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

John Ataguba\textsuperscript{1}, Marie-Gloriose Ingabire\textsuperscript{2}, Jane Doherty\textsuperscript{1,3}, Di McIntyre\textsuperscript{2}

\textsuperscript{1}University of Cape Town, \textsuperscript{2}International Development Research Centre, \textsuperscript{3}University of the Witwatersrand

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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
GNHE is coordinated by three collaborating institutions:

Health Economics Unit
University of Cape Town
South Africa

Institute for Health Policy
Sri Lanka

Fundación Mexicana para la Salud
Mexico

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More information on GHHE is available on [http://gnhe.org](http://gnhe.org)

**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

John E. Ataguba
Health Economics Unit,
School of Public Health, University of Cape Town

GNHE parallel session: Moving, and assessing progress, towards universal health systems within the context of the SDGs
27 September 2016
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

<table>
<thead>
<tr>
<th>OOP spending</th>
<th>User</th>
<th>Non-user</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid OOP</td>
<td>A</td>
<td>C</td>
</tr>
<tr>
<td>No OOP</td>
<td>B</td>
<td>D</td>
</tr>
</tbody>
</table>

- Traditional measures focus on quadrant A
  - Not financially protected: a fraction of HHs or individuals in quadrant A
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 that used limited services because they could not afford comprehensive services?
    • All financially protected?
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

<table>
<thead>
<tr>
<th>Country</th>
<th>% experiencing catastrophic out-of-pocket payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam</td>
<td>6.8%</td>
</tr>
<tr>
<td>Brazil</td>
<td>4.8%</td>
</tr>
<tr>
<td>Argentina</td>
<td>3.3%</td>
</tr>
<tr>
<td>Lebanon</td>
<td>2.9%</td>
</tr>
<tr>
<td>Peru</td>
<td>2.1%</td>
</tr>
<tr>
<td>Egypt</td>
<td>1.9%</td>
</tr>
<tr>
<td>Zambia</td>
<td>1.3%</td>
</tr>
<tr>
<td>Ghana</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mauritius</td>
<td>1.1%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1.0%</td>
</tr>
<tr>
<td>Thailand</td>
<td>0.8%</td>
</tr>
<tr>
<td>Senegal</td>
<td>0.6%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>0.5%</td>
</tr>
<tr>
<td>Morocco</td>
<td>0.4%</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>0.4%</td>
</tr>
<tr>
<td>Namibia</td>
<td>0.3%</td>
</tr>
<tr>
<td>South Africa</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Implication for universal FRP
- ~90% protected
- ~94% protected
- ~97% protected
- ~98% protected
- ~99% protected
- ~99% protected
- ~100% protected
- ~100% protected

Source: Xu et al. 2003 - The Lancet • Vol 362 • 111-117
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

Marie-Gloriose Ingabire and Diane McIntyre

1 International Development Research Centre, 2 Health Economics Unit, University of Cape Town

GNHE parallel session: Moving, and assessing progress, towards universal health systems within the context of the SDGs
27 September 2016

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?

Jane Doherty
Health Economics Unit, University of Cape Town
School of Public Health, University of the Witwatersrand South Africa

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GNHE authors of the African country assessments

- Ghana:
  - Bertha Garshong (Research and Development Division, Ghana Health Service, Ghana)
  - James Akazili (Navrongo Health Research Centre, Ghana Health Service, Ghana)

- Kenya:
  - Jane Chuma and Doris Kirigia (Kenya Medical Research Institute-Wellcome Trust Research Programme, Kenya)

- Nigeria:
  - Hyacinth Ichoku (Department of Economics, University of Nigeria, Nigeria)

- South Africa:
  - Di McIntyre and John Ataguba (Health Economics Unit, University of Cape Town, South Africa)
  - Jane Doherty (Health Economics Unit, University of Cape Town, and School of Public Health, University of the Witwatersrand, South Africa)

- Tanzania:
  - Gemini Mtei and Suzan Makawia (Ifakara Health Institute, Tanzania)

- Uganda:
  - CM Zikusooka, B Kwesiga, S Lagony, C Abewe (HealthNet Consult, Uganda)

- Zambia:
  - Bona Chitha and Dick Jonsson (Department of Economics, University of Zambia, Zambia)
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


• 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>
<thead>
<tr>
<th>Indicators of the level of health care expenditure</th>
<th>Zambia, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total expenditure on health as % of GDP</td>
<td>6.5%</td>
</tr>
<tr>
<td>2. General government expenditure on health as % of GDP</td>
<td>4.2%</td>
</tr>
<tr>
<td>3. General government expenditure on health as % of total government expenditure</td>
<td>16.4%</td>
</tr>
<tr>
<td>4a. Per capita government expenditure on health at average exchange rate (US$)</td>
<td>62</td>
</tr>
<tr>
<td>4b. Per capita government expenditure on health (PPP $)</td>
<td>72</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators of the source of funds for health care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. General government expenditure on health as % of total expenditure on health*</td>
<td>64.1%</td>
</tr>
<tr>
<td>6. Private expenditure on health as % of total expenditure on health**</td>
<td>35.9%</td>
</tr>
<tr>
<td>7. External resources for health as % of total expenditure on health#</td>
<td>32.3%</td>
</tr>
<tr>
<td>8. Out-of-pocket expenditure on health as % of total expenditure on health</td>
<td>23.9%</td>
</tr>
<tr>
<td>9. Out-of-pocket expenditure on health as % of GDP</td>
<td>1.6%</td>
</tr>
<tr>
<td>10. Private prepaid plans on health as % of total expenditure on health</td>
<td>1.3%</td>
</tr>
</tbody>
</table>
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*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophic payment headcount index</td>
<td>0.09%</td>
</tr>
<tr>
<td>Weighted headcount index**</td>
<td>0.00%</td>
</tr>
<tr>
<td>Catastrophic payment gap index</td>
<td>0.01%</td>
</tr>
<tr>
<td>Weighted catastrophic gap index**</td>
<td>&lt;0.01%</td>
</tr>
</tbody>
</table>

Notes:
* Headcount catastrophic is defined as household out-of-pocket spending on health care in excess of the threshold of 40% of non-food household expenditure.
** Weighted headcount and gap indices are a weighted combination of the headcount and gap indices of the number of households. If the weighted index exceeds the unweighted index, the burden of catastrophic payments falls more on poorer households.


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

| Indicator                                                        | Value  |
|                                                                |        |
| 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                              | 29.4%  |
| Percentage point change in poverty gap (pre- to post-payment)     | 2.9%   |

Source: HealthNet Consult 2012b
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)

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

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

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Outpatient visits</th>
<th>Inpatient visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>0.13</td>
<td>0.08</td>
</tr>
<tr>
<td>Non-hospital facilities</td>
<td>0.06</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td>0.12</td>
<td>0.08</td>
</tr>
<tr>
<td><strong>Private for-profit facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>0.24</td>
<td>0.42</td>
</tr>
<tr>
<td>Non-hospital facilities</td>
<td>-0.03</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td>0.18</td>
<td>0.42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.16</td>
<td>0.12</td>
</tr>
</tbody>
</table>

*Massive hospitals have been merged with public hospitals due to the small sample size for these estimates. In addition, massive facilities’ admissions paid by government and some of these facilities operate as district hospitals.

Note: Estimates are based on adult equivalent adjusted household consumption expenditure; n/a = not applicable. Source: Gnehm (2010)
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)

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