



## Moving, and assessing progress, towards universal health systems within the context of the SDGs

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4<sup>th</sup> African Health Economics and Policy Association Conference, Rabat, Morocco  
27 September 2016




GNHE is a partnership formed by three regional health equity networks:

- SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries) in Africa
- EQUITAP (Equity in Asia-Pacific Health Systems) in the Asia-Pacific
- LANET-EHS (Latin American Research Network on Equity and Health Systems) in the Americas






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This presentation is based on the work of GNHE funded by a grant from IDRC through Grant No. 106439.



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## WHR 2010: Definition of UHC

- Access to needed care
- Financial protection
- .... for all

## Overview of session

- Measuring financial protection
- Measuring access to quality care
- Assessments of some African countries
- Discussions



## Assessing financial risk protection in the context of universal health coverage

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**GNHE parallel session: Moving, and assessing progress, towards universal health systems within the context of the SDGs**  
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## Session outline

- Overview of current approaches to assessing FRP
- Compatibility of the current approaches with the UHC agenda
- Understanding FRP in the context of UHC and the SDGs

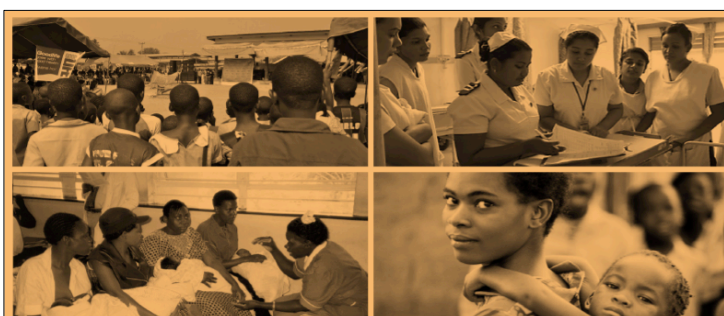
## Introduction

- Traditional conception of financial risk protection (FRP)
  - Use of health services should not impact negatively on the demand for other household necessities
  - Based on direct out-of-pocket spending
  - Relating OOP spending to a threshold (e.g. 10% of HH income)
- Two broad measures of FRP
  - Catastrophic health expenditures
  - Impoverishing health expenditures

## Focus of traditional FRP measures

|              |          | Health service use |          |
|--------------|----------|--------------------|----------|
|              |          | User               | Non-user |
| OOP spending | Paid OOP | <i>A</i>           | <i>C</i> |
|              | No OOP   | <i>B</i>           | <i>D</i> |

- Traditional measures focus on quadrant *A*
  - **Not financially protected**: a fraction of HHs or individuals in quadrant *A*



### Assessing Progress to UHC - The GNHE Perspective\*\*

#### Financial Risk Protection

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Global Network for Health Equity (GNHE)

December 2015

#### Key points

- A key element of Universal Health Coverage (UHC) is financial risk protection (FRP) for all.
- Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.
- FRP must be measured alongside, and in addition to, the other dimensions of UHC, which is access to and health...



## FRP in the context of UHC

- Entire population: a central focus of UHC
  - Quadrants A to D
- Do the current measures fit into UHC?
  - Not really
    - Conceptual issues overlooked: what population group?
  - What about HHs that did not use any health service?
    - All financially protected?
  - What about HHs the used limited services because they could not afford comprehensive services?
    - All financially protected?



Global Network for Health Equity

### AJPH FORUM

## Universal Health Coverage: Assessing Service Coverage and Financial Protection for All

In 2005 the World Health Organization encouraged countries to move toward achieving Universal Health Coverage (UHC)<sup>1</sup> through a process of progressive realization. During the early stages, discussions around UHC were rooted mainly in ensuring that equitable prepayment health financing is established in

Although there are criticisms of UHC, the publication of the 2010 World Health Report<sup>4</sup> attempted to provide further clarity on the concept to encompass three broad dimensions—

population coverage, service coverage and coverage with financial risk protection, all with an equity focus. The report uses

health financing as the “window” to UHC, with an understanding that everyone has access to needed health services that are effective and of acceptable quality, and that no one should face undue financial hardship as a result of the use or the need to use health services.<sup>4</sup> The 2013 World

While this article acknowledges the substantial progress made to date in refining UHC

indicators, it highlights some key issues that need to be understood and clarified to fully assess UHC.

