The Big Push toward Universal Health Coverage: Metrics, Data, and Impact

Adam Wagstaff
Research Manager,
Development Research Group, The World Bank
Robert Marten, Sr. Program Associate at the Rockefeller Foundation, blogpost June, 2013, reporting on WBG President Jim Yong Kim's speech to the World Health Assembly, May 2013

“This was the first time a World Bank President would speak to the World Health Assembly...

Prior to this speech, some questioned whether or not the Bank would work on UHC. This speech removed any doubt...

His words and speech had the World Health Assembly on its feet more than once. Kim’s remarks felt like another defining moment in the ... quest to see UHC become a global reality...”

WBG President Jim Yong Kim, World Health Assembly, May 2013

“We can do so much more. We can bend the arc of history to ensure that everyone in the world has access to affordable, quality health services in a generation...

Now is the time to act.

WE MUST BE the generation that delivers universal health coverage.”

WBG President Jim Yong Kim, World Bank IMF Annual Meetings, Tokyo, 2012

“It is time to bend the arc of history. With global solidarity underpinned by a relentless drive for results, we can, we must, and we will build shared prosperity and end poverty.”

US President Barack Obama, Chicago, 2008

"It's the answer that led those who've been told for so long by so many to be cynical and fearful and doubtful about what we can achieve to put their hands on the arc of history and bend it once more toward the hope of a better day."
PUBMED ARTICLES WITH UHC IN TITLE

2010 UHC World Health Report

Kim's 2013 address to WHA

2005 UHC World Health Assembly resolution
GOING UNIVERSAL

How 24 Developing Countries Are Implementing Universal Health Coverage: Reforms from the Bottom Up

"UNICO" project—24 countries
But what is UHC?

Today will explain rationale of WBG-WHO definition of UHC, and clarify terminological implications

And how can we measure UHC?

Today will pitch a new idea—a UHC index

Recently developed and tested the index in 2 groups of countries w/ WBG collaborators
Acknowledgments

1) What exactly is UHC?

**UHC as rights?**
- Latin America has achieved UHC if UHC is defined in terms of the right to health services
- But people can have the right to health services yet may get to the clinic and find no drugs and/or no doctor
- Countries often lack the resources and/or mechanisms to guarantee rights in practice
- The rights approach tells us nothing about whether people get the care they need, and how much they pay for it

**UHC as membership of an insurance scheme?**
- Latin America has achieved UHC if UHC means having everyone covered by an insurance or financial protection scheme
- Minimizing health-related subsidization, care, and in effect operate a financial protection scheme. So everyone, everywhere is covered by at least one scheme
- Not all people can be in an insurance scheme yet
- Be required to make out-of-pocket payments - often catastrophic ones
- Find that only a limited set of interventions is covered
- In practice, not all schemes are equally generous - equity is the key
- That’s why e.g. Mexico set up a subsided SHI scheme alongside the MSH scheme

**WBG-WHO definition of UHC, and its roots**
- UHC defined as the World Bank and WHO
  
  **“Everyone - irrespective of their disability - gets the health services they need in a timely fashion without suffering any undue financial hardship as a result of receiving them.”**
- This is the basis of the WHO definition of UHC
  
  **“Universal Health Coverage means that everyone in a country has access to quality essential health care services, without suffering financial hardship.”**

**WBG-WHO definition has terminological implications**

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<thead>
<tr>
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<tr>
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UHC as rights?

Over the past 30 years, many Latin American countries have recognized health as a human right and have enacted legislation and implemented policies to support that right.

- Latin America has achieved UHC if UHC is defined in terms of the right to health services.
- But people can have the right to health services yet may get to the clinic and find no drugs and/or no doctor.
- Countries often lack the resources and/or mechanisms to guarantee rights in practice.
- The rights approach tells us nothing about whether people get the care they need, and how much they pay for it.
UHC as membership of an insurance scheme?

