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Short Commentary

HOW SHOULD WE TRACK PROGRESS TOWARD UNIVERSAL HEALTH COVERAGE IN LOW-INCOME COUNTRIES?

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Abstract:

This article discusses the growing international interest in universal health coverage in the context of low income countries and the problems of tracking progress towards this goal as defined by the World Health Organization (WHO). It is argued that the resource constraints of such countries mean that only partial approaches to universal health coverage are being implemented. To ensure that the various partial approaches are in fact moving towards the universal health coverage goal, a framework or guidelines for monitoring progress towards achievement of all the dimensions stated in the WHO definition is needed. The paper discusses the key issues involved in monitoring such progress and proposes areas that require special attention, as well as policy issues that arise, in tracking progress towards the goal of universal coverage.

Introduction

Universal health coverage (UHC) has been an important long-term policy goal for many low-income countries since the early 2000s.[1,2] With endorsements from the World Health Report of 2010[3] and the World Health Assembly resolution of 2011,[4] UHC has shot to the top of the international health policy agenda. Many more low-income countries have now either declared their commitment to, or have already introduced policies and approaches to achieve such a goal.

In the World Health Report, the World Health Organization (WHO) defines UHC in terms of three key dimensions: full population coverage, a comprehensive benefit package of quality health services, and minimal or no out of pocket (OOP) payments.[3] This definition, while useful, gives policy makers in low-income countries only a very general description of the desired end state towards which they should work. However, low-income countries (and even quite a number of middle income ones) face constraints–primarily financial and managerial–in rapidly achieving UHC. More realistic for them in the short to medium term is partial health coverage along some or all of the three UHC dimensions. More detailed guidance from WHO is forthcoming about how to move towards the ultimate goal of UHC and can be informed by the wealth of experiences that countries have adopted to achieve partial coverage, based on their own priorities, resource constraints, and other contextual factors.

WHO is wise not to prescribe specific steps for working towards UHC in low-income settings, which creates a need for establishing guidelines or even a framework to monitor or measure progress towards UHC. This would allow ensuring that the partial approaches are indeed leading to UHC and take account of all relevant issues. How for instance should countries take into consideration factors such as equity and sustainability in addition to the three dimensions of UHC? This paper aims to contribute to the discussion on the monitoring and evaluation framework of UHC, and in the process highlights key policy issues that, if addressed, could facilitate realistic progress towards this worthwhile goal.

Alternative approaches to partial UHC

An examination of low-income countries' efforts to achieve UHC shows only partial coverage along each of the three dimensions.[5] Given the countries' general economic circumstances, this is understandable. At the same time, however, it is not always clear that policy makers are sufficiently aware of, or committed to achieving all three dimensions and that the partial coverage is only the first stage in the journey towards universal coverage. Some of the key issues arising here can be highlighted through a presentation of the two major, though not mutually exclusive, approaches towards UHC in low-income countries.

The two main approaches to partial UHC are (i) the supply side financed priority service approach, and (ii) the demand side

financed, and generally more comprehensive, service approach. The supply side approach is often adopted by countries seeking to accelerate progress towards reaching their health-related Millennium Development Goals in the shortest possible time. It usually takes the form of a political declaration that a defined package of priority health services or care for priority health groups (or even a limited package for the entire population) will be provided 'free' at the point of service (hence the term 'free health care' used frequently to describe this approach, although the demand side approach also aims to provide free or nearly free services at the point of use). In the best case scenario, this entails the state providing increased inputs (human resources, infrastructure, drugs and other supplies, etc) to enable the country's health providers to deliver free maternal and child care services (targeted health care for pregnant women and children under 5 years old) or free primary health care services for all or most of the population. In practice however, it is rare that the required inputs–and hence the associated costs–for sharply increased utilisation are well understood or calculated, let alone available, before implementation begins.

