



# Assessing Progress to UHC - The GNHE Perspective<sup>\*\*</sup>

## Financial Risk Protection

John E. Ataguba<sup>1</sup>, Jui-fen Rachel Lu<sup>2</sup>, Jorine Muiser<sup>3</sup>, Felicia Marie Knaul<sup>4\*\*</sup>

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### Key points

- A key element of Universal Health Coverage (UHC) is financial risk protection (FRP) for all.
- Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.
- FRP must be measured alongside, and in addition to, the other dimension of UHC, which is access to needed health services.
- Assessment of FRP should go beyond the conventional measures of financial catastrophe and impoverishment from out-of-pocket spending, because these under-estimate the level of financial risk.
- Measurement should seek to be inclusive and comprehensive, covering the whole population (both those who use health services and those who are unable to afford the use of health services when needed).
- If the traditional measures are used, they should be interpreted accordingly - as simply the proportion of the population who use health services and are consequently impoverished or face financial catastrophe.

<sup>1</sup>Health Economics Unit, School of Public Health & Family Medicine, University of Cape Town, South Africa.

<sup>2</sup>Graduate Institute of Business and Management and Department of Health Care Management, College of Management, Chang Gung University, Taiwan.

<sup>3</sup>Associate Researcher, Centro Centroamericano de Poblacion (CCP), University of Costa Rica.

<sup>4</sup>Miami Institute for the Americas, University of Miami, and Fundación Mexicana para la Salud.

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\*\*Corresponding author: fknaul@miami.edu



## Introduction

Global consensus among countries, agencies, civil society and experts supported the inclusion of universal health coverage (UHC) in the finalised post-2015 sustainable development goals. Yet, there is an on-going debate on how best to define and measure UHC along several dimensions, including financial risk protection for all (FRP), in order to monitor and assess progress at local and international levels.

This policy brief focuses on how to measure and track FRP as a key element of UHC. It presents the ideas and viewpoints of a diverse group of researchers from countries in Africa, Asia and Latin America who participate in the Global Network for Health Equity (GNHE). GNHE chose to focus on this topic because FRP, despite being a critical dimension of UHC, has not been well measured. The effectiveness of policy, as well as of measurement for knowledge building, has been weakened because conventional measures do not fully capture the myriad dimensions of the phenomenon of FRP.

Specifically, this policy brief seeks to contribute to: (1) developing high-quality, global measurement tools for cross- and within-country comparison of FRP as an essential dimension of UHC, and (2) ensuring that, as a global framework, FRP measurement facilitates the ability of in-country actors, including policy makers, academia and civil society, to explore critical issues and respond at regional, national and sub-national levels.

## What are the conventional measures?

FRP is typically assessed in relation to reported out-of-pocket (OOP) payments for health care. These payments are compared to a threshold in the form of either a selected catastrophic expenditure threshold or a selected poverty line.

The two common indicators of lack of FRP that have been widely applied are (i) financial catastrophe from spending a large proportion of household disposable income through OOP payments, and (ii) impoverishment due to OOP payments.

The former relates to OOP health payments in excess of a given percentage of household resources (for example, total expenditure, income, non-food expenditure or capacity to pay) and is a relative measure. Given that

OOP expenditure is measured relative to a proxy for household capacity to pay, this measure seeks to account for the differential impact of health expenditure of the same monetary amount across socio-economic groups – that is, a relatively small out-of-pocket payment can be disastrous to a very poor household while having almost no financial impact on a richer household. Financial ‘disaster’ is measured as putting at risk the family’s ability to cover basic needs such as food, education or shelter.

The second measure — impoverishment — is absolute in nature, and sums the monetarily non-poor who are pushed into poverty by paying OOP for health services. A strong case – and one supported by GNHE research — has been made to also count as impoverished by OOP expenditure on health all households that were already monetarily poor (and living below a poverty line), and have any actual or imputed level of OOP expenditure above zero. This is because these households are thrown more deeply into poverty.