- Latin America has also achieved UHC if UHC means having everyone covered by an insurance or financial protection scheme.
- Ministries of health deliver subsidized care, and in effect operate a financial protection scheme. So **everyone, everywhere is covered by at least one scheme**.
- But people can be in an insurance scheme yet
  - Be required to make out-of-pocket payments – often quite large ones
  - Find that only a limited set of interventions is covered
- In practice, not all schemes are equally generous – **inequality is the key**. That’s why e.g. Mexico set up a subsidized SHI scheme alongside the MOH scheme.

WBG-WHO definition of UHC, and its roots

UHC definition proposed by WBG and WHO:

"Everyone – irrespective of their ability-to-pay – gets the health services they need in a timely fashion without suffering any undue financial hardship as a result of receiving them."


Cf. egalitarian definition of health equity evident in most OECD countries' policy statements:

Health services ought to be allocated on the basis of need, not ability-to-pay. And payments for health care ought to be linked to ability-to-pay, not to receipt of services.

## WBG-WHO definition has terminological implications

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2) UHC index: principles

Desiderata for a UHC index – i

- UHC has 2 dimensions:
  - Equity means the health services they need, irrespective of ability-to-pay (finance coverage, etc.)
  - Adequacy means financial resilience as a result of bearing medical cost (financial protection, etc.)
- A higher score is better
- Both dimensions need to be aggregated
- Equation to be derived
- Proportion of people outside EU in trade-off UHC dimensions (as in non-exporting area)

Desiderata for a UHC index – ii

- While on the road to universality, policymakers are concerned about who pays out-of-pocket payments and who receives care – the progressiveness of the path to UHC matters
- Need to link:
  - Receipt of health services to medical need
  - Out-of-pocket payments to family’s ability-to-pay
- Want to track progress on UHC overall, and on each dimension – combining the benefits of a “dashboard” and an all-encompassing index
From ingredients... to a UHC index

- Index approach offers promise of having progress towards **UHC captured in a single number**

- The index approach offers several **advantages over a list of indicators**
  - It forces:
    - A more focused discussion of **criteria for inclusion of different indicators**—"if it's in, it counts"; we may need to include second-best indicators for things that must be captured
    - A discussion of **weights**—not everything matters equally
    - A recognition that policymakers are willing to **trade off** success in different areas
    - A consideration of how to **integrate inequality** into the analysis, not leave it as an optional add-on
  - An index approach doesn't mean we can't have a **dashboard** as well—we can use **sub-indices**

- Instead of deriving a **UHC index** from scratch, starting with a theoretical model, opt for a **‘mashup’ index**, i.e. combine elements from existing approaches
  - Cf. Human Development Index (HDI) from which proposed UHC index borrow several ideas
What we could do with a UHC index

- See how far countries are from attaining UHC
- Track countries' progress towards UHC over time
- Compare UHC performance across different types of health system

Evaluate (actual and likely) effects on UHC of WBG projects

WBG could use to:
- Monitor performance of lending portfolio
- Inform choices between alternative operations

Evaluate (actual and likely) effects on UHC of govt. programs and reforms
Desiderata for a UHC index – i

- UHC has 2 dimensions:
  - *Everyone gets the health services they need, irrespective of ability-to-pay* [Service coverage, SC]
  - *Nobody suffers financial hardship as a result of receiving needed care* [Financial protection, FP]
- A higher score is better
- [0,100] to make it easy to understand
- Sub-indices need to be aggregable
- Index should reflect policymakers' willingness to trade off UHC dimensions (at a non-constant rate)
Desiderata for a UHC index – ii

- While on the road to universality, policymakers are concerned about **who** pays out-of-pocket payments and **who** receives care – the **pro-poorness of the path to UHC matters**
- Need to link
  - Receipt of health services to medical need, and
  - Out-of-pocket payments to family’s ability-to-pay
- Want to track progress on UHC overall, **and** on each dimension – combining the benefits of a “dashboard” and an all-encompassing index
Overview of the UHC index

