Universal access to health care systems: defending rights and overturning the pyramids

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Editorial

Universal access to health care systems: defending rights and overturning the pyramids

Valéry Ridde[1]

Didacticians often say that to convey a message, it is sometimes better to use a metaphor instead of long explanations. The history of public health is full of examples of this approach. In 2000, 'Health for All' was one of these slogans. However, one must admit that we are still far from reaching this goal. Even though the health care system is only one of the determinants of population health, the fact that the majority of the planet's population is unable to access or use 'modern' health care systems for treatment evidently contributes to social health inequalities. And when the population is able to access health care systems, it is often at the cost of incurring debt and even increasing its poverty level (1). This is why public health has recently been trying to adopt a new slogan; that of universal access to health care services. In fact, this will be the focus of the 2010 World Health Organization (WHO) report, the topic of the first global forum on health care systems research in November 2010, and the central theme at the 2nd conference of the African Health Economics and Policy Association that will take place in March 2011 in Senegal to discuss this objective for Africa.

As UNICEF highlighted in its 2009 report, 80% of maternal deaths could be avoided if women's rights to access reproductive and maternal services and basic health care were respected (2). The same applies to the 40% to 70% of newborn deaths, newborns who could be saved through public health interventions (3). In my opinion, the concept of *right* is central; nevertheless, it is still often forgotten by health promotion actors, who are rarely trained around this issue, even though the Bangkok and Jakarta Charters mention such human rights. On the other hand, it is important to note that human rights organizations rarely venture to specifically defend the right to health, even though it is included in almost all national constitutions. And yet, the '*rights*' approach to improving access to health care systems can be effective, as has recently been discovered by several NGOs supported by *Amnesty International*'s campaign (4) in Burkina Faso. It is the *rights* approach that supported the President's declaration in February 2010, committing to do everything in his power to ensure barriers and access of obstetric care are removed. In Burundi, a *Human Rights Watch* report, denouncing the holding of patients that could not pay services in hospitals, also seems to have contributed to convincing the President to eliminate payment for health care at the point of service (5).

The financial barrier to universal access is the most-widely known and the least difficult to address. The recent debates on health care reform in the USA show how crucial financial access to health care services is on another continent, even if issues and lobbies differ in Africa. By removing direct payment at the point of service, we can respond to needs up to now not addressed (7). This recommendation has been asserted for women and children in a recent appeal from all United Nations agencies, the European Commission and numerous heads of state (6). What is surprising, however, is to see how many heads of state advocate for measures in low-income countries that they themselves do not apply in their own country. Several presidents who signed the appeal have, in the last few years, largely increased the share directly paid by the user at the point of service (like in France for example) going against all knowledge supporting equitable financing and universal access to health care services (8). The Ministry of Finance in Quebec has also just declared that 'everyone benefits from it [the health care system] and therefore everyone should pay'.

But obviously, removing the financial barrier at the point of service is not sufficient to make access truly universal, since disease generates other costs and the determinants of such access are numerous and interrelated. Geographical, social and cultural accessibility (3,9), along with popular beliefs about disease (10), are often summoned to demonstrate the complexity of this concept that I cannot comprehensively cover in these few lines. In particular,

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Andersen updated three major parameters of access to services: environmental factors (including the health care system itself), the population determinants (including the organization of societies or social organization), and health behaviours (including use of services and state of health) (11). The interrelation between these three determinants is critical in understanding that universal access is a complex objective still distant in many countries. The introduction of this editorial highlighted the importance to sometimes use metaphors. The pyramid is the most frequently used image that is employed when experts examine health care systems and describe the way they function. Everyone refers to the health pyramid, particularly in Africa (12), including partners in the health field (13), critical anthropologists (14) and authors of a recent public health manual (15). When African public health students present their health care system, they will, almost systematically, use a triangle where the summit is constituted of national and university hospitals and the base of primary care centres. Researchers in Kenya claim that, 'hospitals sit at the apex of the pyramid of primary care in the health systems of many low-income countries' (16). Although we know the majority of health issues can be resolved by primary health care (17), the summit is still understood as comprising national and university hospitals. This 'hospital-centrism' denounced in Alma-Ata prevails, even though its reduction in the 1980s was beneficial in Africa (18). Nonetheless, this pyramidal vision, not restricted to Africa, is hardly surprising given that it is, in most cases, a mirror image of societies that are themselves hierarchical, some evidently more than others. A sociologist analysing social health inequalities in France confirms my viewpoint: 'the health care systems are organised on the same foundations as the societies that create them' (19). Is the health pyramid not an image of the social pyramid as 'the metaphor supposes a way of thinking and seeing influencing the way of understanding the world' (20)? The WHO Commission on the Social Determinants of Health (SDH) underlined health equity as a 'marker of social progress', as described by Sir Michael Marmot. The Commission highlighted that in order to achieve equity, we should fight against inequalities in the distribution of power and resources (8). The hierarchical, and sometimes *stratachical*, organization of societies has also penetrated the microcosm of health training where doctors and chief nurses are at the summit of the micro-pyramid. Teamwork is rare, and medical staff meetings are mostly 'moments reaffirming hierarchical statuses' (14); everyone wants to play the role that society has assigned them. Since hospitals are at the top, primary health care actors from the frontlines want to join them. Who can blame those who want to climb the health pyramid, as others wish to climb the social pyramid. These two processes are often concurrent. And yet climbing a pyramid often leaves one breathless, and can be dangerous for those who do not respect health educators' instructions of doing at least 30 minutes of physical activity every day. Do we not refer to a social ladder as if some were at the bottom and others at the top? Mountaineers are often more valued than potholers. I can still hear the voice of a doctor, immersed in this counter-productive use of the health pyramid metaphor, telling me that, 'there are thinkers and non-thinkers'. Thus, the work of health workers located at the base of the pyramid is belittled, and everyone wishes to rapidly leave the base to climb the various levels, when it is at this very level that populations desire to be taken care of and where costs are minimal.

Of course, this view might be considered as communist in the USA, as was President Obama's vague attempt to reform the health care system. However, my comments move away from these political considerations and from the resurgence of the fight against social classes. Beyond the technical aspects of universal access that have already been covered and will continue to be addressed in the 2010 WHO report, the aim is to show to what extent the health care system is a social system in itself (21). Therefore, it seems that universal access to health care services is not just a technical matter in choosing a funding mechanism for example. It is rather a groundbreaking vision that we need to ensure the overturn of the health pyramid before addressing the social pyramid. It is neither a question of destroying it, nor is it a question of inciting revolution, but the objective is to shift the current vertical pyramid to a horizontal disposition. In 1986, the authors of the Ottawa Charter called it the reorientation of health services. In certain countries, a network coordination of the health care system proposed instead of a hierarchical one (17); specialities in general medicine were created and some people do not refer to the health pyramid any longer.

However, their behaviour and ways of thinking unfortunately remain strongly influenced and determined by hierarchical order. And yet, historian Joseph Ki-Zerbo said, during the 8th International Conference on Health Education in 1973, that

> the human being is a vertical animal. This verticality already is a mark of the reign of and priority given to the encephalon over everything else (22).

If such is the case, and this morphological verticality nevertheless allows us to think of the horizontal nature of social organizations, then we need to push health care systems more horizontally and less vertically, to overturn the pyramids towards the achievement of the right of universal access to health care services.

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