

Japan's Global Health Strategy in the Post-Covid-19 Era

VOL. 16

Synergies between Universal Health Coverage and Health Crises: How to Bridge the Two

Ayako Takemi

*World Health Organization (WHO) Consultant; Project Researcher, University of Tokyo
Institute for Future Initiatives*

The COVID-19 threat has impressed upon the world anew the importance of strengthening infectious disease response capability at the national and regional levels, and of boosting global health security (GHS). Many have commented on and analyzed the important role of universal health coverage (UHC) in the response to infectious disease, in particular with regard to the fight against COVID-19. UHC means “that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.” While synergies between GHS and UHC are often pointed out at the conceptual level, when it comes to specific indicators and analyses, there is a deeply rooted tendency to see GHS as involved in building capabilities geared toward infectious disease response, while UHC is viewed as being focused particularly on improving financial and geographical access to healthcare during normal times, especially in developing economies. Further analysis is needed on the details of the relationship between the two and the measures that ought to be taken in an international framework. There have been many diverse cases during the COVID-19 response that have demonstrated the important role of UHC in achieving GHS. It has also highlighted some viewpoints that fundamentally bridge the concepts, two examples of which are management capacity and community engagement. A brief overview of these topics is given here.

The Role of UHC in the COVID-19 Response: Considerations When Using Assessment Criteria

Opinions are divided at the indicator level regarding the extent to which UHC has contributed to the response to the COVID-19 outbreak.¹ When the pandemic first broke out, it was pointed out that analyses of the correlation between existing UHC measurement indicators and mortality rates showed a rather negative relationship. Dongarwar and Salihu (2020), for example, argued, “UHC does not appear to protect against mortality in a pandemic environment such as with COVID-19.” Some studies, however, implied the opposite.²

When looking at these early studies, several points need to be kept in mind regardless of the conclusion. These include, for example, (1) the possibility that cases may not be tallied properly due to differences in capability for detecting infected persons, and (2) the possibility that the results may be influenced by the scope and substance of the indicators used for measurement. As will be discussed below, since detection capability can be assured only when there is sufficient health access and coverage, it is possible that, depending on the numerical indicators used, the actual situation may not be fully captured. Moreover, UHC measurement indicators frequently focus mainly on the guarantee of access to healthcare in developing economies,³ inevitably leading to a tendency to give high ratings to developed countries equipped with basic healthcare facilities. In addition, it must be remembered that the levels of damage caused by COVID-19 have varied at different points in time.

Examples from Various Countries of the Potential for UHC to Contribute to GHS

Based on specific cases in various countries, the significance of UHC in outbreak response comes into view more clearly. UHC is used here in its basic sense—“that all people have access to the health services they need, when and where they need them, without financial hardship, (including) the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care,” along with the healthcare system to make that achievable. From this standpoint, UHC played major roles in each of the phases of infectious disease response, namely, prevention, detection, response, and recovery.

One of the most prominent of these is detection. In an assessment announced by the WHO, it was estimated that in African countries, only around 14.2 percent of COVID-19 cases have been properly detected.⁴ A lack of test kits and difficulty in distributing them, as well as limits to the number and capacity of test laboratories,⁵ are among the reasons assumed to be behind this problem. The prevalence of asymptomatic COVID-19 cases makes this situation all the more serious.⁶ While testing tends to be seen primarily as an infectious disease response, thereby positioning it as one area of GHS, the underlying issue was not only a lack of material resources but also issues with the basic healthcare system for implementing the testing program.⁷

UHC also plays an important role in response and recovery. As is already well known, in

countries around the world including Peru, the United States, Brazil, Italy, and Mexico, it has been reported that structural inequities exacerbated the COVID-19 situation. In particular, all of these demonstrated that the impact of COVID-19 was “disproportionately large” as a result of race, gender, and social class disparities. While this is a wide-reaching problem, inequitable health access is a particularly major issue. In developing economies, financial barriers and geographical barriers to access are serious problems. In Peru, UHC is thought to have been strengthened on the financial front by the expansion of its health insurance program, but this is limited to very basic matters, and inadequate resource allocation and coverage remain an issue.⁸ These impacts are made more severe not only by the living environment and other issues related to sanitation, but also by the problem of lifestyle-related and other noncommunicable diseases (NCDs), which are exacerbated by limited access to health care, nutritional status, and so on, and by the further socioeconomic consequences of not having a stable livelihood. This vicious cycle makes inequality more entrenched and delays recovery both on the health and economic fronts.

