

Universal Health Coverage and Health Systems Strengthening (2021)

Position Statement

The Australian Medical Students Association (AMSA) believes that:

1. Access to health services is a human right of all people internationally, regardless of financial, social, or other circumstances;
2. Universal health coverage (UHC) is an essential requirement for all people to achieve their universal human right to health and wellbeing;
3. The introduction of managed care into the Australian Healthcare system undermines the principle of UHC and should therefore be opposed;
4. Healthcare system strengthening (HSS) is vital to create sustainable healthcare systems and is necessary to achieve UHC;
5. Any strategy to achieve UHC and/or HSS should be culturally respectful, ethical, adapted to the local context, and should promote population equity in regards to healthcare;
6. The accomplishment of the Sustainable Development Goals (SDGs), especially pertaining to UHC and HSS, is vital for a healthier and more sustainable future, both nationally and internationally.

Policy

AMSA calls upon:

1. International governments to:
 - a. Treat the realisation of UHC (as defined by UN SDG 3.8) as a national priority;
 - b. Use fairness and equity principles as guiding values for formulating strategies aimed at achieving UHC;
 - a. Implement the World Health Organisation three-part strategy to achieving UHC;
 - b. Commit to preventing the 'five unacceptable trade-offs' in order to ensure an ethical, fair, and just realisation of UHC;
 - c. Expand priority areas in the healthcare system ensuring that:
 - i. Services are expanded in the order of high priority before medium-priority services, and medium-priority before low-priority services;
 - ii. Criteria used to classify services into priority classes, at a minimum:
 1. Take into consideration the cost-effectiveness of the service, the necessity of the service in the population,

- vulnerability of the population, and the financial risk protection that coverage of the service provides;
 - 2. Take into consideration, and be sensitive to, the relevant local circumstances, context and culture;
 - 3. Be made available to the public ;
 - d. Implement strategies to reduce barriers to healthcare coverage, in doing so ensuring that:
 - i. Removing barriers to vulnerable and disadvantaged groups are prioritised;
 - ii. A combination of universal-targeting, equity-promoting and individual-targeting strategies are used;
 - e. Reform health financing systems, including:
 - i. Shifting away from out-of-pocket payments and instead, implementing a prepayment and pooled funding system;
 - 1. Out-of-pocket payments should ultimately be eliminated for high-priority services, low income and vulnerable groups, and other disadvantaged subpopulations as a first priority
 - ii. Mandatory prepayment contribution to pooled funds taking priority over implementing voluntary contribution strategies;
 - iii. Mandatory prepayment contribution, which should be determined by an individual's ability to pay;
 - iv. Healthcare benefits received from pooled funds, which should be based purely on need and not take into consideration contribution to the pooled fund;
 - v. The consideration of country-specific factors in any healthcare system reform strategy;
 - f. Design and implement healthcare system strengthening interventions that, at a minimum:
 - i. Have appropriate scope and scale;
 - ii. Are sustainable;
 - iii. Have positive outcomes in health equity, financial risk protection, and system responsiveness;
 - g. Ensure all healthcare service strengthening strategies involve, at a minimum:
 - i. Prioritisation of community-level delivery;
 - ii. Outreach to underserved populations in primary healthcare models;
 - iii. Implementation of service integration frameworks and models, with special consideration of appropriate support service demand;
 - iv. Respect, consideration, and adaptation to the local context and culture;
 - h. Implement appropriate measures to strengthen the distribution, performance and supply of the health workforce (as recommended by UN SDG 3.c) through measures such as:
 - i. Implementing good-quality training and education programs, as well as performance monitoring and management systems;
 - ii. Efficient and effective healthcare worker organisation, and retention strategies;

- iii. Building healthcare workforce surge capacity and task-shifting approaches to address shortages;
 - i. Create strong health information systems that have the ability to, at minimum:
 - i. Generate population and facility-based data;
 - ii. Track the 14 UHC service coverage indicators;
 - iii. Detect and respond to public health emergencies;
 - iv. Synthesise information and promote the application of data;
 - j. Promote and provide equitable access to and use of products of assured quality, safety and effectiveness, including but not limited to:
 - i. Essential medicines and medical products;
 - ii. Vaccines;
 - iii. Medical technology;
 - k. Implement healthcare technology, medical product and vaccine supply chain strengthening strategies such as:
 - i. Bulk procurement of medicines;
 - ii. Improvement of stock management and prescribing practices, for example through:
 - 1. Training of staff to reduce inappropriate antibiotic prescriptions
 - 2. Supervisory programmes aimed at improving stock management practices at health facilities
 - iii. Targeting stock-outs and loss due to expiration;
 - l. Provide good health system leadership and guidance that involves:
 - i. Policy guidance such that health system priorities and the roles of key actors in achieving these priorities are identified and clearly articulated;
 - ii. Generation and interpretation of Intelligence such that there is appropriate monitoring of health systems, and identification of opportunities for actions and policy options;
 - iii. Coalition building to collaborate across government ministries, sectors and communities;
 - iv. Design and implementation of appropriate regulations and incentives to support health systems strengthening;
 - v. Ensuring accountability and transparency of all health systems actors;
 - vi. Mobilisation and supervision of public and private sectors and civil society to support health systems strengthening;
 - m. Perform an up-to-date analysis of UHC within their nation and report recent measurements and progress towards achieving UHC;
 - n. Join multi-stakeholder partnerships in advocating for, and developing global and national capacity towards the global and national achievement of UHC, as defined by SDG 3.8, and the other health-related SDG 3 targets.
2. International multilateral, bilateral and other NGOs to:
- a. Prioritise funding towards horizontal disease programs where possible, given their significant impact on health systems strengthening and sustainability of service delivery.

3. The World Health Organisation to:

- a. Advocate for reforms in countries throughout the world to achieve UHC, especially in regards to health financing and patient-centred care;
- b. Advocate for greater transparency and accountability regarding funding requirements for vertical disease programs;
- c. Create incentives for global health donors to support horizontal disease programs.
- d. Advocate for commitment from global health donors to supporting the development of health systems and UHC, especially by:
 - i. Facilitating the development of effective health information and digital health systems through partnerships with domestic agencies;
 - ii. Encouraging a cooperative approach to health security;
 - iii. Encouraging collaboration and exchange of information and policy in all aspects of UHC and health systems;

5. The Australian Federal Government to:

- a. Further Australia's international efforts in supporting the development of health systems and UHC globally, especially by:
 - i. Treating the ongoing UHC gaps in Australia's foreign aid recipients, including regional neighbours and major recipients Papua New Guinea and Indonesia, as a priority for foreign aid expenditure
 - ii. Dedicating foreign aid to support the development of effective and resilient health systems;
 - iii. Continuing to develop information-sharing relationships with international counterparts of the Department of Health, Australian Institute of Health and Welfare and/or other relevant agencies;
 - iv. Proposing reforms to the World Health Organisation to improve the organisation's effectiveness and providing a more efficient forum for international cooperation on health issues;
- b. Conduct a comprehensive parliamentary-level review of the the role of private healthcare insurance in relation to Medicare and UHC, and identifying whether reforms are required to maintain necessary levels of UHC, considering:
 - i. The decreasing number of young people taking up insurance;
 - ii. The value of the current private health insurance rebate from the Commonwealth and whether the funds could be spent more effectively in the public system;
 - iii. The value of the Medicare Levy Surcharge and Lifetime Health Cover Loading in increasing private health insurance uptake, and whether these measures decrease investment in provisions to reach UHC;
- c. Adopt the recommendations outlined by the 2017-18 Senate *Inquiry into the Value and Affordability of Private Health Insurance and Out-of-Pocket Medical Costs*, at minimum:
 - i. Recommendation 12 - which recommends that the Commonwealth Government amend relevant legislation to prohibit the current practice of differential rebates for the same treatments provided under the same product in the same jurisdiction;
 - ii. Recommendations 13-19 which relates to increased transparency and regulation of private healthcare in Australia;