While free care eliminates the financial barrier (one dimension of UHC), resource constraints often make the resultant increase in utilisation unsustainable. Experience shows that free care is frequently undermined as unofficial charges, supply shortages, bad quality of care, etc. choke off the increased demand.[6,7]

Rightly or wrongly, many policy makers in low-income countries perceive that donors and international NGOs favour 'free' health care policies. Not surprisingly therefore, they often adopt the free care approach, sometimes as a temporary measure, in immediate post-conflict areas and in other situations of extreme poverty, where it is judged that the population is not able to pay user charges. Often this is done with an expectation of substantial donor financial and other assistance. Even if assistance materialises for a time being, it raises the challenge of the policy's long-term sustainability (unless, as stated, the policy is clearly a temporary measure). In addition, a clear pathway of how to transition this one-dimensional approach to include all three broad dimensions of UHC has not been demonstrated or explicitly laid out in such countries. Examples of countries implementing the supply side 'free care' approach are Burundi, Liberia, Sierra Leone, Uganda and Zambia.

The second major approach towards UHC that countries increasingly employ is demand side financing, that is, the national health insurance route. Again there are variations related to financial feasibility or similar considerations. Coverage may be limited initially to only one (or at most two) of the three UHC dimensions and then expanded over time. For example, a country might provide a reasonably comprehensive package of benefits to a limited segment of the

population (e.g. the formal sector), and then progressively extend this package to other population groups (Tanzania, Nigeria and Zimbabwe are examples).[8,9,10] A second is to provide a limited (or 'thin') benefit package to the entire population and then expand the package over time (as Kenya is doing).[11] A third model combines features of the others, beginning with an attractive benefit package albeit with high copayments and then gradually reducing the OOP payment. (China's rural health insurance, the new cooperative medical scheme, is using this approach. It was able to reach high population coverage in the short term, and now is shifting focus to reducing high OOP payments).[12] Each of these three models has advantages and disadvantages, but all demonstrate a potential way to work towards UHC.

It is perhaps also worth noting that, among low-income African countries, Ghana and Rwanda have embarked upon the more ambitious approach of providing a fairly comprehensive benefit package to a large section of the population, with only a modest copayment (in Rwanda) or none at all (in Ghana). However, in both countries, ensuring the quality and availability of health care infrastructure nationwide remains a challenge; in addition in Ghana, an important priority remains ensuring equitable access for the poorest.[13,14]

Overall, the demand side approach usually prioritises sustainable coverage of an attractive benefit package for the population group(s) concerned, which is, as resources permit, extended to include the other UHC dimensions (full population coverage and minimal OOP payments). The *short-term* equity implications of the approach can be less favourable than those of a *best case* supply side approach if 'exemptions' policies for the poor and vulnerable are not well designed and effectively implemented from the start. However the policy makers in these cases tend to argue that, even with imperfect exemptions, what matters for them is that that situation is still far better in equity terms than *what existed prior* to implementation of the national health insurance programme.

Tracking progress towards UHC and associated policy issues

Each of the two approaches discussed above at least initially falls short of UHC as defined by WHO, and each has associated political, economic, and/or social costs. Policy makers in consultation with stakeholders must consider these costs in the context of their countries and decide on the trade-offs to make in working towards UHC.

Resource and other limitations (e.g. managerial capacity) compel most low-income countries to begin the journey towards UHC by implementing partial coverage regimes. Indeed most of the advanced countries which have achieved what might be described as full UHC followed this trajectory. Among the issues to be considered are therefore whether short-term or intermediate-term health financing policies are consistent with movement towards greater coverage over

time, whether they take sufficient account of other vital health system goals, and how their progress towards the UHC goal can be monitored or assessed.

