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MEASURING AND MONITORING COUNTRY PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE: CONCEPTS, INDICATORS, AND EXPERIENCES

MEETING SUMMARY - JULY 20, 2012
WASHINGTON, DC

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Health Systems 20/20 is USAID's flagship project for strengthening health systems worldwide. By supporting countries to improve their health financing, governance, operations, and institutional capacities, Health Systems 20/20 helps eliminate barriers to the delivery and use of priority health care, such as HIV/AIDS services, tuberculosis treatment, reproductive health services, and maternal and child health care.

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ACRONYMS

DHS	Demographic and Health Survey
FRP	Financial Risk Protection
HMIS	Health Management Information Systems
ILO	International Labour Organization
JLN	The Joint Learning Network
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring & Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MERG	Monitoring and Evaluation Reference Group
NCDs	Non-Communicable Diseases
OOP	Out-of-Pocket
RH	Reproductive Health
SARA	Service Availability and Service Readiness Assessment
THE	Total Health Expenditures
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

As countries declare their commitment to achieving Universal Health Coverage (UHC) and introduce policies aimed at that goal, there is a need to develop indicators to measure and monitor progress. The World Health Report 2010 outlined a conceptual framework with three broad dimensions of UHC: population coverage, service coverage, and financial coverage. However, additional work is needed to operationalize measurable indicators of these dimensions. There is particular urgency now as the global community begins to outline a post-Millennium Development Goals (MDG) agenda; a simple metric of UHC could be a compelling 'umbrella' indicator for health post-2015, but conceptual and practical challenges remain.

A meeting was held in Washington, DC on July 20, 2012, with 43 key global stakeholders engaged in UHC-related efforts. Participants in the meeting came from the following organizations: Bill & Melinda Gates Foundation, Center for Global Development, International Development Research Centre, International Labour Organization, Management Sciences for Health, Program for Appropriate Technology in Health, Results for Development Institute, Rockefeller Foundation, Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), USAID-funded Health Systems 20/20 Project, USAID MEASURE/Demographic and Health Survey (DHS) Project, USAID MEASURE/Evaluation Project, the World Bank, and the World Health Organization. It aimed to advance the discussion on measurement of UHC; review conceptual and analytic work conducted to date; identify major areas where further work is required; and outline next steps for the next 6 to 9 months.

Several key themes emerged from the discussion:

- **Areas of consensus**: There was general consensus around the conceptual framework for UHC comprising financial risk protection (FRP) and coverage with good quality health services for all. Quickly identifying a small set of key indicators in preparation for post-MDG discussions was perceived to be of high priority.
- **Varying objectives and audiences for indicators**: It was noted that the objectives of UHC indicators may vary according to the audience. A small number of simple, intuitive, easy-to-communicate indicators and cross-country benchmarking are useful for global advocacy purposes, but these metrics may be of limited use to country-level health planners and policymakers, who need more comprehensive, detailed, and actionable country-specific indicators for policy and management.
- **Lingering conceptual challenges with measuring UHC**: These include difficulties with cross-country comparability of health coverage indicators given the elasticity of health spending, variations in disease burden, and variations in benefits packages; concerns about whether financial protection indicators (such as impoverishment due to out-of-pocket [OOP] health spending) fail to capture those who are already very poor or those who fail to seek any care due to poverty; difficulties in distinguishing between legal/nominal affiliation with a health scheme and effective coverage (whether services received are of sufficient quality to improve health); and how best to capture risk factors and factors outside the health system that could affect coverage.
- **Involvement of country stakeholders**: It was emphasized that country stakeholders should be involved in discussions about UHC measurement going forward. Based on lessons learned from previous global monitoring and evaluation (M&E) efforts, involving countries in this process from the

beginning motivates participation in gathering and reporting data for new indicators, and ensures the relevance and utility of the metrics.

- **Additional investments needed**: Areas highlighted as priorities for research and investment going forward included: additional analytic work on service coverage indexes and tracer indicators; measurement of non-communicable diseases services; developing better indicators of the quality of health care; greater standardization, better data quality, and increased frequency for expenditure surveys; and strengthening routine health information systems and other non-survey data sources.

Possible next steps included:

- Develop a governance process for measurement of UHC; establish a Monitoring and Evaluation Reference Group (MERG) or a working group.
- Convene a meeting involving country-level stakeholders to facilitate common understanding and identify country-level needs for indicators.
- Come to consensus on criteria for selecting high-level indicators.

MEETING OBJECTIVES

Overall Meeting Purpose: Move towards consensus on ways to measure country progress towards Universal Health Coverage (UHC). Agree on what indicators are readily available; assess current experiences on monitoring UHC; identify major areas where further work is required; and begin to develop an agenda and priorities for the next 6-9 months.

Specific Objectives:

- Present and discuss a proposal for a hierarchy of indicators related to the three dimensions of the UHC conceptual framework: Population (who is covered?); Services (which services are covered?); and Direct Costs (what proportion of the costs is covered?).
- Present analytic work to date on application of concrete metrics for measuring UHC using available secondary data
- Solicit feedback and expert advice on indicators presented, identifying gaps needing additional conceptual work or improved data gathering methods
- Plan ahead by reviewing key processes and lessons learned from previous experiences with measuring country performance using global metrics
- Discuss next steps to follow-up on this meeting

SUMMARY MEETING NOTES

SETTING THE STAGE

Ariel Pablos-Mendez, Assistant Administrator for Global Health Bureau of USAID, opened the meeting and welcomed participants to the event.

