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Universal Health Coverage

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Objectives

- Be able to define universal coverage, its goals and its associated interventions
- Be able to raise questions about universal health coverage as it evolves

Beyond effective coverage…

Effective Coverage

- What proportion of the target population gets and benefits from the intervention (effective coverage)

- Not to be confused with Universal Health Coverage

Universal Health Coverage (UHC) defined…

- A major goal (process or policy) of health reform and health systems …

- UHC ensures that **all** people have access to **needed** promotive, preventive, curative and rehabilitative **health services**, of sufficient **quality** to be **effective**, without suffering **financial hardship**. (WHO, 2010)

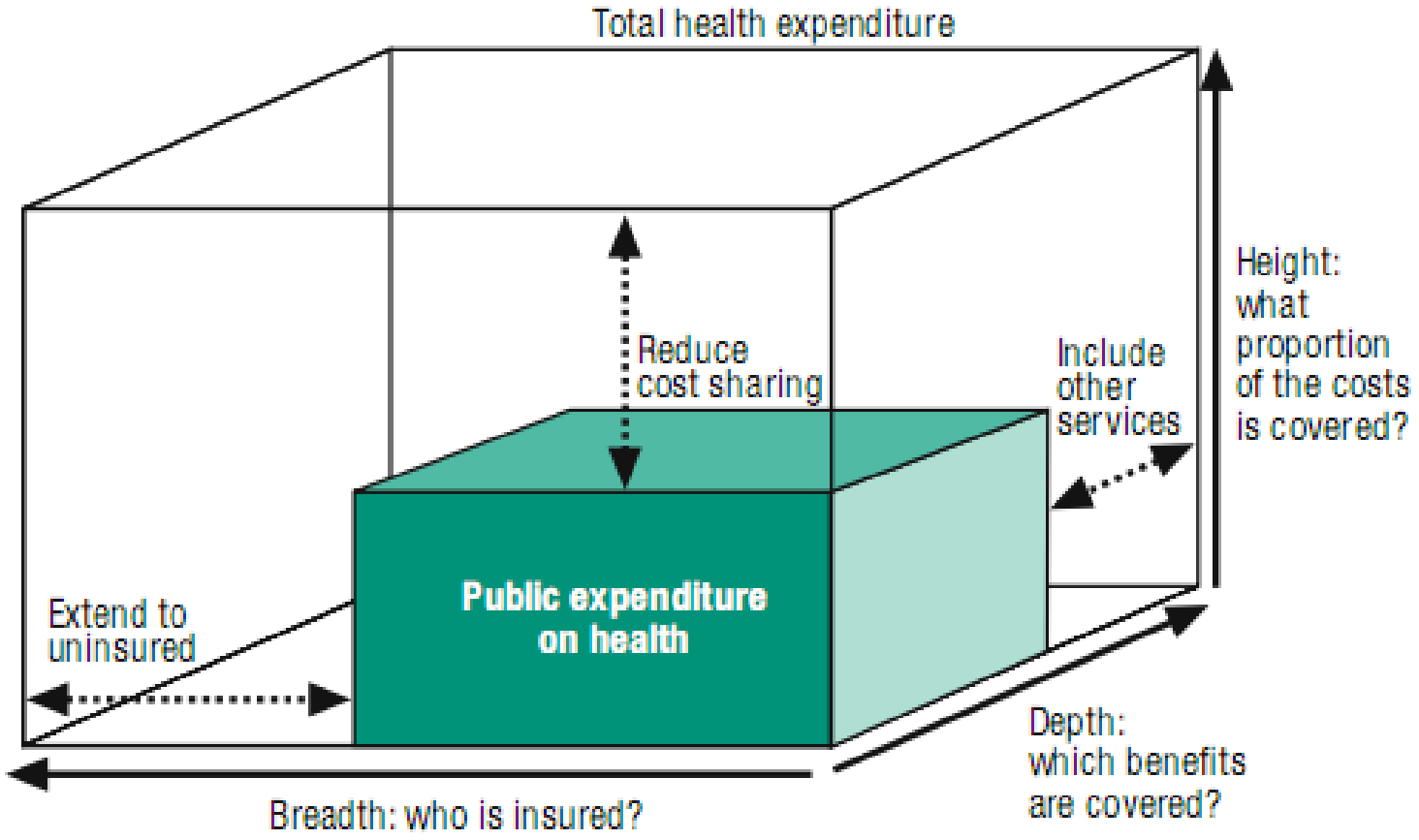
- Embodies 3 related objectives:

  • **equity in access to health services** - those who need the services should get them, not only those who can pay for them;

  • that the **quality** of health services is good enough to improve the health of those receiving services; and

