Progress Toward Universal Health Coverage*

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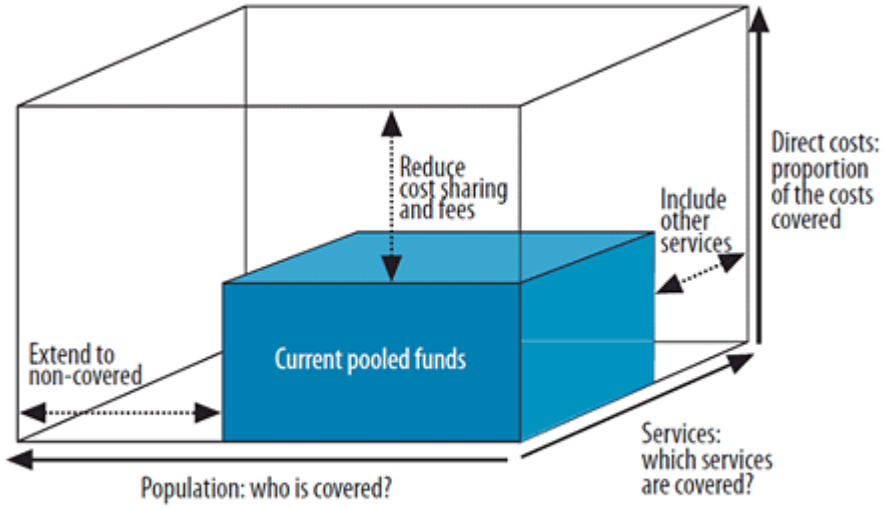
* Draws on joint work with World Bank's Health, Nutrition & Population Global Practice, Pan-American Health Organization / WHO Regional Office for the Americas, and World Health Organization (Geneva)

Some appetizers

The popular (but rather misleading) UHC cube

A Rather Misleading Cube



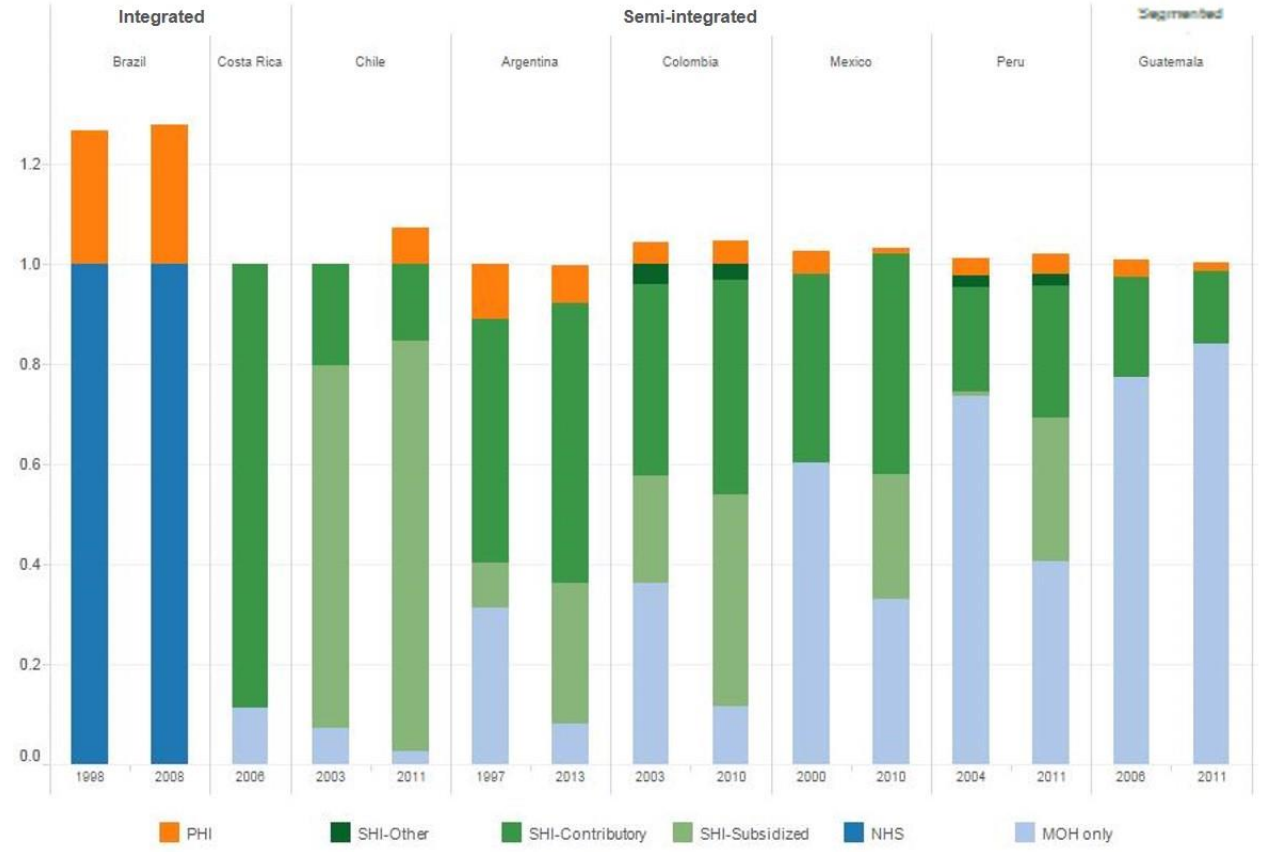
Three dimensions to consider when moving towards universal coverage

- According to the UHC cube, UHC is about
  - Extending coverage to those who aren't covered
  - Expanding the range of services covered to those with coverage
  - Reducing cost-sharing among those with coverage

Monitoring Progress towards Universal Health Coverage at Country and Global Levels. Boerma T, Eozenou P, Evans D, Evans T, Kieny MP, Wagstaff, A. (2014) Monitoring Progress towards Universal Health Coverage at Country and Global Levels. PLoS Med 11(9): e1001731. doi: 10.1371/journal.pmed.1001731

Actually “extending coverage to those who aren’t covered” is a non-issue

- Everyone in the world is covered by subsidized public health facilities operated by the MOH
- Some people are <u>also</u> covered by a formal health insurance scheme, e.g.
  - a (contributory) social health insurance scheme, or
  - a private health insurance scheme



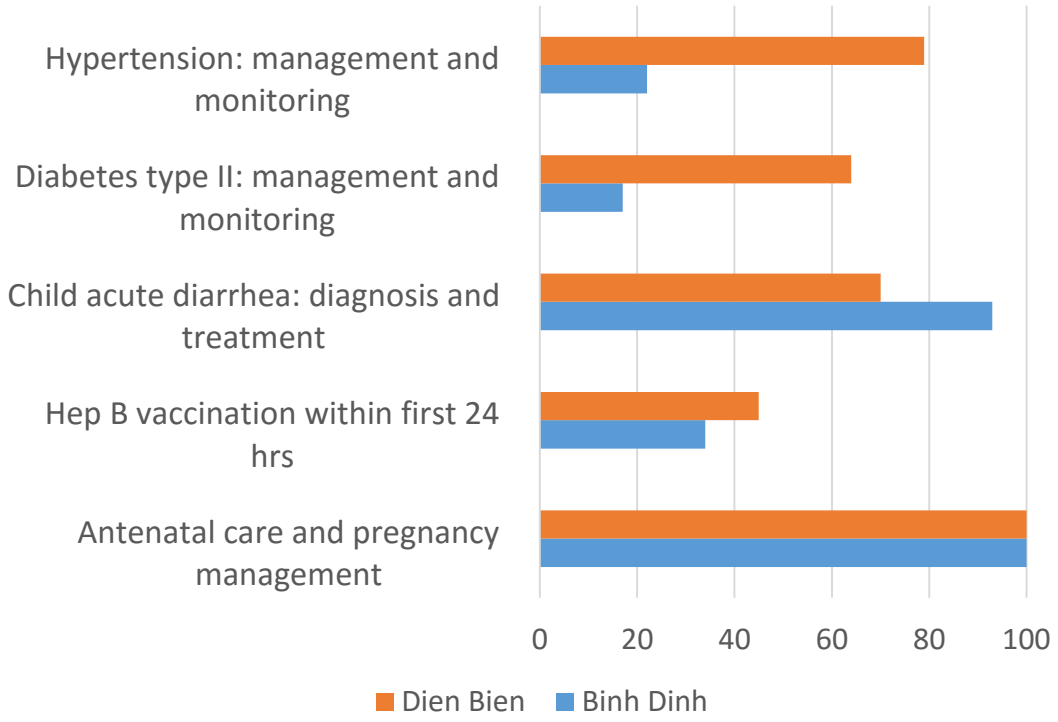
By the same token, we can't measure UHC by seeing which countries have everyone in "a scheme"