It goes without saying that this is an ethical issue from the standpoint of equality, but it is also a broader problem in terms of ending the pandemic. Around May 2020, for example, Singapore, which appeared initially to have had a superior COVID-19 response thanks to its thoroughgoing contact tracing and seemed to be free of infections, saw a sharp rise in cases, most of which were in the migrant laborer community, so-called dormitory workers living and working in harsh conditions.⁹ Research into the situation indicated that because these laborers did not have adequate access to essential services close to their residence, they had to travel over long distances.¹⁰ The implication to be gained from this example is that the saying that “no one is safe until everyone is safe” is not just a simple slogan, but a warning about the need for a response to deal with infectious disease.

The Common Capabilities and Perspectives Needed for GHS and UHC

We have so far looked at the important role that elements of UHC can play at each phase of the infectious disease response. In addition to these, there are a number of capabilities that are shared on a more “abstract and fundamental” level by both GHS and UHC. Here we examine the importance of management capability and community engagement.

There are four requirements for realizing GHS: (1) properly assess the situation, (2) secure resources, (3) determine allocation of the resources, and (4) distribute the resources. With COVID-19 posing a major threat, attention has focused on (2), which is of course often the biggest issue at the height of an emergency. What needs to be reiterated, however, is that (1), (3), and (4), and the management structure for realizing these, are extremely important, and that in this sense, organizational readiness in normal times, and especially the UHC-related elements of that, have great significance.

UHC indicates a state of “having achieved equitable health access,” and includes in its scope the policy measures for this achievement. The achievement of UHC frequently may occur in parallel with an assessment of a healthcare situation in which “no one is left behind,” and at

the very least alleviates major geographical and social status inequalities and gaps. In the case of COVID-19 as well, the geographical inability to access hospitals or primary healthcare services clearly made it difficult to assess the situation. There have also been discussions on the implications of the pursuit of economic rationality in the healthcare system and the delays in the assessment of the situation due to the use of private insurance.

In Peru, the Ministry of Health lacked an entity for compiling data, making it difficult to obtain information on the nationwide need for ventilators and other equipment or available hospital beds. Studies in India indicate that clear, evidence-based information should have been shared and acted on for COVID-19 management. These and other cases from various countries show the importance and challenges of establishing a management system for compiling information, assessing the overall situation in real time, and quickly sharing and acting on the latest evidence-based information. As noted above, UHC has a strong potential to contribute to a better grasp of basic information. At the same time, UHC itself stands to benefit from information management. When resources are limited, assessing the situation and allocating resources appropriately are essential to ensure the objective of equitable health access. Surge capacity, for example, which is often studied in the context of GHS, consists basically of four stages: “identify the medical need, identify the resources to address the need in a timely manner, move the resources expeditiously to locations of patient need (as applicable), and manage and support the resources to their absolute maximum capacity.”¹¹ Conceptually, if not on the same timeline, this can also be applied to UHC. That is, the timely identification of basic information and of needed resources, and the use of this information in allocating resources, will lead to the realization of a resilient healthcare system, the necessity of which has been demonstrated by the COVID-19 threat. It is still fresh in our memory how countries like Portugal, Cyprus, and Jordan, among others, responded with flexibility to COVID-19 by adopting flexible responses, such as ensuring health access for immigrants (whose access during normal times is partially restricted). The COVID-19 threat showed that UHC is not a static state but must be proactively maintained.

Considering the above points, information management and response, and the management needed for these, have the potential to become foundational elements common to both GHS and UHC. At the same time, a key point for management, as is pointed out in the case of India,¹² is proper consideration of local contexts. While there is a tendency to understand the strengthening of management as being more compatible with a centralized system, a “one-size-fits-all” approach is not appropriate, especially in an environment where there are regional differences in the levels of damage and available health services, so greater emphasis should be placed on how to achieve proper decentralization through management.

Element (4) of GHS, implementing resource allocation, likewise cannot be separated from UHC. For example, when the underlying supply chain is concentrated in urban areas, the provision of necessary materials to rural villages and hamlets cannot be guaranteed. In the case of COVID-19 as well, vaccines distributed under the COVAX program initially could be received only in urban areas where an ultra-cold chain system (a logistics system able to manage vaccines at very low temperatures) and the power supply needed to maintain it are

available.¹³ Experts have noted that the EVM (Effective Vaccines Management, a nine-item management process) in use in normal times for routine vaccinations for children can be applied as is for the supply of COVID-19 vaccines, enabling services to be fully provided without constructing a new management system from the ground up.¹⁴ This is not limited to developing economies. In the United States, for example, the importance of having supply chain management consistent for both normal and emergency times has been pointed out and verified.¹⁵ A big difference can be observed in response capabilities depending on whether or not the basic infrastructure and channels for a flexible response to emergencies exists.

