

## Beyond clinical skills: key capacities needed for universal health coverage

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Global commitment to achieving universal health coverage (UHC) has grown stronger in recent years.<sup>1</sup> With this commitment has come the realization that, for UHC to be attained, the health workforce must possess clinical and non-clinical skills and competencies that respond to actual population needs.<sup>2</sup> The workforce is vital to well-functioning health-care delivery systems and equitable access to health services, but it is not enough to produce more health workers and place them where they are needed: we must also transform their education.<sup>3</sup>

Several capacities beyond clinical skills that are key to attaining UHC are uncommon in the health sectors of low- and middle-income countries. Experiences in China,<sup>4</sup> Mexico<sup>5</sup> and Thailand,<sup>6</sup> and in other countries rapidly progressing towards UHC, have demonstrated the need for capacity in two broad areas: policy formulation and policy implementation.

### Policy formulation

In countries pursuing UHC, the health sector needs not only professionals who are clinically competent, but also people with the capacity to generate country-specific evidence on the feasibility, sustainability and equity of different financing sources – e.g. taxes, health insurance premiums, out-of-pocket payments and donor contributions. It also needs professionals able to generate evidence on purchasing modalities and on the cost-effectiveness of new health technologies for the design of benefit packages.

Another essential capacity is that of translating evidence into policy. This is a nonlinear process: analysing evidence for decision-making takes skill and long-term institutional capacity, which can be developed through mechanisms such as independent policy “think tanks”.<sup>7,8</sup> The process of informing policies must be country-led and executed through national institutions, not foreign experts.

The capacity to design UHC systems is also critically important. All sorts of choices must be made, including how to pay providers, and each has implications for financial risk protection, access to care, health system accountability and responsiveness, cost containment and system efficiency.<sup>9</sup> For example, certain measures introduced in countries of the Organisation for Economic Co-operation and Development, including closed-end payments, have resulted in improved microeconomic incentives for health-care providers.<sup>10</sup>

Also indispensable is the capacity to monitor progress towards UHC, including the level and distribution of service utilization and financial risk protection. Health sector professionals need to know how to track and analyse the evidence needed to monitor equity. They must also be adept at designing and adapting survey instruments and other means of collecting the evidence.<sup>11</sup>

Finally, several longer-term, normative activities are required to feed into the process of generating and monitoring evidence. These involve the capacity to perform regular updates of national health accounts to show the nature of expenditures and service purchases by governments, donors and households. Evidence of changes in the burden of disease and exposure to risk factors, especially for noncommunicable diseases, laid the foundation for long-term health policy and systems research.

### Policy implementation

The capacity to raise revenue is the foremost requirement when implementing policy. In a contributory scheme, collecting premium payments from informal sector workers is difficult because of their irregular incomes and high mobility. Under a mandatory system financed through payroll taxes, there must be enforceable sanctions for evading contributions and falsely reporting items such as payroll size and number of employees.

Another requirement is active purchasing capacity. Measures to ensure that health-care providers act in the interests of the population and to counteract the unintended effects of either open- or close-end provider payments need to be supported by evidence and require operations skills. Medical and financial audits, rewards for good performance and sanctions for poor work promote mutual accountability between health-care providers and health service purchasers.

In the transition towards UHC, fragmented schemes targeting different population groups, a legacy from the past, must be dealt with.<sup>12</sup> Convening, negotiating and consensus-building capacities are needed to harmonize benefit packages and payment methods and to minimize gaps across schemes, but these skills are not traditionally taught to health sector professionals. Developing these capacities requires an enabling and supportive environment – facilitated through networking with partner institutes, such as research centres and academic institutions – and a sound insurance agency governance structure.<sup>13</sup>

### Conclusion

The capacities described herein must be part of the discussion surrounding UHC and the necessary institutions must be in place to nurture them. UHC undoubtedly depends on doctors, nurses and allied health professionals, but also on researchers, policy analysts, economists, actuarial scientists, financial managers, auditors and lawyers. International development partners must help countries to strengthen the needed capacities and to share their experiences with other countries seeking to attain UHC. ■

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