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Service Coverage</th>
<th>Financial Protection</th>
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<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Impoverishment</td>
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<td>Domains</td>
<td>Treatment</td>
<td>Catastrophic spending</td>
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<tr>
<td></td>
<td>Prevention indicator 1 ... Prevention indicator n</td>
<td>Prevention indicator 1 ... Prevention indicator n</td>
</tr>
<tr>
<td>Indicators</td>
<td>Treatment indicator 1 ... Treatment indicator n</td>
<td>Impoverishment</td>
</tr>
<tr>
<td></td>
<td>Prevention indicator 1 achievement index</td>
<td>Catastrophic spending</td>
</tr>
<tr>
<td>Inequality-adjusted Indicators</td>
<td>Prevention indicator 1 ... Prevention indicator n</td>
<td>Prevention indicator 1 ... Prevention indicator n</td>
</tr>
<tr>
<td>Domain Index</td>
<td>Treatment (SC_P)</td>
<td>Impoverishment (FP_IMP)</td>
</tr>
<tr>
<td></td>
<td>Treatment (SC_T)</td>
<td>Catastrophic spending (FP_CATA)</td>
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<tr>
<td>Dimension Index</td>
<td>Service Coverage (SC)</td>
<td>Financial Protection (FP)</td>
</tr>
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<td></td>
<td>Universal Health Coverage (UHC)</td>
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</table>

Inequality-adjustment in the UHC index

- Policymakers want to see a pro-poor path to UHC
- So attach higher weight to (good) outcomes among the less well-off
- Use achievement index*:
  - **Pro-rich inequality lowers the achievement index below the population mean**
  - Equal to $I = \frac{2}{n} \sum_{i=1}^{n} y_i (1 - R_i)$ where $R_i$ is the person’s (fractional) rank in the income distribution
  - Also equal to the population mean times the complement of the concentration index, i.e. $I = \mu(1 - C)$
  - And equal to area under ‘generalized concentration curve’
  - Analogous to Sen’s‡ abbreviated social welfare function (except he looks at ‘pure’ inequality, and we’re looking at inequality in a health indicator across the income distribution)
  - Cf. HDI inequality adjustment which adjusts for ‘pure’ inequality

Weighting components of UHC index

- Use geometric weighted averages (cf. Cobb-Douglas function) to combine inequality-adjusted sub-indices
- Allows for nonlinear tradeoffs, i.e. diminishing marginal rate of substitution, or equivalently aversion to inequality across e.g. dimensions
- For service coverage:
  - $SC_P = SC_{P_1}^{\alpha_1} SC_{P_2}^{\alpha_2} ... SC_{P_n}^{\alpha_n}$
  - $SC_T = SC_{T_1}^{\beta_1} SC_{T_2}^{\beta_2} ... SC_{T_n}^{\beta_n}$
  - $SC = SC_P^{\pi} \cdot SC_T^{1-\pi}$
- For financial protection:
  - $FP = FP_{CATA}^{\gamma} \cdot FP_{IMPOV}^{1-\gamma}$
- For UHC:
  - $UHC = SC^{0.5} \cdot FP^{0.5}$
UHC contours and index
3) UHC Index: operationalization
Decisions needing to be taken in operationalizing the UHC index

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Domain</th>
<th>Indicator</th>
<th>As % Domain</th>
<th>As % Dimension</th>
<th>As % UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service coverage</td>
<td>Prevention</td>
<td>Prevention indicator #1</td>
<td>(\alpha_1)</td>
<td>(\pi)</td>
<td>0.5</td>
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<tr>
<td></td>
<td></td>
<td>Prevention indicator #2</td>
<td>(\alpha_2)</td>
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<td></td>
<td></td>
<td>Prevention indicator #n</td>
<td>(\alpha_n)</td>
<td></td>
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</tr>
<tr>
<td>Treatment</td>
<td>Treatment</td>
<td>Treatment indicator #1</td>
<td>(\beta_1)</td>
<td>1-(\pi)</td>
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<td>Treatment indicator #2</td>
<td>(\beta_2)</td>
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<tr>
<td></td>
<td></td>
<td>Treatment indicator #n</td>
<td>(\beta_n)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial protection</td>
<td>Impoverishment</td>
<td>% not impoverished at $y\text{-}a\text{-}day</td>
<td></td>
<td>(1-\gamma)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Catastrophic payments</td>
<td>% not incurring catastrophic payments using x% of total consumption</td>
<td></td>
<td>(\gamma)</td>
<td></td>
</tr>
</tbody>
</table>
Service coverage indicators