At the same time, community-level engagement has also been pointed to as being important to both GHS and UHC. Numerous case studies have highlighted the role of localized community responses, notably in areas where there is inadequate coverage by a robust medical care system.¹⁶ In Syria, they have recorded successful outcomes from their strengthening of bottom-up local governance, and of the Volunteer against Coronavirus campaign.¹⁷ The Idleb Health Directorate, White Helmets, and other community-based aid organizations have also played major roles.¹⁸ There are also reports that health worker shortages in rural areas have had a significant impact on the COVID-19 response, and thus community support for primary healthcare, which is also at the core of UHC, addresses issues common to both.

“Revisiting” UHC—Scope and Concept

As noted earlier, while the UHC concept can be defined rather flexibly, its scope and perspective have become limited to a certain extent. This is significant in the sense of helping to prevent the UHC concept from becoming excessively broad. When it comes to UHC, we must consciously avoid the problem that “pointing at everything is the same as saying nothing.” With the COVID-19 response in developing economies in particular, the issue of financial hardship, which has always been considered a central issue in UHC, and problems of access to health care resulting from the burden of increased health expenditures, have continued to arise. It is therefore essential to continue to assist and further boost the areas that UHC has long emphasized, including support for basic health financing and health system strengthening.

Meanwhile, the implication of the COVID-19 threat is that UHC is not an issue for a limited set of nations and regions, and that it is meaningful to view UHC more flexibly. The UK, having introduced the NHS, is often treated as one of the representative countries that have achieved UHC.¹⁹ As for the quality of its health access, however, even if the level is naturally high on a global scale, when judged against the ideal, it is often judged harshly due to the worsening of its health financing.²⁰ In the case of Peru taken up earlier, it was noted that while health coverage itself was expanding, they have not secured equal access in terms of the level of healthcare provided. Indicators for assessing UHC achievement, such as the introduction of health insurance and the out-of-pocket ratio for medical expenses, are of course important, but a broader perspective could be introduced that considers the quality and the flexibility of infectious disease response, for example. In this regard, there are many cases where assumptions differ greatly when looked at globally, and we do not always need to stick to

quantitative indicators. One proposal would be to share and verify qualitative best practices, as implied in the recommendation by the Independent Panel for Pandemic Preparedness and Response (IPPPR).

Amid the expectations for synergies between GHS and UHC, one point that may become important is how, when working to achieve GHS, we can incorporate crisis response into the process of realizing UHC. As each country works to strengthen UHC, it will be necessary to go beyond just looking at whether its efforts have met the UHC criteria as a “static” state, and to look from the perspective of establishing a flexible framework able to respond to diverse situations, including infectious disease response and crisis management. In the process of strengthening UHC, it may be helpful toward this end to run simulations of infectious disease response based on diverse scenarios.

And finally, even while emphasizing existing definitions, more detailed verification should be carried out to determine whether UHC is contributing to the underlying framework for achieving GHS and vice versa.

※This is the English translation of the original Japanese version published on March 11, 2022 at: <https://www.jcie.or.jp/japan/report/activity-report-15246/>.

This policy brief series is the product of [a joint research project](#) conducted by the Japan Center for International Exchange (JCIE) and the Tokyo University Institute for Future Initiatives (IFI) to provide analyses on global and regional health governance systems and structures and to offer concrete recommendations about the role Japan should play in the field of global health.

¹ On this point, see Haruka Sakamoto, “Synergies between Universal Health Coverage (UHC) and Health Security,” Global Health Governance (GHG) Study Group Policy Brief vol. 10 (2022), <https://www.jcie.org/analysis/books-reports/japans-global-health-strategy-in-the-post-covid-19-era-vol-10-synergies-between-universal-health-coverage-and-health-security/>.

² For example, see Ryan R. Hale, “The Protective Effects of Universal Healthcare on the Spread and Containment of COVID-19” (Doctoral dissertation, Vanderbilt University, 2021); and relating to vaccine access, see Deepa Dongarwar & Hamisu M. Salihu, “COVID-19 Vaccination Rates by Global Universal Health Care Coverage Status,” *International Journal of Translational Medical Research and Public Health* 5, no. 1 (2021): 33–36.