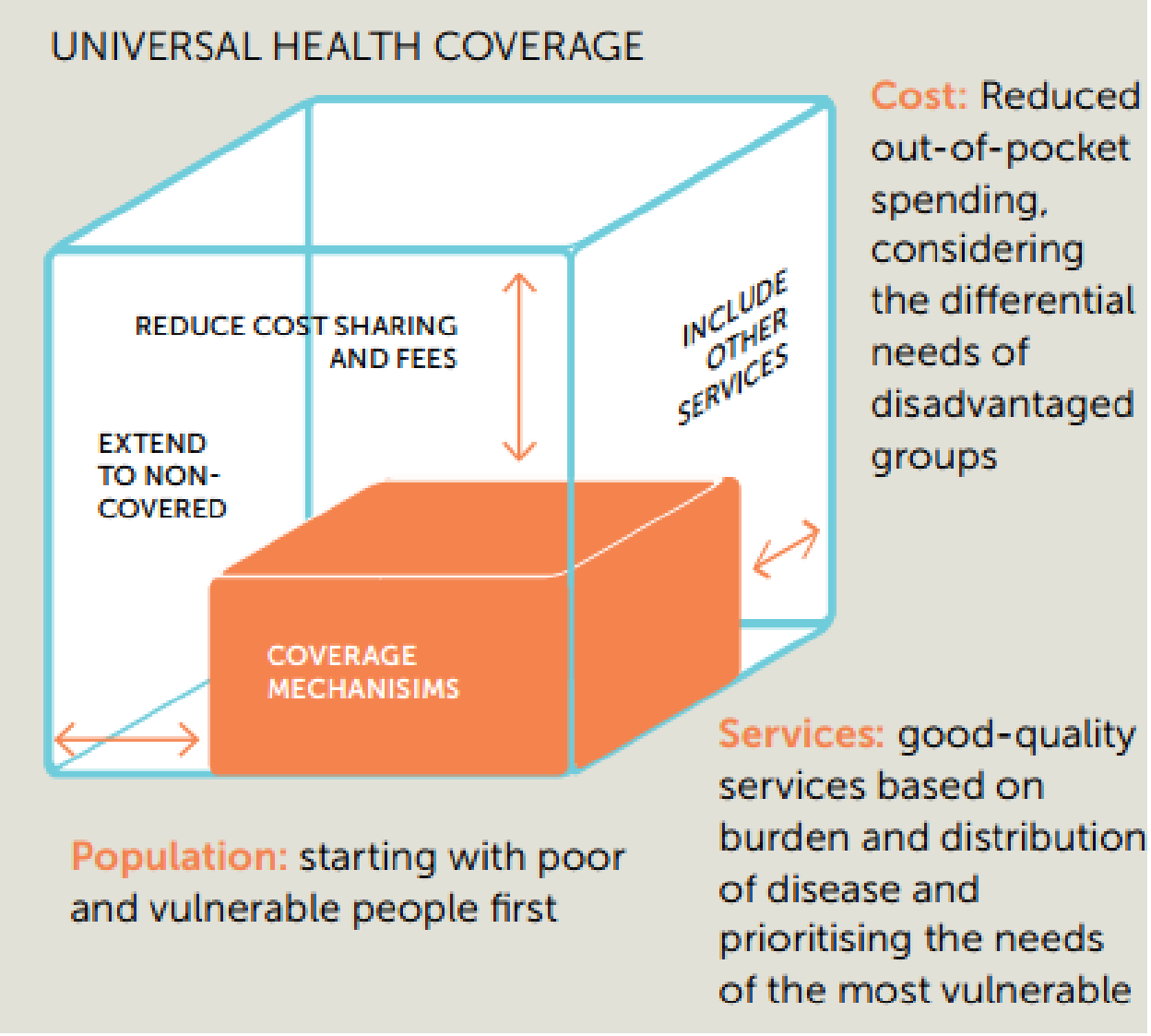
  • **financial-risk protection** - ensuring that the cost of using care does not put people at risk of financial hardship.

Towards Universal Health Coverage



Towards Universal Health Coverage

Swiss TPH



Universal Health Coverage: A commitment to close the gap (2013) Rockefeller, SC, WHO, UNICEF

Universal Health Coverage

- No country fully achieves all the coverage objectives with constantly moving target - new technologies; increasing costs; aging (and increasing) population; changing disease patterns

But all countries want to:

- Reduce the gap between need and utilization
- Improve/maintain quality
- Improve financial protection

Why is UHC important?

- Financial risk protection helps to increase coverage with needed services: **instrumental** to other goals
- Coverage with health services helps improve and maintain health **instrumental**
- BUT: UHC is valued for its own sake as well: **intrinsic goal**
- People sleep well at night knowing the health services they might need to use are available and affordable (but they hope they don't ever have to use them)

UHC as a movement

- 2003: WHO Department of Health System Financing suggested UHC as the goal of health system financing strategies
- **2005: World Health Assembly Resolution where UHC was accepted as goal of health financing systems requesting WHO to help countries**
- **2010: World Health Report 2010**. Health Systems Financing: The Path to Universal Coverage – introduced the UHC Cube to a broader audience
- **2011: WHA Resolution: UHC objective of all health system development – broader than financing**

