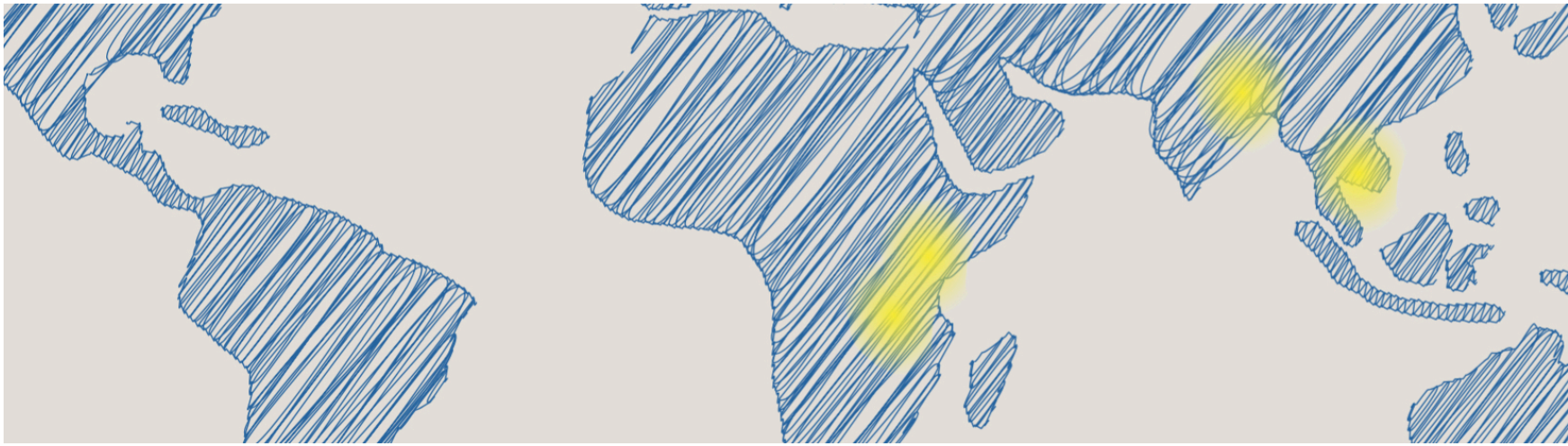
How to achieve UHC: global lessons

Eight international conference on public health among GMS countries
Moving towards universal health coverage: strengthening quality of care



Werner Soors, Phnom Penh, 5 November 2016

‘Towards UHC’ scoping reviews

- The ITM public health unit ‘Equity & Health’ has been working on social protection in health & universal health coverage for over a decade
- 2014, two identical requests – from P4H and DGD: **“What is known on conditions and practices for advancing towards UHC in LMIC?”**
- 2015: review of Bangladesh, Cambodia, Kenya & Tanzania – for P4H, and of DR Congo, Ghana, Peru, Senegal, Thailand & Uganda – for DGD
- 2016: dissemination workshop[1] & policy brief[2]

[1] Towards universal health coverage: a workshop for dissemination & reflection. Antwerp, 8 February 2016 http://www.itg.be/itg/GeneralSite/Default.aspx?L=E&WPID=688&MIID=637&IID=474

[2] Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania. P4H Knowledge-Learning-Innovation brief 1, 2016 http://health.bmz.de/what_we_do/Universal-Health-Coverage/Towards_Universal_Coverage_in_the_majority_world/giz2016-en-universal-health-coverage-P4H.pdf

Revisiting the UHC concept

- UHC is "**a situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status and residency**"[3], and "**where people are empowered to use these services**"[4]
- Implicit underlying concepts:
  - ✓ Equity
  - ✓ Solidarity
  - ✓ Redistribution

[3] Nitayarumphong (1998) Universal coverage of health care: challenges for the developing countries. *In:* Nitayarumphong & Mills [Editors] Achieving universal coverage of health care. Bangkok, MPH, Office of Health Care Reform, pp 3-24

[4] Commission on Social Determinants of Health (2008) Closing the gap in a generation: equity through action on the social determinants of health. Geneva, WHO, p 100
http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