- d. Oppose and take action to reverse the authorisation of the Honeysuckle Health and Cigna joint venture to form a health services buying group;
 - e. Conduct a thorough parliamentary-level evaluation of the potential health implications of managed care, preferred provider contracts, uncompetitive behaviour by private health insurance funds or health service buying groups and prior authorisations;
 - f. Develop legislation prohibiting preferred provider contracts, health service buying groups and managed care, in particular prohibiting:
 - i. The collection of market bargaining power by buying groups of private health insurance funds;
 - ii. Preferred provider contracts or measures that achieve similar results;
 - iii. Prior authorisation processes, “step therapy” or similar cost-control processes that enable private health insurance funds to override decisions made by treating doctors, or deny or delay cover for treatments covered by a policy;
6. The Australian Federal, State, and Territory Governments to:
- a. Develop and ground its SDG progress in a comprehensive SDG action plan contextualised in both the global and unique Australian health settings;
 - b. Have a single point of government responsibility for the development and reporting on the SDGs;
 - c. Prioritise strategies which improve access for disadvantaged groups including, but not limited to:
 - i. Those from low-socioeconomic backgrounds;
 - ii. Rural and regional communities;
 - iii. Australians with disabilities;
 - iv. Indigenous Australians and Torres Strait Islanders.
7. Australian Universities to:
- a. Consider joining multi-stakeholder partnerships advocating for, and developing global and national capacity towards the global and national achievement of UHC and other health-related SDGs;
 - b. Provide holistic education on UHC and health systems strengthening in the medical school curriculum in accordance with the AMSA 'Global Health and the Medical Curriculum' policy.

Background

Universal Healthcare Coverage

Universal Healthcare Coverage (henceforth referred to as UHC) is achieved when all people can access the health services they require without risking financial hardship [1]. UHC represents a fulfilment of the human right to healthcare, which is derived from the internationally recognised right to health [2]. The right to health was defined by the 1946 Constitution of the World Health Organization (WHO), based on a conception of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” [2]. Subsequent international agreements affirmed that the right to health enjoins on governments the responsibility to provide healthcare services to citizens [2].

Access to healthcare can be broken down into many parts, including physical accessibility, financial affordability and acceptability [1,3]. Physical accessibility refers

to having health services within reach of those who need it, when they need it, while financial affordability - also known as financial risk protection - describes the capacity for people to bear the price of health care without risking financial hardship [3]. Health service acceptability can be attributed to a number of social and cultural factors which influence a person's willingness to seek and accept the provision of health care [3].

Several quantitative measures can be used to assess progress on these elements of UHC.

Financial risk protection can be assessed by measuring the incidence of catastrophic out-of-pocket spending of over 10% and over 25% of the household budget on healthcare services [4].

Additionally, the WHO's 'UHC service coverage index (SCI)' is an important tool for measuring the provision of essential health services and will be referenced several times in this document. The UHC SCI is an aggregate of 14 statistical indicators in four domains, namely 1) maternal and child health, 2) non-communicable diseases, 3) infectious diseases, and 4) service capacity and access [1,4,5]. Results are reported on a unitless scale of 0 to 100 which approximates but does not exactly align with the percentage of the population who have full access to essential services. The WHO defines "nearing or reaching 100" on the SCI as representing the achievement of UHC for all, but does not provide a precise cutoff mark [5].

Achieving UHC will reduce the financial and societal burden of chronic disease on health systems, alongside its associated risk factors and ultimately enables more equitable health outcomes across various socioeconomic segments of the population [6]. This translates to increased life-expectancy in the population while reducing the risk of long-term health adversities due to improved preventive health measures [6]. Further, the risk of bankruptcy due to medical treatment is mitigated, protecting those most vulnerable in the community [6].

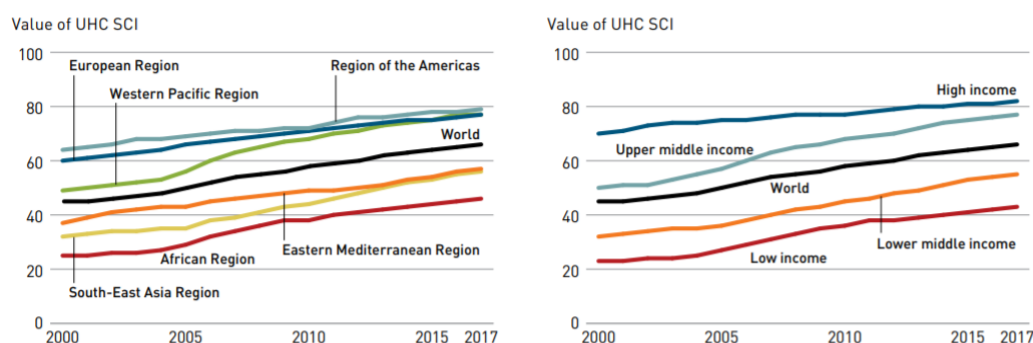
International Dimensions

International Gaps in UHC

The World Health Organisation (WHO) produces global monitoring reports of the trends and international gaps in UHC, the most recent of which was released in 2019. The 2019 report found that significant gaps in the coverage of essential health services remains a global issue despite progress over the past two decades [7].

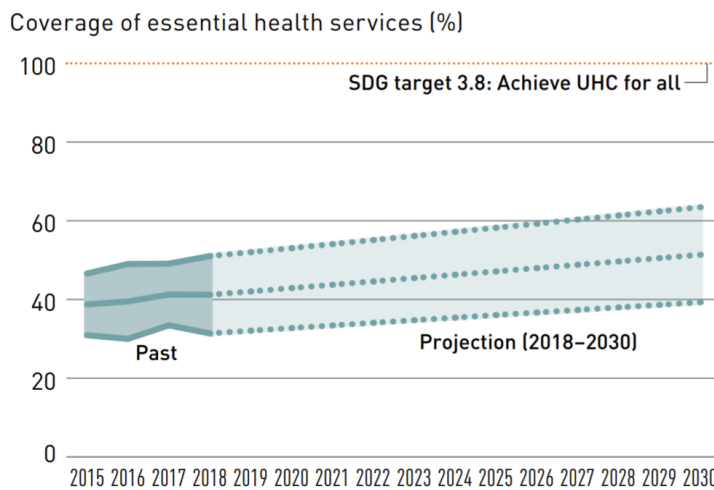
Overall, the global UHC SCI rating has improved from 45 in the year 2000, to 66 in 2017 [7]. SCI ratings for all individual geographical regions and income groups have also increased (see Figure 1).

Figure 1: The UHC SCI increased across all geographical regions and World Bank Income Groups - 2000-2017 (7)



However, trends are currently not on track to reach the Sustainable Development Goal (SDG) (see page 30 for further information on the SDGs) of UHC for all by 2030 (see figure 2). WHO projections suggest that assuming current rates of improvement continue, between 3.1 to 5.2 billion people will continue to lack access to essential services at the end of this decade [7].

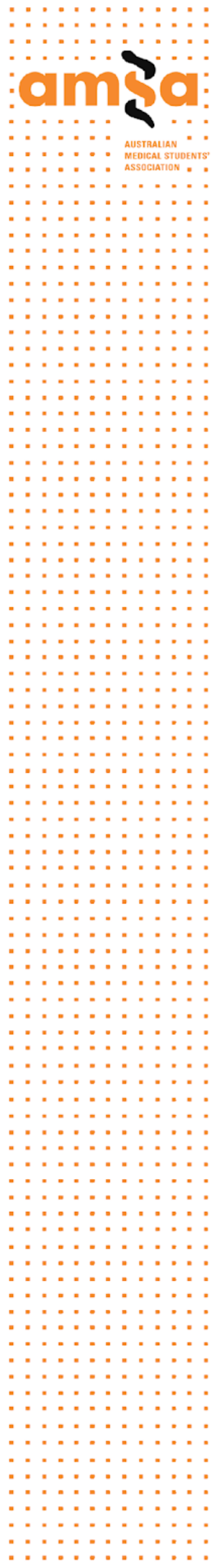
Figure 2: Based on current trends, coverage of essential health services will not meet SDG targets by 2030 (7)



Additionally, progress on financial affordability of healthcare has, in fact, regressed since 2000 in all global regions, with the exception of North America [8]. In 2015, more people were spending large proportions of their household budget on healthcare than in 2000 (see Table 1). Given that the capacity to access health services without suffering financial hardships is a core element of the conception of UHC, this backslide is highly concerning. The reasons for this regression are complex but appear to be tied to increases in GDP in many countries. This is because increased wealth tends to lead to increased exposure to healthcare services, which in the absence of publicly funded options causes increases in out-of-pocket spending [8].

