**Paper 2: Access to and use of needed care: assessing progress to UHC and understanding how and why**

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A key element of UHC is that of access to needed health services for all. As it is challenging to measure access directly and comprehensively, the actual *use* of services is seen as the only feasible proxy measurement at the national level. Some argue that the most appropriate indicator is coverage of specific health services, such as measles immunisation coverage. Unfortunately, this reduces assessment of UHC coverage to measurement of a narrow range of services, which are selected on the basis of the availability of data.

Others argue that total health service utilisation rates should be measured. They can be compared to a minimum threshold, such as 5 outpatient visits per person per year and 100 discharges per 1,000 population. Alternatively, each country could estimate ‘ideal’ average utilisation rates in their context, based on the country’s demographic and epidemiological profile and current use of different services in well-functioning facilities and/or service protocols. This would allow the actual use of services to be compared to expected use to meet the needs of the population.

However, aggregate level utilisation rates obscure inequities in use and particularly do not highlight the plight of those who are not able to use the health services they need. Although utilisation rates that are below the minimum threshold are likely to reflect not only infrequent use of services, but also the existence of unmet need, it does not quantify the extent of unmet need. Also, it simply points to a problem and provides no insights into why utilisation is inadequate or inequitable and so does not provide guidance on how to address these challenges. Equity analyses which compare utilisation rates across different groups and across small geographic areas can help to identify communities with the lowest utilisation rates, where unmet need is likely to be the greatest. However, a detailed assessment of access barriers within different communities is required to assist in identifying effective ways to address these barriers. Such assessments should consider all access dimensions and draw on not only quantitative but also qualitative data, for example to understand the nature and cause of barriers related to the acceptability dimension of access. This paper highlights the need to not only use indicators that are relevant for global comparisons, but also to compile a range of data at sub-national levels that can provide insights into why there is or isn’t progress towards UHC within that country.