for the world’s poorest populations, and brings together various domains including health and economics.

Growing evidence shows that UHC is financially sustainable and feasible, as access to health improves overall population health, reduces disability and therefore enables financial growth of countries(18-20). In fact, countries where all individuals have access to health services when needed, as per the UHC definition, demonstrate good economic growth and overall



quality of life improvement. Taking trauma as an example, countries where trauma incidence is high, especially in the young population, and there is no UHC have low productivity, high rates of disability and financial burden due lack of manpower to progress the economy. Trauma is unpredictable and often requires emergency treatment which should be available to all; investing in UHC to ensure all those young men and women suffering from accidents, road traffic injuries and other unpredictable pathologies would mean a reduction in morbidity and mortality, which in turn would increase the number of young adults able to work and contribute to bettering their country.

UHC 2030: what's been achieved and what still needs to be done

With the goal of achieving UHC, a number of international players have come together in efforts to improve the current situation by 2030, this is the beginning of the UHC2030 movement (21). This movement aims to bring together efforts to strengthen health systems globally, and it acts as a unified platform to collect and coordinate efforts made by individual countries, international partnerships and NGOs.

Global initiatives – principles

As outlined in the 'Timeline of UHC' section above, a large number of global initiatives and high-level forums have emerged, collectively aiming to promote a collaborative and multidisciplinary approach to solving the challenges faced when working towards UHC.

There are a number of recurring themes featuring in all recent high-level meetings, forums and events around UHC. These themes are the pillars and principles behind international collaborative efforts in this field.

- Health is a human right: this simple statement emphasises that we must ensure all groups of people, especially the most vulnerable groups such as children and disabled individuals have a voice and are included in our commitment to UHC. This is also linked to the "Leaving No One Behind" goal (22), highlighting that the design and delivery of health services must be guided by the people's needs
- Financial feasibility: UHC produces high returns across an individual's lifespan by increasing the overall health of the population, reducing disability and enabling a greater percentage of people to lead healthy, productive lives actively giving back to their society



- Advocacy is a fundamental tool: despite the momentum around UHC, a lot of work still needs to be done to raise awareness of its multiple aspects. Moving towards UHC2030, we need a strong leadership and panel of advocates to lobby for change (23).

Country-level initiatives

While it is imperative to understand the move towards UHC provision at an international level, on a practical level it is necessary to consider individual country-level UHC initiatives, to see how the broader international principles discussed above link in to day-to-day practice.

In doing so, it is important to acknowledge the relative increase in understanding of local needs and challenges that local people and local organisations will have when it comes to the barriers to and opportunities available for implementation of UHC in the given area. This requires effective and ongoing dialogue between governments, ministries of health (MOHs), non-governmental organisations (NGOs), clinicians and, of course, the target population group.

In considering UHC initiatives at a local level, we find it useful to use Okoroh et. al.'s schema of 'breadth, depth, and height' of health expenditure (24) (see Fig. 1), to ask three questions:

- Breadth: who is insured by the government's UHC policy?
- Depth: which benefits are covered by the policies?
- Height: what proportion of the cost is covered?

Okoroh et al's analysis remains to date the only systematic synthesis of studies looking at local-level incorporation of surgery into UHC policies around the world. In their research, several broad principles arose in relation to the way surgery was incorporated into UHC policies, and which again can be analysed from the perspectives of breadth, depth, and height. Their findings are summarised briefly in the paragraphs below.