Table 1 - Financial Risk Protection has worsened since 2000 [8]

	2000	2015
Proportion of global population whose out of pocket healthcare spending exceeds 10% of household budget	9.4%	12.7%
Proportion of global population whose out of pocket healthcare spending exceeds 25% of household budget	1.7%	2.9%



UHC gaps in nations receiving Australian foreign aid

The largest individual recipient of Australian foreign aid is Papua New Guinea, which will receive \$588 million in the 2021-22 financial year [9], followed by Indonesia, which will receive \$299 million [10]. Health sector investment is a major target for the aid budget and 'Health Security' is defined as one of three major pillars in Australia's development partnership with Indonesia [10].

Both nations continue to experience significant gaps in the coverage of essential health services. Despite these challenges, Australia's contributions to both these nations will decrease relative to its contributions in 2020-21 [9, 10]. The overall foreign aid budget for 2021-22 will also decrease by 4.9% following inflation [9]. AMSA's 'Australian Foreign Aid' policy outlines AMSA's position that Australia has a 'moral obligation and duty of care' to contribute to global health outcomes through its foreign aid contributions and advocates for an increase in Australia's contributions to 0.7% of GNI.

Papua New Guinea (PNG)

PNG, Australia's closest neighbour, had a UHC SCI rating of 40 in the WHO's 2019 global monitoring report, indicating relatively poor healthcare coverage [7]. Ratings across all four domains of the index are significantly below SDG targets and the mean threshold of 60 in the WHO Western Pacific region (see table 2).

Table 2 - UHC SCI ratings are poor across all domains in PNG (7)

SCI Component	SCI Component Rating (out of 100)
Reproductive, Maternal, Newborn and Child Health	56
Infectious Diseases	33
Non Communicable	46
Service Capacity and Access	29

Regarding financial risk protection, WHO estimates suggest relatively few PNG residents face financial hardship from healthcare costs, though this may be partly the result of the limited accessibility of health services [11]. These assessments are complicated by the poor data collection in PNG as discussed in the literature gaps research section of this document.

Indonesia

Indonesia had a UHC SCI rating of 57 in the 2019 report, with a particularly poor rating in the Infectious Diseases domain (see Table 3) (7). Progress has been made since the introduction in 2014 of 'Jaminan Kesehatan Nasional': a single-payer national health insurance scheme which came to cover 70% of Indonesians by 2017 (12). However, insufficient health service availability and high out-of-pocket costs remain barriers to the achievement of UHC targets (12).

Table 3 - UHC SCI ratings by domain in Indonesia (7)

SCI Component	SCI Component Rating (out of 100)
Reproductive, Maternal, Newborn and Child Health	79
Infectious Diseases	36
Non Communicable	58
Service Capacity and Access	65

Strategies to Achieve UHC

No country has zero healthcare coverage and all start at a different baseline level. As such, there is no single path to achieving UHC that every country can follow [13].

Instead, every country should advance in at least three dimensions to work towards achieving UHC. These include expanding priority services, including more people, and reducing out-of-pocket payments [13]. However, these advancements come with multiple ethical considerations in terms of promoting fairness and equity; which includes deciding the specific services that are in need of expansion first, whom in the population requires cover first and the method by which to shift from out-of-pocket payment towards a prepayment model [13,14].

Expanding Priority Areas

Healthcare services should be divided into high, medium and low priority services to simplify decision making processes. Expanding the high-priority services should occur first, while low or medium priority services should generally not be expanded before high-priority services have near full coverage. Similarly, low-priority services should not be expanded before medium-priority services are fully expanded [13,15].

Flexible criteria, employing logical rationale, should be used to determine a services-prioritisation level. However, it should be noted, criteria should be sensitive and relevant to local circumstances, and integrated with public accountability and participation. Healthcare service expansion and strengthening should not *only* occur when more resources become available, but the same criteria should be used to inform the redistribution of existing resources. Every nation should be transparent about their criteria for service selection, in order to promote democratic accountability and prevent corruption [13].

When selecting services, emphasis needs to be placed on areas beyond treatment and curative healthcare by also including prevention, rehabilitation, health promotion, palliative care and population-based interventions. Many nations have different criteria models; however, there are overlapping themes which include priority given to cost-effective services and services benefiting the 'worse-off' and most vulnerable, with priority given to coverage that offers substantial financial risk protection. Through expanding coverage of services, financial protection is provided directly through decreasing service payments, but also indirectly against the wider financial burden that goes beyond the service, such as loss of earnings due to inability to work and medical expenses for other services in the future. Additional criteria may need to be used when selecting priority services including disease (severity, health loss and

burden), social factors (socioeconomic status, geographic living area, gender, race, ethnicity, religion and sexual orientation), financial and social effects of ill health and costly treatment (carers costs, health expenditures and economic productivity) [13].

For the expansion of priority areas, this is referencing the healthcare services themselves. However, it should be noted that research into novel and new technology should be encouraged regardless of whether its utility will fall into low or medium services. Setting priorities in terms of research should not be based on whether the research will be used to serve low, medium or high-priority services. Instead, research priority areas should be determined by asking a series of questions about the context, approach, inclusivity, information, planning, criteria, methods, evaluation and transparency of the research. To promote UHC, research should include finding innovative methods to improve the coverage of existing interventions, as well as investigate methods to improve health either within or outside of the health sector [16]

Including more people

The scope of health coverage should be universal, and as such, nations should seek to reduce all barriers to coverage for all citizens. However, when nations cannot extend coverage to everyone immediately, an ethical dilemma presents itself concerning to whom coverage should be extended first [15].

Different groups in society have unequal probabilities of receiving health services. Generally, groups can be categorised according to their socioeconomic status, gender, area of living and health status, but in some contexts can also include ethnicity, race, religion and sexual orientation [17]. Countries should strive to reduce barriers to vulnerable and disadvantaged groups. These barriers include access barriers, both physically and financially, as well as cultural, work, family or any other factors that may prevent people from maximising their use of healthcare services. Such barriers inhibiting the utilisation of healthcare should first be reduced for high-priority services to ensure a just realisation of UHC [13].

Additionally, there should be a balance between fairness and benefit maximisation when it comes to resource allocation to these groups. With fairness, to uphold this value, there should be equitable distribution of resources and benefits across people. However, for benefit maximisation, it is concerned with increasing the total sum of benefits (such as additional life years or quality of life). When allocating resources to expand services to promote UHC, these two principles should be balanced, and targeting strategy should attempt to uphold both values simultaneously [13].

In regards to targeting individuals in a population, there is ongoing debate within healthcare more broadly about 'pro-poor' policies [18,19, 20]. Even though countries should first reduce relevant barriers for disadvantaged groups, the appropriateness of selecting criteria for determining these groups needs to be adapted to the local context. Many different strategies can be implemented to target groups, services or individuals in a population.

Universal-targeting strategies can be utilised where all members of a population are eligible to receive benefits. Eligibility to access these services depends on whether an individual identifies as being part of the population; for example, groups such as children under the age of six or females. However, there are no qualifiers such as

income, race, education etc [21]. An example of a universal strategy includes the broad implementation of depression and suicide support schemes such as Beyond Blue [22]. However, it should be noted that these strategies can sometimes advantage those people in the population that are already in a favourable position, while not providing the same proportion of benefits for those in less favourable circumstances. Consequently, depending on strategy design, there is a risk it may widen the health gap [21].

While universal-targeting strategies can be used to promote UHC, more targeted approaches should also be utilised. This can include implementing equity-promoting targeting strategies. This involves giving priority to expand those services that address conditions which disproportionately affect disadvantaged groups [18]. The type or level of inequity that should be prioritised depends on the values of societies and as such, should be different from one country to the next. Many current equity-promoting strategies do tend to focus on geographic inequalities or populations that are considered to be most vulnerable or low on the socioeconomic scale [23]. Examples of equity-promoting strategies which target vulnerable populations is the state-led project in Benin called ARCH. This program includes multiple social protection services such as providing social insurance subsidisation for vulnerable groups [24].