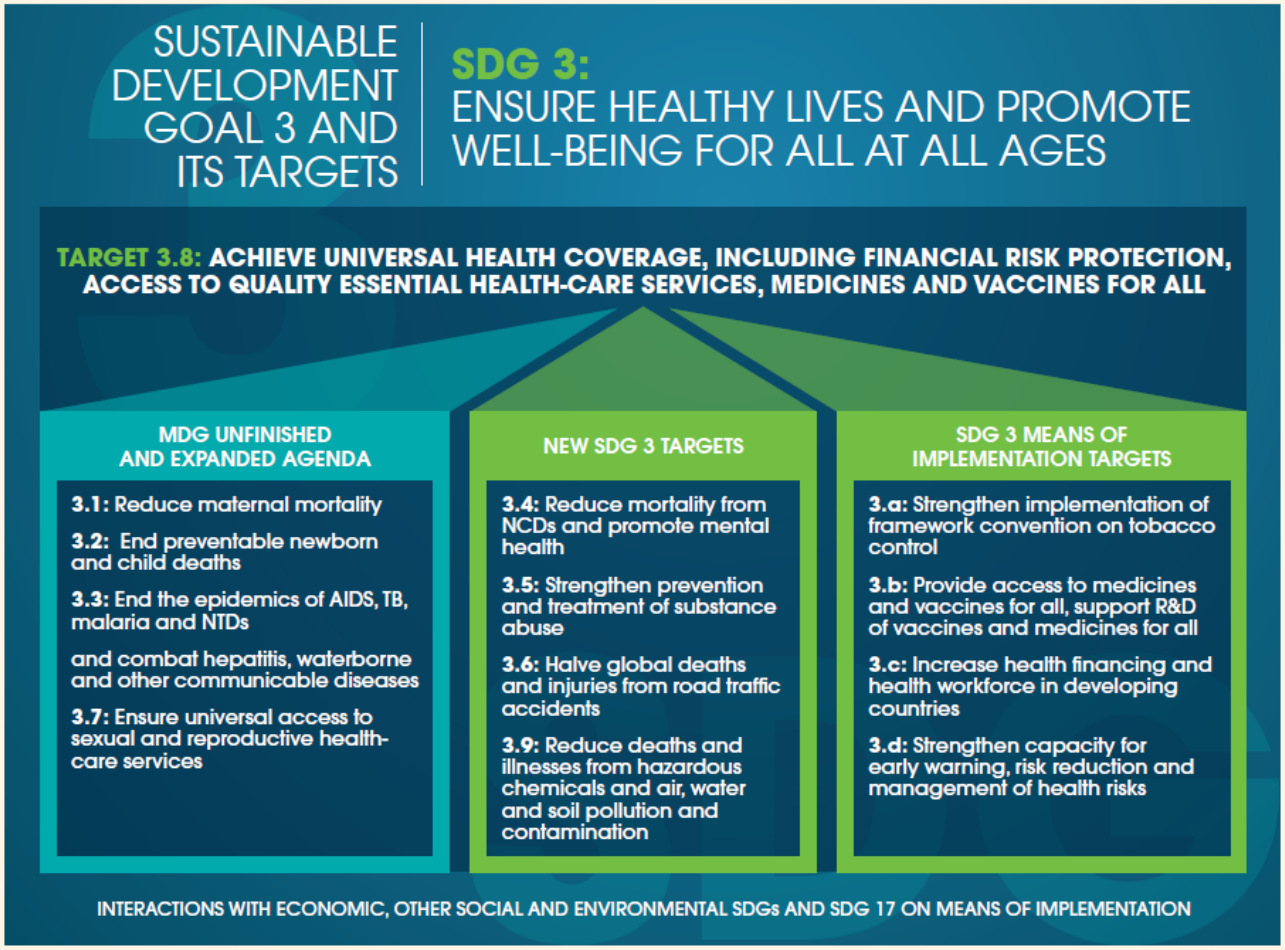
UHC as a movement

- 2012: Bangkok Statement, Mexico Declaration, Tunis Declaration, Kigali Ministerial Statements on UHC
- 2012: Rio Declaration on Sustainable Development
- **2013: Joint WB/WHO Ministerial Meeting on UHC; WB/WHO Joint Monitoring Framework**
- 2014: Lancet commission on Investing in Health
- 2015: WHO/WB Tracking Progress towards UHC. First Global Monitoring Report
- **2015: Sustainable Development Goals**

Health in Sustainable Development Goals

Health in Sustainable Development Goals

Figure 9.1
A framework for the SDG health goal and targets



Challenges in measuring progress towards UHC

- Reliable data on a broad set of health service coverage and financial protection indicators
- Disaggregating data to expose coverage inequities
- Measuring effective coverage: not only whether people receive the services they need but also whether quality was sufficient to obtain the desired health improvement

WHO/WB monitoring framework

8 Tracer Indicators of Health Service Coverage used by WHO/WB

- reproductive & newborn health (family planning, antenatal care, skilled birth attendance);
- child immunization (3 doses of diphtheria, tetanus and pertussis (DTP);
- infectious disease (antiretroviral therapy (ART), tuberculosis (TB) treatment);
- and non-health sector determinants of health (improved water sources and improved sanitary facilities).

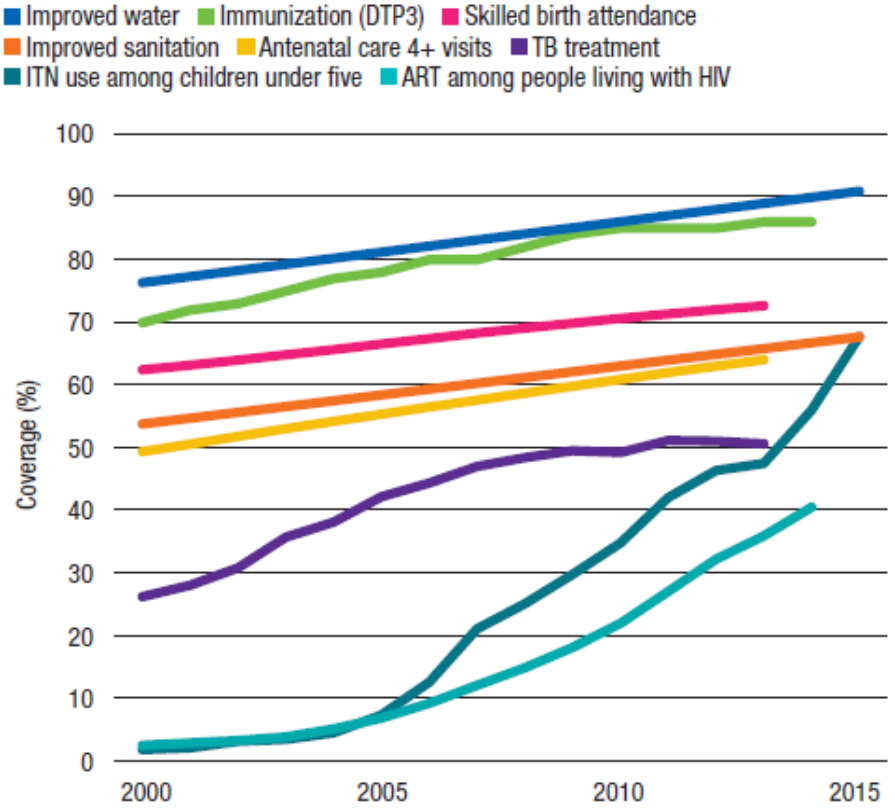
Results of Global Monitoring

Health Services:

- More people get the services they need than at any time in history, with coverage in some > 80% (DTP3 84%; SBA 73%; reproductive health 76%)
- Only 37% of people living with HIV receive treatment; 55% new TB cases diagnosed and successful treatment; 36% of the world's pop lack access to improved sanitation – high health risks.
- Inequality still a problem within and between countries – see earlier slides