- SC indicators should capture ‘effective coverage’*, i.e. not just whether someone received a service, but also they:
  - they needed it (i.e. correct diagnosis), and
  - the service had the intended effect on health status (i.e. correct treatment, administered correctly)
- Should SC indicators include public health interventions?


- SC indicators should capture a large spectrum of the services received by patients, in quantity or expenditure terms. So should go beyond MDG indicators
- Measuring coverage of some services is easy, but often these services cover a tiny fraction of a typical health system’s expenditures. Cf. the drunk, the lost quarter, and the lamppost
Financial protection indicators

- **Impoverishment**: Equals 1 if household is (a) below poverty line using consumption net of out-of-pocket spending and (b) above poverty line using household consumption gross of out-of-pocket spending.
- **Catastrophic spending**: Equals 1 if household's out-of-pocket spending > x% of its total consumption.
- Rescale so higher values are better – use % not experiencing impoverishment and catastrophic spending.
- In practice, % experiencing impoverishment and catastrophic payments never gets close to 100. So, we rescale (cf. HDI):
  - \( FP_{IMP} = \frac{(1-Impov)-(1-Impov_{MAX})}{(1-Impov_{MIN})-(1-Impov_{MAX})} \)
  - \( FP_{CATA} = \frac{(1-Cata)-(1-Cata_{MAX})}{(1-Cata_{MIN})-(1-Cata_{MAX})} \)

193 potentially relevant health, multipurpose and expenditure surveys in Latin American & UNICO countries. But what's in them?
# UHC Index 1.0. Indicators, weights and thresholds

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<tr>
<td>Service coverage</td>
<td>Prevention</td>
<td>Antenatal care (4+ visits)*</td>
<td>1/4</td>
<td>1/4</td>
<td>1/2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child fully immunized*</td>
<td>1/4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Breast cancer screening (women aged 40-49)*</td>
<td>1/4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cervical cancer screening (women aged 18-49)*</td>
<td>1/4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td>Skilled birth attendant at delivery*</td>
<td>1/6</td>
<td>3/4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child treated for acute respiratory infection*</td>
<td>1/6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child treated for diarrhea*</td>
<td>1/6</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Inpatient admission in last year†</td>
<td>1/2</td>
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</tr>
<tr>
<td>Financial protection</td>
<td>Impoverishment</td>
<td>% not impoverished at $2-a-day†</td>
<td>1</td>
<td>1/2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Catastrophic payments</td>
<td>% not incurring catastrophic payments using 25% of total consumption*†</td>
<td>1</td>
<td></td>
<td>1/2</td>
</tr>
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* Inequality-adjusted. † Relative to WHO benchmark rate (0.093). ‡ Rescaled using global maxima (CATA: 0.25; IMPOV: 0.15).

Limited (readily available) microdata even on these few indicators in Latin American & UNICO countries.

4) UHC Index in action
UHC Index—latest year available

UHC Index—latest year available

UHC trends in selected countries

5) UHC Index + IE evidence: What did reforms really achieve?
Getting evidence on reforms and UHC

- Lots of types of reform **might** affect the UHC indicators and help a country towards UHC
- What matters are (a) the **actual impact** of the reform, and (b) its **pro-poorness**
  - Get this information from **credible impact evaluations**—prospective and retrospective
- **What's a "UHC" reform depends on the evidence**, not on what it's called:
  - Some "UHC" reforms may not be so UHC-friendly after all!
  - Some "non-UHC" reforms may actually be more UHC-friendly!