There can also be individual target strategies. These strategies involve identifying specific individuals in the population through a series of criteria and then allowing them to access certain services and schemes [25]. An example of such a strategy is providing healthcare fee-exemption schemes to individuals in the population who meet predetermined criteria [13]. These strategies are reasonably effective at achieving policy objectives and enhancing program efficiency; however, their impact on improving access is still up for debate [25]

However, it should be noted that targeted strategies can be less efficient in creating health benefits because some populations can be more costly to reach than others. Nevertheless, targeting disadvantaged groups in some contexts does in fact complement cost-effective strategies. As such, it is important to take into consideration the cost-effectiveness of programs; however, the equitable and fair realisation of UHC should take precedence over these financial considerations [13].

Furthermore, every strategy that promotes UHC requires the support of the population. As such, if the scope of the targeting is narrowed to a small subpopulation, support may be lost. Therefore, it is important to take this into consideration during the design of strategies, programs and policies. This will ensure that equitable health strategies can be effectively implemented in a population [13].

Reducing out-of-pocket payments

As UHC includes both access to services and financial risk protection, it follows that out-of-pocket payments represent barriers to achieving UHC. Therefore, achieving UHC requires reform in the health financing system, with a shift from out-of-pocket payment towards prepayment and fund pooling for health services [14]. In implementing this shift, nations need to consider which subpopulations should be subject to a reduction of out-of-pocket payments first, and, when increasing

prepayment and fund pooling, how much each citizen should contribute to the pool in return for which benefits [13].

Out-of-pocket payments are made to healthcare providers or third parties at the time of service delivery, while prepayments are made by a potential recipient of a service or supply before need and delivery for a particular service. Examples include various taxes and premiums [26]. Out-of-pocket payments expose individuals to substantial financial risk. These payments often impede on access to needed services; faced with payments, people delay service use, seek suboptimal alternatives or do not seek services at all. It creates a large healthcare access barrier, particularly for low-income groups (who are often in equal or greater need and will benefit most from services). Additionally, any unexpected payments can cause financial strain on the patient and their family, potentially pushing people into poverty, or those who are already poor into destitution [13,27].

On the other hand, a pooled funding system facilitates efficient and equitable realisation of UHC. The pooled funding system provides the population with financial protection through the pooling of risk. Risk pooling means that those who require less health services subsidise those that have a greater demand for health services. For example, the young, who generally have lower health risk, subsidise the old who generally have a higher health risk and as such, financial accessibility for the elderly is improved. Without risk pooling, payments made for health services are directly related to the needs of the individual; as such, the more 'sick' people pay more. However, this is inconsistent with the need to provide all people with financial risk protection and equity of access to services. The pooling of funds, and therefore of risk, ensures that costs of accessing healthcare are shared - promoting financial accessibility [28].

Prepayment systems allow for pooling of funds. These systems can take the form of many models including private and social insurance programs. However, mandatory contribution mechanisms (such as taxation and mandatory social health insurance) are more efficient in promoting UHC compared to voluntary mechanisms [29]. This is because voluntary mechanisms result in a higher likelihood of high-risk individuals joining a pooled scheme, compared to low-risk individuals [30]. As such, mandatory systems ensure that all people including the rich, young and healthy, are part of the pooled scheme that they may not ordinarily opt into if it were to be voluntary. Through having a mandatory system, it does mean that some individuals may pay more than they receive in personal benefits. However, they will have financial-risk protection for any unforeseen or emergency scenario, and can still receive personal benefits for any health services they may require currently or in the future. This model of social medicine promotes fairness and equity principles, and progresses countries towards achieving UHC. Therefore, mandatory prepayment with pooling is recommended for healthcare systems [29,31].

The financial healthcare model of having the pooling of funds with mandatory prepayments into this pool, should be adapted to accommodate a country's current healthcare system structure. For example, the current composition and development of private and public health systems, along with health insurance schemes, needs to be taken into consideration. Therefore, the shift in financing structures still depends on a range of country-specific factors and as such, this model should be adjusted accordingly [13].

There are multiple ethical dilemmas that present themselves when a nation begins the transition from out-of-pocket payments into a mandatory prepayment system. One of these critical issues is with respect to which subpopulations should receive reduced out-of-pocket payments first. Out-of-pocket payments should first be eliminated for high-priority services, low-income groups and other relevant groups who are disadvantaged in terms of financial service access [13]. It should be noted that reducing out-of-pocket payments is one part of a holistic strategy that should be implemented to increase physical and financial access to healthcare.

Another crucial question that needs to be considered is the amount of financial contribution each individual should make to the pool and which benefits each person should receive. In order to implement this, payment into the pool and use of pool funding should be decoupled [32]. A commonly used guide is to have mandatory payments which increase with an individual's ability to pay, while benefits are received only based on need. This model promotes the principle of right to health, and a collective responsibility for affordable access [13].

Overarching strategy

By considering these three requirements to achieving UHC, the World Health Organisation has a three-part strategy that nations can adopt in order to realise UHC [13]:

1. Categorise services into priority classes. This can be done through using relevant, just criteria related to cost-effectiveness, community vulnerability assessments and financial risk protection.
2. Expand coverage for high-priority services to the whole population. This involves both improving access, and eliminating out-of-pocket payments.
3. Ensure disadvantaged groups are not left behind. Every country will have a different classification of disadvantaged groups, but generally it will include rural and low-income populations.

In this approach, the requirement for establishing appropriate priorities, in terms of population groups and services, is critical to achieving UHC. This strategy should be amended and adapted to every country, depending on their current healthcare system and access, as well as the culture and appropriateness of strategies in the local context [13].

Unacceptable Trade-offs

When formulating strategies to achieving UHC, there are five unacceptable trade-offs which need to be avoided, as they would prevent a fair and ethical transition to a UHC model [13,33]:

1. Expanding coverage for low or medium-priority healthcare services before there is near universal coverage for high-priority services. This also includes reducing out-of-pocket payments for these low or medium-priority services prior to high-priority services.
2. Giving priority to very costly high-priority healthcare services when the health benefits are relatively small, compared to alternative, less costly services.
3. Expanding coverage for well-off groups before worse-off groups.
4. Creating universal coverage strategies only for those with the ability to pay and not including those who do not, even if such an approach would be easier.

5. Shifting from out-of-pocket payment systems to mandatory prepayment systems in a way that causes the healthcare financing system to become less progressive (such as by, for example, having contribution to the system not being determined by an individual's ability to pay).

Vertical and Horizontal Health System Approaches

Vertical and horizontal health programs are two broad divisions of healthcare delivery, especially in developing nations. The use of one or the other is centrally related to issues of health system governance, financing and global politics which dictate where funds are used within individual nations' health systems [38].

Vertical healthcare systems focus on tackling a specific health problem and developing appropriate strategies to reduce, manage or eradicate it. This system is often disease or health-problem specific, and therefore are not particularly integrated into health services. Examples include programs which address malaria or HIV/AIDS as well as the eradication of smallpox [34].

These programs are often appealing to Western funders as it enables the funding of specific programmes with measurable outcomes, providing funders with tangible programs. For example, a Western funder can say that through investing a certain amount of money into the prevention of a specific disease, they were able to decrease the incidence rate of that disease by a certain amount. However, this results in the external stakeholders being key deciders in determining which issues should be addressed and by what means. Consequently, local communities lose their autonomy and power of self-determination, which can result in unethical and unsustainable programs limited by funder stipulations and are often run separately to - rather than bolstering - existing health system structures [35]. Thus, vertical disease programs often support rather than strengthen health systems: by improving health services in one domain but neglecting to strengthen the underlying structures which would lead to improvement across health services as a whole [37]. The advantages of vertical programs include that they provide greater services specialisation and concentration, increased profile for high-priority diseases or services, improved accountability and transparency, rapid results in weak health systems and better odds of success in those weak systems. However, vertical programs can have negative spillover effects, lack long-term sustainability, discourage comprehensive approaches and demotes community autonomy. Consequently, they can undermine the key principles of partnership, collaboration and self-determination in global health [36].