These two broad measures have been constructed and applied by global entities, researchers and countries since the publication of the World Health Report of 2000. Many countries have used these indices to advocate for health system reform, with a focus on protecting the poor and populations most vulnerable to financial ruin as a result of financing their health care out of pocket.

## What are the limitations of conventional measures?

Despite their ubiquitous use, these conventional FRP indices and measures have been widely criticised. They have been characterised both as inadequate for capturing the full dimensions of financial risk and of limited effectiveness for in-country policy making.

At least four reasons underpin this critique:

1. they do not capture households or families that do not use health care services due to financial or other related barriers and which may in fact be those most at risk;
2. they do not capture the multidimensional nature of financial risk (for example, they do not take into account all direct costs related to accessing health care, or the reality that households may decide to sell assets or borrow money in order to do so);

3. the thresholds used to categorise households and families as impoverished or paying catastrophic payments are arbitrary and may underestimate the lack of, and need for, FRP; and,
4. as point-in-time measures they do not capture the dynamics of financial risk, such as the fact that more families may be affected over a year than a shorter period, that families may experience onerous and repeated expenditures over a longer period of time, or that there is lost income due to ill health, either before or after the actual health expenditure occurs.

It is important to note that each of these four limitations suggests that current figures are very likely to overestimate FRP and underestimate the number of households who are subject to, or at risk of, catastrophic and/or impoverishing health expenditures. This means that existing global and national figures underestimate the challenges facing the achievement of FRP and signals the importance of the issue of FRP in shaping health reforms, attaining UHC, alleviating poverty and achieving the sustainable development goals.

## GNHE's approach to improving the measurement of FRP?

GNHE seeks to respond to this debate with feasible alternatives to measuring the need for FRP across and within countries. Its main proposals do not require the collection of new data sets, and reinforce elements of the work undertaken by the World Health Organisation (WHO) and World Bank working group and others, while contributing additional key aspects. These proposals seek to strengthen both the rigour and relevance of FRP estimates.

The starting point for GNHE is the generally agreed-on definition of FRP: that no one should face undue financial hardship related to the use, or the need to use, appropriate health services. The corollary of this definition is the importance of inclusive, comprehensive measurement. Financial risk protection measures should ideally scrutinise 100% of the population, need and OOP payments, and not be restricted to those who use health services, as is currently the practice. This comprehensive and inclusive approach is somewhat different from existing frameworks because it stresses the importance of identifying households that have been invisible to previous measures of financial risk by dealing appropriately with the issue of non-users, unmet need and repeated expenditures.

This position on non-users and unmet need implies that conventional indicators should be presented as "conservative" and likely to underestimate the real extent of lack of FRP. For example, if conventional FRP calculations show that a low percentage of households is affected in financial terms as a result of using health services, it does not necessarily imply high FRP: this is because financial risk is measured only for those that used health services and within the specific reference period. In other words, results based on the conventional measures of financial catastrophe should be interpreted and presented explicitly as "the proportion of the population who use health services and face financial catastrophe because they use health services". There should also be a careful discussion about the poverty line and thresholds used for equity monitoring, and indicators should be disaggregated as much as data allow.

Lastly, GNHE argues that FRP is not a stand-alone indicator, and should always be analysed and measured in combination with use of services and as a proxy for service access.

## Including non-users of needed health care in FRP estimates

GNHE recommends taking non-users of health care into account, not only through measures of health care utilisation, but also through FRP, and argues that lack of data should not constrain the development of more appropriate measurement approaches. When survey expenditure data are only available for households that use health care services, this should not be a compelling argument for excluding non-users from FRP assessments or, consequently, from FRP policy.

On the contrary, many household surveys report which households in need of appropriate health services were unable to access care. This information can provide the basis for estimating the population of non-users at risk of impoverishment. Thus, GNHE argues that all households *below* a poverty line who report unmet need for health services should be considered at risk. These families should "count" in both the estimates of impoverishment and financial catastrophe.