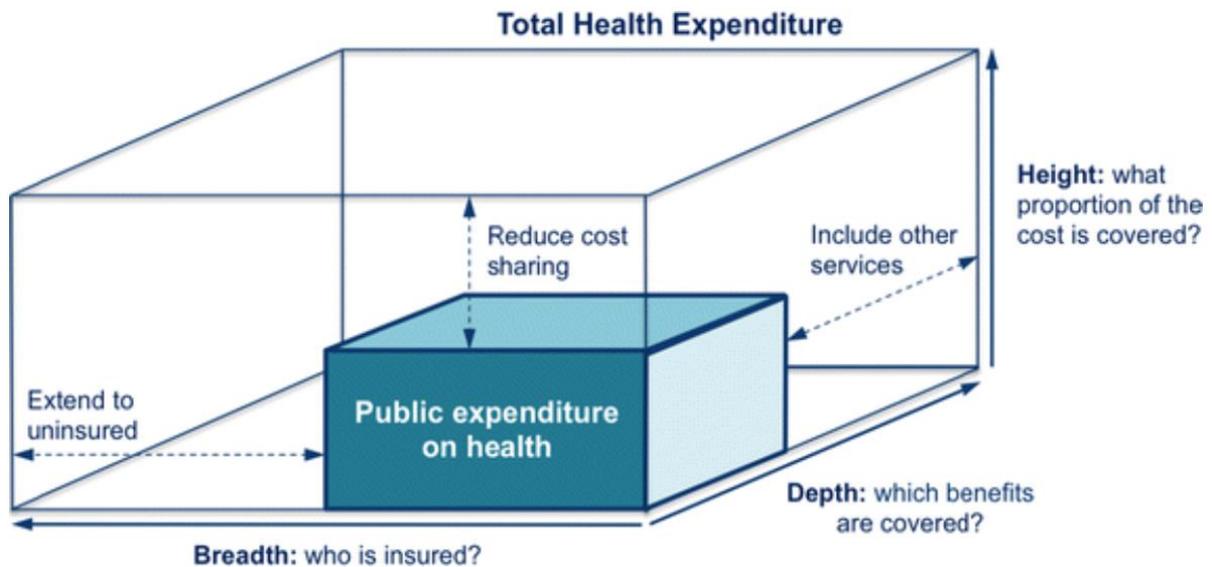


Figure 1: Total Health Expenditure - figure taken from Okoroh et. al.

- **Breadth:** Most countries began their implementation of UHC, including coverage for surgical care, with a focus on ‘vulnerable or specific populations’. These populations included people under the poverty line, women, and children under 5. Most commonly, these populations had their coverage provided for in the form of abolition of user fees, meaning that other populations had to pay costs but these vulnerable groups did not. For example, Gawande (2015) refers to the RSBY card launched by the government of India, which comes under the Indian National Health Insurance Scheme and allows families below the poverty line to purchase a card for the equivalent of \$US0.50 and covers them for all medical care, including essential surgical care, up to the cost of approximately \$500US.
- **Depth:** the way countries approached the depth of UHC varied considerably, and depended on the particular health care structures in place in a given country. For example, some countries, such as Thailand, Chile, and Brazil, use primary care providers as ‘gatekeepers’ to surgical services, whereas others, such as India and Kenya, provided a more hospital-care focussed approach. Therefore, in the former group access to surgery (and therefore, UHC policies) are directed more towards primary care providers, whereas in the latter group they are more directed towards inpatient care.
- **Height:** similarly to the other factors, the amount provided to patients seeking support to access surgery varied considerably between countries, though in



almost all countries studied there remained a significant amount of ‘catastrophic OPP’ (defined by the WHO as more than 20% of total household expenditure). The exact support mechanisms in place varied, with some countries adopting income-stratified co-payment systems and others using National Health Insurance Schemes.

Within these parameters, it is important to consider which surgical services specifically are being covered by these policies. Again, Okoroh et al remain the principal source of information on this point; they found that the most common surgical areas explicitly included in the UHC policies of individual countries were those related to obstetric-, trauma- and oncologic-related surgical issues.

In terms of obstetric coverage, enhanced obstetric insurance coverage has been associated with positive outcomes in multiple countries, including in probability of safer delivery and penetration of prenatal care, though practical barriers around availability of skilled delivery attendants and access to health centres remain an issue. In relation to trauma services, the key issue that arose was that no country included in the study required by law for all patients presenting with trauma to be treated regardless of their ability to pay. Given the significant burden that non-violent injury represents to the global surgery load, this presents an important area for advocacy. Finally, they found that multiple countries included cancer-care within their UHC frameworks, most commonly cervical and breast cancer, with two countries (Taiwan and Chile) having state-funded national cancer programs available to support patients.

Another theme arising from the study was the different ways in which different countries balance provision of healthcare between the public and private sectors, and the degree of dependency on individual patients having access to private healthcare. For example, in Brazil, some 25% of the population have private health insurance, and many private contractors are available.

This has important ramifications for the provision of emergency and trauma surgical services, as theoretically patients with private health insurance could be transferred immediately to private services (which may themselves be less congested, and which also frees up the public service).



Again, different countries have dealt with this in different ways, with trauma patients in Chile being able to access initial care in any facility (public or private) before being transferred to their preferred facility, but those in Rwanda and Nigeria being required to first access emergency services at public/government health facilities.

Finally, Citron et. al. make the important point that 'global surgery' can be nothing without access to good quality pathology and laboratory medicine (PALM). This is undeniable, and like all other facets of providing access to global surgery, PALM needs to be integrated at every level of provision of surgical care to ensure the most efficient use of surgical resources.

NGO Initiatives

There are several Non-Government Organisation initiatives who are working towards providing surgery and anaesthesia on a global scale.

Lifebox, launched in 2011, is the only Non-Governmental Organisation devoted to safer surgery and anesthesia in low-resource countries, with a network in more than 100 countries worldwide. (25) Over the last five years, they have provided 15,000 pulse oximeters to 100 lower and middle income countries, estimated to have made surgery safer in 10 million patients.

Partners in Health is a non-profit health care organisation, which works to provide healthcare in developing countries through building hospitals and medical facilities, hiring and training local staff and delivering health care. (26)

Finally, the International Student Surgical Network (InciSioN), is an international, non-profit organisation which comprises of medical students and young doctors working to provide education, advocacy and research on Global Surgery. (27) There are National Working Groups in thirty countries working towards providing safe surgery to all.



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