Equity, solidarity & redistribution

- **Equity**, "creating opportunities and removing barriers to achieving the health potential of all people"[5], core of UHC
- **Solidarity**, based on empathy as well as interdependence[6], but also a pursuit of unity in society
- **Redistribution**, essential mechanism to put equity and solidarity in practice. Long contested, yet again valued[7]. Of extreme importance when designing and implementing each of the health financing functions

[5] Whitehead & Dahlgren (2006) Levelling up (part 1): a discussion paper on concepts and principles for tackling social inequities in health. Copenhagen, WHO Europe, pp 4-5
http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf

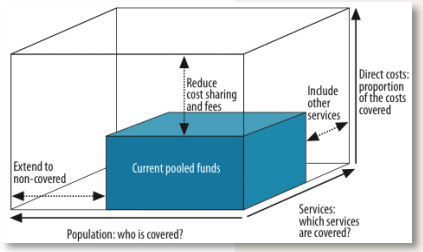
[6] See e.g. Durkheim (*De la division du travail social*, 1893) and Kropotkin (*L'entraide : un facteur de l'évolution*, 1902)

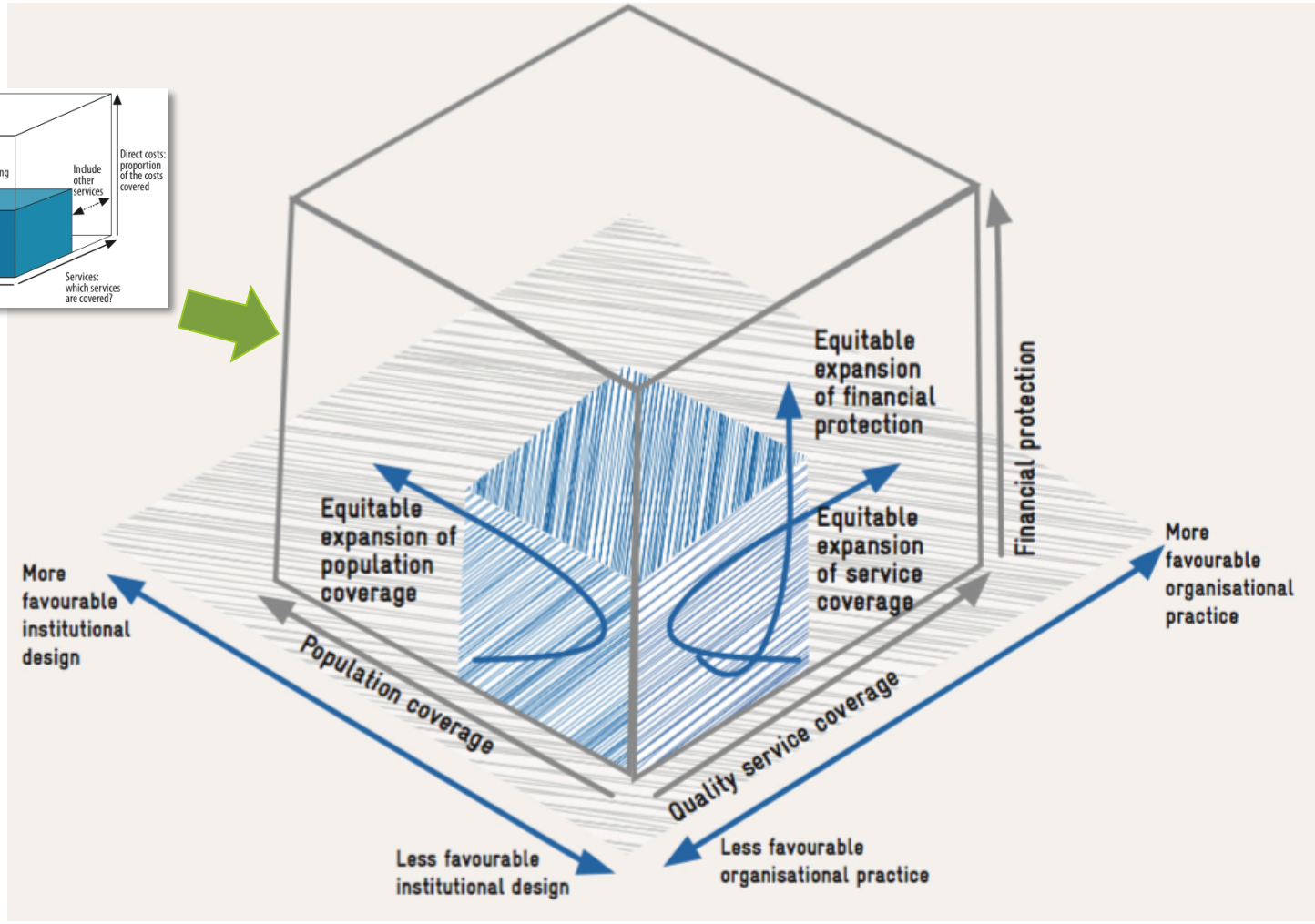
[7] Ostry, Berg & Tsangarides (2014) Redistribution, inequality and growth. Washington, IMF
http://www.imf.org/external/pubs/ft/sdn/2014/sdn1402.pdf