WHO/WB monitoring framework – progress of the 8 tracers

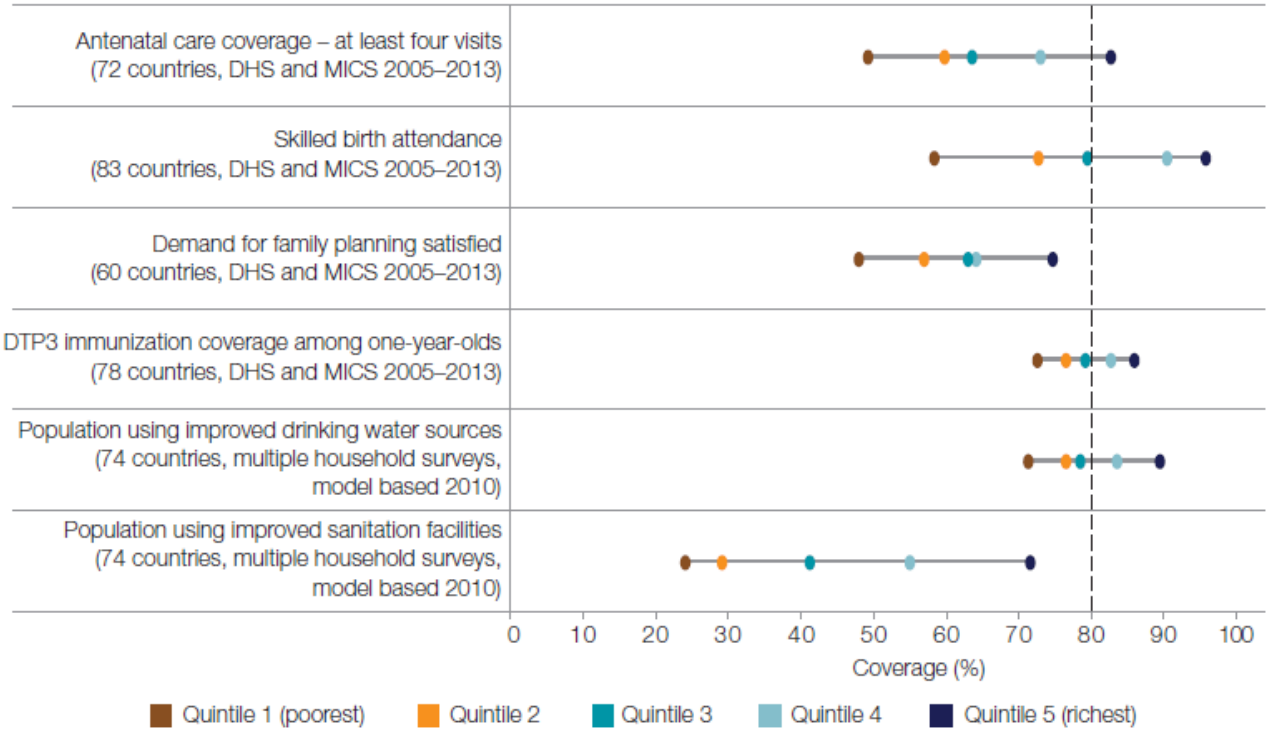
Figure 3.2
Global levels and trends of health MDG-related UHC tracer indicators, 2000–2015[10]



Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals. **World Health Organization 2015** http://www.who.int/gho/publications/mdgs-sdgs/en/

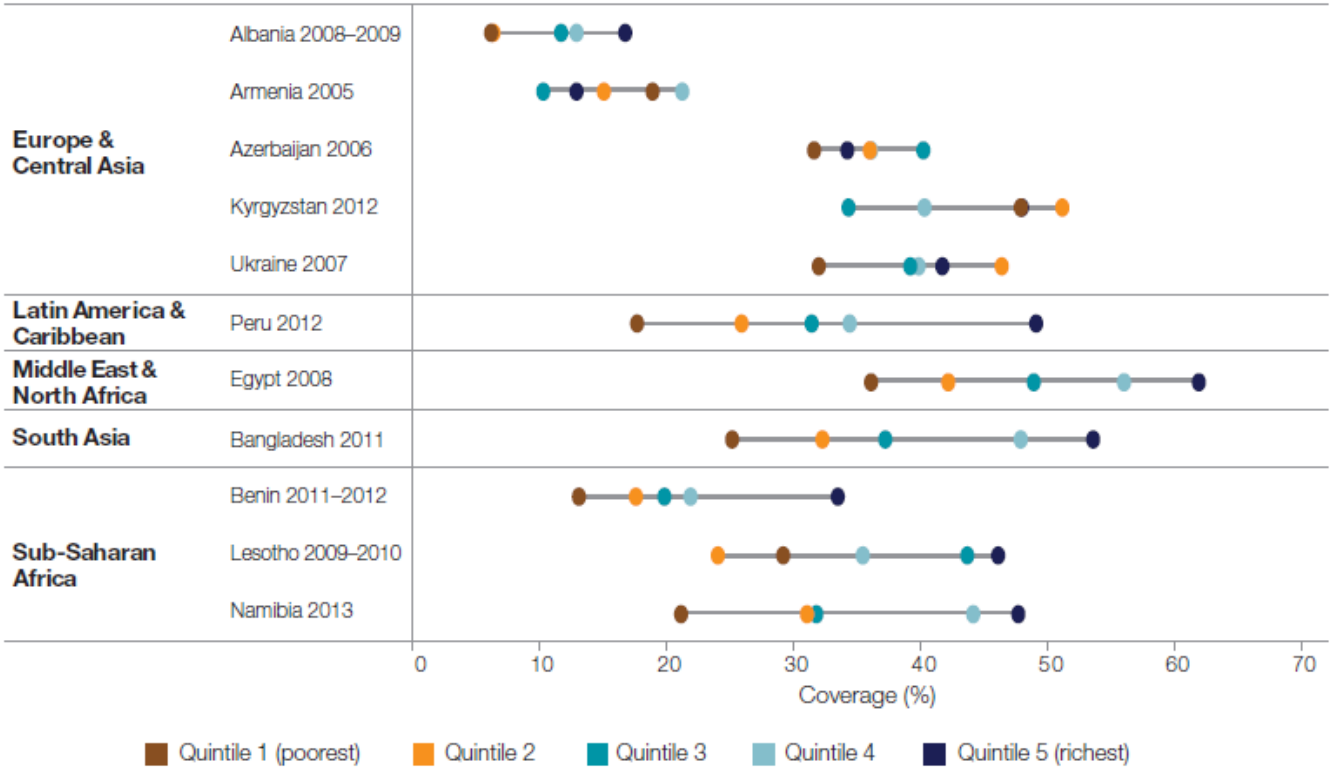
Inequalites in coverage of selected interventions