### POPULATION DIMENSION DOWNPLAYED?

Social policies, initiatives, and many indicators of the UHC

dimensions do not sufficiently address this key population dimension. For example Wagstaff et al.<sup>5</sup> assess prevention sub-dimension using only antenatal services among females (mainly aged between 15 and 49 years) and immunization services among children aged 12 months. In addition, treatment services (i.e., inpatient and outpatient utilization) were assessed without considering inpatient admissions for children and outpatient utilization for almost the entire population. While these are considered as indicators, it can be argued that there is a lack of attention, despite the fact that the

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1780 Editorial Ataguba and Ingabire

AJPH October 2016, Vol 106, No. 10

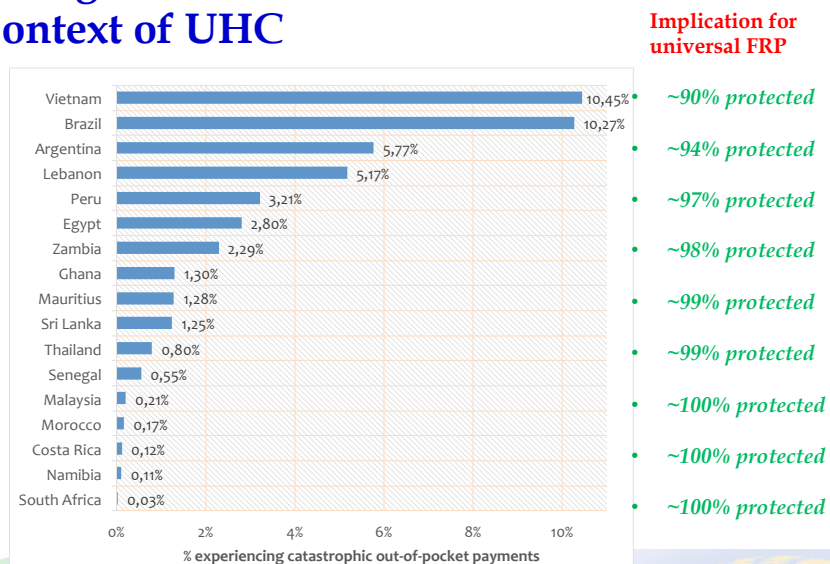


Ataguba & Ingabire (2016) American Journal of Public Health • Vol 106 • No 10 • 1780–1781 AJPH FORUM

## What should FRP capture in the context of UHC?

- A detailed conceptualisation of FRP within the context of UHC
  - UHC - **everyone** has access to needed services that are effective and acceptable without **anyone** facing undue financial hardship
- **Current measures are inadequate and exclude a non-trivial segment of the population: re-scaling of measures of catastrophe and impoverishment**
  - E.g. If catastrophic headcount is 4% in a country, it is assumed that 96% of HHs are financially protected.
  - What happens to HHs that are too poor to pay for health services? Are they finally protected?

## Using traditional measures of FRP in the context of UHC



## Assessing FRP within UHC

- FRP for UHC needs to answer the following:
  - Is everyone within a defined geographic space, if the need arises, able to use health services without any undue financial hardship?
  - Is FRP equitable?
    - Using different equity stratifiers
  - *A priori* vs. *a posteriori*
    - Current measures are essentially *a posteriori* measures
    - FRP for UHC should be *a priori*

## Conclusion

- Traditional measures do not relate to the focus of UHC; the entire population
  - If used, should be interpreted accordingly
- FRP in the context of UHC has to encompass the entire population
  - Current users and non-users
  - *A priori* measures
- A need for more methodological work on assessing FRP for UHC





## Measuring access to needed health services

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## Outline

- Some conceptual issues
- Proposed and alternative measures of use
- Key considerations for progress towards UHC
- Final comments



## Conceptual issues

Access to needed services for all

- Conceptually, access is distinct from use:
  - Access relates to the 'degree of fit' between health system (supply) and individuals (demand)
- End goal: those who need particular services do actually use them
- Measure(s) to focus on service use, if possible, relative to need

