



# **MEASURING FINANCIAL PROTECTION AND ACCESS TO SERVICES IN THE UHC AGENDA**

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## Introduction

Ensuring country progress towards Universal Health Coverage (UHC) such that a basket of health services is available to everyone without causing financial hardship has become high on the policy agenda such that the monitoring is likely to be one of the objectives of the post-2015 development goals. UHC itself consists of three dimensions: i) the range of health services according to need; ii) the level of financial protection; and iii) coverage for the entire population.

Tracking the progress towards UHC requires the development of a set of suitable indicators which in turn should be part of an overall framework of monitoring health system performance. Discussions have focused on the need for two discrete components of health system performance: the levels of coverage for health interventions and financial risk protection, with a focus on equity.

At the same time, there has been significant momentum in countries implementing health accounts according to the System of Health Accounts framework to provide detailed information on expenditure and financing. The information gleaned from the supply (expenditure) side according to a service and disease breakdown is vital to strengthen in the ability to meet the identifiable population needs. Moreover, it is noted that each country - whether high-income or an emerging economy - has a specific profile and needs that should drive the specific measures and domains for monitoring.

## Proposed indicators

### 1. Health Services Coverage:

#### a. MDGs:

i. Aggregate: A measure of MDG-related service coverage that is an aggregate of single intervention coverage measures

ii. Equity: A measure of MDG-related service coverage as described in 1a.i for the poorest 40% of the population.

#### b. CCIs:

i. Aggregate: A measure of CCIs-related service coverage that is an aggregate of single priority interventions to address the burden of NCDs, including mental health and injuries.

ii. Equity: A measure of CCI service coverage as described in 1b.i for the poorest 40% of the population.

### 2. Financial Risk Protection Coverage:<sup>1</sup>

#### a. Impoverishing Expenditure:

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<sup>1</sup> In computing catastrophic spending, ability-to-pay is measured as non-food consumption. The threshold for catastrophic spending is set at 25%. The international \$1.25-a-day poverty line is used in computing impoverishment. The poverty gap version of the “protection against impoverishment” was used.

i. Aggregate: A measure of the level of household impoverishment arising from out-of-pocket expenditures on health, equal to the ratio of the poverty gap in a world without out-of-pocket payments to the actual (larger) poverty gap.

b. Catastrophic Expenditure:

i. Aggregate: The fraction of households incurring catastrophic out-of-pocket health expenditures.

ii. Equity: The fraction of households among the poorest 40% of the population incurring catastrophic out-of-pocket health expenditures.

## Concrete suggestions for improving the two measures

### *How to link the service coverage and the financial protection indicators*

There are challenges in how these two indicators should be used together and how each of the measures should be interpreted with respect to the other. In many countries the quintile with the lowest income has a lower incidence of catastrophic payments than richer quintiles. This reflects the perverse nature of user fees. When people are very poor, they simply do not use services for which they have to pay, so do not suffer financial catastrophe. As they grow slightly richer, they begin to use services, but then suffer the adverse financial consequences linked to paying for care. Therefore a trend towards fewer people with catastrophic costs may not necessarily be a positive thing, meaning that the indicator of service coverage becomes the more important.

Discussions have already raised the need for a number of necessary refinements and the need to clearly define some terminology. For example, from an OECD perspective, the definition of health spending needs to be carefully defined to exclude LTC spending - i.e. restricted to the curative/rehabilitative (treatment/care) and public health/prevention services. This will avoid the cases - mostly in high-income countries - of elderly people running down assets to pay for their LTC - which really takes it out of the scope of what is intended under UHC.

On health services coverage, the two composite measures in a disease-based approach - on the existing MDGs, recognise the extensive investment to date, but also the shift to NCDs (CCIs) to instil a more permanent and long-term challenge for measuring UHC. That said, there needs to be some clarity on the boundaries and the weighting - from 'equal' to 'unequal' - within the groups to come up with a measure for the MDGs or CCIs as a group will be an obvious challenge. In this respect, it is worth reiterating the need to disaggregate the service levels by disease categories by population characteristics, such as age group, gender, status, etc. (and here it should be aligned with a disease account approach to the measures of financial protection).