Figure 2.4. Median coverage of selected interventions by wealth quintile, in low- and middle-income countries



Inequalites in Hypertension treatment coverage

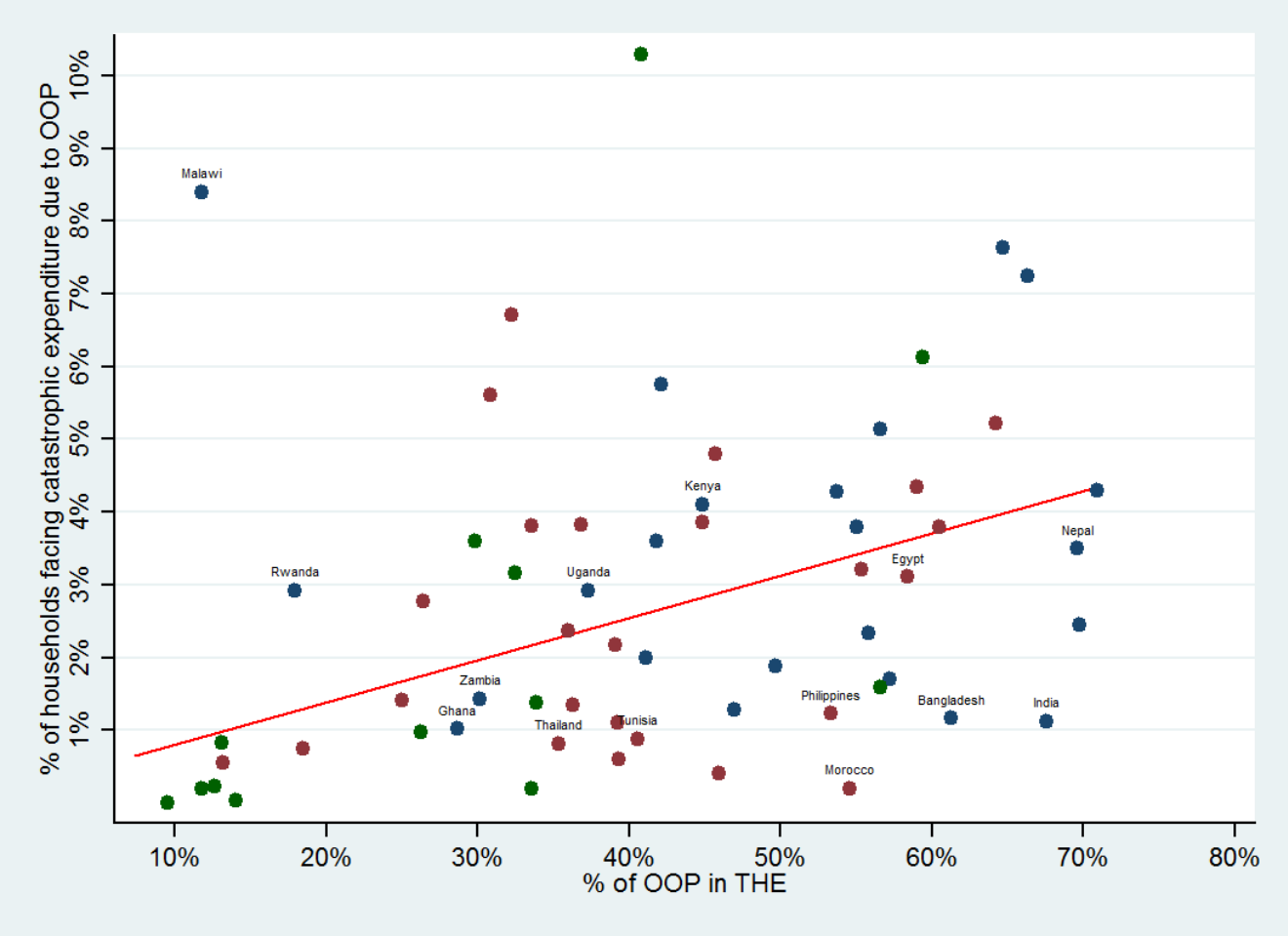
Figure 2.7. Percentage of adults with raised blood pressure[a] or on medication for hypertension, who are currently taking medication for hypertension, by wealth quintile[b]