Horizontal approaches refer to an integrated approach to health service delivery, using a primary care approach to delivering care through existing systems, and focusing on community-led strategies to address the health needs of the community. They have the ability to strengthen the health system and are advantageous in terms of cost-effectiveness and sustainability compared to vertical programs [35].

An example of a horizontal disease program is the Integrated Management of Childhood Illness (IMCI). This program unifies and consolidates the management of several childhood diseases with high morbidity and mortality rates, such as diarrhoea, pneumonia, malnutrition and malaria. In a vertical system, each of these diseases would have had its own program with individualised structure, funding and reporting [39]. Instead, horizontal disease programs, such as IMCI, facilitates the integrated management of multiple determinants of health, promotes the efficient use of scarce funding and resources, and improves the possibility of patient centred care over the spectrum of life-cycle and health problems [40].

Horizontal approaches are the key to successful health system strengthening, however are limited by current global health financing structures as they are usually publicly financed and thus, receive no external funding to support them. As such, they tend to be poorly monitored and evaluated which limits their success [34]. Further, in countries with already weak health care systems funding may not be enough to actually improve primary health care services.

There will always be circumstances where a vertical approach is needed, such as in the case of important disease outbreaks, e.g. COVID-19, where it is beneficial to have a targeted response and to achieve outcomes more quickly. However, from a long-term sustainability perspective, horizontal approaches are essential for health systems strengthening and equipping health systems to cope with the ever-changing health landscape.

Domestic Dimension

Role of Government – An Overview

The Australian federal, state & territory, and local governments share responsibility for funding, operating, managing, and regulating the Australian health system [41].

Healthcare in Australia is underpinned by Medicare – a public health system which is designed to provide UHC for all Australian/New Zealand citizens, permanent residents, and citizens of countries with reciprocal agreements. It is supported by private health insurance, which operates alongside the public system. The health system is structured around three levels of care – primary care, which is the first point of contact with the healthcare system (GPs, ambulance officers, allied health specialists), secondary care (care delivered by specialists or acute care in emergency department) and tertiary care (consultative specialist care as a hospital inpatient).

The main roles of each level of government are outlined below; [42]

Australian Federal Government:

- Develops national health policy
- Funds medical services through Medicare, listed in the Medicare Benefits Schedule (MBS)
- Regulates and subsidises certain medication through the Pharmaceutical Benefits Scheme (PBS)
- Jointly funds public hospital services by providing tied grants to States and Territories for use in the public health system
- Funds population specific services, including but not limited to
 - o National Aboriginal Community Controlled Health Organisations
 - o Health Services for Veterans
 - o Residential Aged care
- Funds medical research
- Supports access to and regulates private health insurance schemes

State and Territory Governments:

- Jointly fund public hospitals
- Manage public hospitals
- Regulate and license private hospitals and health premises
- Regulate products with health impacts such as alcohol and tobacco
- Deliver community-based immunisation services and ambulance services

Local Governments and Municipalities:

- Can deliver community/home-based health and support services
- Environmental health services, including but not limited to waste disposal and water fluoridation

Additionally, all levels of government are jointly responsible in the education, training and regulation of health professionals, funding palliative care and responding to national health emergencies.

Australian healthcare system and its relationship to UHC

Private Healthcare

In Australia, private health insurance (PHI) is a voluntarily acquired agreement that covers individuals and families by providing financial assistance for the cost of specified health services. Private health insurance is 'community rated' which means that insurance cannot be refused to any person, regardless of their risk profile or likely usage of health services. Insurers also cannot charge customers more due to an anticipated higher usage of health services. Typical policies include cover for hospital treatment in public or private facilities, and/or cover for general medical services such as dental and optical care, as well as ambulance cover. Policyholders pay a monthly premium for cover [43,44]. As of December 2020, 44.1% of the Australian population had some form of private patient hospital cover. All states and territories showed a decrease in the proportion of hospital cover between 2017 and 2020 of about 2-3%. The biggest decrease was within the 25-29 age group of 2.14% between 2019 and 2020, and an average decrease of 4.76% per annum between 2017 and 2020 [45]. Current legislation combines incentives and penalties to encourage more people to adopt PHI. The first penalty is the Medicare Levy Surcharge, which is an additional tax levy between 1-1.5% of taxable income, charged on top of the standard Medicare Levy for high-income earners (over \$90,000 annual taxable income for singles) who do not have PHI. [46] The second penalty is Lifetime Health Cover, which penalises individuals who have not taken out PHI by the age of 31 by charging a 2% loading on their premiums for 10 years when they do take out a policy [47]. The third measure is the private healthcare insurance rebate, an incentive which seeks to make policies more affordable by subsidising a certain proportion of premiums. The exact amount subsidised is based upon an income test. The rebate is estimated to cost the government between \$6.5 and \$8 billion [48, 49].

Challenges & The Role of the Rebate

These strategies are considered to be necessary to counteract the increasing cost of premiums (regular payments from the policyholder to the fund). Community rating means that insurers, instead of charging higher-risk individuals more, must equally distribute the estimated costs of claims amongst all policyholders. This has led to premiums rising by 30% between 2011 and 2019, over 3 times the equivalent rise in wages. Young people are therefore increasingly uninterested in taking out a policy, which further exacerbates the problem as these young people, who are least likely to claim costs, are needed to balance out the costs from older policyholders and stop the rise in premiums. Neither have any of the aforementioned incentives or penalties been able to stem the rise in premiums by increasing the uptake of policies. As stated above, PHI is decreasing in popularity among Australians, especially young people, with only the introduction of the rebate in 1999 being seen to have a major effect on insurance coverage [49, 50].

The increasing problems with the incentives or penalties have led to controversy, particularly in regards to the role of the PHI rebate. In 2019 the Grattan Institute commissioned a working paper into the history and future of PHI. This paper stressed that the way in which the effectiveness of PHI-related policies is assessed is entirely contingent on the role it is designed to play within the Australian healthcare system. As a result, whether the rebate should continue as it is depends on whether PHI is designed to complement or substitute funding to public health services [49].

PHI as a complement to the public system would include roles such as:

- Covering services not covered under Medicare, such as dental or optical services
- Allowing patients to be able to choose their treating doctor as a private patient within the public system
- Allowing patients to access private healthcare facilities with higher-quality or more comfortable amenities and services
- Allowing patients to access care more quickly by bypassing public hospital waiting lists

In this situation, the report concludes that there is little justification to continue the rebate, for the following reasons:

1. Subsidising the access of only some individuals to services such as comfortable facilities, choice of doctor, or being able to bypass waiting lists, with no publically available equivalent, is not consistent with the principles of UHC, specifically those of equity and need-based access
2. The \$6.5-8 billion spent on the rebate would be more useful if redirected to funding the public system
3. Subsidising private health increases competition between private and public systems, which would increase costs for the public system
4. It is suggested that decreasing the rebate would overall decrease government costs, due to the amount paid out to subsidy being higher than the public spending required to replace it [51]

On the other hand, the report states that there is justification for the rebate to continue if private healthcare is intended to be a partial substitute to the public system to the extent that a significant proportion of patients will use the private system as a standard approach to healthcare. However, in this case, the report argues that governments need to form legislation and executive action to ensure effective and sustainable UHC is maintained, due to the following reasons:

1. Private hospitals tend to prefer more profitable or simpler outpatient procedures, which would mean the public system would be forced to take on more expensive, chronic or complicated inpatient procedures [52]
2. Subsidising private health increases competition between private and public systems, which would increase costs for the public system
3. Healthcare workers, particularly specialist medical practitioners, may be less interested in working in the public system, causing a shortage of workers
4. A system dominated by private health may cause inflation in prices for services, which would increase costs for both the patient (paying insurance) and the government (paying the rebate) [49]

With consideration of the above factors, there are growing calls to decrease the level of subsidy paid out or completely remove the rebate altogether. A later report from the same authors of the Grattan report recommended a restructuring of the rebate system such that the rebate exists only for policyholders over 55, and the phasing down of the MLS and LHC, effectively focusing the PHI system on older Australians [53]. On the other hand, The Australian Greens have proposed a policy to remove the rebate and redirect the funding to public health services, including dental covered by Medicare. This proposal is supported by the Australian Health Care Reform Alliance [54].