- Recognized the meeting as critical to advancing consensus on ways to measure country progress towards universal coverage.
- Described USAID's support for National Health Accounts to more accurately measure the burden of health expenditures on households and the Demographic and Health Survey (DHS) to provide standardized survey data to track health coverage.
- Suggested that the best road map for scaling up UHC is one developed by each country within its political, economic, historical and cultural context.
- Highlighted how countries in Africa and around the world are seeing an unprecedented growth of GDP and, as a result, will inevitably spend more on health.
- Predicted that with growth, countries may see: an explosion of unregulated private services paid for OOP; a gradual deterioration of their health services; and weak systems of financing and governance which bring growing inefficiency and regressive financing.
- Warned that the worst impact of weak financing and governance is on the families: health bills become the number one cause of impoverishment.
- Proposed the way forward to address these problems – by adopting policies aimed to reach UHC.
- Reminded that the various dimensions of universal coverage pose challenges to measurement and monitoring of progress toward universal coverage at the country level.
- Challenged the attendees to find simple metrics that cover all the dimensions of universal coverage and efficient data collection and information systems.

David Evans, Director of the Department of Health Systems Financing, World Health Organization (WHO)

- Noted that UHC can be thought of as "Health for all" with financial risk protection (FRP).
- Introduced this meeting as a follow-on to a more technical discussion of UHC measurement in Rotterdam (October 2011).
- Identified key questions: How do we measure progress towards UHC? How do all the indicators from the different dimensions fit together?
- Identified growing momentum towards a "post-Millennium Development Goals (MDG) agenda" – UHC may become the "umbrella" agenda for health.
- Commented that choosing indicators will probably be easier than specifying goals or targets.

SESSION 1: OPTIONS FOR MEASURING UHC DIMENSIONS

Session Purpose: To present and discuss a proposal for a hierarchy of indicators related to the three dimensions of the UHC conceptual framework, and discuss implications for disease-specific measurements

David Evans: "Universal Health Coverage: Concepts and Measurement"

- Presented recently drafted paper outlining a framework or hierarchy of indicators for measuring UHC. Reviewed basic definition of UHC using the 3-dimensional "box": Population (who is covered?); Services (which services are covered?); and Direct Costs (what proportion of the costs is covered?). Tracks coverage of needed health services which are of good quality, with FRP; extent to which box is filled represents extent of coverage.
- Key definitional questions: *What services did people need to use? Did they get them? Were they of good quality? How much did they pay? What were their incomes?* Extremely difficult to measure in practice because of data needed.
- Presented UHC "results chain" or logical framework: inputs, processes, outputs, outcomes, and impacts. All components of this chain influence ultimate impacts on health. Noted importance of measuring inputs and outputs, not just outcomes (service coverage) and impacts (financial protection), as inputs/outputs are critical for health policy and planning decisions.
- Comments on specific indicators: Utilization does not necessarily mean coverage, because it does not capture whether individual got what was needed. Quality indicators are difficult to measure. FRP indicators are perceived to be "more straightforward" and less subject to debate. Noted ongoing debate on how to measure inequality for FRP indicators.
- Offered suggestions for post-MDG agenda:
    - WHO is considering proposing one indicator for FRP: "Proportion of population impoverished because of OOP [out-of-pocket health spending]" as an indicator that will be most politically convincing for a post-MDG goal. At least one measurement point is available (or estimated/extrapolated) for 112 countries.
    - Composite indexes are not favored by many technicians due to their arbitrary weighting schemes, but political objectives (such as simplicity) are important to keep in mind as well. There is strong lobbying to reduce emphasis on health in the post MDG agenda. UHC may be a compelling umbrella concept around which to organize a health agenda.

Audience reflections and discussion

- Concern that the UHC box does not adequately capture elasticity of health financing, especially if fiscal space is not fixed. It varies country by country and over time.
- In addition to financial barriers, does the framework capture those who lack legal access to services? How do we deal with social barriers that exclude people from the health system? How can the financial impoverishment indicator capture those who fail to seek care for financial reasons?
- While the UHC box captures the non-use of services, it does not capture the reason for exclusion from services. Was it financial exclusion or social exclusion? This is why it is important to include indicators for other steps in the results chain (inputs/outputs).

Ties Boerma, Director, Department of Measurement and Health Information Systems, WHO: "Framework for Measurement of Service Coverage Dimension of Universal Health Coverage"

- Service coverage indicators should focus on *effective coverage* of *proven interventions* – interventions need to result in health gains.
- There is a need for a simple measure to be able to get onto the post MDGs agenda. Proposes an index or small set of tracer indicators for selected intervention areas, representing the full range of services.
- Input/output indicators are relevant as proxies, e.g. SARA index (service availability; service readiness assessment)
- Measuring quality of care is complex and comparability across countries is an issue. Example: OECD measures 30-day hospital mortality rates after acute myocardial infarction. However in low-income settings, service availability and readiness may be appropriate proxies for quality.
- Challenges:
    - Limited availability of good standard measurement methods
    - Shortage of quality data that is also frequently collected
    - Increasing relevance of non-communicable diseases (NCDs) suggest a pressing need for investment in their measurement
- Recommendations for post-2015 development agenda –
    - Consider an ALL country focus rather than just a low-income country focus
    - Balance country-specificity of indicators with global comparability: consider small "core" set of indicators for global monitoring.
    - Promote health outcomes as good impact measures for post-MDG era; development is not possible without good and equally distributed health.