Measuring financial protection

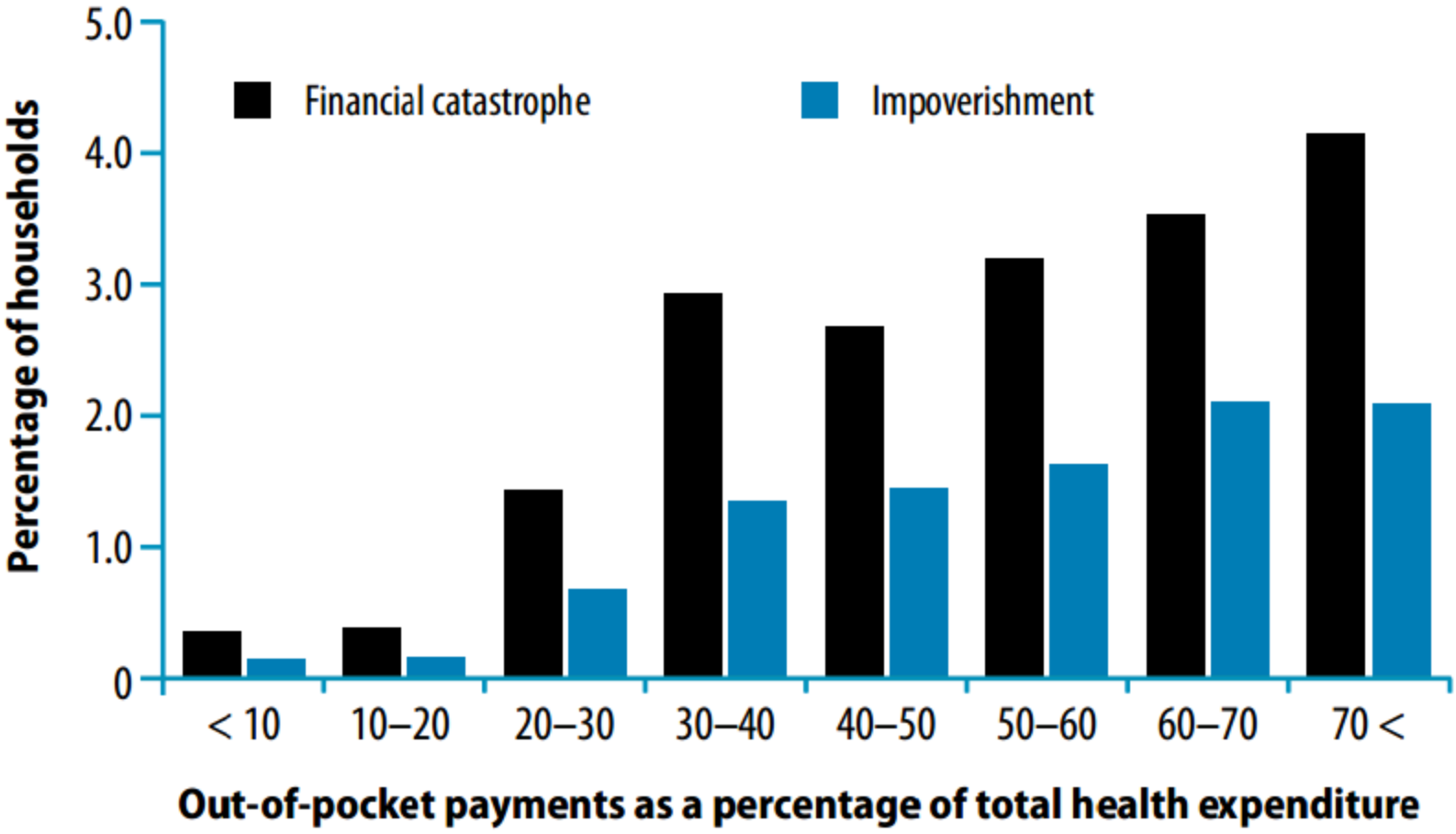
- Adverse economic welfare effects can be due to actual health payments or the risk of health payments: **Risk vs. burden**
- Common measures focus on the adverse economic effects of health payments on households – **the burden caused by the lack of financial protection – ex post, not ex ante**
- Adverse economic effects are felt through short run changes in consumption of goods/services, changes in social situation or long-run decrease in human capital

Catastrophic spending by households
>40% non-food expenditures



Source: Compiled by WHO from latest data

Financial protection



WHO Report 2010

Measuring financial protection

Saksena P, Smith T, Tediosi F. Inputs for universal health coverage: a methodological contribution to finding proxy indicators for financial hardship due to health expenditure. BMC Health Serv Res. 2014 Nov 25;14:577.

Abstract

Background: Universal health coverage is high on national health agendas of many countries at the moment. Absence of financial hardship is a key component of universal health coverage and should be monitored regularly. However, relevant household survey data, which is traditionally needed for this analysis is not frequently collected in most countries and in some countries, has not been collected at all. As such, proxy indicators for financial hardship would be very useful.

Methods: We use data from the World Health Survey and use multi-level modeling with national and household level characteristics to see which indicators have a consistent and robust relationship with financial hardship. To strengthen the validity of our findings, we also use different measures of financial hardship.

Results: There are several household level characteristics that seem to have a consistent relationship with financial hardship. However there is only one strong candidate for a proxy indicator at the national level– the share of out-of-pocket payments in total health expenditure. Additionally, the Gini coefficient of total household expenditure was also correlated to financial hardship in most of our models.

Conclusion: The national level indicators related only weakly to the risk of financial hardship. Hence, there should not be an over-reliance on them and collecting good quality household survey data is still a superior option for monitoring financial hardship.

Keywords: Universal health coverage, Financial hardship, Financial burden, Financial risk protection, Catastrophic health expenditure, Impoverishment, Out-of-pocket payments, Health payments, Health expenditure

Measuring financial protection

- Catastrophic expenditure
- Impoverishment
  - Common financial protection measures rely on cross-sectional data and thus measure short run changes in consumption of goods/services
  - Like all indicators, not perfect but reasonable approximations of the underlying things that we want to capture
  - Quantitative measurement using cross-sectional data needs to be interpreted carefully

Catastrophic health expenditure

- Occurs when spending on health exceeds a certain threshold of household "capacity to pay"

- Common definitions of catastrophe (difference concepts of capacity to pay):
  - Health spending > 10% (sometimes 25%) of total income/expenditure
  - Health spending > 40% non-food expenditure
  - Health spending > 40% of non-subsistence expenditure (WHO definition = non-essential food expenditure)
  - Health spending > (40% of total expenditure – I$1.25/day)