Preferred provider systems

Private Health Insurance (PHI) is slowly but surely shifting towards a managed care model with preferred providers [56]. A 'preferred [healthcare] provider' is defined as a provider which has a contractual agreement with a specific health fund, [55] where the medical fees charged to patients are set and controlled by the insurer. In order to receive the maximum possible rebate from the insurer, the patient must attend a preferred provider practice - if they choose instead to attend a non-preferred provider practice (henceforth referred to as an 'independent provider') they shall receive a lower rebate [56]. These differential rebates - where patients receive varying payments depending on which doctor they choose - act as an inherent restriction on patient choice and autonomy [56,57]; the limitation created by financial deterrent or incentive. Private health insurers, then, have an increasingly strong tether on influencing patient choice [57,58] – or lack thereof – in terms of available healthcare pathways. Given that a central tenet of UHC is empowering patients by giving them choice, managed care is inherently antithetical to the provision of UHC [49].

Insurers can simply choose not to provide coverage to the patient for certain services if they don't meet the insurer's business needs [59]; thereby inserting a commercial relationship in one which should consist solely of doctor and patient [56]. A 2017-18 senate inquiry [63] found that private health insurers' use of data obtained from Health Industry Claims and Payments Service (HICAPS) terminals could be used inappropriately for commercial gain, including the ability to generate preferred provider contracts [55]. This increased access to data, combined with the 'for-profit' health insurance sector prioritising reporting to shareholders is likely to lead to increased use of selective contracting, to minimise expenditure and maximise their profits [55, 56]. Furthermore, in 2021, nib, an Australian insurance company, announced its partnership with the US managed care giant Cigna Health Insurance, into a merger called Honeysuckle Health [61, 62]. While preferred provider contracts already do exist in the current Australian healthcare system, this merger would see considerable expansion of managed care in Australia, where the insurer would exercise greater control over patient care [61,62]. This would likely increase the power imbalance between doctor and patient – according to the CEO of the Australian Doctors Federation – given that the practitioner would effectively become a business partner of the corporate health fund [58, 60]. More broadly, preferred provider arrangements can create inequity with consideration to access to services between fund members who live rurally: those who may not have preferred providers in close proximity will receive less benefit from their insurance despite paying the same premiums as their metropolitan counterparts [59]. Given that equitable access and quality of care are both central to the provision of UHC, managed care proves, once more, to be an ineffectual framework [49].

Healthcare providers have also voiced concerns of patients being misdirected (or mistakenly choosing) preferred providers who may not have the requisite specialised skills required for certain procedures [57] due to these financial limitations, which would compromise quality of care. This considered, the Australian Medical Association (AMA) has postulated that if national legislation required that insurance bodies paid the same amount to practitioners, rather than instigating preferred provider contracts, out-of-pocket expenses for patients would substantially reduce, [55] which would in turn increase access and transparency for patients in their use of healthcare systems. Abolishing the preferred provider system is supported by various medical bodies, including but not limited to the AMA, Australian Society of Orthopaedic surgeons, Australian Society of Anaesthetists, Australian Society of Ophthalmologists and the Royal Australasian College of Surgeons many of whom have formed an alliance under the “Send the eagle home” initiative, which aims to prevent this US-style managed healthcare in Australia [60].

Prior Authorisations

Prior authorisation (PA) is a health plan cost-control process that commonly appears in the United States and forms a part of managed care. A prior authorisation scheme requires physicians or other healthcare providers to obtain advance approval from a patient’s health fund before a prescription for medication or medical service is delivered, in order to obtain coverage of costs by the health fund [63]. A failed authorisation means that the insurance provider will refuse to cover the costs of that particular treatment/procedure even if recommended by the treating doctor, meaning patients either pay for the treatment out of pocket or simply do not take the treatment. Alternatively, some providers will require the patient to undergo “step therapy” by which the patient must first undergo treatment/procedures that the provider does cover, and from there only after unsuccessful results from the preferred treatments will the fund reconsider authorisation for the treatment/procedures initially requested by the treating provider [64].

A 2017 survey of American physicians reported that 92% of the surveyed physicians reported delays in patient care due to PA, with 78% stating that rejection or other issues relating to the process can contribute to abandonment of an intended treatment. 92% of those physicians also believed that delays of care due to PA have had a negative impact on clinical outcomes, with 61% reporting that it can have a significant negative impact [65]. Policies for step therapy are also reported to be inconsistent with medical guidelines for various chronic conditions or special treatments. In one study, 98% of analysed policies required a step therapy process for approval of an anti-TNF to treat ulcerative colitis in a manner inconsistent with guidelines developed by the American Gastroenterological Association. [66] The requirement to fill out paperwork when requesting PA has been reported to result in increased workload and cost for physicians, pharmacists and other healthcare workers and organisations. The survey of American physicians suggested that each week, an average of about 29 PA’s were completed, resulting in an average 14.6 weekly hours of workload completed by the physicians or their staff to complete PA requests [67].

Prior authorisation currently does not exist within the Australian private healthcare system. However, preferred provider contracts and health buying groups such as the aforementioned Honeysuckle proposal may be able to create a system of prior

authorisation when they negotiate contracts with healthcare providers, by refusing to sign preferred provider contracts to providers who refuse to abide by the PA requirements. The Private Health Insurance Act 2007 does not appear to explicitly prohibit denial of claims, and further allows PHI providers to deny claims for individuals with pre-existing conditions, pregnancy for pregnancy/birth-related claims, or mental health conditions for psychiatric care-related claims, for varying periods but in general no longer than 12 months. Additionally, the fact that the insurance provider decides whether a policyholder has a qualifying health status rather than the holder's own treating doctor sets a potential precedent for PA decided by the PHI provider [68]. While there is not sufficient literature on how feasible prior authorisation is in Australia, professional associations such as the Australian Society of Plastic Surgeons have expressed concerns that preferred provider contracts and health service buying groups will be able to manipulate healthcare providers into an effective system of PA [69].

Australia's involvement with WHO and International Health Systems

Australia's country cooperation with the World Health Organisation (WHO) is predicated on the strategic priorities of health security, people-centred health systems in achieving UHC, and regulatory strengthening and promoting organisational excellence within WHO itself. Currently, the Therapeutic Goods Administration, the Australian Institute of Health and Welfare (AIHW) and the Australian Radiation Protection and Nuclear Safety agencies host WHO collaborating centres, which facilitate the collation and dissemination of information, the development and standardisation of nomenclature, technology, procedures and substances, as well as collaborative research. The Federal Department of Health is primarily engaged with WHO through the management of disease outbreaks and working towards global cooperation on standards and plans with international counterparts. Foreign aid regarding health policy and healthcare is managed by the Department of Foreign Affairs and Trade (DFAT) [70]. DFAT's core contribution to WHO during the 2021-22 financial year was \$12,400,000 [71]. Outside of WHO, DFAT delivered \$4 billion of aid during the 2019-2020 financial year, of which \$1.4 billion was directed towards the Pacific, \$1 billion to Southeast and East Asia, and \$226.2 million to South and West Asia. On the other hand, only \$199.8 million dollars of foreign aid was directed to both the Middle East and Africa, suggesting that increased investment in different regions may be desirable. Furthermore, in recent years overall foreign aid has decreased relative to the proportion of national income, down from 35c per \$100 in 2011 to 19c per \$100 in 2020 [72, 73].

Australia's efforts with WHO has a strong focus on neighbouring countries in the Western Pacific Region. In terms of health security, Australia has a strong interest in helping WHO enforce the International Health Regulations treaty and the Asia-Pacific Strategy which helps implement said treaty. However, a large part of health security and regulations is the implementation of effective information and digital health networks in other countries, which is why Australia is also involved in assisting developing countries build those networks in a similar manner to AIHW. Another focus of Australia's efforts, the promotion of patient-centred care and UHC, has been noted by the Regional Office, and WHO encourages further collaboration so that other Western Pacific countries can form similar patient-centred systems [70]. Australia has been vocal in regards to reform within WHO itself, especially during COVID-19 through its position on WHO's executive board which concluded its tenure at the end of 2020.