Audience reflections and discussion

- It may be more politically compelling and appealing to combine service coverage and FRP indicators since one indicator is better than two; you do lose specificity but this may be balanced by greater ease in communication. However, information merged into an index should always be presented with details underlying it.
- There is an increasing number of indicators to choose from in health. It is important to focus on what is actually used for decision making.
- Selecting indicators based on intervention areas introduces underlying assumptions about country's health needs. How should this be handled?
- Utilization can be useful as a proxy of services needed when usage rates are very low. However, it is less clear that utilization reflects need when utilization numbers are close to what they "should be".
- With regard to indicators of risk factors: do we only want indicators related to health sector or should we include other sectors that are also instrumental (water and sanitation, tobacco, road traffic safety, NCDs)? Further discussion is needed on this topic.
- Could life expectancy work as a single indicator proxy for service coverage? Concerns expressed that life expectancy is sensitive to many factors outside the health system, and also subject to a long

lag time for measurement.

SESSION 2: EVIDENCE ON MEASURABILITY OF POTENTIAL UHC INDICATORS

Session Purpose: To present analytic work to date on application of concrete metrics for measuring UHC using available secondary data

Marianne El-Khoury, Associate, Health Systems 20/20 Project: "Indicators for Measuring UHC: A Five-Country Reality Check"

- Potential indicators for measuring UHC were reviewed for 5 countries to expose issues related to indicator validity, data availability, and data quality. See Annex for list of potential indicators.
- Percentage of population with health coverage is a measure easily obtained through household surveys and reflects breadth of insurance coverage in population, but is a limited measure of effective coverage and not collected consistently.
- Catastrophic health expenditures and impoverishment indicators can reflect incidence/hardship from healthcare spending and highlight inequities in distribution, but does not capture those who fail to seek care or are below poverty line, assumes household resources are fixed, and they require household surveys and questions that are not standardized.
- Out of Pocket Spending as a Percentage of Total Health Expenditures (OOP as a % of THE) reflects FRP at the macro level and estimates are produced routinely at the country level but inequities in distribution are not captured, figures are often imputed, and there is wide range in methodology that makes international comparison problematic.
- Reproductive Health (RH) and Maternal and Child Health (MCH) service utilization indicators can highlight distribution, are clearly defined and available, but do not reflect quality of service and other diseases are less/not reported.
- Overall challenges include lack of data quality and availability of household expenditure surveys, much work still needed to develop aggregate indicators of quality, some conceptual weaknesses with FRP indicators, and availability of metrics for non-MCH/RH indicators.

Audience reflections and discussion

- Indicators such as "percentage of population reporting health insurance coverage" can be misleading, misreported, or manipulated by government leaders. Reported coverage with insurance may not equal effective financial protection or service coverage. "Legal" coverage may not translate into access to services.

Xenia Scheil-Adlung, Health Policy Coordinator, International Labour Organization (ILO): "Measuring Deficits in Social Health Protection Coverage in Vulnerable Countries"

- Key questions: what kind of progress are we measuring? And how does it link to UHC goals?
- ILO definition of UHC: all residents should have necessary financial protection to access a nationally defined set of essential health services (including MCH). ILO approach separates components of UHC into those that are within the health system and those outside the health system. Several key

dimensions to measure UHC:

  - Affiliation: is a key indicator of coverage; measures deficits in "affiliation" or enrollment to a national health system, public, or private scheme. It is a prerequisite to any risk pooling and a key indicator of coverage
  - Affordability: is a relative concept. Affiliation with a financial protection scheme correlates globally with reduced OOP, but increased affiliation within a country may not correlate with OOP over time. If wages are too low, then medicines may not be affordable, suggesting OOP may not be sufficient to measure FRP coverage. However, in the absence of better proxies OOP is used as the indictor for affordability.
  - Financial Protection: measured by inclusiveness of benefits package. In the absence of better indicators OOP is used to express financial protection.
  - Availability: Access Deficit Indicator based on health workforce. Availability is the difference between the national density of staff and the average in low-vulnerable countries (defined by poverty and extent of informal economy -- see below).
  - Quality: THE per capita; maternal mortality ratio (not discussed).
  - Poverty and extent of informal employment: Coverage is lowest in countries with highest level of poverty and informal economies.

- Indicators above are measured in countries grouped by levels of poverty and extent of informal economy. This allows us to create comparable country groups in terms of challenges towards UHC. Averages in country groups with low levels of poverty and informal economy also serve to create benchmarks e.g. in terms of deficits in per capita expenditure and availability of health work force.
- Measuring equity is a challenge; emphasized importance of disaggregating data by gender, age, and rural/urban.