### *The contribution of SHA: e.g. how to embed the measurements of OOP within SHA; would it be possible to come up with measures of OOP for a specific set of services?*

For financial protection, the need to embed the measurements of OOP within the international framework of the System of Health Accounts is important to ensure consistency in health financing information. Moreover, the data and measurement challenges needed to track service "access" by disease categories emphasise the role of the disease-specific accounts under SHA as a way to monitor these efforts. The expansion of SHA and disease accounts and the strengthening of comparability/linkage of the corresponding data/survey instruments (e.g. DHS) are considered important parts of the UHC process.

By improving the information from the supply (expenditure) side according to service (function of care) and disease (age and gender) categories through the development of health/disease accounts, this can lead to a strengthening in the ability to meet the identifiable population needs.

### *Sources of data (e.g. admin data, surveys, etc.) and pros/cons*

The identification and development of appropriate data sources (either survey instruments or administrative information) is paramount given the importance of the availability of underlying data to carry out and implement UHC monitoring. If this area is not emphasised prior to the process of UHC monitoring, many countries will face significant challenges.

### *Health Expenditure Surveys*

Standard measures of financial protection indicators can be produced for any country that has reliable household survey data. The World Bank has sponsored Living Standards Measurement Surveys (LSMS) from which information on household health expenditures can be extracted and the World Health Surveys sponsored by WHO also contained a household expenditure module. More recently the USAID-backed DHS surveys have also included an optional expenditure module. There is considerable variability in the types of questions used to obtain household health expenditures, making comparability across countries and over time in the same country quite difficult. As a longer run goal it is important to obtain agreement on a standard instrument that would enhance comparability, either for independent surveys or to piggy-back onto other household surveys carried out for various other reasons. Currently the DHS would appear to be the most probable.

Surveys are infrequent, suffer from sampling/no-sampling errors and face problems of timeliness. They should be consolidated with other more reliable data sources (administrative provider data). OECD has produced Guidelines for improving (...) comparability of Private Health Expenditures (...) (HWP No. 52).

### *Health accounts*

Even without an in-depth analysis of survey data to determine catastrophic and impoverishing effects, international evidence strongly suggests that high levels of OOP spending should be cause for concern. Analysis of data from nearly 80 countries undertaken by WHO reveals a strong correlation between the share of OOP in total health spending and the percentage of families that face catastrophic health spending.

Evidence shows that when OOPS as a proportion of Total Health Expenditure is below 15-20%, the incidence of financial catastrophe caused by out-of-pocket health expenses is negligible [WHO: World Health Report 2010 – Health systems financing: the path to universal coverage. Geneva: WHO; 2010.]. In 2009, OOPS made up over 20% of THE in 34 AFR countries (76%); and more than 50% in 14 countries.

The best source of health expenditure data is from national health accounts which combines expenditure data from all sources and through all types of financial agents. The System of Health Accounts (SHA) developed by the OECD for its countries has become, more or less, the internationally agreed classification standard, including the disease (age and gender) sub-accounts.

Despite the logic of using the incidence of financial catastrophe as the core indicator, it can be argued that a simpler 'flag' indicator is the ratio of out of pocket spending to total health expenditure (OOPs/THE) – or the inverse, the ratio of prepaid expenditures (taxes and insurance) to THE. Undoubtedly there is a high correlation between this indicator and the incidence of financial catastrophe (and impoverishment).

While it may appear simpler, it requires exactly the same data from household expenditure surveys as the indicator on financial catastrophe described above. So if the surveys are available to estimate OOPs/THE, they are available to estimate the incidence of financial catastrophe. Experience has shown that policy makers can immediately see the political relevance of the incidence of financial catastrophe and/or impoverishment, whereas the ratio of OOPs to THE may not have the same immediate policy impact.

## Conclusion

UHC offers a great opportunity for all countries to reduce the financial risks and ensure access to health care services for the most vulnerable in society. The objective of developing and monitoring suitable and robust performance indicators progress is to assist countries in setting their own priorities and assess progress toward UHC.

Providing the necessary and continuous information required to feed the framework will be an ongoing challenge, with a need for enhanced facility surveys and health information system, coupled with consistent and applicable measures of effectiveness (quality) and efficiency.

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