A Misleading Map

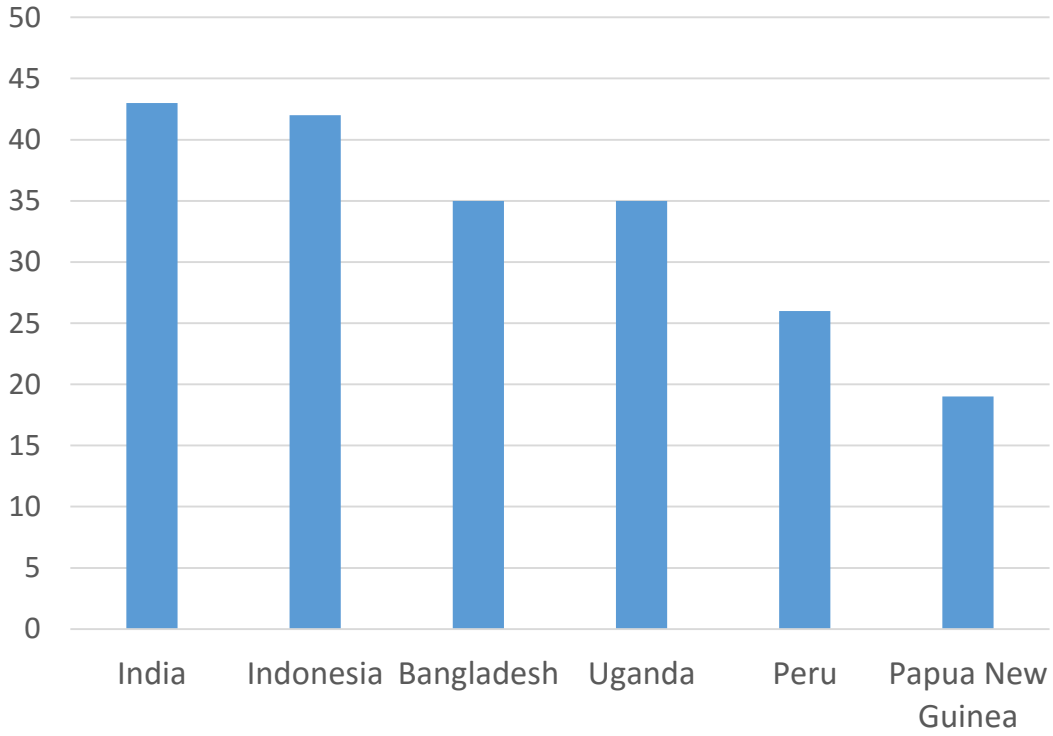
MAX FISHER JUN 28, 2012 The Atlantic magazine "Here's a Map of the Countries That Provide Universal Health Care (America's Still Not on It)"

What's not covered is an issue. Promises are often vague—reality is starker and costly to document

Percent of commune health stations that can perform selected services, Vietnam



% staff absent w/out reason on unannounced visit—primary facilities



World Bank, "Quality and Equity in Basic Health Care Services in Vietnam: Findings from the 2015 Vietnam District and Commune Health Facility Survey", June 2016

Quality a major challenge: Even in a hypothetical case, providers ask too little and do few few exams

Figure 4.3.2. Median number of history questions asked by condition

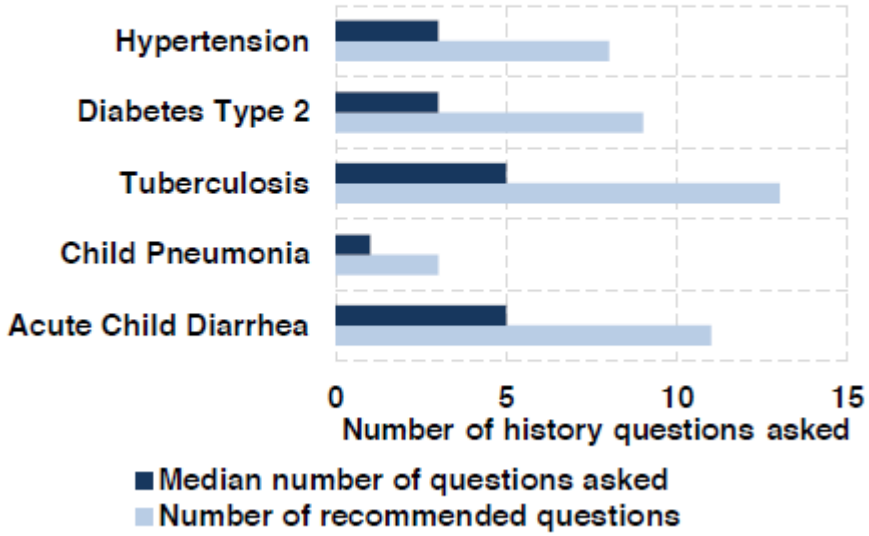
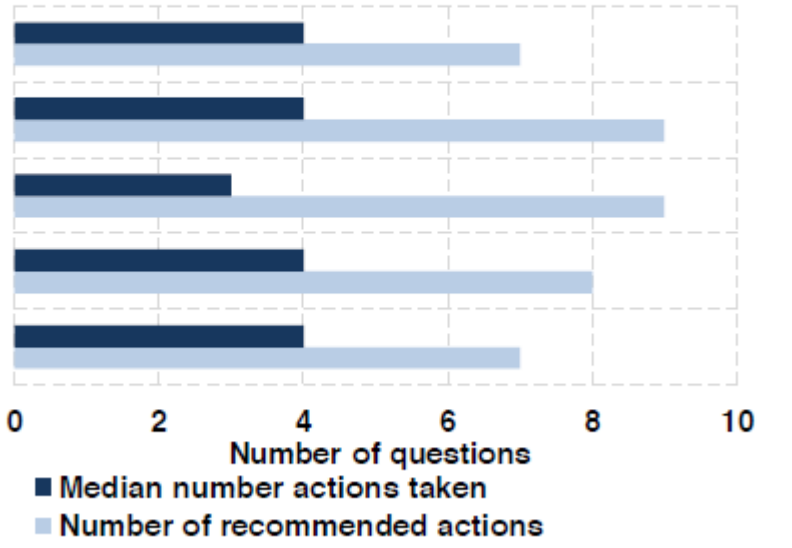


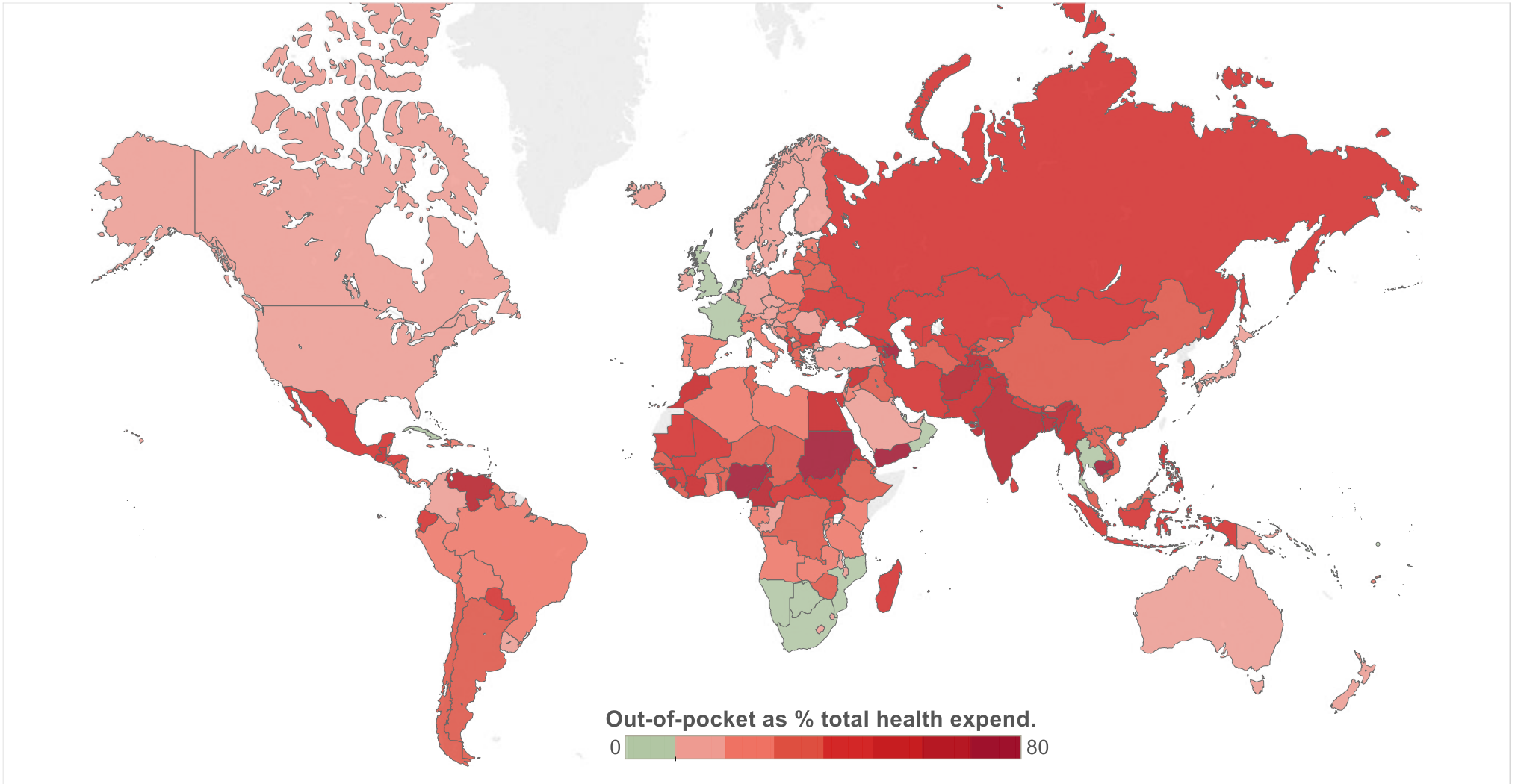
Figure 4.3.3. Median number of physical examination actions by condition