Audience reflections and discussion

- Participants expressed interest in understanding how the ILO's work on coverage and social protection has been coordinated or linked with the WHO UHC efforts.
- There was further discussion about "effective coverage" vs. legal affiliation to a social protection scheme.

Amanda Folsom, Program Director, Results for Development Institute: "Measuring UHC: Reflections from the Joint Learning Network"

- The Joint Learning Network (JLN) is a network of 10 lower and middle-income countries in Africa and Asia committed to moving towards UHC. JLN supports these countries in knowledge sharing and joint problem solving, and as part of that is addressing the question of measurement.
- There is country-level demand for better measurement of UHC. JLN countries have been brainstorming key indicators, what data they will need to collect. JLN is working to form a dashboard of these indicators.
- Country priorities for indicators needed for measuring progress: 1) enrollment of target populations in schemes, 2) use of priority services, 3) health impact measures (morbidity/mortality), 4) FRP indicators like OOP spending, and 5) quality indicators.

- Emphasized need for *adaptable* and *actionable* indicators,
    - Adaptable – country specificity preferred; a desire for menu of indicators that they can select based on context
    - Actionable – timing of data collected to measure impact of reform, reduce lag time. Survey-based, population level indicators can be limited in terms of actionability. Ability to disaggregate data is key – importance of sub populations, especially by equity measures
- Criteria: Sensitivity of indicators, timeliness, availability, measurability, disaggregation (e.g. equity dimension), understandability
- Emphasized the importance of bringing country perspectives into these discussions going forward.

Cesar Nuñez, Director of Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support team for Latin America: "Implications for Disease-specific Measurements: Lessons from the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Experience"

- Political commitment to HIV/AIDS necessitated careful monitoring and evaluation (M&E) of progress. As a result, core indicators were developed in 4 broad categories including national commitment and action; national knowledge and behavior; national impact; and global commitment and action. UNGASS progress reports have been prepared every 2 years since 2004; Global AIDS Response Progress report submitted annually by many countries.
- M&E Reference Group (MERG) objectives are to harmonize and set international M&E standards and norms, review and endorse M&E policies/standards/indicators/tools, and coordinate the global M&E agenda—important mechanism for ensuring ongoing M&E.
- The 2011 Political Declaration Targets are important examples of helping individual countries evaluate their response at regional, national, and global levels using clinical indicators. Data sources include population and surveillance surveys, patient tracking systems, HIS, records/reviews from health facilities and schools.
- Countries should consider the applicability of each indicator to their epidemic (e.g. Know Your Epidemic studies). If the epidemic is concentrated, then no need to report on other indicators reflecting epidemics in different population groups, though should still regularly monitor.
- UNAIDS recommends that the reporting process be a multi-sectoral one with inclusion of other government sectors, other health sector authorities, and civil society organizations.
- Stressed the importance of trained M&E staff in making monitoring possible. Difficulties caused by the high turnover/movement between divisions or ministries of people with M&E knowledge.

Audience reflections and discussion

- Participant expressed interest in understanding how the MERG formed and how it operates.
- To advocate for health specific goals on the post-MDG agenda, we may have to combine goals and leverage from disease-specific components. The importance of combining efforts and working together in this environment was stressed.

SESSION 3: PLENARY DISCUSSION

Following the morning presentations, the floor was opened for general discussion. Key themes are summarized below:

1. Aim for simplicity and keep political feasibility in mind

- Many non-technical observers think of UHC as a binary measure: either a country has UHC or it doesn't. Is there a way we can come up with such a simple, intuitive ("populist") measure?
- Whatever we come up with needs to be politically palatable. Politicians tend to "get" UHC intuitively, and many UHC reforms are politically driven. One participant proposed that outpatient utilization rates would be a straightforward, easy-to-interpret indicator– "crude but powerful."
- The suggestion was made to link the UHC agenda with the broader poverty alleviation and development agenda for advocacy purposes – to frame the process of moving toward UHC as an opportunity for moving a country out of poverty.
- Several participants commented on the political urgency of the post-MDG agenda. Health goals may have diminished presence among the post-MDG goals, compared to their current prominent role. A strong, applicable, politically-palatable UHC indicator may be the best chance for health after 2015.

2. Indicators should be actionable

- Several participants emphasized the importance of actionable data that are useful to planners and managers at the country and sub-national levels – not just for cross-country comparisons.
- Indicators also need to be actionable for national-level politicians. Leaders want to be able to take concrete action in their countries based on the data. Important to consider which subset of indicators will motivate political action. Make sure these can be measured easily, frequently, and that results will be available in a timely manner.
- The "results chain" can help to separate "what is the outcome or impact we care about" from "how do we get there" (inputs/processes/outputs).
- Question about which dimension of coverage to prioritize first: what is most important to focus on when a country is at a particular level of coverage? Should all dimensions increase proportionally or should one dimension come first?
- Regardless of the quantitative measures we develop, it is essential to gather qualitative data to clarify trends. For instance, the prevalence of informal and under-the-table fees could make "official" affiliation or coverage measures meaningless. Other social, cultural, and legal barriers affect how and whether people access services. Qualitative research can help to explore these issues.