Among other proposals were removing the right of individual countries to veto proposed health strategies, implementing an independent organisation tasked with examining WHO's performances during global health emergencies such as COVID-19, and giving WHO the power to send investigatory teams into countries to determine factors behind disease outbreak and that country's response [74].

Domestic Gaps in Universal Health Coverage

Australia aims to provide UHC in the form of Medicare, where eligible Australians are offered subsidised health services. According to WHO's 2018 report of UHC service coverage index, Australia is performing well across most UHC indicators within the Western Pacific region. The mean threshold was 60, and Australia had performed better than the threshold across all 4 indicators. Indeed, Australia only performed in the 60-80% band for UHC with respect to noncommunicable diseases. All other indicators were above the 80% band [75].

Despite a successful overall UHC, the WHO report highlights that not all people have equitable access to the necessary health services or financial ease in accessing this. For example, Australia's migrant population - such as international students and various asylum seekers - do not have access to Medicare at all. As a result, Australia's healthcare falls short of WHO's standard for UHC delivery.

This next section will consider several groups identified by WHO and the Australian Institute of Health and Welfare which are disproportionately affected by the inequitable distribution of UHC.

Low socioeconomic background

Between 2017-2018, Australians spent an average of less than 0.4% of their personal wealth on healthcare [76]. Yet, upon further segmentation of the population, the lowest income quintile spent a disproportionately large amount of their personal wealth on healthcare expenditure. Indeed, Callander et al (2018) identified that approximately 30% of households in the lowest income bracket spent 'catastrophic' (being greater than 10% of income on healthcare expenditure) levels on healthcare during the 2006-2014 period [77]. More recently, the 2018 WHO UHC report estimated that 4.7% of households spent greater than 25% of their budget on healthcare, with the poorest 20% disproportionately making up 85% of these households [78].

Thus, a major gap in domestic achievement of UHC is that not all Australians can access healthcare without financial hardship. As evidenced, those of lower socioeconomic background are more likely to spend 'catastrophic' amounts of money to attain a better standard of health.

Rural and Regional areas

Those living in rural and regional Australia do not have the same access to high-quality healthcare services as their metropolitan counterparts, leading to an overall poorer outcome in health [78]. Data from the 2016 Australian Bureau of Statistics Survey of Health Care found that Australians living in remote and very remote areas were six times more likely than Australians in major cities to report that not having a nearby GP created a barrier to seeing one [78]. Additionally, in 2017-2018, preventable hospitalisations were 2.5 times higher in very remote areas when compared to metropolitan centres, highlighting gaps in health prevention [78].

Australians with disabilities

Many health services are inaccessible to Australians with disabilities because of a variety of reasons: inaccessibility of buildings and hospitals, financial hardships, discrimination displayed by the healthcare system. Indeed, 2 in 5 people with disabilities (under 65 years of age) had difficulty accessing healthcare services [79].

Indigenous Australians

Indigenous Australians also do not have equitable access to healthcare services for various and complex reasons. For example, in 2017-2018, the AIHW highlighted widespread problems in accessibility as Indigenous patients' Medicare Benefits Schedule (MBS) claims for specialist services were 44% lower than those of non-Indigenous patients [80]. Even when the level of remoteness was accounted for, Indigenous populations had a consistently lower number of MBS claims for healthcare services compared to non-Indigenous populations. Moreover, the National Indigenous Australians Agency highlights that inequities in healthcare access is a major contributor to the life expectancy gap between Indigenous and non-Indigenous patients [81].

Indeed, this problem with access is exacerbated by the fact that Indigenous populations living remotely often have fewer specialists and primary healthcare practitioners within their service area [82]. Resultantly, these patients may need to travel longer distances to receive their required healthcare which presents logistical and financial difficulties. For example, a study funded by South Australia Health identified that patients may spend between three to sixteen hours to travel to a specialist, yet they may eventually cancel their health appointments as the travel and associated accommodation costs are too high [83]

Health system strengthening strategies

The core functions of a health system as outlined in WHO's 'health systems building blocks' framework [84] include:

- 1) service delivery,
- 2) health workforce,
- 3) health information systems,
- 4) access to essential medical products, vaccines and technologies,
- 5) financing, and
- 6) leadership and governance.

Health system strengthening (HSS) has been defined by WHO as 'improving these six health system building blocks and managing their interactions in ways that achieve more equitable improvements across health services and health outcomes.' [84]

HSS interventions possess several key characteristics: Firstly, the scope of the intervention is significant, such that it has benefits across multiple blocks, and benefits beyond a single disease [85, 86]. Secondly, the scale of the intervention is significant, such that it has national reach and affects multiple levels of the health system. [85, 87] Thirdly, the intervention is sustainable, such that long-term systematic impact is maintained over time [85, 86]. Finally effects of the intervention pertain to positive outcomes in health, equity, financial risk protection and

responsiveness of systems. [85] Systems thinking is an approach to HSS which examines the structures and relationships between parts of the health system in an attempt to target interventions in such a way that they have the biggest impact on strengthening the system as a whole. [87]

Strengthening service delivery

Service delivery has been defined as the immediate outputs that arise from the inputs of a health system, such as health workforce, supplies, and financing. [88] The ideal characteristics for strong service delivery as outlined by WHO framework for service delivery [88] are briefly as follows:

- 1) the ability to offer a comprehensive range of health services appropriate to the population.
- 2) accessibility of services such that they are close to the people with routine entry points at a primary care level and no undue barriers
- 3) coverage of all people within the defined target population
- 4) continuity of care across health conditions, patient's life-time, service networks and levels of care
- 5) Provision of high quality services in a timely manner that are safe, effective and address the patients needs
- 6) Services centred on the person as opposed to the disease or financing
- 7) Coordination within health service networks, between networks a, with other sectors and partners including community organisations
- 8) Management of health services ensures efficiency with minimum wastage of resources and is held accountable for performance.

Strengthening community-level service delivery, and the reach of services to underserved populations is a key focus of HSS [85]. Community-based interventions, and strengthening of services closer to the community, are associated with improved outcomes, particularly in child and maternal health [89]. Delivery of services close to home may also improve the uptake of services [89]. Community participation plays a critical role in the success of service delivery strategies, and direct community engagement - such as community-directed distribution of services - has been linked with increased treatment coverage [89].

Strengthening primary health care (PHC) is critical for improving health systems and population health. Evidence demonstrates that increased PHC supply is linked with improved health outcomes, and that PHC is associated with more equitable health distribution in comparison to specialty care [90]. Specific interventions to strengthen PHC, such as scale-up of PHC workers, have been effective in increasing service coverage and narrowing inequities. [89] However, PHC service delivery in many low and middle-income countries remains fragmented, and thus recommendations centre on the need for integrated health services [85].

Integration of service delivery is central for building efficient, patient-centred health care systems [91], and there is good evidence linking integration interventions with improved health outcomes [89]. Interventions promoting integration include: integrated care pathways, which enable ease of navigation for patients through the system and provide coordination of services for users; governance models which guide the planning and implementation of service integration strategies; integration of particular interventions, such as integration of perinatal intervention with other health

care services; integration between types of health services; and integration of care models, particularly those that promote collaborative involvement with primary care [92].

Service delivery strengthening interventions typically focus strongly on the supply of services, with little attention given to demand [89]. However, appropriately raising demand for services is a recommended strategy [84], and evidence demonstrates that HSS interventions which incorporate demand generation elements - such as community demand generation programmes, social engagement, and promotion strategies - tend to have increased effectiveness [89].

The provision of packages of integrated services has been identified as an important area for attention, as have strategies to improve the quality of service delivery, such as provider-based improvement interventions. Positive outcomes have been seen with these strategies. However, results have been variable and as programs are designed to specific country contexts, these results may not be reproducible across countries [89].

Importantly, the implementation of health service strengthening strategies is just as important as the type of strategy used [91]. Effective strategies tend to involve the identification and minimisation of context-specific constraints, mobilisation of adequate resources, and continuous adaptation to the local context [91]. Indeed, the tailoring of interventions to the specific context in which they are being implemented is central to their success, [86] and while particular strategies may show effectiveness in one country these results are often not replicable for other countries [89, 91].