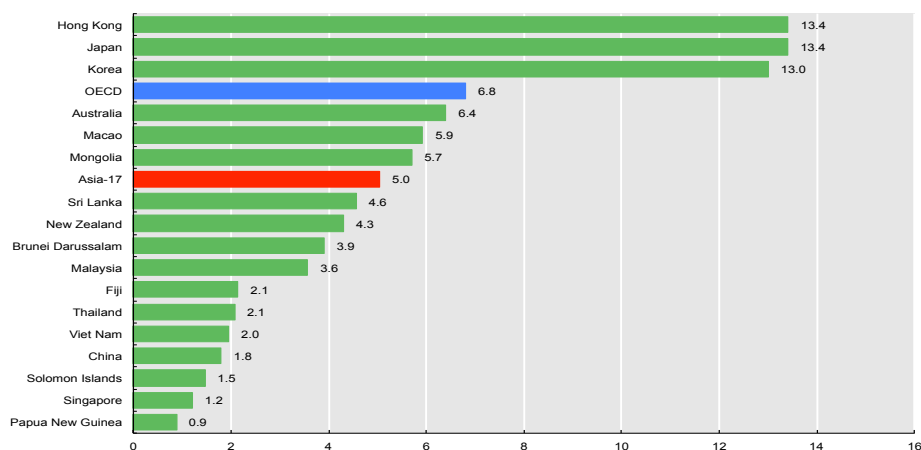
## What measures of use?

- Challenge: get accurate estimates of numerator (use) and denominator (need)
- Easiest for individual services, especially where denominator is based on demographic data
  - e.g. Immunization coverage, Antenatal visits, Assisted deliveries, Antiretroviral Therapy and TB treatment coverage
- Great efforts led by WHO and World Bank: proposed indicators with social determinants and equity consideration
- Concern about narrow MCH services or disease specific focus

## GNHE proposal

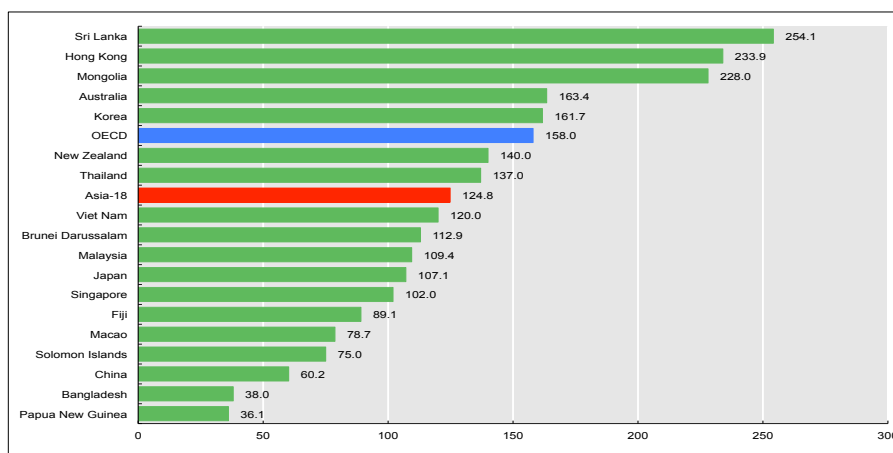
- Alternative is to measure total use:
  - Difficult to relate this to need for health care
- Propose a set of 'reasonable' targets for 'adequate' use
- Preventative and curative services
- Assess equity in use

## Outpatient consultations per capita



Discussion: African countries to consider average of 4 outpatient visits per capita per year?

## Hospital discharges per 1,000 pop



Discussion: African countries to target average of 100 discharges per 1,000 population?

## Key considerations for progress

- Unmet need
  - Key question: is service use in line with need?
  - But, if not, what should we do about it?
  - Need to understand underlying access barriers
- Equity – beyond average

## Effectively addressing access barriers

Need to understand access barriers:

- Explore at country/local level
- Requires qualitative work
- Not only health system interventions required  
- aim at the fit between supply and demand

## Equity in use

- Compare utilisation across different groups (e.g. gender, wealth, residence)
- Compare with indicators of need if possible, but as a minimum, equal use as a target
- Recognising greater burden of ill-health on lower socio-economic groups, pro-poor distribution of use would be a better target

## Concluding comments

- It is important to consider overall service use and not just a few services, to get a sense of overall health system performance:
  - Minimum targets for overall use
  - Plus assess equity in use
- Supplement with direct assessment of access:
  - Ensure the fit between the supply and demand
  - Use mixed methods