3. There are lingering conceptual challenges with defining and measuring UHC

- The challenge of cross-country comparisons and benchmarking was highlighted, especially given the elasticity of health spending and the variation in disease burden and health technologies across countries. Do we need to consider both relative comparisons and absolute benchmarks?
- Some limitations of financial protection measures were noted.
    - The "impoverishment due to OOP spending" indicator may fail to capture inequalities in financial burden – it overemphasizes those in the middle quintiles (most likely to fall below

some poverty line) and ignores those both at the top and bottom ends of the wealth distribution, regardless of how much their socio-economic status is changed by health spending.

  - Catastrophic expenditure indicators fail to capture financial burden of ill health among those who fail to seek health care due to inability to afford care.

- The need to reflect both dimensions of coverage – FRP and service coverage – was reemphasized. Service coverage measures should capture lack of access due to unaffordability as well as lack of access due to other reasons. Public health and economists need to work together to capture both concepts.
- The challenges of measuring enrollment or affiliation were noted. While it may be politically easy to say that "everyone has a right to free care," it is usually not the reality.

4. Priorities for better data gathering

- Participants noted the need for capacity building to strengthen data collection processes. The importance of strengthening routine HIS at country level was emphasized.
- A modular approach could be considered: start with "the basics" then get more sophisticated with add-on modules.
- Need to strengthen general data availability, especially for NCD measures
- However, the quest for better data should not get in the way of political objectives and rapid action. Need to help policy-makers in their decision making processes. The glass is half full in terms of having data to use.
- To motivate countries to participate in gathering and reporting data for new UHC indicators, it is important to involve countries in their development from the beginning.

SESSION 4: SMALL GROUP DISCUSSIONS

The participants were asked to spend 45 minutes in small groups (7-9 per table) discussing: indicators/metrics presented, priority areas for further research, additional areas to prioritize for attention, and key next steps. Key points reported by the groups are summarized below.

General overall comments

- There was general agreement across groups that UHC is both service coverage and financial protection. Financial protection has been more clearly defined to date, thus some felt there should be greater initial focus on refining the service coverage indicators.
- Fewer indicators are generally better than more, at least for the purposes of global advocacy. The global community will need to refine the indicators over time, and be comfortable retiring some indicators.
- There was general acknowledgement that indicators are needed at multiple levels: high-level indicators or indexes for country benchmarking; actionable indicators to provide information for management and decision-making in country. Different underlying objectives imply different criteria for selecting indicators:

- Garner political commitment to UHC
- Hold countries accountable for progress
- Empower patients/clients/citizens to demand quality of care to meet needs
- Drive performance based management.

- Historical experience shows that to make an index or set of indicators "work" there needs to be 1) a transparent process to develop the index 2) involvement of countries in its development 3) feasible data collection.

General comments on financial protection indicators

- The aim of the financial protection dimension may need further clarification. Is it about ensuring basic financial access to the poor/to the masses, or do we care about protecting a small group of people from truly catastrophic/impoverishing expenses? Different indicators have very different implications for policy design and imply different financial prioritization.
- Some perceive that a weakness of financial indicators is that they fail to capture those who can't access care. Others argue that these should be captured by looking at service coverage indicators – thus the need to look at the two dimensions in an integrated way.
- The indicator of "percentage impoverished by health expenditures" is appealing, but what about those already below poverty line? What are the equity implications? Additionally, there continue to be issues with differences in measuring poverty lines by country if trying to use the indicator for cross-country comparison.

General comments on service coverage indicators

- Some felt that the proposed list of service coverage indicators is too long, too MCH-dominated, and too reliant on DHS statistics (only collected every 3-5 years) which are not made available rapidly enough for policy action.
- Many commented on the need for greater global focus on NCDs.
- Some suggested focusing on a small, defined group of indicators; composite indicators (tracers) linked to the cube dimensions and to service delivery platforms. Some suggested moving away from disease specific indicators.
- Country-level indicators of service coverage must be feasible and relevant to country context in order to catalyze action.
- One suggestion was to use "number of service visits" as a proxy indicator of coverage.
- One group commented on lingering conceptual challenges related to prevention and health promotion. If prevention and health promotion are part of the "service coverage" concept, then it is critical to measure risk factors for disease as well as health outcomes. But are we concerned about the effectiveness of the *health care* system, or the effectiveness of society to promote healthy people? How do we capture factors external to the health care system? For example: can a highly obese society be successful at achieving universal coverage, or is this a sign that UHC has not been achieved? Low hypertension prevalence can be achieved either by successful screening and treatment, or successful prevention in the first place. Should these matter equally, or should a country be "rewarded" for successful prevention more?

Priorities for indicator research and development

- *Better measurement of quality of care*. Important components: defining and adhering to set standards, measuring the patient's experience, measuring the timeliness of care. Suggestion was made to focus on proper clinical procedures first, then bring in 'softer' quality elements such as patient satisfaction.
- *Define a basic/essential service package*. What is the minimum number of services? What does complete primary care coverage include? Has the country defined a benefits package?
- *Select global tracer indicators*. Choose priority topics to combine into an index. Develop service delivery and FRP "scorecard" with set of key indicators.
- *Better define what "enrollment" or "affiliation" really means*. Is this equivalent to "health care as a right"? If so, right to what? How can this right be enforced? This relates to the question of having a defined benefit package.
- *Come to consensus on criteria for selecting indicators*. Possible criteria: timeliness, small number of core indicators, feasible, comprehensible, actionable, equity-catalyzing, weighting issues, level of disaggregation, sample size needs
- Prioritize ability to disaggregate indicators by gender, urban/rural, and geographic region. Ensure that indicators can be "unpacked" to a sub-national level so that they are relevant and policy-focused.