Source: Calculations from the Vietnam District and Commune Health Facility Survey (2015).

World Bank, "Quality and Equity in Basic Health Care Services in Vietnam: Findings from the 2015 Vietnam District and Commune Health Facility Survey", June 2016

Out-of-pocket expenditures large % of health expend. in some countries, but do they cause hardship?



What we'd like to know about UHC

A measure to know how close we are to achieving it

Steps we might take to get there

Measuring progress towards UHC

A definition of UHC

Everyone – irrespective of their ability-to-pay – gets the health care they need

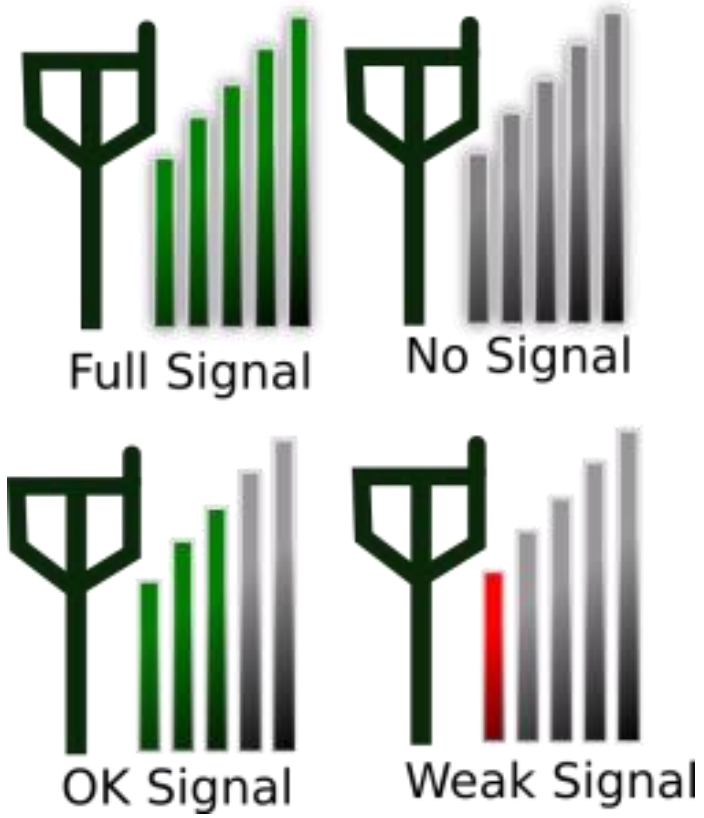
Service coverage

AND

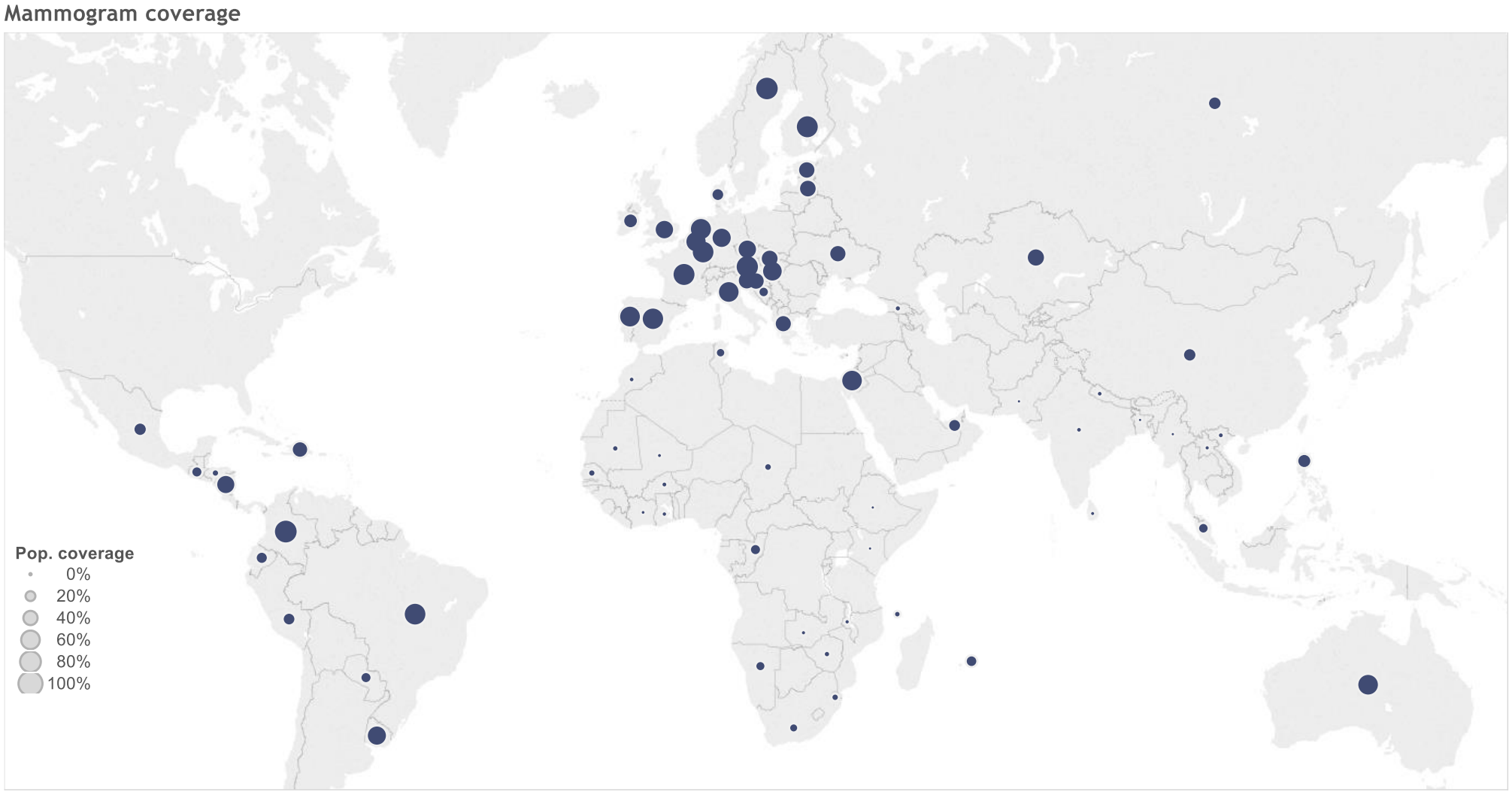
Nobody suffers financial hardship as a result of getting the care they need

