Universal health coverage and social determinants of health

As the global health community embraces universal health coverage, a lesson from the 1978 Declaration of Alma Ata is worth remembering. The Declaration was a landmark in global public health and was the conclusion of one of the most important international conferences on primary health care. But in Alma Ata, it was recognised that there was more to improving population health than primary health care. The Declaration called for resources to be devoted to peaceful aims, “and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share”. However, the part of Alma Ata about social determinants—acceleration of social and economic development—was largely forgotten and left out of the international agenda. Improvement of access to primary care is a worthy and necessary goal but, by itself, will not revolutionise global health, nor reduce large health inequalities. For example, the UK has an equitable health service that is free at the point of use, but widening health inequities. Action also needs to be taken to address the social determinants of health: the conditions in which people are born, grow, live, work, and age, and the inequities in power, money, and resources that give rise to them.

There is a danger of going down the same route again with universal health coverage to the apparent detriment of action on social determinants of health. WHO is clear in its definition of universal health coverage: all people obtain the health services they need without suffering financial hardship to pay for them, a well run health system, a system for financing, access to essential medicines and technologies, and well trained health workers. Universal health coverage is a noble goal, but so too is action on social determinants to achieve health equity. The latter should not be forgotten.

Both WHO and the UN declaration on universal health coverage note the importance of locating universal health coverage in the context of action on social determinants of health. However, these two things are not interchangeable. Health care is just one determinant of population health. Other inputs to health, such as social protection, good employment, and early years care, should not be forgotten, but they have been. For example, a joint WHO and World Bank report on universal health coverage does not mention social determinants of health amid its commendable concern that people should not be impoverished by the cost of health care.

This situation can be dealt with in two ways: work to include social determinants of health within universal health coverage, or recognise that these are complementary activities, both of which are important for population health. We should do both. For example, economic austerity is bad for health, not only because of its effects on funding of health services, but because of adverse effects on housing, income, and employment.

Universal health coverage is unlikely to direct much attention to action by ministers of finance to reduce childhood poverty, provision of pre-school education, or community empowerment to negotiate loans to improve housing quality. However, much can be done to improve social determinants of health from within the health sector, including changes in clinical practice, partnership working, advocacy, education and training, and employment conditions of health-sector workers.

One important way to ensure that social determinants of health remain central to the concerns of those pursuing universal health coverage is to include social determinants in a monitoring framework, which is easy to implement and has two components. First, monitoring of all health and health-care measurements by socioeconomic position, sex, geographical distribution, or other relevant markers of health equity, such as education. If health and
Clostridium difficile is the most burdensome gastrointestinal infection and one of the main infectious causes of morbidity and mortality in industrialised countries.1 Prevention of C difficile infection relies on methods to reduce transmission of the pathogen, through effective hand hygiene, barrier precautions, isolation of patients, and environmental cleaning. Perhaps even more important are attempts to reduce host susceptibility to infection by decreasing unnecessary antibiotic use.2 Antibiotic use disrupts and depletes the normal gastrointestinal flora, allowing C difficile to thrive and generate clinical disease.3

When antibiotic treatment is unavoidable, reinforcement of the colonic flora might be another means to decrease susceptibility of patients to C difficile. Definitive restoration of the colonic ecosystem through stool transfer has unequivocal benefit in treatment of established C difficile infections and prevention of recurrences.4 A more palatable, or at least less pungent, approach to boost colonic defences is the use of non-pathogenic microbial supplements—known as probiotics. Probiotics have been widely marketed in commercial preparations, and widely studied as a means to prevent C difficile. Two recent meta-analyses have summarised the results of previous trials, detecting large reductions in the risk of antibiotic-associated diarrhoea (AAD) in general (relative risk [RR] 0·58, 95% CI 0·50–0·68)5 and C difficile infections in particular (0·34, 0·24–0·49).6 These impressive effect sizes are motivating many health-care institutions to consider routine probiotic coadministration with antibiotic treatments.

However, in The Lancet, Stephen Allen and colleagues’ question the usefulness of routine probiotics. Their PLACIDE trial, done at five centres in England and Wales, is the largest trial to be reported in this discipline (n=2941). The study is rigorous, with central