Rebuilding the UHC cube

① Integration of the **quality** aspect in the service coverage dimension
② Consideration of **equity** as a core feature of each dimension
③ Consideration of **equitable re-design** of existing coverage policies in each dimension as a prerequisite for expansion
④ Consideration of **expansion** in each dimension as **justifiable only when equitable**
⑤ Conceptualisation of the cube as embedded in and resulting from a **political economy dynamic**
⑥ Assessment of that dynamic in terms of **institutional design** and **organisational practice**

Our framework: a floating cube





Applying the framework

- We applied our framework (the floating cube) on 2005-2015 data[8] for Bangladesh, Cambodia, Kenya, Tanzania (for P4H), RD Congo, Ghana, Peru, Senegal, Thailand & Uganda
- For each country, we analysed the adapted dimensions: **equitable population coverage**, **equitable quality service coverage** and **equitable financial protection**
- Having taken into account political economy, patterns in design & practice, we identified **six transversal ('global') lessons**

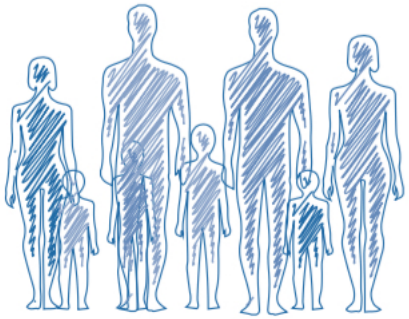
[8] Sources: PLoS Medicine, PubMed, the LSHTM collection Resilient and Responsive Health Systems, P4H Intranet, the World Bank Open Knowledge Repository, Google Scholar, and our research unit's own UHC database

Equitable population coverage

In all 10 countries under study, progress in population coverage leaves **much to be desired**

Where population coverage is narrowly defined as insurance coverage, progress in **effective coverage**[9] **is often lagging behind**

While population coverage overall is slowly on the rise, **expansion of population coverage is rarely equitable**, as illustrated among others by the excluded slum populations in Bangladesh and the growing 'missing middle' in Cambodia



[9] Effective coverage is a metric of health system performance composed of need, use and quality. Effective coverage quantifies "the gap between actual and potential benefits from health services" and can be defined as "the fraction of potential health gain that is actually delivered throught the health system, given its capacity". See Lindelow *et al.* (Assessing progress towards universal health coverage, 2015) & Ng *et al.* (Effective coverage, 2014)

Equitable quality service coverage

In all 10 countries under study, **quality of care** and **equity in service delivery** are key challenges, and interrelated

Quality of care is a necessary condition for substantial expansion of service coverage, which points to the need for **health systems strengthening hand-in-hand with UHC efforts**

Supply-side deficiencies including lack of quality of care also **limit the impact of non-systemic efforts to increase equity in service delivery**

