Universal Health Coverage: Assessing Service Coverage and Financial Protection for All

In 2005 the World Health Organization encouraged countries to move toward achieving Universal Health Coverage (UHC)[1] through a process of progressive realization. During the early stages, discussions around UHC were rooted mainly in ensuring that equitable prepayment health financing is established in countries and that direct out-of-pocket payments are minimized. As a result, much emphasis was placed on identifying pathways toward UHC within the context of national health insurance reforms.[2] This focus, therefore, means that the many countries that have their citizens' right to health care enshrined in their constitutions and those that have different forms of tax-financed (e.g., free health care) or social insurance systems for their population would have attained UHC when in fact it is not always the case.[3] Many of these countries still need more to ensure that those who need health services are getting them and that no one faces financial hardships or is unable to use health services.

Although there are criticisms of UHC, the publication of the 2010 World Health Report[4] attempted to provide further clarity on the concept to encompass three broad dimensions—population coverage, service coverage and coverage with financial risk protection, all with an equity focus. The report uses health financing as the "window" to UHC, with an understanding that UHC involves ensuring that everyone has access to needed health services that are effective and of acceptable quality, and that no one should face undue financial hardship as a result of the use or the need to use health services.[4] The 2013 World Health Report further escalated the need for UHC through evidence-based research.[5]

While there is now a fairly clear meaning of UHC, there are debates around how to adequately assess each dimension, especially in the context of finalizing indicators for the Sustainable Development Goals. In fact, these discussions are ongoing globally. Boerma et al.[6] and recently, Wagstaff et al.[3] provided an initial attempt to generate respectively, a set of indicators or a single index for assessing UHC. Because the aim is to make genuine advances toward UHC, there is a need for further discussions regarding how to select and weight different indicators taking into account their representativeness in terms of the overall population and equity considerations. Moreover, it remains important to consider the way each UHC dimension and indicator is assessed empirically.

While this article acknowledges the substantial progress made to date in refining UHC indicators, it highlights some key issues that need to be understood and clarified to fully assess UHC.

POPULATION DIMENSION DOWNPLAYED?

Social policies, initiatives, and programs are by design aimed at some designated populations. In the context of UHC, the primary focus is *everyone,*[4] usually within a defined geographic space. Thus, we argue that this dimension of UHC is central. In fact, it is implicit in the other two dimensions because you cannot achieve any of the other dimensions without reference to the population. This means that if *everyone* is to have access to needed health services that are of acceptable quality, it should encompass all individuals. Financial risk protection is similar. Unfortunately, even with the explicit recognition for a disaggregated UHC assessment using different equity stratifiers,[6] many indicators of the UHC dimensions do not sufficiently address this key population dimension. For example Wagstaff et al.[3] assess prevention subdimension using only antenatal services among females (mainly aged between 15 and 49 years) and immunization services among children aged 12 months. In addition, treatment services (i.e., inpatient and outpatient utilization) were assessed without considering inpatient admissions for children and outpatient utilization for almost the entire population. While these are considered as indicators, it can be argued that there is a lack of representativeness. Because there is an absence of any analysis of the statistical representativeness or validity of the indicators, extrapolating a nonrepresentative indicator to the entire population will present a challenge. The proportion of the entire population covered by preventive services, for example, cannot be deduced from the proportion of children and child-bearing women covered by a set of preventive services. Similarly, in many countries there is a focus on ensuring that pregnant women attain at least four antenatal visits before delivery; however, there is limited emphasis on postnatal care for women and newborn beyond immunization for children, despite the fact that the

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majority of under-five mortality occurs in the first year.

ASSESSING SERVICE COVERAGE AND FINANCIAL PROTECTION

While we recognize the issues relating to, for example, how to assess effective coverage and to capture quality in assessing health service coverage[6,7] or aggregating indicators and dimensions in the context of UHC, we argue that more conceptual work is needed. This is in terms of refining the measurement of the various indicators for UHC to be inclusive of *everyone* as contained in the definition of UHC. On the service coverage front, for example, a more inclusive empirical measure of coverage needs to be developed to capture the provision of care over the life course of individuals as well as across the different elements of service delivery. Similarly, on the financial protection front, the current indicators (financial catastrophe [i.e., a situation where a household spends more than a certain proportion of their total consumption directly out-of-pocket on health services] and impoverishing [i.e., when direct out-of-pocket spending on health services pushes a monetarily non-poor individual into poverty] expenditures on health services) are also narrowly originated because they are based on the proportion of the population that has used health services. They miss, for example, the critical portion of the population who are unable to use the needed health services because of unaffordable payments. In fact, a problematic suggestion is that the current narrow indicators of financial risk protection be rescaled[6] to obtain the "fraction of the population not incurring catastrophic spending and not impoverished."[3(p1706)]

It may be argued that data quality and availability are a limiting factor on the types of indicators that have been used in the past to assess progress toward UHC. A recognition of this means that there is a need to invest in ensuring that we have the right indicators and, where possible, incorporate the most appropriate questions into routine data collection architecture for effective monitoring and evaluation. The Sustainable Development Goals and the health data collaborative represent a great opportunity to do so.

CONCLUSIONS

As countries strive to achieve universalism in health coverage, a fundamental question that needs to be answered is whether *everyone* has access to the needed health services of acceptable quality without *anyone* facing any financial hardship as a result. It is our hope, therefore, that this article will open up the space for future engagement between academics, researchers, and policymakers in ensuring that UHC indicators are being assessed adequately with respect to *everyone* rather than with respect to those that the current data repository allows. Appropriate and accurate indicators will make for effective monitoring and evaluation of progress toward UHC taking into account the continuum of care over the life course of individuals, with a particular attention to the most vulnerable populations often excluded from the health system. We argue that if UHC is a serious goal in itself and a means to improving health outcomes, which indeed it is, we do not need to be limited by the currently available data. AJPH

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