Financial protection

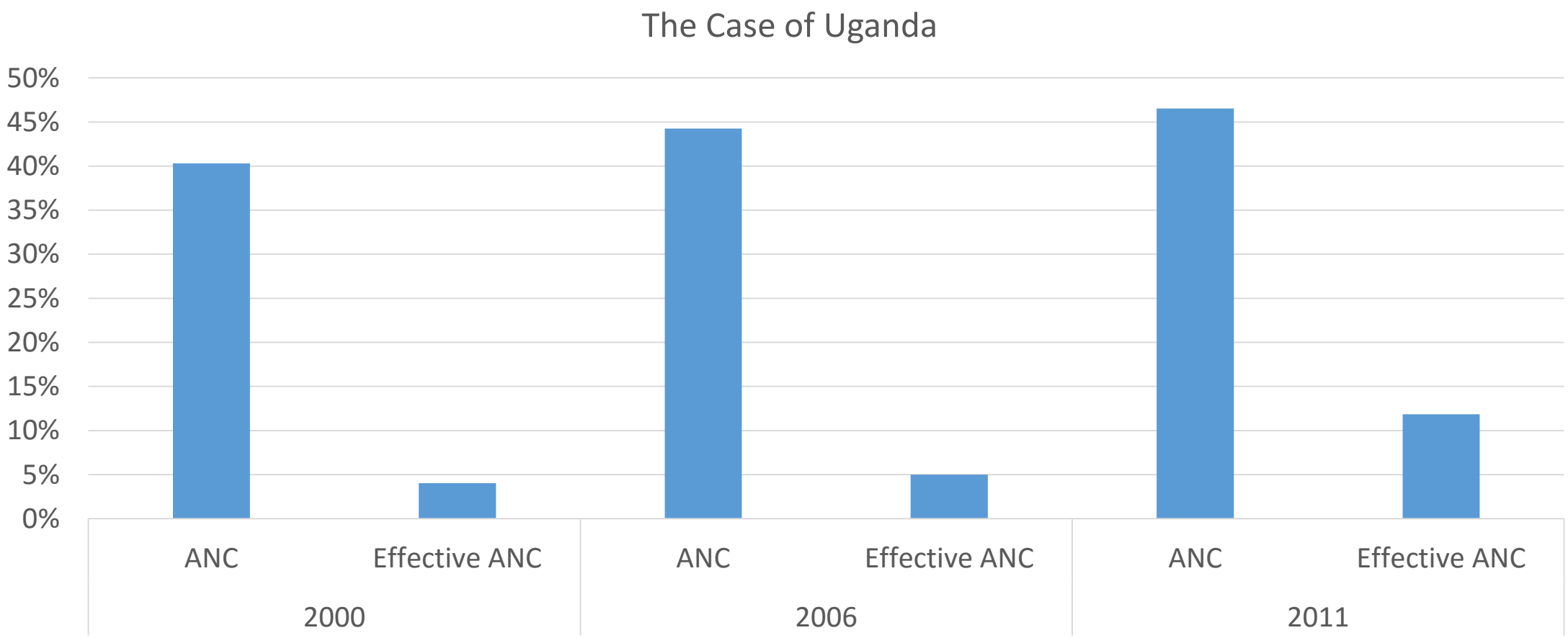
Assessing service coverage (in health)



Service coverage: mammogram coverage at the population level



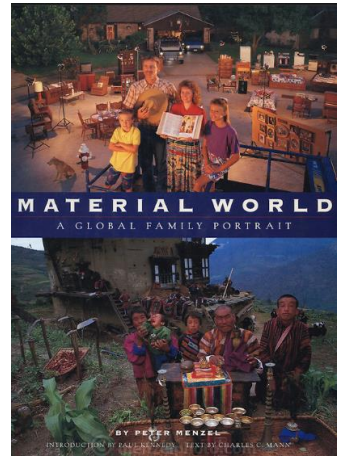
Capturing the quality of care by shifting from ‘coverage’ to ‘effective coverage’



ANC = 4+ antenatal care visits. Effective ANC = 4+ antenatal care visits plus received blood test and had blood pressure measured

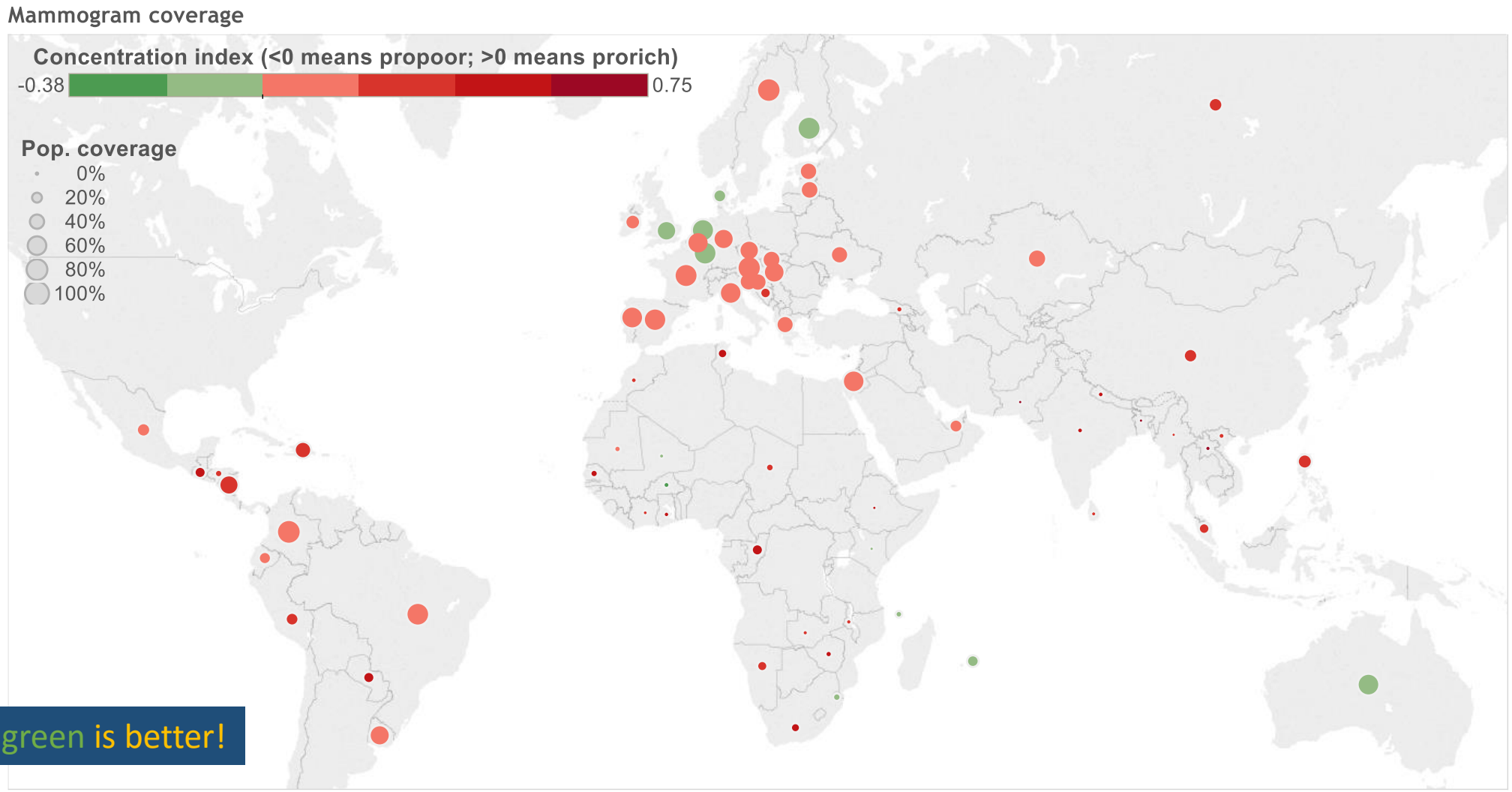
Service coverage: 5-year inpatient admission rate

Stratifying by ‘wealth’ in health surveys using asset ownership and housing characteristics