Equitable financial protection

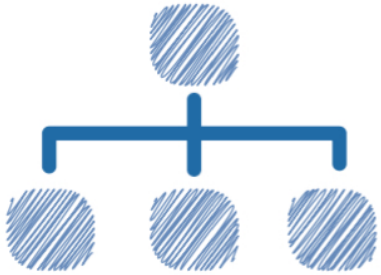
Both catastrophic health expenditure (CHE) and incidence of impoverishment (IoI) proved of limited use in (representing only a fraction of financial hardship) and lacking comparability between (CHE because of different shares and thresholds, IoI because of different national poverty lines) the study countries

Judged by out-of-pocket-payments (OOP), financial protection is **unsatisfactory** in all countries under study, is **hampered by fragmentation** of insurance schemes and other social protection mechanisms, and **rarely equitable**

Stratified OOP data, needed to make OOP a solid proxy of financial protection, are (partly) available in only available in a minority of countries

Institutional design & organisational practice

While context- and path-dependency as expected lead to different pictures, important transversal findings can be distinguished here,



such as the **core role of health systems strengthening** when embarking on and sustaining UHC policies,

and the **explicit political character of fragmentation/ harmonisation processes**

L1: Health systems strengthening

Not only is **quality of care** in all countries under study a **major determinant of progress in service coverage**, it also **influences population coverage and financial protection**, and equity in each dimension

Health systems strengthening, leading to quality of care, should thus be considered **a condition for progress towards UHC**: "UHC is what we want, HSS is what we do"

Practical implications:

- HSS efforts should be part of all UHC policies
- Where health systems are particularly weak, it might be wise to focus on HSS first

L2: Choice of health financing mechanisms

No conclusions on advantages of tax-based vs insurance-based health financing mechanisms

Countries that rely on schemes based on voluntary affiliation have serious difficulties to progress towards UHC: **compulsion, with subsidisation for the poor, is a necessary condition for universality**

Balanced practical implication:

- Need to reconsider support for all forms of voluntary health insurance
- But also not ethical to make voluntary insurance mandatory as long as quality of care is sub-standard

L3: Fragmentation vs harmonisation

In all but two countries (Ghana, Thailand) **health financing is fragmented**, i.e. separate risk pools exist, leading to **sub-optimal and usually inequitable financial protection**

Practical implication:

Harmonisation of risk pools, at least by introducing cross-subsidisation, ideally reaching a unified risk pool, should be **considered a policy priority**

L4: Need for a political approach

Where health financing is fragmented, and where efforts are made towards **harmonisation**, this happens to be an **extremely difficult task**, which is essentially political as it is conditional on bringing in line a range of actors with different interests and power stakes

Practical implications:

- National actors, health activists: need for more understanding and insight into how to influence policies
- International actors: financial & technical support to be complemented by political support & capacity building?

L5: Need for better data & monitoring

Our findings confirm the **need for better data and monitoring**; this is particularly the case for the equity aspects of UHC (stratified data!)

Positive deviants like Ghana and Thailand (with good evidence-to-decision-making links) highlight the need to even greater attention to the **role of domestic capacity for applied policy research** (evaluation!)

L6: Fiscal space for progress

Again the positive deviants of Ghana and Thailand: UHC can contribute to economic progress and wellbeing, beyond health

The question ***Do we want fiscal space for health?*** might thus be more important than the (too much) asked *Does this country have the fiscal space for progress in UHC?*

Addendum: Nobody left behind?

- The imperative of the 2010 Agenda for Sustainable Development – 'Ensuring that no one is left behind' – is a perfect impetus for the equity dimensions of UHC that are so much lagging behind: we do not want to be as inefficient as we have been too often
- Monitoring & evaluation based on stratified data will improve our answers to the question ***who is left behind?***
- But at micro-, scheme, project and programme level we will also need better answers to the questions ***how & why are people again and again left behind?***

The SPEC-by-step tool

- Developed in the Health Inc research project
- Using a **social exclusion lens** to assess social health protection (SHP) / coverage (UHC) initiatives
- Grafting the social-political-economic-cultural (**SPEC**) dimensions of social exclusion onto a **step**-wise deconstruction of SHP/UHC programmes, and in each step zooming in on the **left behind**

A useful tool: SPEC-by-step