Priorities for improved data gathering

- Given how expensive it is to collect survey data, the global community needs to invest in better real-time data collection methods such as Lot Quality Assurance Sampling (LQAS) and better Health Management Information Systems (HMIS).
- Need to continue building measurement capacity in-country
- Need to invest in more frequent survey data collection, better standardization, and faster production of results. Politicians need quick information; survey every 5 years doesn't usually fit with political cycles.

Next steps

- Develop a governance process to keep moving forward; promote consistency in actors at the table, so as not to reinvent the wheel each time.
- Aim to achieve joint consensus for monitoring across United Nations (UN) agencies and partners; need harmonization. Establish something similar to the MERG reference group or a working group.
- Prioritize coming to consensus on high-level indicators first, given time constraints. Country representatives' input will be needed for lower-level indicators.
- Conduct a mapping of what different organizations are doing now; make people aware of what is happening.
- Conduct further research on composite indicators/indexes, looking at correlations among indicators.

SESSION 5: LESSONS LEARNED IN USING GLOBAL METRICS TO MEASURE COUNTRY PERFORMANCE

Ties Boerma: "Using Global Metrics to Measure Country Performance: Lessons Learned During the MDG Countdown"

- Presented experiences from the *Countdown to 2015,* which tracks progress on MDGs.
- WHO chose to use a coverage index rather than a coverage gap as the positive measure was more easily understood by policymakers. Index works well to summarize levels, trends and inequity; good way to summarize multiple interventions.
- Dependence on surveys is a disadvantage (infrequent, expensive); if facility-based coverage estimates are adequate, they should be used increasingly, at least for some indicators.
- Several aspects of the *Countdown to 2015* model deserve consideration for UHC monitoring, including country UHC monitoring, regular global analytical reports, and country profiles.

Audience reflections and discussion

- A United Nations Children's Fund (UNICEF) paper, "Narrowing the Gap" estimates the potential coverage gains from reducing the gap between the lowest and highest quintiles. For all high-impact interventions examined, it is most-cost effective to focus on increasing coverage among the poorest and most marginalized children and households first, as they have the highest burden of disease. Thus, while the poorest are the hardest to reach, expanding coverage to them is cost-effective as this will be only way to achieve the MDGs, and set the stage for sustainable universal coverage and access to health services.
- Representatives from the World Bank highlighted country data sheets summarizing recent data from DHS, World Health Surveys, household surveys, and others sources by wealth quintile. These analyses provide key measures of financial protection. However, measuring financial protection can be very challenging because there are no standard data sets -- they tend to be very country specific. Financial indicators can be good for monitoring over time within a country, but it is harder to compare/benchmark countries against each other.
- It was noted that a standard household expenditure instrument would be useful, with standardized questions to add to any survey. However when this was discussed at a conference in Geneva a few years ago, no organizations would agree to change a standard questionnaire. There will be little progress unless changes are made and standard instrument/surveys exist to facilitate easy comparison of information and data.

SESSION 6: NEXT STEPS AMONG PARTICIPANT ORGANIZATIONS

At the end of the day representatives from each of the organizations at the workshop presented their organizations' next steps to advance the UHC agenda and their planned UHC measurement work for the next 6-9 months.

Bill and Melinda Gates Foundation:

- Currently reviewing its plans. Noted that there is a need to develop generic measurements, not disease specific.

International Labour Organization:

- Implementation of Social Protection Floor recommendations. Will hold a brainstorming meeting in early September on how to implement; focusing first on Sierra Leone.
- Will complete and publish updated data. Focusing on publishing the next World Social Security Report and related advocacy activities.

International Development Research Center, Global Network for Health Equity

- Working to ensure that country-level groups are part of the process to determine global health coverage indicators. This is a good opportunity to have health and economics groups work together.

Management Sciences for Health:

- Providing technical support to Ministries of Health and Schools of Public Health to assess equity and financial protection; promoting capacity building. Through disease-specific projects, support progress towards UHC.

MEASURE/Evaluation project:

- Flagship USAID-funded M&E project focused on measuring access and health care coverage.
- Working with partners at international level on M&E issues. Develop tools/methods to improve M&E systems in countries. Provide capacity building and training on M&E in countries.
- Improve routine health information systems to be a valid source for indicator measurement, including a geospatial measurement.
- Want to make data sets more compatible. Using more rapid sampling methodology, outcome cluster sampling and LQAS.

MEASURE/DHS project:

- USAID-funded project that conducts DHS.
- Working to improve wealth quintiles to make them comparable across time and countries – multidimensional poverty index as a guide.
- Testing and developing a health expenditure module to add to DHS surveys.
- In one year, the DHS project will be up for bid. New project may revise DHS core questionnaires, potential opportunity for adding new indicators.