Strengthening health workforce

Strategies to improve the performance of the health workforce need to address distribution and performance of existing health workers, as well as health workforce supply [84]. Health workforce density is positively correlated with population health outcomes [93]. Recommended actions to strengthen the health workforce include training and education programs, organisation of health workers for effective service delivery, monitoring of performance, ability to scale-up the health workforce, and efforts to retain effective workforces, including rural workforces, in the context of local and international labour markets [84]. Successful approaches in this area have included task-shifting to address shortages [94,95], and implementation of performance management systems [96].

Strengthening health information

Strengthening of Health Information Systems (HIS) ensures reliable and timely health information is available for decision makers [84]. This is recognised as important not only on sub-national and national levels, but also importantly on an international level, given the role of HISs in adequate responses to epidemics and other public health emergencies [84]. A strong HIS is one which is able to generate population and facility based data, has the capacity to detect and respond to public health emergencies, and has the capacity to synthesise information and promote application of this knowledge [84]. Evidence of interventions in this area is currently limited, but promising improvements in coverage and health outcomes have been seen following investments in HIS [85].

Strengthening medical products, vaccines and technologies

Strategies in this area aim to ensure equitable access to and the appropriate use of essential medicines and medical products, vaccines and technologies, that are safe, effective, and of assured quality [84]. Approaches may broadly include targeting of national policies, manufacturing practices, prices and trade agreements, and systems of procurement, supply, storage and distribution [84]. Supply chain strengthening strategies in particular have been recognised as critical for ensuring essential medicines and medical products are available and affordable to patients when needed, and has been an area of strong investment [85]. Interventions for supply chain strengthening may target stock-outs and loss due to expiration, procurement of medicines in bulk to obtain lower prices [89]. Interventions to improve prescribing practices and stock management have also been demonstrated to be effective, for example through training of staff to reduce inappropriate antibiotic prescriptions and supervisory programs aimed at improving stock management practices in health facilities [97]. Notably, there is good evidence for involvement of the private sector in supply chain management [89].

Strengthening financing

Strategies to achieve sustainable health system financing focus on the collection of sufficient revenue, the pooling of revenue to allow sharing of risks, and the purchasing of interventions and services. [84] The overall strategy is very similar to that which aims to achieve UHC. Evidence from low-income countries demonstrates that public spending on health is associated with improved health outcomes and more equitable distribution of health outcomes compared to private spending. [98,99] External aid has also been linked with improved outcomes, but effects are dependent on the approach of aid delivery [85]. Successful approaches tend to harmonise with domestic priorities and systems. [85]

Strengthening leadership and governance

Good leadership and governance is recognised as the most critical component in a health system [96]. Strategic guidance and oversight are key to achieving SDGs, mitigating inequities, strengthening the health system and improving health outcomes [100]. This requires both technical and political actions, and consists of several key components [84]. There should be effective policy guidance such that priorities and the roles of key actors for achieving priorities are identified and clearly articulated. Intelligence should be generated and interpreted in order to monitor progress towards goals, and identify opportunities for actions and policy options. Coalitions should be built in order to collaborate across government ministries, sectors and communities. Appropriate regulations and incentives should be designed, implemented and fairly enforced. Accountability should be ensured such that all health system actors are held accountable and actions are transparent. Responsibility for these processes ultimately falls to the government. However, other actors contribute to the functions of leadership and governance, and thus a key strategy of governments should be appropriately mobilising and overseeing other networks of power, including the public and private sectors and civil society [100]. There is evidence demonstrating that interventions targeting leadership and governance, including mechanisms to promote increased accountability and civil participation, can be linked with improved health outcomes. [89]

Sustainable Development Goals pertaining to UHC and Health Systems Strengthening

The Sustainable Development Goals (SDGs) are a collection of 169 specific targets spread across 17 broad and interdependent global goals, designed by the United Nations as a blueprint to achieve a better and more sustainable future. The SDGs were included in the 2030 Agenda for Sustainable Development UN Resolution passed in 2015 [101], and the Commonwealth of Australia is one of the 193 countries committed to their realisation by 2030 [102].

Among the 17 SDGs, Goal 3 centres on the "[ensuring of] healthy lives and [the promoting of] well-being for all at all ages" [103]. On UHC specifically, target 3.8 aims to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" [103]. Realisation of UHC is recognised by the 2030 Agenda for Sustainable Development as key to considerable progress and achievement of the other health-related SDG targets [104]. Thus, naturally, goals such as 3.2 or 3.4, relating to reducing neonatal mortality and premature mortality from non-communicable diseases respectively [103], would be significantly positively impacted by achievement of UHC.

Furthermore, it is acknowledged that one of the necessary components towards the attainment of these health-related targets, especially SDG 3.8, is an adequately-trained, motivated and equitably-distributed health workforce [105]. This pertains, at least in part, to SDG 3.c, which involves "substantially [increasing] health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States". With the World Health Organisation projecting in 2016 a shortfall of 18 million health workers required for the realisation of UHC by 2030 [106], primarily in low and lower-middle income countries, further development, focus and funding towards SDG target 3.c is needed.

Numerous partnerships exist advocating for and developing global capacity to achieve UHC and the 17 SDGs in general. The UHC Partnership is one of WHO's largest platforms for international cooperation on UHC and primary care. Funded by several nation donors, of which Australia is not a part, the organisation's health policy advisors and health experts work with national health ministries to strengthen health systems towards and promote political dialogue around UHC [107]. Another collaboration is the International Health Partnership for UHC 2030, of which Australia is a partner, providing a multi-stakeholder platform for the acceleration of equitable and sustainable progress towards UHC and health systems strengthening [108]. However, the effectiveness of such partnerships was scrutinised by a 3-year research project, ending in December 2020, coordinated by the Centre for International Environmental Studies at the Graduate Institute, Geneva. The 'Effectiveness of Partnerships for Advancing the SDGs' findings posited that even though partnerships are often vulnerable to shifting political interests and aren't able to provide a comprehensive measure of its impacts, they tend to contribute meaningfully towards organisational learning, capacity building and the dissemination of new knowledge and practices [109]. The effectiveness of these long-term impacts of partnerships were positively associated with the specificity of partnership arrangements, the credible commitment of resources by partners, the capacity to foster adaptation and

experimentation, and the presence of innovative governance and funding mechanisms [109].

Seen as a significant step towards its commitment to the achievement of SDGs by 2030 to date, Australia released, in July 2018, its first - and, as of September 2021, its latest - Voluntary National Review (VNR) on achieving the SDGs [110]. However, a paper reviewing Australia's progress and implementation of the health-related SDGs, published in 2019 in the Australian Medical Journal (AMJ), was critical of the Australian government's efforts, finding that corporate and non-government sectors had been the main stakeholders promoting the nation's SDG commitments until 2018 [111]. The paper's authors recommended Australia to develop and ground its progress in a comprehensive SDG action plan contextualised to both the global and unique Australian health setting, as well as having a single point of government responsibility for the development and reporting on the SDGs, instead of being divided across government departments, which was seen as being "antithetical" to the SDG vision of national policy coherence [111].

Research

The 2019 UHC Global Monitoring Report describes formal and accurate monitoring of service coverage, affordability and equity markers as "critical to attaining universal health coverage (UHC)" [112]. Such monitoring is important because of its role in identifying priorities for investment in order to most efficiently improve coverage and affordability of healthcare [112]. However, evaluation of global progress is complicated by significant gaps in the literature. The 2019 report relies on statistics dating in some countries back to the early 2000s, which tell us nothing of the progress (or lack thereof) since. In particular, when monitoring the 2013-2017 period, the report found that on average countries had data for only 40% of the 14 UHC SCI indicators [112].

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Policy Details

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Category: G – Global Health

History: Adopted, Council 3, 2021
Aahana Dudani, Edward Meehan, Rishov Doloj, Kumaran Manivannan, Shani Nguyen, Leticia Peart, Symret Singh, Jasmin Somers, Angelyn Neoh, Sally Boardman