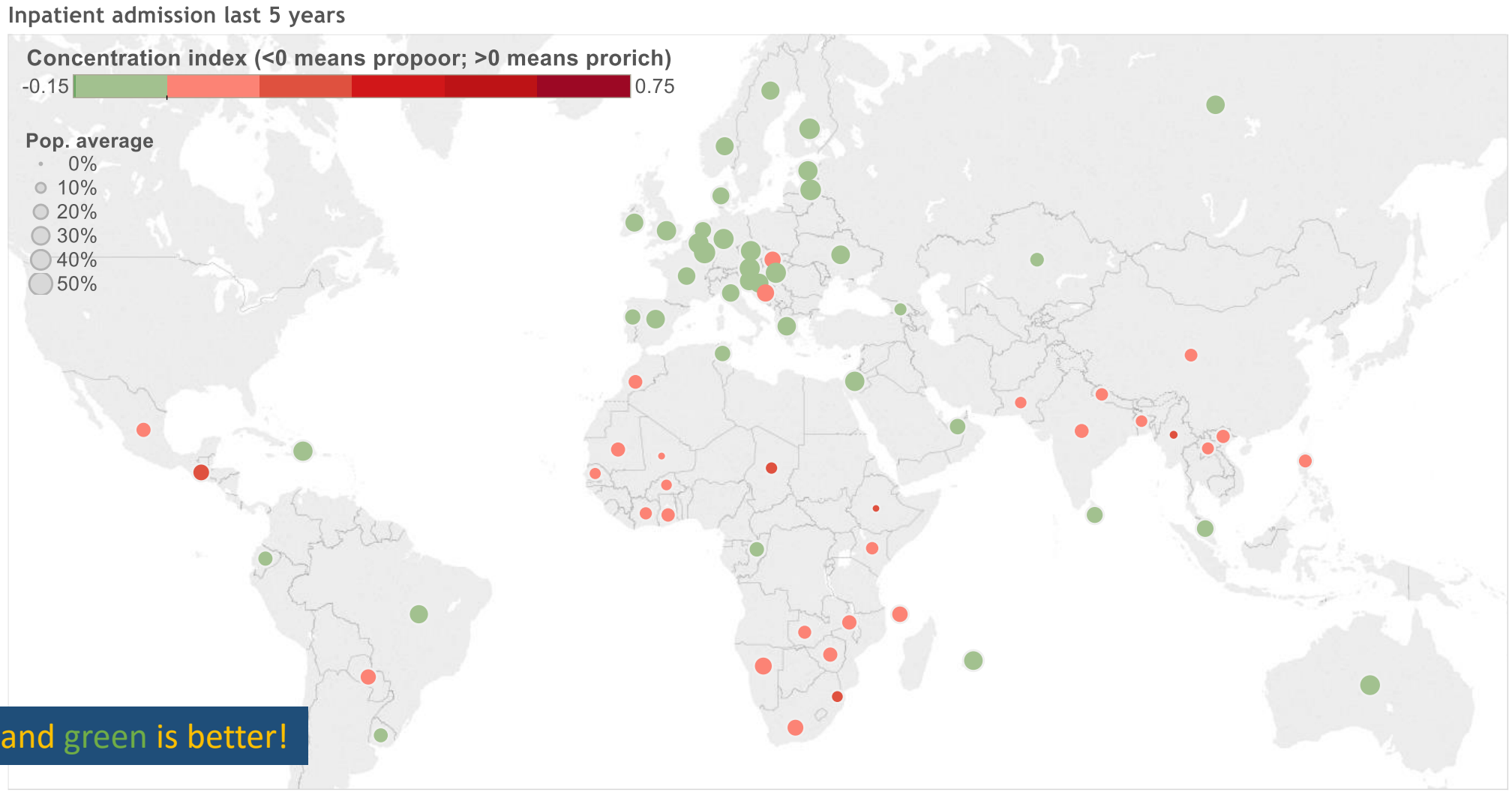
Clockwise: Western Samoa, China, Bhutan, Mali, Cuba, USA

Mammogram coverage mostly prorich



LARGE and green is better!