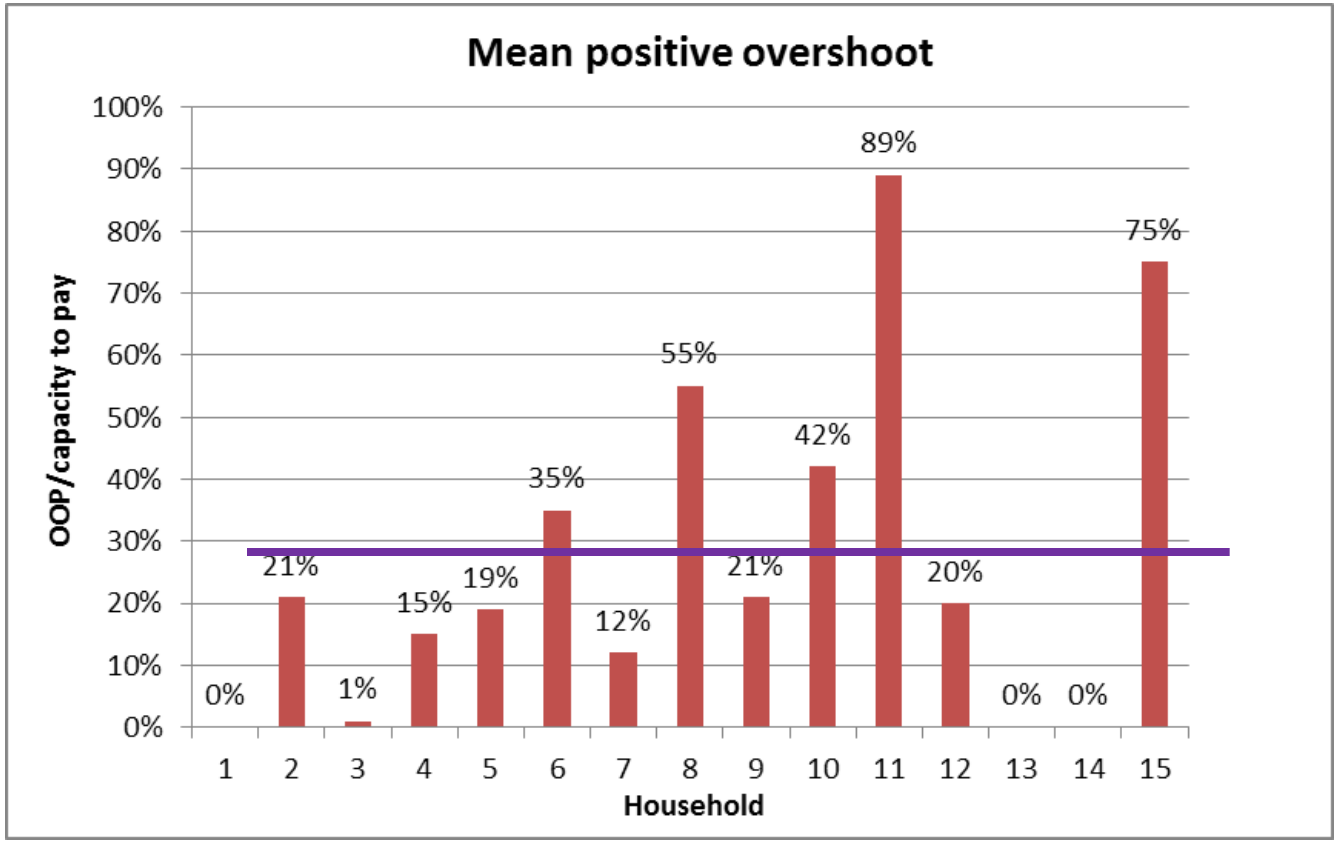
WHO's catastrophic health expenditure indicator

WHO methodology chooses a threshold that is relatively high (40%)

- Households that are shown to have catastrophic health expenditure really are likely to have a high financial burden from OOP
- Indicator is not likely to be driven by non-discretionary spending on OOP
- Construction of the indicator is equity driven
- Any given health expenditure less likely to be catastrophic in richer households

Catastrophic health expenditure indicator

Mean positive overshoot (mean of the positive deviations above capacity to pay)



Impoverishment due to health payments

- Poverty represents a dearth of resources/capabilities
- If health payments push a household below a poverty threshold (i.e. basic spending level), a household is considered to be impoverished due to health payments
- If a household that is already below the threshold of basic spending makes health payments, the household becomes poorer due to health payments
- Can be measured by the increase in the depth of poverty due to health payments

Impoverishment due to health payments: What poverty line?

National poverty line

- Pros: Speaks easily to national policymakers, media, public
- Cons: Prone to political manipulation, difficulty in international comparisons

Fixed international poverty lines (e.g. Int $1.25, Int $2.00)