PATH: JLN

- Continuing to work on health data standards with 10 JLN countries. What are the relevant

standards, what can be applied, evolved, introduced?

- Designing/implementing a web-based tool to align in-country data; country owned tool for some, collaborative for others.
- Providing capacity building in countries on information systems – collaborating with them so they can design/develop their own strategies and fill in the needs of their systems.

Results for Development Institute: JLN

- Developing a tool, expanding coverage dashboard refinement – can share list of indicators, draft
- JLN platform could be used to facilitate exchange of ideas from this discussion.
- Follow up with JLN countries in global discussion about UHC agenda and implementation.
- Starting to measure other types of service coverage that are not easily measured from service data; information about transactions from insurance companies that are harder to measure via surveys.

Rockefeller Foundation:

- Funds UHC-related activities. Convenes other groups around this subject.
- Planning another meeting in September with a USAID partner, Secretary General's office, United Nations Development Programme, to make sure that UHC is top priority.
- UNWomen, UNICEF – equity consultation with different partners; how to think about indicators from child health prospective
- With WHO, providing support for UHC agenda– road map, discussion/consultation with countries.
- Support JLN, grantees and countries. Collaborate with World Bank to provide technical support for JLN meeting.
- Goal: to get a group of donors to come together, pool resources for a fund to develop a mechanism to support UHC.

UNICEF:

- Committed to an equity-focused and human rights-based agenda; that is, not just child survival, but also child welfare and social protection. Operational research is being carried out with several partners to explore how monitoring progress towards UHC should be linked to indicators that assess the adequacy and quality of a country's social protection framework.
- Restructuring the organization to focus on results that achieve equity and 'narrow the gaps' in health outcomes across all groups. UNICEF is carrying out an equity-based analysis of health systems in 26 first wave countries. Also, working with all interested countries to assess, diagnose, and overcome bottlenecks to UHC notably service provision, social, and financial bottlenecks faced by children.
- Focus much effort on providing evidence and best practices to counties wishing to reorient health, education, WASH, and nutrition systems at the subnational-level towards an equity agenda; the organization is using DHS, multiple indicator cluster surveys, HMIS and other data to both help country offices and the organization conduct periodic course corrections, and assist governments to assess if the gaps are closing between those accessing care and those left behind.

- The post-2015 agenda includes collaboration with partners to build a sustained focus at the sub-national level on equitable coverage, access and outcomes; and to collaborate with our partners on policy development and research elements, particularly operational research on reaching and protecting every child.
- Organizationally, UNICEF has committed itself at the highest levels to assess whether its work is actually resolving problems and achieving results for children. This rigorous evaluation of what works, through a formal 'monitoring for equity and results' framework, requires collaboration with partners to ensure our work is aligned with national priorities as well as the evolving post-2015 consensus on UHC. Internally, this approach will be used to make the organization accountable for ensuring UNICEF's policies and strategies are aligned with work that is being done on the ground to remove bottlenecks to equitable UHC.

USAID:

- Improving production and use of data through the MEASURE projects – generate data that can be used
- Adding expenditure module to DHS to improve quality of expenditure data and to drive down costs (done with Health Systems 20/20 support).
- Consolidation of HSS activities under new USAID Health Systems Office.
- Drive forward the UHC agenda in USAID Missions worldwide; improve coherence in country assistance activities.
- Continue to be part of collaboration with UN agencies and the larger community on measuring UHC.

World Bank:

- 25 country case studies, developed a tool that measures systematically the 'nuts and bolts' of whether a country has a process to move towards UHC and some of the key areas to consider; piloted in 5 countries and had a number of issues; tool to be used for template preparation.
- Provides training in measurement of coverage equity and protection, as well as use of the World Bank-developed ADEPT software.
- Producing around 100 short country datasheets (factsheets) with indicators of equity and financial protection and 10 longer country reports

World Health Organization:

- Leads implementation of the recommendations in the World Health Report 2010, "Health System Financing: The Path to Universal Coverage". David Evans is the WHO focal point.
- Health Statistics Information Systems- Accountability framework agenda aligns with the UHC agenda – working to improve surveillance, vital statistics, etc.
- Strengthening midterm reviews as part of national health strategies; generating data quality report cards using HMIS data; data verification and assessment (yearly, routine before national review).
- Focusing on the coverage component of UHC for the post-2015 development goals. Ties Boerma is the WHO focal point.

Those not present at this point in the day included the following organizations: Center for Global Development, UNAIDS and United Nations Population Fund. The Health Systems 20/20 project will end September 30, 2012.

