Comment

Universal health coverage: the post-2015 development agenda

The passage of a UN General Assembly resolution on universal health coverage (UHC) in December, 2012, underlines how UHC is becoming a key global health objective. Adopted by consensus, the resolution urged member states to develop health systems that avoid substantial direct payments at the point of delivery and to implement mechanisms for pooling risks to avoid catastrophic health-care spending and impoverishment. This resolution sets the stage for UHC to become a unifying central health goal in the post-2015 Millennium Development Goal framework.

The Millennium Development Goals (MDGs) transformed global health: they galvanised politicians and citizens, stimulated civil society, encouraged robust monitoring and evaluation frameworks, motivated research communities, and created new institutions. By focusing global communities on a common agenda, the MDGs confirmed that progress for poor and marginalised people is possible. Yet the MDGs also had major shortcomings. They ignored the central role of health systems, overlooked emerging health concerns such as non-communicable diseases, tended to exacerbate fragmented health systems by focusing on final health outcomes related to vertical programmes rather than on building integrated health systems, and at times contributed to inequities in health.

To redress these shortcomings and respond to new challenges, the global health community should consider using UHC to frame the health goal from a system perspective. UHC is defined by WHO as universal access to needed health services without financial hardship in paying for them. UHC allows for a greater focus on the equitable distribution of access to health services and demands a universal focus within and across countries. Moreover, UHC is a goal relevant for all countries, rich and poor, as illustrated by the broad support for the UN resolution on UHC.

Uniting the health sector around one health goal focused on UHC with multiple subgoals recognises that “one size” does not fit all, but that there are a set of system-level constraints to scaling up access to health. Challenges such as absorptive capacity, human resources for health, and health financing must be addressed. One global UHC goal would recognise these similarities in constraints, while giving each country the opportunity to customise their approach to achieving this system-level goal.

To achieve sustainable UHC, health systems need to deliver and measure progress on two inter-related components: access to coverage for needed health services (prevention and treatment) and access to coverage with financial risk protection. One possible indicator of the latter is out-of-pocket spending on health (the share of health spending paid for by the patient at the point of service). Worldwide, about 150 million people a year face catastrophic health-care costs because of direct payments such as user fees, while 100 million are driven below the poverty line. To the extent that people are covered by a risk-pooling mechanism, their out-of-pocket expenditure will not cause financial hardship. Out-of-pocket expenditure for health also illuminates inequities in that richer countries—and richer populations within those countries—tend to have lower out-of-pocket expenditure. Additional indicators of access are needed for coverage, and experts at WHO are leading a working group on this challenging issue.

The UN resolution on UHC illustrates the impressive momentum behind the need to accelerate action towards UHC as a strategy for improving health and ameliorating inequities in health. Using the post-MDG process as a platform to build on the movement that sees health systems as the backbone of a healthy population, we hope to ensure that in another 15 years,
all of the world’s people will have access to health at an affordable cost. The time is ripe to be bold. A system-level approach working towards UHC could have a transformative effect in the battle against poverty, hunger, and disease. If we prioritise health as a human right, in addition to a healthier population, social and economic development will flourish. By focusing on UHC in the post-2015 framework, the international community has an opportunity to endorse a country-driven agenda, as well as build and improve upon the robust legacy of the MDGs.

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Defining the role of sequential therapy for *H pylori* infection

Antibiotic treatment to eradicate chronic *Helicobacter pylori* infection has become the mainstay of treatment for peptic ulcer disease, and reports indicate that *H pylori* eradication might also prevent gastric cancer.1,2 The relative effectiveness of different eradication regimens varies between geographical regions, however, and the determination of whether one regimen will perform better than another in a particular population has seemed to require comparative clinical trials. In *The Lancet*, Jyh-Ming Liou and colleagues3 report findings that lend support to the idea that the best eradication regimen can be reliably predicted if the prevalence of antibiotic-resistant *H pylori* in the region is known, as has been previously suggested.4

The investigators present the results of a well-executed, randomised, open-label clinical trial that included 900 Taiwanese adults and compared three eradication regimens for *H pylori*: 14 days of triple therapy (lansoprazole, amoxicillin, and clarithromycin), 14 days of sequential therapy (7 days of lansoprazole and amoxicillin followed by 7 days of lansoprazole, clarithromycin, and metronidazole), and 10 days of sequential therapy (5 days of lansoprazole and amoxicillin followed by 5 days of lansoprazole, clarithromycin, and metronidazole).3 Both of the metronidazole-containing sequential regimens were more effective in eradicating the infection than was the 14-day triple therapy regimen, although only the 14-day sequential regimen was statistically significantly more effective than 14-day triple therapy (90.7% vs 82.3%; p=0.003). Similarly, eradication success with the 14-day sequential group was greater than in the 10-day group (87.0%), but not statistically significantly so.

The most innovative aspects of the study relate to the effect of antibiotic resistance on treatment outcome; in logistic regression models, clarithromycin resistance decreased the effectiveness of all three regimens, and metronidazole resistance decreased the effectiveness of both the sequential regimens. A meta-analysis5 of earlier studies that assessed 10-day sequential therapy in southern Europe and parts of Asia had suggested that the advantage of 10-day sequential therapy over triple therapy was attributable to its greater success against clarithromycin-resistant strains of *H pylori*. However, this finding was derived from just two studies, which included only 45 patients with clarithromycin-resistant infections.6 The meta-analysis results also suggested that metronidazole resistance did not diminish the success of 10-day sequential therapy in the 71 patients with metronidazole-resistant infections. Thus, Liou