³ Included in UHC-SCI, one of the main UHC assessment indicators, is the category “service capacity and access.” A certain degree of consideration has been taken by including in this category such indicators as hospital access, health workforce, and health security. That the focus when conducting a worldwide analysis, however, is on issues of special concern in developing economies such as family planning, AIDS, malaria, water, and sanitation, is consistent with the claims in this paper.

⁴ WHO, “Six in Seven COVID-19 Infections Go Undetected in Africa,” 14 October 2021 <https://www.afro.who.int/news/six-seven-covid-19-infections-go-undetected-africa>.

⁵ A separate but similar problem pointed to is the lack of a sense of urgency about testing. It has been noted that there is little economic incentive to identify cases, and developing economies in particular, faced with numerous healthcare issues in addition to COVID-19, may tend to lack the motivation to build a strong testing capability.

⁶ Ibid.

⁷ Ibid. See also Martha Munezhi & Nazik Hammad, “Ethical Health Leadership: Lessons from Low-band Middle-Income Countries during COVID-19,” *Healthcare Management Forum* 34, no. 1 (January 2021): 62–67.

⁸ Camila Gianella et al., “Good Health Indicators Are Not Enough: Lessons from COVID-19 in Peru,” *Health and Human Rights* 22, no. 2 (2020): 317.

⁹ Jason Beaubien, “Singapore Was a Shining Star In COVID-19 Control—Until It Wasn't,” NPR, May 3, 2020,

<https://www.npr.org/sections/goatsandsoda/2020/05/03/849135036/singapore-was-a-shining-star-in-covid-control-until-it-wasnt>.

¹⁰ Huso Yi et al., “Health Equity Considerations in COVID-19: Geospatial Network Analysis of the COVID-19 Outbreak in the Migrant Population in Singapore,” *Journal of Travel Medicine* 28, no. 2 (2021): taaa159.

¹¹ US Department of Health & Human Security, “What is Medical Surge?”

<https://www.phe.gov/Preparedness/planning/mscc/handbook/chapter1/Pages/whatismedicalsurge.aspx>.

¹² Yamini Aiyar et al., “India’s Resurgence of COVID-19: Urgent Actions Needed.” *Lancet* 397, no. 10291 (May 25, 2021): 2232–34.

¹³ Author interviews, February 2022. Also, UNICEF, “Going Ultra-Cold: How UNICEF Is Supporting Countries for COVID-19 Vaccine Roll-Out,” January 24, 2022, <https://www.unicef.org/supply/stories/going-ultra-cold-how-unicef-supporting-countries-covid-19-vaccine-roll-out>.

¹⁴ Author interviews, February 2022.

¹⁵ National Academy of Sciences (NAS), “Building Resilience into the Nation’s Medical Product Supply Chains,” March 2022 (recommendations prepared by the NAS at the request of US Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response), https://www.nap.edu/resource/26420/Supply_Chain_Recommendations.pdf.

¹⁶ WHO, “Six in Seven COVID-19 Infections Go Undetected in Africa,” October 14, 2021,

<https://www.afro.who.int/news/six-seven-covid-19-infections-go-undetected-africa>; Brynne Gilmore et al., “Community Engagement for COVID-19 Prevention and Control: A Rapid Evidence Synthesis,” *BMJ Global Health* 5, no. 10 (October 13, 2020); Nicola Luigi et al., “The Role of Hospital and Community Pharmacists in the Management of COVID-19: Towards an Expanded Definition of the Roles, Responsibilities, and Duties of the Pharmacist,” *Pharmacy* 8 no. 3 (August 7, 2020): 140.

¹⁷ AbdulkarimEkzayez et al., “COVID-19 Response in Northwest Syria: Innovation and Community Engagement in a Complex Conflict,” *Journal of Public Health* 42, no. 3 (May 21, 2020): 504–9.

¹⁸ Ibid.

¹⁹ Arush Lal et al., “Fragmented Health Systems in COVID-19: Rectifying the Misalignment between Global Health Security and Universal Health Coverage,” *Lancet* 397, no. 10268 (December 1, 2020): 61–67.

²⁰ Michael Anderson et al., “LSE–Lancet Commission on the Future of the NHS: Re-laying the Foundations for an Equitable and Efficient Health and Care Service after COVID-19,” *Lancet* 397 (May 22, 2021): 1915–78.