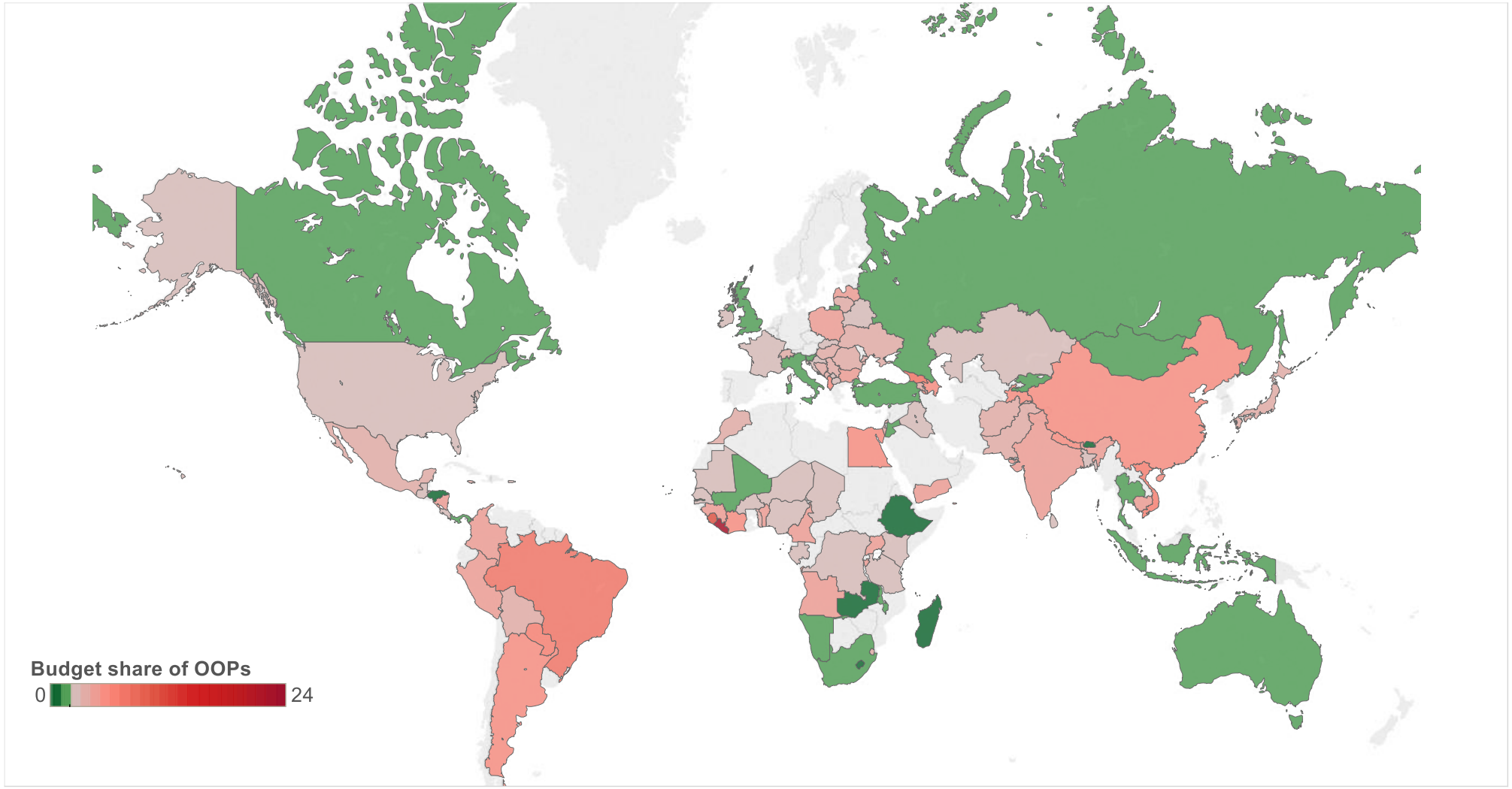
Inpatient admissions often propoor



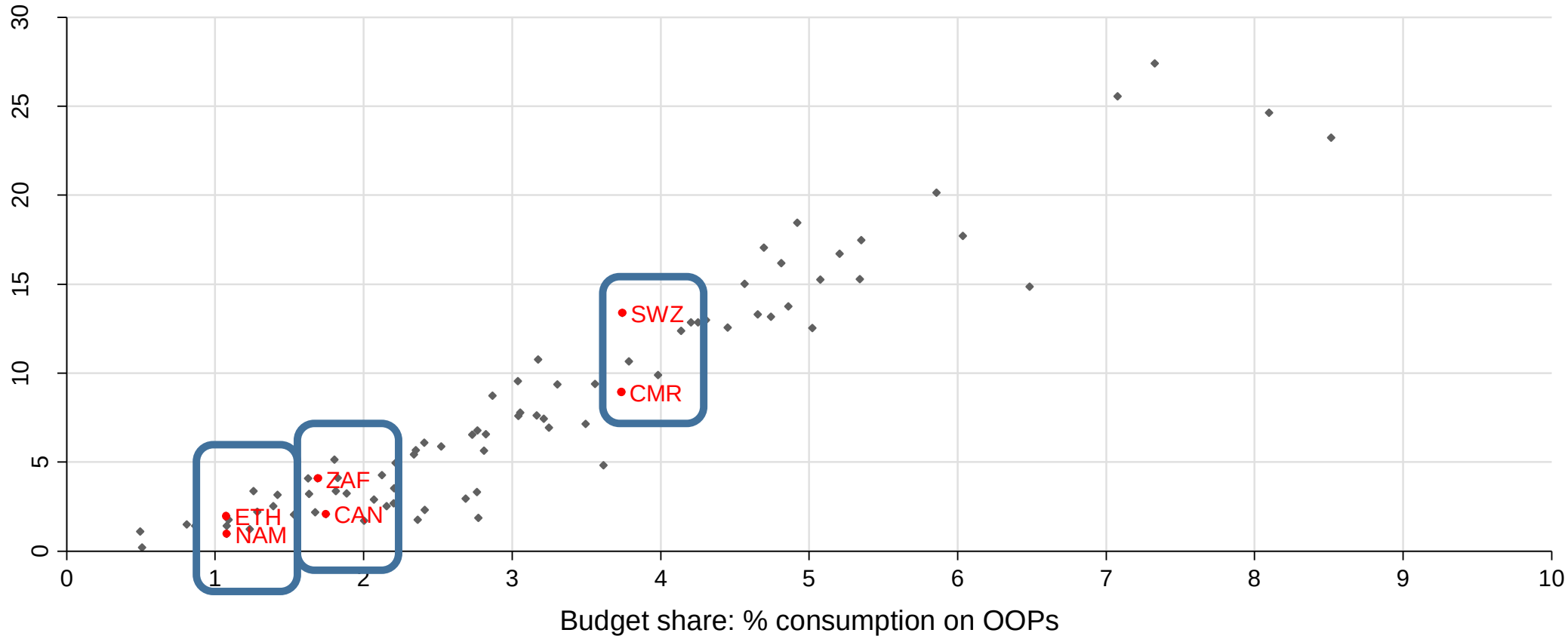
LARGE(ISH) and green is better!

Assessing financial protection (in health)

Health out-of-pocket spending as % of household consumption



Budget share isn’t always a good guide to incidence of catastrophic spending

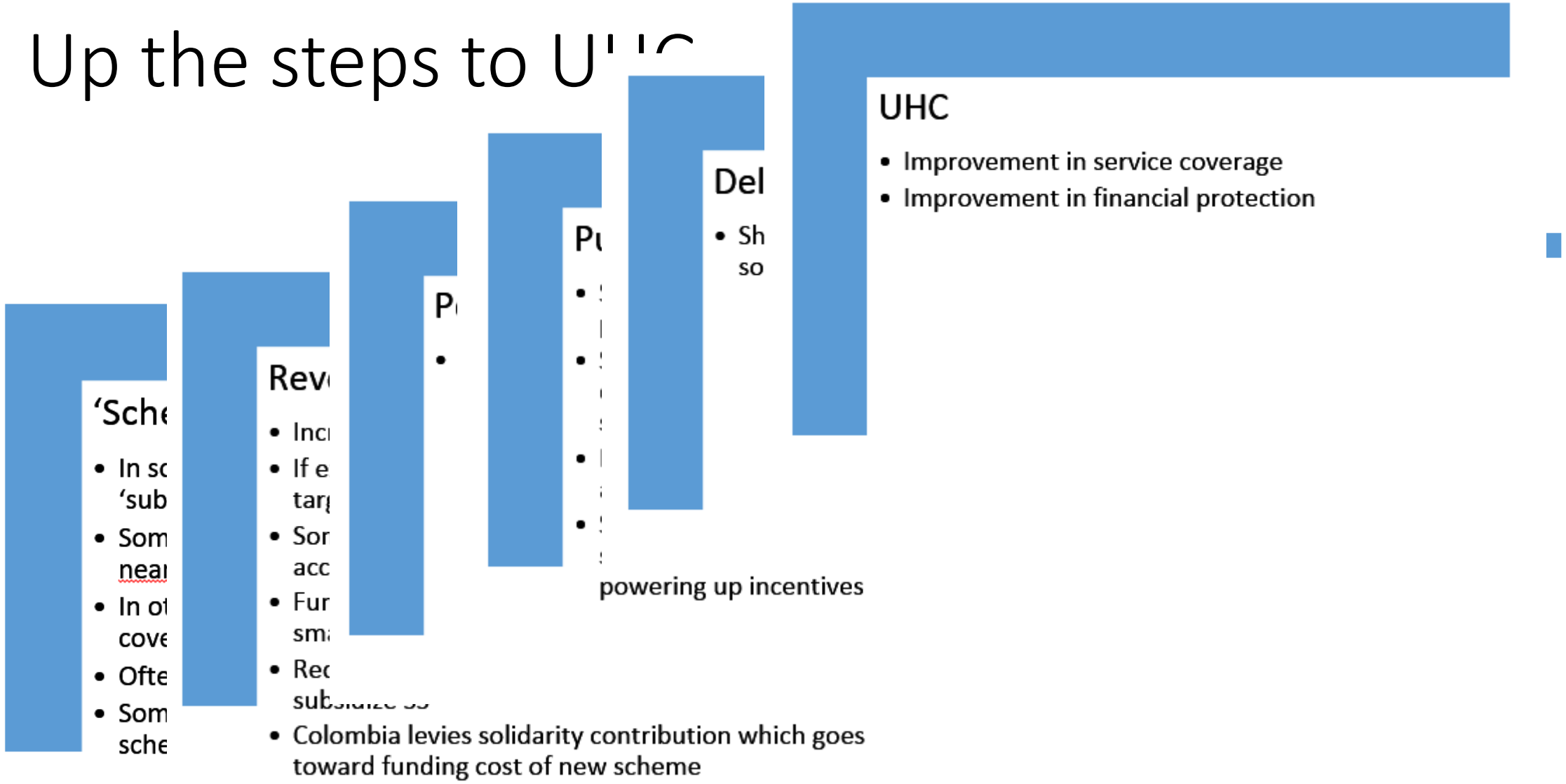


Out-of-pocket expenditures contribution to the poverty gap around the world

$4.00 poverty line at PPP

Getting to UHC

Up the steps to U



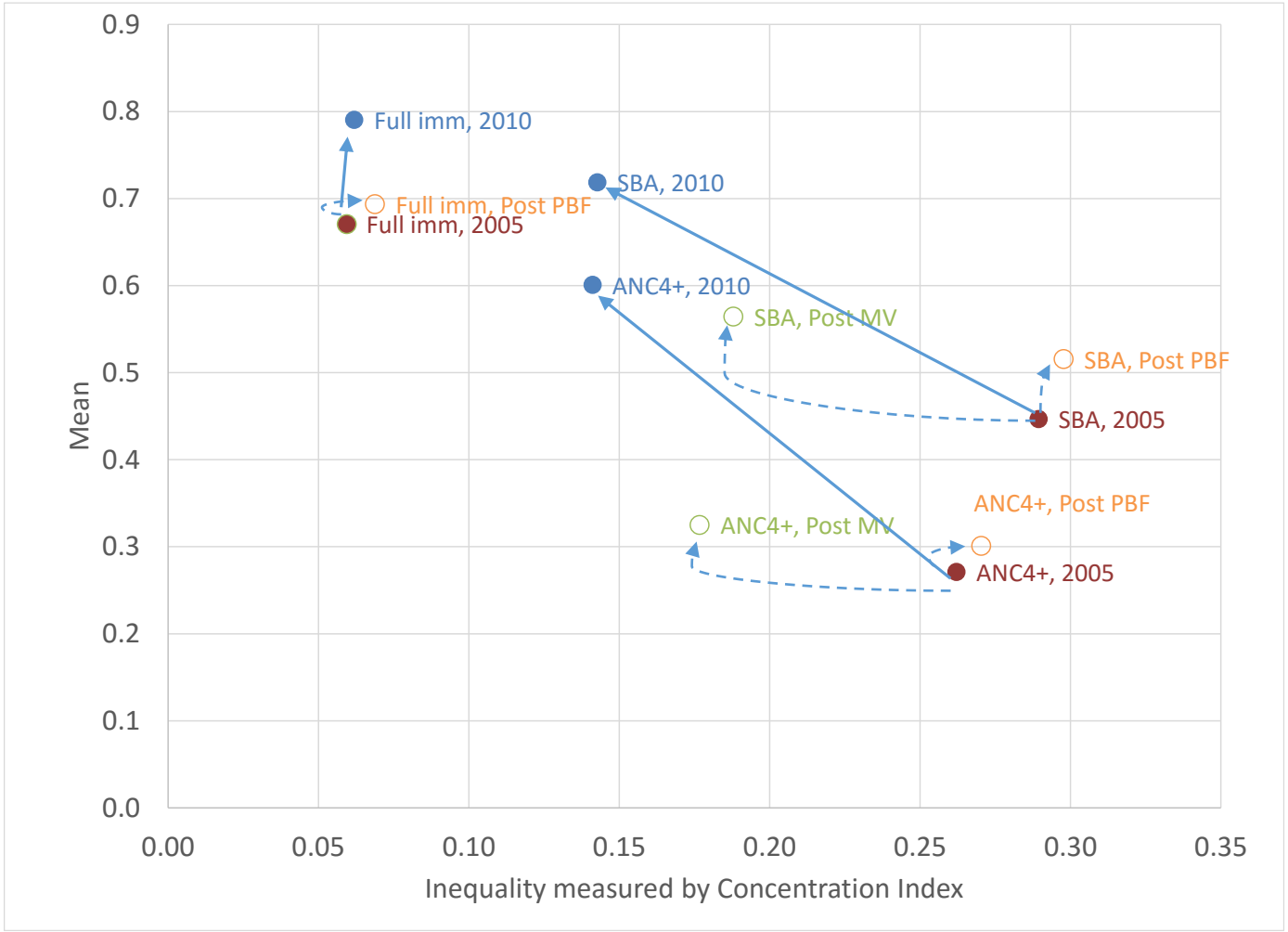
Do the steps actually work?