## In support for SDGs

- Continue the discussions on appropriate indicators for countries to assess their progress
- Invest in improving health information systems – e.g. Health Data Collaborative
- Look forward to the discussion



## Where are different African countries on the road to UHC and what contributes to differences in UHC status?

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## Session outline

- What framework and indicators did the Global Network for Health Equity (GNHE) use to assess progress towards UHC?
- (What progress have the different member countries from Africa made on the road to UHC?)
- Lessons from the assessment approach



## The GNHE approach

- Based on an early version of McIntyre D, Kutzin J. 2016. *Health financing country diagnostic: a foundation for national strategy development*. Geneva: World Health Organization. Available at: [http://www.who.int/health\\_financing/tools/diagnostic/en/](http://www.who.int/health_financing/tools/diagnostic/en/)
- Adapted to practical constraints faced by country authors in accessing data
- Predicated on the assumptions that:
  - to understand the full implications of financing arrangements, it is necessary to understand related aspects of provision
  - it is necessary to understand the local context to interpret indicators and understand policy implications
  - when comparing indicators to understand relative progress, choose comparison countries carefully (e.g. similar income group, context, structural features etc.)



## The GNHE template (1)

### Key health care expenditure indicators

Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Zambia, 2012

| Indicators of the level of health care expenditure                               |       |
|--|-------|
| 1. Total expenditure on health as % of GDP                                       | 6.5%  |
| 2. General government expenditure on health as % of GDP                          | 4.2%  |
| 3. General government expenditure on health as % of total government expenditure | 16.4% |
| 4a. Per capita government expenditure on health at average exchange rate (US\$)  | 62    |
| 4b. Per capita government expenditure on health (PPP \$)                         | 72    |
| Indicators of the source of funds for health care                                |       |
| 5. General government expenditure on health as % of total expenditure on health* | 64.1% |
| 6. Private expenditure on health as % of total expenditure on health**           | 35.9% |
| 7. External resources for health as % of total expenditure on health#            | 32.3% |
| 8. Out-of-pocket expenditure on health as % of total expenditure on health       | 23.9% |
| 9. Out-of-pocket expenditure on health as % of GDP                               | 1.6%  |
| 10. Private prepaid plans on health as % of total expenditure on health          | 1.3%  |



## The GNHE template (2)

Structure of the health system according to financing functions  
(represented graphically as a “function chart”)

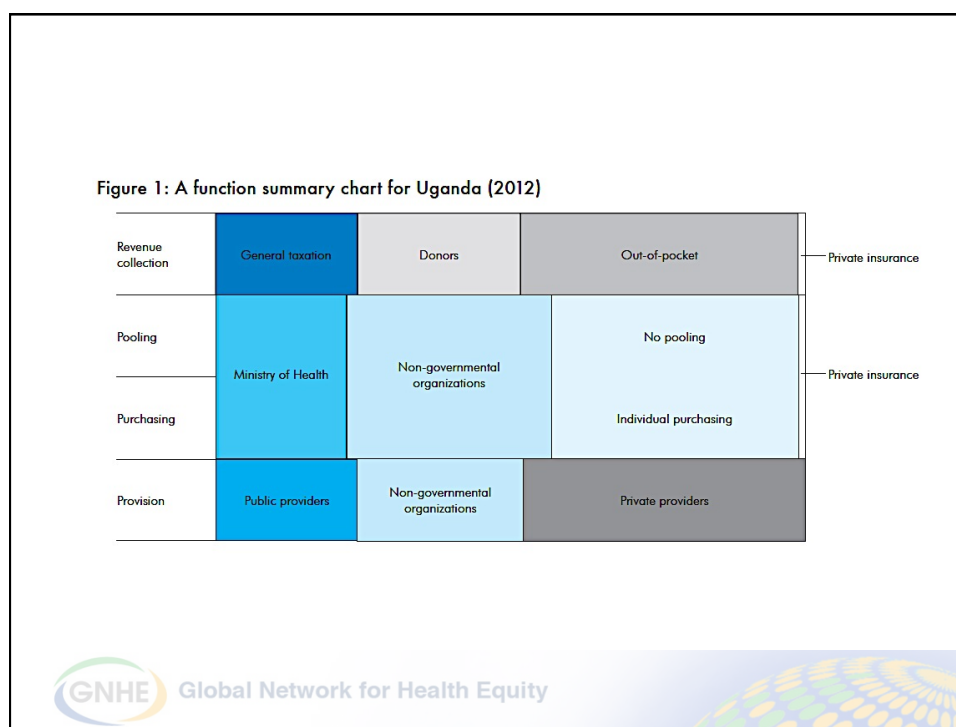
- Revenue collection
  - relative importance of donor financing and user fees
  - exemptions for user fees
  - relative importance of direct versus indirect taxes
  - relative importance of mandatory versus voluntary health insurance schemes
- Pooling:
  - the extent to which each source is pooled
- Purchasing arrangements
  - for different pools
- Provision arrangements