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Cambodia's maternal vouchers (MV) and performance-based financing (PBF) reforms—impacts on mean and concentration index

Cambodia's maternal vouchers and performance-based financing reforms—impacts on UHC

= maternal voucher scheme, PBF = performance-based financing
How far have reforms pushed a country toward UHC?

• Some reforms impact on some indicators, others on others
• Not all indicators are weighted equally
• Impacts are often quite small, even if statistically significant
• Some reforms affect only a sub-population
• Some shift use from private to public sector, e.g. MV schemes
• Some have pro-rich impacts which reduces increase in UHC index

• Numbers underestimate FP impacts because insufficient data to estimate effects on impoverishment
Performance-based financing
Maternal vouchers

Cambodia 2010 (22.1)
Cambodia 2005 post PBF (20.1)
Cambodia 2005 post MV (20.5)
Cambodia 2005 (19.9)

Note: MV = maternal voucher scheme, PBF = performance-based financing.
How far have reforms pushed a country toward UHC?

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6) Looking backwards and forwards

We now have clarity on what UHC is and how to measure it.

- UHC definition requires a shift in language, away from rights and schemes to service coverage, financial protection, and equity.
- UHC index combines the benefits of a mashup index and a dashboard, allowing us to see performance on UHC and FP separately as well as their contribution to UHC overall.
- Approach explicitly recognizes tradeoffs across dimension and domain indicators.
- Inequality is integrated into the UHC index, not as an add-on.

What have we learned from use of UHC Index? What’s left to do?

- See how BQ countries use their existing UHC frameworks to inform decision-making on UHC.
- Track countries’ progress towards UHC and FP targets.
- See what BQ countries are actively doing to enhance country data.
- Determine if program performance has improved over time.
- Evaluate spatial and temporal effects of UHC on MDG progress.
- Look at lessons learned and identify additional areas for UHC measurement.
- Evaluate key risk factors affecting UHC.
- What’s next?
- What’s left to do?
- What’s next for UHC?
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We now have clarity on what UHC is and how to measure it.

- UHC definition requires a **shift in language**, away from rights and schemes to service coverage, financial protection and equity.
- UHC index combines the benefits of a **mashup index and a dashboard**, allowing us to see performance on SC and FP separately as well as their contribution to UHC overall.
- Approach explicitly recognizes **tradeoffs** across dimension and domain indicators.
- **Inequality** is **integrated** into the UHC index, not as an add-on.
What are the things we'd like to see in UHC Index 2.0?

Better and more SC indicators

- Move to effective coverage, i.e. properly capture 'need', and (likely) effectiveness of interventions (i.e. quality) received
- More treatment indicators especially for non-communicable diseases (NCDs), e.g. hypertension and diabetes treatment

Better and more data

- WHO has conducted a "STEPS" survey capturing NCDs in 95 countries. But even WHO staff don't have access to the microdata!
- On October 15 2015, President Kim launched a $100m p.a. data initiative to increase the quantity and quality of household surveys. A big opportunity to collected more and better health data at household level
- Use new technology to collect better health data
- Need better indicator for hospitalization—one that captures better 'need' and captures likely effectiveness of inpatient care
- Move beyond HH surveys? Merge admin. data with e.g. facility exit surveys, social assistance entitlement data, etc.?
What have we learned from use of UHC index? What's left still to do?

See how far countries are from attaining UHC. *All countries are still working towards UHC*—top-performing countries in Latin America have scores of ~80

Track countries’ progress towards UHC over time. *Most countries seem to be making progress, but progress has been bigger on SC*

Compare UHC performance across different types of health system. *Latin America study suggests fully-integrated or advanced semi-integrated systems do better*

Evaluate (actual and likely) effects on UHC of WBG projects

WBG could use to:
- Monitor performance of lending portfolio
- Inform choices between alternative operations

*Nothing yet but index could help WBG track its performance and guide its project choices*

Evaluate (actual and likely) effects on UHC of govt. programs and reforms. *Reforms (including some “non-UHC” reforms) have mostly helped, but often not by much, leaving countries a long way from UHC*