Image courtesy of Paul | FreeDigitalPhotos.net

Cambodia's success: performance-based financing (PBF) vs. maternal voucher (MV) interventions?

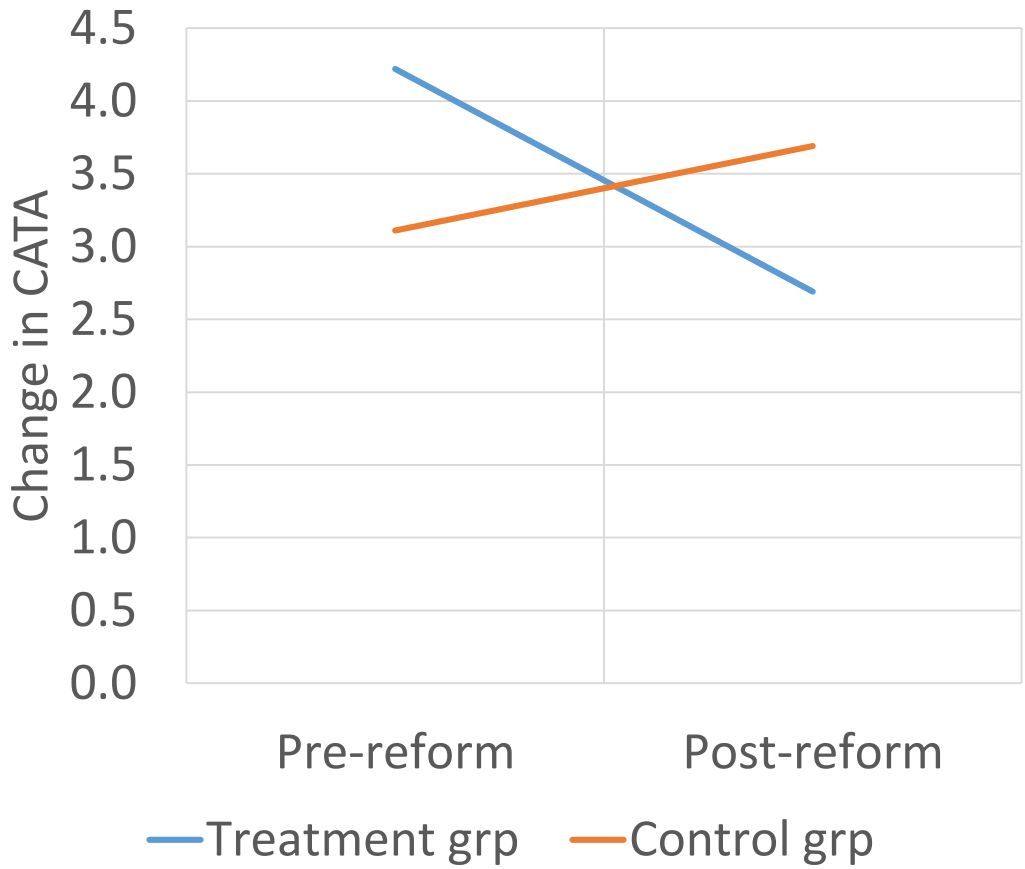
- Cambodia has improved its maternal and child health indicators
- It experimented with performance-based financing, and maternal vouchers. MCH interventions were targeted in both
- How did the programs changed averages and inequalities?
- Very limited use of randomization in development of the two schemes. But they were rolled out in a staggered fashion across health districts over time, and independently of one another—generalized diffs-in-diffs or 'step wedge' design
- Authors allow impacts to differ between poorest 40% and the rest. Can use results to see effects on level and inequality

Cambodia's success: performance-based financing (PBF) vs. maternal voucher (MV) interventions?



Thailand's success in reducing CATA: deeper insurance coverage for households not in formal sector?

- Thailand has reduced the incidence of catastrophic out-of-pocket expenditures
- In 2002, Thailand brought households not covered by formal-sector & civil servants schemes (~80% of pop.) into a formal "Universal Coverage" (UC) scheme
- It also changed the incentives facing public providers
- Did the reform help?
- Comparing pre-post changes in treatment group (UC) and control group (formal-sector workers & civil servants), we can see UC reform's effect on CATA
- Reform accounts for all (and more) of the observed reduction in CATA in the population as a whole



Other emerging evidence

Effects (beneficial) on financial protection of new 'insurance scheme'

Country	Effect
China	No
Georgia	Yes
India	Yes
Indonesia	No
Mexico	Yes
Thailand	Yes
Turkey	No
Vietnam	Yes

Other programs

- Effects of 'schemes' for specific services, e.g. maternal and child health
- Vouchers, e.g. for maternity care
- Conditional cash transfer programs
- Pay-for-performance schemes for primary and hospital care

TakeAways

- **Concepts:** UHC is about ensuring everyone – irrespective of their ability to pay – gets the health care they need, without suffering financial hardship
  - Vital to look beyond "being covered" to the advice and care people actually get relative to their need, and the payments they actually make relative to their ability-to-pay
- **Metrics:** Need systematic tracking; not just aggregates, but by income or 'wealth' group. Good data are key
- **Possible steps to success (no set path):** formal schemes for underserved groups; raising (and targeting) additional revenues; broader pooling; purchasing (benefit packages to clarify entitlements and responsibilities; mixed payment systems to enhance accountability); delivery (broadening out)
- **Evidence-based policymaking:** feeding metrics and evaluation efforts into policymaking; iterating along the road to UHC

Further reading

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Collection Review

Monitoring Progress towards Universal Health Coverage at Country and Global Levels

Ties Boerma[1]*, Patrick Eozenou[2], David Evans[1], Tim Evans[2], Marie-Paule Kieny[1], Adam Wagstaff[2]

1 World Health Organization, Geneva, Switzerland, 2 World Bank Group, Washington, D.C., United States of America

Abstract: Universal health coverage (UHC) has been defined as the desired outcome of health system performance whereby all people who need health services (promotion, prevention, treatment, rehabilitation, and palliation) receive them, without undue financial hardship. UHC has two interrelated components: the full spectrum of good-quality, essential health services according to need, and protection from financial hardship, including possible impoverishment, due to out-of-pocket payments for health services. Both components should benefit the entire population. This paper summarizes the findings from 13 country case studies and five technical reviews, which were conducted as part of the development of a global framework for monitoring progress towards UHC. The case studies show the relevance and feasibility of focusing UHC monitoring on two discrete components of health system performance: levels of coverage with health services and financial protection, with a focus on equity. These components link directly to the definition of UHC and measure the direct results of strategies and policies for UHC. The studies also show how UHC monitoring can be fully embedded in often existing, regular overall monitoring of health sector progress and performance. Several methodological and practical issues related to the monitoring of coverage of essential health services, financial protection, and equity, are highlighted. Addressing the gaps in the availability and quality of data required for monitoring progress towards UHC is critical in most countries.