## Relatively high levels of spending don't guarantee UHC: the example of Uganda (2012)

- high total spending on health (as % GDP) BUT
- this is dominated by unsustainable (donor funding) and regressive (OOPs) sources
- mandatory prepayment (through tax funding) amounts to only 1.9% GDP and serves only around a third of the population
- OOPs persist despite abolition of user fees in public sector because of a two-tier system
- provision through the public and NGO sectors tends to be verticalised, reflecting fragmented risk pools and lack of population-based planning and resource allocation
- health care facilities are maldistributed





## **Mandatory health insurance can face equity challenges, too: the example of Ghana (2012)**

- NHI scheme is a pro-poor policy with a generous benefit package
- However, poor people find it hard to pay registration fees and premiums
- Flat-rate premiums are implemented in practice (due to problems in assessing socioeconomic status) and are regressive
- The scheme consequently caters for the better-off (coverage is around one third of the population)
- Poor people subsidise the scheme through VAT contributions
- OOPs remain relatively high (and are increasing)

## The GNHE template (3)

### Financial protection and equity in financing

- catastrophic payment and impoverishment indicators

Table 2: Catastrophic payment indicators for South Africa in 2005/06\*

|  |        |
|--|--------|
| <b>Catastrophic payment headcount index</b><br>(the percentage of households whose out-of-pocket payments for health care as a percentage of household consumption expenditure exceeded the threshold) | 0.09%  |
| Weighted headcount index**   | 0.06%  |
| <b>Catastrophic payment gap index</b><br>(the average amount by which out-of-pocket health care payments as a percentage of household consumption expenditure exceed the threshold)                    | 0.01%  |
| Weighted catastrophic gap index**  | <0.01% |

**Notes:**

\* Financial catastrophe is defined as household out-of-pocket spending on health care in excess of the threshold of 40% of non-food household expenditure

\*\* The weighted headcount and gap indicate whether it is the rich or poor households who mostly bear the burden of catastrophic payments. If the weighted index exceeds the un-weighted index, the burden of catastrophic payments falls more on poorer households.

Source: Mills et al (2012)

Table 3: Impoverishment indicators for Uganda in 2010 using \$2.50 poverty line (2005 PPP)

|   |       |
|---|-------|
| Pre-payment poverty headcount                                       | 65.8% |
| Post-payment poverty headcount                                      | 69.9% |
| Percentage point change in poverty headcount (pre- to post-payment) | 4.0%  |
| Pre-payment normalised poverty gap                                  | 26.7% |
| Post-payment normalised poverty gap                                 | 29.6% |
| Percentage point change in poverty gap (pre- to post-payment)       | 2.9%  |

Source: HealthNet Consult 2012a

## Progressivity of domestic financing sources and their relative contribution to the overall progressivity of the financing systems: the example of Tanzania

Table 4: Incidence of different domestic financing mechanisms in Tanzania (2007)

| Financing mechanism   | Percentage share | Kakwani index |
|---|------------------|---------------|
| <b>Direct taxes</b>   |                  |               |
| Personal income taxes   | 10%              | 0.410         |
| Corporate profit taxes  | 6%               | 0.290         |
| Total direct taxes  | 16%              | 0.370         |
| <b>Indirect taxes:</b>  |                  |               |
| VAT   | 21%              | 0.140         |
| Excise tax  | 12%              | 0.320         |
| Import tax  | 6%               | 0.060         |
| Total indirect taxes  | 39%              | 0.180         |
| Other taxes   | n/a              | n/a           |
| Mandatory health insurance contributions (National Health Insurance Fund) | 8%               | 0.500         |
| <b>Total public financing sources</b>                                     | <b>64%</b>       | <b>0.270</b>  |
| Community-based health insurance (The Community Health Fund)              | 0.4%             | -0.480        |
| Out-of-pocket payments  | 36.1%            | -0.070        |
| <b>Total private financing sources</b>                                    | <b>36.5%</b>     | <b>-0.074</b> |
| <b>Total financing sources</b>  | <b>100.0%</b>    | <b>0.110</b>  |