CLOSING REMARKS

David Evans, WHO

- Observed a general consensus among those present to support and advocate for UHC as a global movement with two components: FRP and coverage with good quality health services.
- Remaining open questions related to measuring progress towards UHC:
    - What action steps are needed to expand coverage?
    - How best to capture social and economic determinants of health coverage as these influence *why* we are not getting to where we want to be?
    - What do we do next? We have proposed some indicators of coverage, health services and FRP. How do we move towards consensus?
- Suggested three levels at which to discuss measurement needs – each audience expects different indicators for different purposes:
    - Country and subnational level – decision makers and policy makers within a country need multiple indicators to help them understand what is happening and know what to do about it. Here, there is a need for further direct input from country researchers and policy makers. At this level they are not interested in indexes but in indicators that will help them make a policy choices.
    - Country President level – need for summary measures
    - Global level: Urgently need a goal for post-MDG framework. This is a political discussion, and decisions are being made now. Global goals and metrics are valuable to pressure countries to make changes, rather than valuable for their own sake: being evaluated against other countries increases chances that countries will work to make progress.
- Next steps:
    - Proposed a meeting involving country-level stakeholders to facilitate common understanding, identify country-level needs for indicators.
    - WHO to develop a "roadmap" for the process of moving towards UHC – guidance to help countries roll out initiatives and measure progress.
    - WHO needs to suggest a process for obtaining consensus at international level, so that not everyone is pushing their own MDG-type indicator for UHC. There is likely going to be a large meeting in December 2012/January 2013 and continued consultations until then.
    - Emphasized importance of consistent/coordinated process rather than proliferation of numerous separate indicator systems.

POTENTIAL LIST OF UNIVERSAL HEALTH COVERAGE INDICATORS

Indicator	Source
1. Financial Protection	
1. Percentage of population with (self-reported) insurance coverage	Captured in some expenditure surveys, some DHS
2. Out-of-pocket expenditures on health as a percentage of total health expenditures	WHO database, NHA reports
3. Out-of-pocket expenditures on health as a percentage of total private health expenditures	WHO database, NHA reports
4. Percentage of population whose health expeditures exceeds 10% of total expenditures	Estimations using household expenditure surveys
5. Percentage of population whose health expeditures exceeds 40% of non-food expenditures	Estimations using household expenditure surveys
6. Mean positive overshoot: Average amount by which out-of-pocket spending exceeds threshold, for those with catastrophic payments	Estimations using household expenditure surveys
7. Percentage of population whose health expenditures put them below the poverty line	Estimations using household expenditure surveys
8. Average deficit by which consumption falls below poverty line	Estimations using household expenditure surveys
2. Service Coverage	
Service utilization (Percentage of relevant populations)	
1. Births delivered in a health facility	DHS
2. Births assisted by a skilled provider	DHS; UNICEF/UNFPA; WHO database
3. Women receiving ANC from a skilled provider	DHS; UN MDGs Indicators; WHO, UNICEF
4. Married women in reproductive age using modern FP method	DHS; World Contraceptive Use 2011 (United Nations, 2011)
5. Family Planning Needs Satisfied	DHS
6. Received all basic vaccines	DHS; WHO database
7. Received Measles vaccine	DHS; WHO database, UNICEF
8. Received 3 doses of DPT vaccine	DHS; WHO database; UNICEF
9. Received BCG vaccine	DHS; WHO database
10. Received ORT and continued feeding for diarrhea treatment	DHS; MICS; UNICEF
11. Sought Treatment for ARI	DHS; MICS
12. Children under 5 with fever who received anti-malarial drugs	DHS; WHO database
13. Population with advanced HIV and access to ART drugs	UN MDGs Indicators
Other service/tracer indicators	
14. Households with at least one mosquito net	DHS for select countries
15. Children under 5 sleeping under ITNs	DHS; WHO database; for select countries
16. Pregnant women sleeping under ITNs	DHS for select countries

Indicator	Source
17. TB treatment success rate under DOTS, percentage	UN MDGs Indicators
18. Percentage of women with serious problems in accessing health care for themself[1]	DHS for select countries
Service availability and service readiness	
19. Hospital beds per 10,000 population	WHO database, national HMIS
20. Providers (by type) per 10,000 population	WHO database
21. Health Centers per 100,000 population	WHO database
22. Median or average availability of 14 selected generic medicines (%)	WHO & HAI
23. Median consumer price ratio of 14 selected generic medicines	WHO & HAI
24. Service Readiness Index	Service Availability and Readiness Assessment
Service quality	
TBD	
3. Population Coverage	
Indicators above by subgroups (e.g. geographical, income groups) whenever possible	Household surveys with either household asset variables or expenditure data (e.g. DHS, expenditure surveys)

[1] Depending on country questionnaire problems include: 'Distance to facility', 'getting money for treatment', 'getting permission to go for treatment', 'having to take transport', 'not wanting to go alone', 'concern no female provider available', 'concern no provider available', 'concern no drug available'

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PRESENTATIONS FROM MEETING

Copies of presentations can be accessed through the Health Systems 20/20 Project website: http://www.healthsystems2020.org/content/resource/detail/92797/

David Evans, Director of the Department of Health Systems Financing, WHO: "Universal Health Coverage: Concepts and Measurement"

Ties Boerma, Director, Department of Measurement and Health Information Systems, WHO: "Framework for Measurement of Service Coverage Dimension of Universal Health Coverage"

Marianne El-Khoury, Associate, Health Systems 20/20 Project: "Indicators for Measuring UHC: A Five-Country Reality Check"

Xenia Scheil-Adlung, Health Policy Coordinator, ILO: "Measuring Deficits in Social Health Protection Coverage in Vulnerable Countries"

Cesar Nuñez, Director of UNAIDS Regional Support team for Latin America: "Implications for Disease-specific Measurements: Lessons from the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Experience"