Introduction

A movement towards universal health coverage (UHC)—ensuring that everyone who needs health services is able to get them, without undue financial hardship—has been growing across the globe [1]. Close to half of the countries of the world—across all income levels—are currently engaged in health reforms that aim to extend, deepen, or otherwise improve coverage with needed health services and/or financial protection. These reforms have led to a sharp increase in the demand for expertise, evidence, and measures of progress and also a push to make UHC one of the goals of the post-2015 development agenda [2].

UHC has been defined as the desired outcome of health system performance, whereby all people who need health services (promotion, prevention, treatment, rehabilitation, and palliation) receive them, without undue financial hardship [3]. UHC has two interrelated components: the full spectrum of good-quality, essential health services according to need and protection from financial hardship, including possible impoverishment due to out-of-pocket payments for health services. Both components should benefit the entire population. In the context of this framework, "essential" is used to describe the services that a country decides should be available immediately to all people who need them. The contents of the services vary by setting.

The dimensions have commonly been depicted as a cube, shown in Figure 1 (adapted from [3,4]). The first axis represents the population, the people who need health services. The services axis depicts the quality health services they need. The vertical axis is the proportion of the total cost of providing services to the population that is financed through "pooled financing systems" as opposed to direct payments by patients, shown in Figure 1 as the box labelled "current pooled funds."

In this illustration, a little more than a half the population is covered for about half of the possible services they need, but only half the cost of these services is met from pooled funds. There is thus a shortfall of service coverage among those who receive services, inequity in service coverage (a large fraction of the population receives no services), and a lack of financial protection (those who receive services pay a large part out-of-pocket and hence risk financial hardship). To get closer to UHC, the country would need to provide services to the people who currently need them but don't receive any, provide more services to those who currently receive some but not the full range of services they need, and raise the fraction of health spending financed through pooled funds to improve financial protection. At the same time, health services need to be of sufficient quality to achieve the desired outcomes, so improving quality will be a priority in many settings.

Each country progresses in filling the different dimensions of the box (Figure 1) according to its preferences and constraints, trading off what services are provided, who gets them, and how much they are financed out of pooled funds. As such, UHC is the ultimate objective or goal, with countries starting from different places, with

Citation: Boerma T, Eozenou P, Evans D, Evans T, Kieny M-P, et al. (2014) Monitoring Progress towards Universal Health Coverage at Country and Global Levels. PLoS Med 11(9): e1001731. doi:10.1371/journal.pmed.1001731

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Competing Interests: The authors have declared that no competing interests exist.

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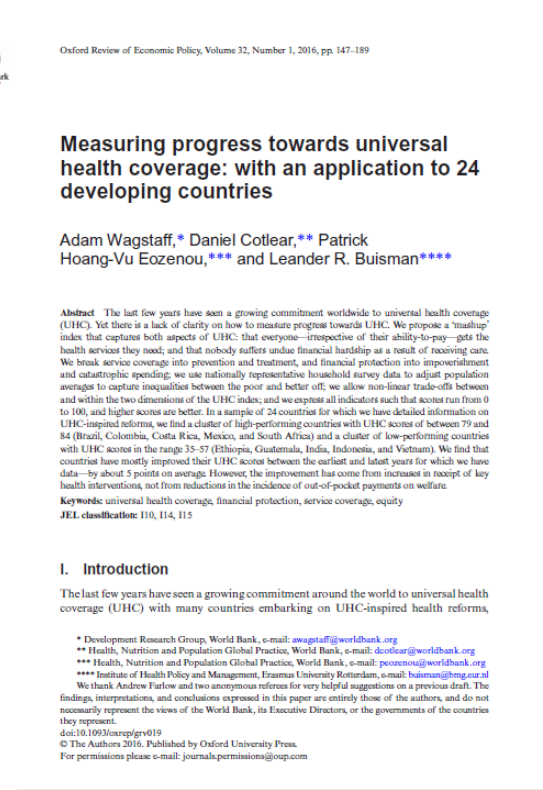

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Measuring progress towards universal health coverage: with an application to 24 developing countries

Adam Wagstaff,* Daniel Cotlear,** Patrick Hoang-Vu Eozenou,*** and Leander R. Buisman****

Abstract The last few years have seen a growing commitment worldwide to universal health coverage (UHC). Yet there is a lack of clarity on how to measure progress towards UHC. We propose a 'mashup' index that captures both aspects of UHC: that everyone—irrespective of their ability-to-pay—gets the health services they need; and that nobody suffers undue financial hardship as a result of receiving care. We break service coverage into prevention and treatment, and financial protection into impoverishment and catastrophic spending; we use nationally representative household survey data to adjust population averages to capture inequalities between the poor and better off; we allow non-linear trade-offs between and within the two dimensions of the UHC index; and we express all indicators such that scores run from 0 to 100, and higher scores are better. In a sample of 24 countries for which we have detailed information on UHC-inspired reforms, we find a cluster of high-performing countries with UHC scores of between 79 and 84 (Brazil, Colombia, Costa Rica, Mexico, and South Africa) and a cluster of low-performing countries with UHC scores in the range 35–57 (Ethiopia, Guatemala, India, Indonesia, and Vietnam). We find that countries have mostly improved their UHC scores between the earliest and latest years for which we have data—by about 5 points on average. However, the improvement has come from increases in receipt of key health interventions, not from reductions in the incidence of out-of-pocket payments on welfare.

Keywords: universal health coverage, financial protection, service coverage, equity

JEL classification: I10, I14, I15

I. Introduction

The last few years have seen a growing commitment around the world to universal health coverage (UHC) with many countries embarking on UHC-inspired health reforms,

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We thank Andrew Farlow and two anonymous referees for very helpful suggestions on a previous draft. The findings, interpretations, and conclusions expressed in this paper are entirely those of the authors, and do not necessarily represent the views of the World Bank, its Executive Directors, or the governments of the countries they represent.
doi:10.1093/oxrep/grv019

By Adam Wagstaff, Tania Dmytraczenko, Gisele Almeida, Leander Buisman, Patrick Hoang-Vu Eozenou, Caryn Bredenkamp, James A. Cercone, Yadira Díaz, Daniel Maceira, Silvia Molina, Guillermo Paraje, Fernando Ruiz, Flavia Sarti, John Scott, Martin Valdivia, and Heitor Werneck

Assessing Latin America's Progress Toward Achieving Universal Health Coverage

ABSTRACT **Two commonly used metrics for assessing progress toward universal health coverage involve assessing citizens' rights to health care and counting the number of people who are in a financial protection scheme that safeguards them from high health care payments. On these metrics most countries in Latin America have already "reached" universal health coverage. Neither metric indicates, however, whether a country has achieved universal health coverage in the now commonly accepted sense of the term: that everyone—irrespective of their ability to pay—gets the health services they need without suffering undue financial hardship. We operationalized a framework proposed by the World Bank and the World Health Organization to monitor progress under this definition and then constructed an overall index of universal health coverage achievement. We applied the approach using data from 112 household surveys from 1990 to 2013 for all twenty Latin American countries. No country has achieved a perfect universal health coverage score, but some countries (including those with more integrated health systems) fare better than others. All countries except one improved in overall universal health coverage over the time period analyzed.**

The developing world—and some parts of the developed world, too, including the United States—is in the midst of a major push toward universal health coverage.[1] This aim to achieve universal health coverage raises two questions: "How can we track progress toward universal health coverage?" and, "When can we say a country has reached universal health coverage?" Two commonly used metrics involve assessing citizens' rights to health care and counting the number of people participating in a financial protection scheme that protects them from catastrophic health care costs. The latter could be a social health insurance scheme or a national health service–type system that pools resources, from tax revenues, social insurance contributions, or both, and that provides access to health services that are zero-price (or close to zero-price) at the point of use.[2] On these two metrics, many—if not most—countries have already reached universal health coverage. Yet many countries continue to engage in coverage-oriented reforms, which suggests that these two metrics do not fully capture the core ideas of universal health coverage.

The countries of Latin America,[3] which are the focus of the empirical exercise in this article, illustrate the point nicely. All twenty countries have explicit provisions in their constitutions or some other legal mechanism that guarantees the right to health care for all citizens[4] (see the "UHC initiatives in Latin America" section in the online Appendix).[5] These countries do well on the metric of membership in a financial protection scheme: As early as the 1920s, ministries of health began providing subsidized if not free care to their entire populations.[6] What neither

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