First, in terms of the population coverage dimension, there is a need to distinguish between nominal and effective coverage. Merely lifting the financial barrier for a population group(s) (or the entire population) does not necessarily translate into effective coverage for everyone targeted. Data on assisted deliveries in some countries which have lifted financial barriers do not always show a significant increase in such deliveries. Other barriers–service availability and quality, cultural barriers, availability of affordable transportation–may also impede utilisation. In addition, even a high effective population coverage, for example over 90% of registered beneficiaries, may not be satisfactory if those who remain without coverage are the most vulnerable.

To ensure achievement of the population coverage dimension of UHC therefore, countries need to track not just the trend over time in terms of population nominally covered by the UHC programme, but also the identification and removal of additional barriers that might prevent specific vulnerable groups from effectively benefiting from the policy or programme, as well as the socio-economic profile of the beneficiaries vis-à-vis those not yet included.

Secondly, it should be noted that benefit packages differ not only in their quality but also in their comprehensiveness. Determining which benefits to include depends on the country context, for example, the country's disease burden. At a minimum, a country's 'comprehensive' or attractive benefit package should include all services at the primary and secondary level, and possibly other levels of care to provide a continuum of care. It also should cover key community health interventions regarding the major diseases and conditions constituting the disease burden and those afflicting the poor and vulnerable.[15] Another relevant point here in the light of the preceding analysis is that there can be different ways to finance the different levels of care, e.g. a supply-side approach may be more appropriate for the community and primary level (many 'public good' services are found at these levels); and a demand side 'health insurance' approach for secondary and higher level care (rare, expensive "insurable health events").

Tracking progress in extending the benefit package to the population should therefore include both availability and quality of care (which can be done through health care quality and user satisfaction surveys) as well as the degree to which the package responds to the health needs and epidemiological profile of the country. Both quantitative and qualitative techniques should be brought into this examination.

Thirdly, as regards OOP payments, it is known that some policy makers insist on retaining a copayment (at a level not affecting the accessibility of essential health services) in order to prevent moral hazard and encourage efficient resource

use and management. If they do this, then the goal of UHC requires that even such 'modest' payments should be 'progressive' in that the poor should be exempted from them. Moreover, they should not be imposed on priority health services whose consumption needs to be encouraged.

The tracking of progress in financial protection should therefore include monitoring the level of OOP payments by socio-economic group or quintiles, the level of catastrophic spending on health care, and OOP payments on priority health services.

Monitoring the sustainability of the UHC programme as a whole is also important. There are various methods of doing this. For the supply side financing policies, a tool such as the Marginal Budgeting for Bottlenecks one pioneered by UNICEF and the World Bank can provide a useful assessment of financial sustainability at any stage in the process, though it is best done prior to implementation. For the demand side (health insurance) mechanisms, actuarial analyses are a good tool, again best done prior to implementation. In both cases, repeated application of the method at different periods after the programme begins operations is advisable to identify needs for mid-course corrections and programme adjustments, or to provide data for increased resource mobilisation efforts.

Conclusion

Because most low-income countries are not in a position to attain full UHC for some time, countries by definition will continue to implement phased approaches such as supply-side financing to offer free care and demand-side financing in the form of health insurance. In order for this incremental process to translate into progress towards UHC, policy makers need to constantly monitor and periodically evaluate their progress along all the three dimensions of UHC to ensure they are on the right track.

While the paths to UHC may vary, this paper presented/proposed commonly used criteria for monitoring and evaluating progress:

- Population coverage is effective and equitable;
- The benefits package is comprehensive and of acceptable quality;
- Out of pocket payments are not burdensome on anyone;
- The poor are exempted from paying out of pocket; and
- Priority health services remain free at the point of use.

In addition, we have argued that it is important to be on the lookout for any additional factors that may impede access for some sections of the population so that they can be addressed. The sustainability of the program overall must also be under periodic review so that the attention of policy makers may be drawn in good time to any measures that might be necessary to protect the social gains made and to ensure continued expansion of the

program towards the desired goal of universal coverage.

We declare that we have no conflicts of interest. This article reflects only the personal opinions of the authors and not those of their employers or any other organization to which they belong.

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