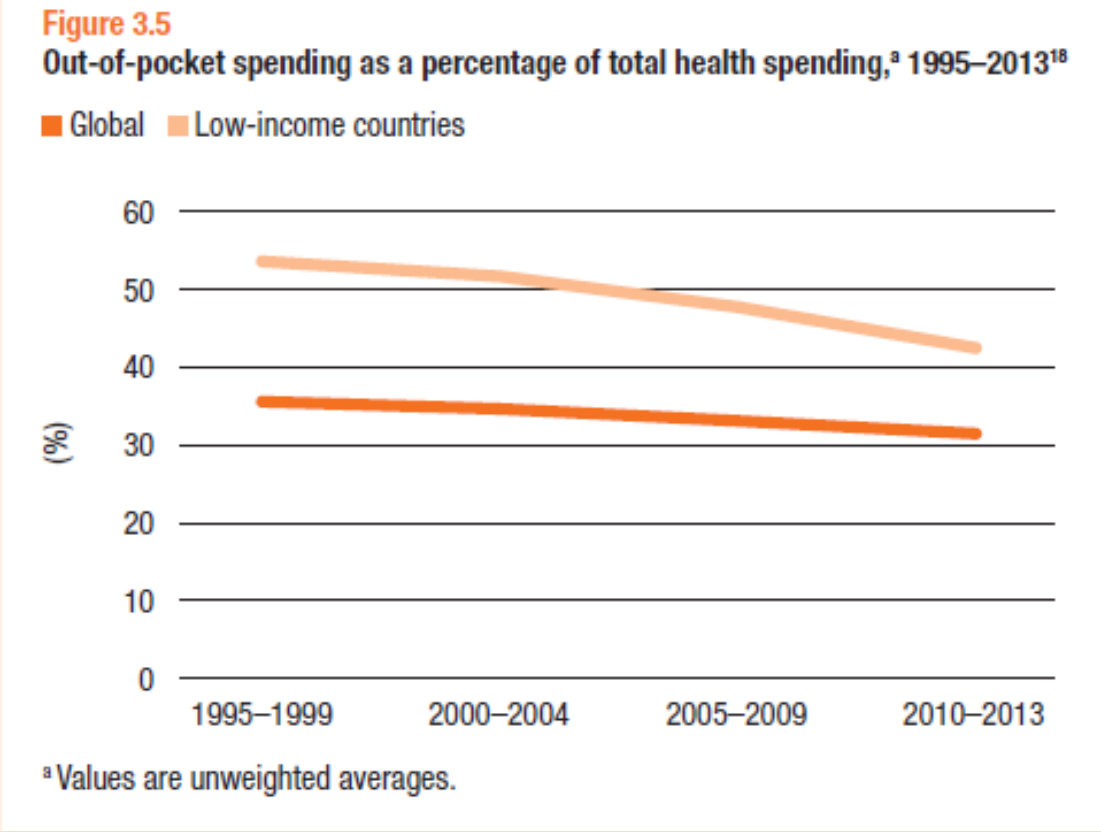
- Pros: Speaks easily to policymakers and media
- Cons: In many countries, almost all population is poor/rich – no variance so indicator is not sensitive to change

Relative poverty line

- Pros: Adaptable to all countries, explicitly takes into account inequalities
- Cons: More complicated to calculate for analyst, more difficult to understand from media, public

Results of Global WHO/WB Monitoring

- OOPs/THE fallen from 36% in 2000 to 32% in 2013 – closer to the 20% desirable level.



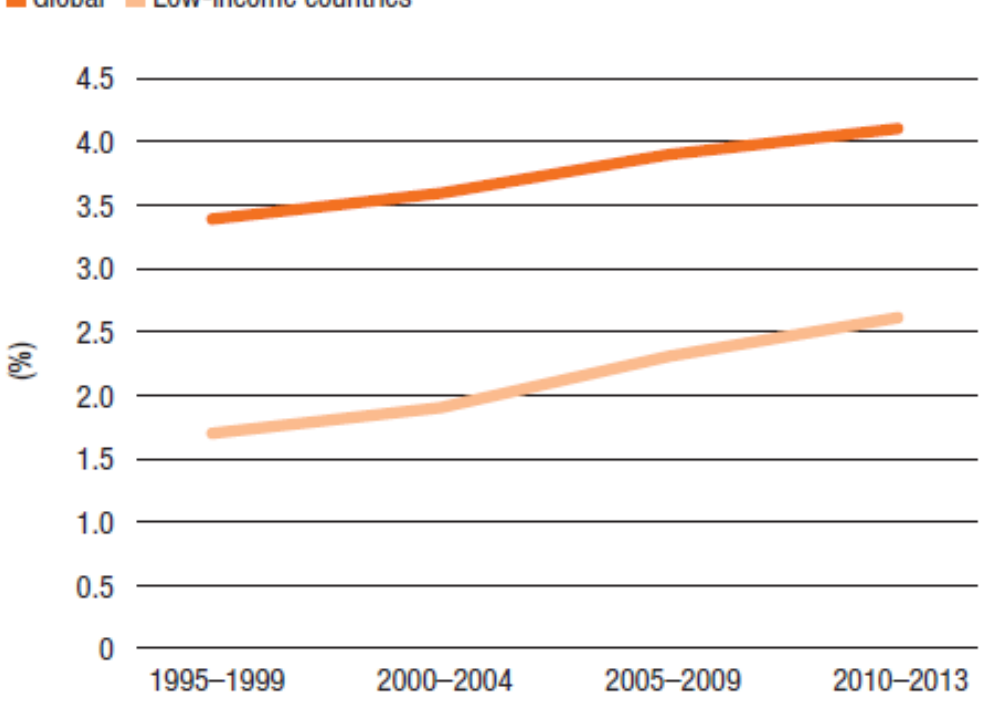
Results of Global WHO/WB Monitoring

- Among 23 countries with two HH expenditure surveys during 2000–2011, the majority succeeded in reducing the incidence of catastrophic and impoverishing health payments: country median values fell by 29% and 24% respectively

- WHO/WB updating jointly the estimates of 100 million pushed into poverty and 150 million suffering finanial catastrophe

Results of Global WHO/WB Monitoring

Figure 3.6
Public expenditure on health as a percentage of GDP,[a] 1995–2013[18]



[a] Values are unweighted averages.

Readings and tools

WHO/WB Tracking Universal Health Coverage. First Global Monitoring Report

http://www.who.int/healthinfo/universal_health_coverage/report/2015/en/

WHO/WB UHC Monitoring Framework
http://www.who.int/healthinfo/country_monitoring_evaluation/UHC_WBG_DiscussionPaper_Dec2013.pdf

World Bank: ADePT – software tool
http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTPROGRAMS/EXTADEPT/0,,menuPK:7108381~pagePK:64168176~piPK:64168140~theSitePK:7108360,00.html

WHO: survey upload interface – can produce any indicator of ex post financial protection. Also technical support available on request