Note: Estimates are based on per adult equivalent expenditures; n/a = not applicable.  
Source: Mtei (2012)

## The GNHE template (4)

### Equitable use of health services and access to needed care

Table 5: Concentration indexes for benefit incidence of health service use in Ghana (2009)

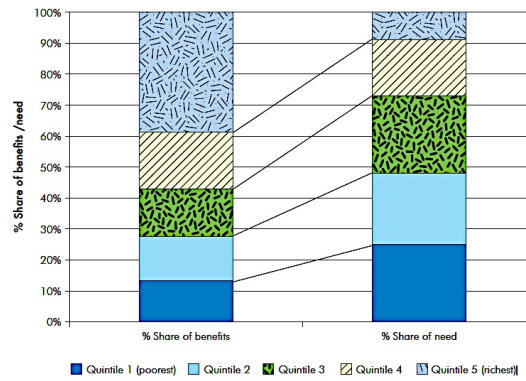
| Type of service                      | Outpatient visits | Inpatient visits |
|--------------------------------------|-------------------|------------------|
| <b>Public facilities*</b>            |                   |                  |
| Hospitals                            | 0.13              | 0.08             |
| Non-hospital facilities              | 0.06              | n/a              |
| <i>Total</i>                         | 0.12              | 0.08             |
| <b>Private for-profit facilities</b> |                   |                  |
| Hospitals                            | 0.24              | 0.42             |
| Non-hospital facilities              | -0.03             | n/a              |
| <i>Total</i>                         | 0.18              | 0.42             |
| <b>Total</b>                         | <b>0.16</b>       | <b>0.12</b>      |

\*Mission hospitals have been merged with public hospitals due to the small sample size for these estimates. In addition, mission facilities' salaries are paid by government and some of their facilities operate as district hospitals.

Notes: Estimates are based on adult-equivalent adjusted household consumption expenditure; n/a = not applicable  
Source: Garshong (2011)

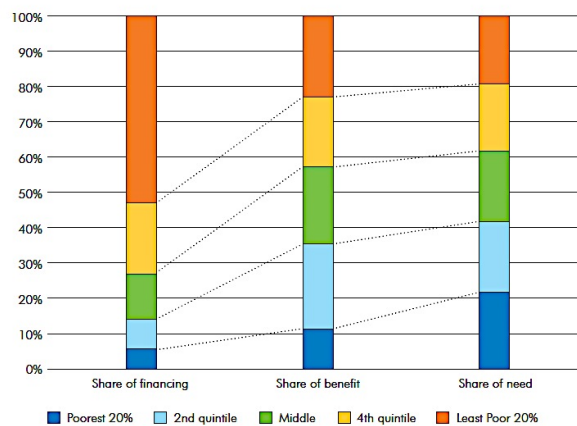
## Access problems in a country with relatively good financial risk protection

Figure 3: Distribution of health benefits compared to need for health care in South Africa (2008)



Note: need for health care is assessed using self-assessed health status  
Source: Ataguba and McIntyre (2012)

Figure 2: Distribution of financing, benefits and need across wealth groups in Tanzania in 2008



Source: Mtei et al. (2012); Mtei (2012)

## The GNHE template (5)

### Critical analysis

For example, why are catastrophic expenditures in Zambia quite high when:

- OOPs relatively low as % total health expenditure
- OOPs progressive
- PHC free at rural health facilities?

=>actual OOPs higher than recorded, fees charges at public hospitals and urban PHC facilities, fees charged by private facilities (which may be used by poorer patients if the quality of public facilities is perceived to be poor), high level of poverty makes even small payments catastrophic?

## Conclusions

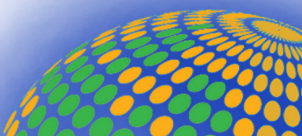

- need a variety of indicators, including those that identify inequities
- situate these within a detailed understanding of the health system (both financing and provision, both public and private)
- this nuanced approach, together with local knowledge, mitigates data constraints (to some extent)






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