For those with unmet need but above the poverty line, the analysis is more complex. This is because it is difficult to define what expenditure would have been for these households if they had had the resources, because it is typically very difficult to identify specific health needs and

the expected cost of care. GNHE proposes calculating the average health spending of other households at similar levels of income who experienced impoverishing expenditure as a result of seeking health care, and applying these to the equivalent households that chose not to seek needed care. This technique can be further refined by characterising households in more detail by age, gender, education and place of residence. Analysts should be especially mindful of identifying households living close to, although above, the poverty line.

## Expanding the definition of direct and indirect costs of accessing health services and of illness

To date, there is no consensus on which out-of-pocket costs should be used to assess FRP in health. GNHE advocates a broad set of OOP payments, including not only all direct health care costs and health insurance coinsurance fees that families and households incur, but all indirect or associated costs. These should encompass transportation costs to health facilities (including to referral facilities), “hotel” and subsistence costs associated with hospitalisations and facility visits, and payments to others to care for young children or older family members in order to accompany a family member to obtain health services.

Similarly, foregone household income should be considered in calculating FRP because the intention is to assess OOP payments relative to a household’s capacity to pay (or its full income). Direct income loss by the patient, especially if they lack disability insurance, as is often the case in low-and middle-income countries, must be considered. Lost income for caregivers should also be taken into account.

More difficult to measure, but important to consider, is the sale of assets to finance health care as this generates a stream of reduced income and financial insecurity for the family. Many household surveys ask families if they were forced to sell assets to finance health care. All families who report sale of assets and live at, or below, the poverty line should be considered lacking in financial risk protection, even if their OOP spending is very small. The same is true for families close to, or above the poverty line, for whom the loss of an income stream would place them below the poverty line. This can often be estimated from income and expenditure surveys.

## Thresholds for catastrophic and impoverishing health spending

Using a pre-determined absolute poverty threshold (such as the one defined by the World Bank and/or a national poverty line) or level for financial catastrophe, is arbitrary and affects both the quality and usefulness of data for policy-making. These thresholds often leave out large numbers of families who are not considered lacking in financial risk protection because they fall above the arbitrary threshold but who, in reality, are vulnerable. Similarly, simple income measures do not always capture the other dimensions of poverty adequately. Again, the limited conceptualization of risk inherent in conventional thresholds generates an underestimate of the need for FRP.

In measuring lack of financial risk protection in the short term, GNHE recommends applying and comparing a set of thresholds and poverty lines, and evaluating the households that are left out of more restrictive definitions. This will provide a range of estimates of households at risk of lack of financial protection in health.

In the longer term, GNHE recommends use of a broader, multi-dimensional measure of poverty. Further research is required to develop appropriate and practical measures, drawing on current international debates.

## Accounting for risk over time

The period over which risk of catastrophe or impoverishment is experienced has been largely ignored in measurement. This generates serious underestimates of the number of families at risk, and creates difficulties in identifying the groups whose situation is most precarious.

This is because using a one-time measure that considers risk over a one- or three-month period-the standard in household surveys and hence in estimates of FRP-is flawed. The period over which a family is at risk of financial catastrophe as a result of health care use is a function of their wealth and income. An extremely poor family may be driven rapidly into destitution if OOP is a large proportion of weekly income, especially if they have no assets or savings. This is one of the reasons why GNHE strongly advocates for including all families below the poverty line with any expenditure on health as impoverished. For a richer family, however, catastrophic expenditure may not occur within a short period of time because the household initially has some savings or assets on which to draw: repeated OOP payments across the year

may accumulate, however, eventually thrusting these families into poverty once their resources have been depleted.

In order to gain a more dynamic view of how financial risk unfolds for households, GNHE recommends that countries use a time horizon of one year in estimating FRP. Without longitudinal expenditure data it is difficult to calculate how many additional households suffer lack of FRP period of time that goes beyond the reference period of the survey (usually one month or one trimester), and the partially cumulative nature of financial risk is missed. GNHE argues that, when only conventional estimates are available, these should be considered appropriate only to the reference period of the survey data.

Although these are only available for a very small number of countries, GNHE recommends using existing longitudinal surveys to estimate a conversion factor from monthly or three-monthly estimates to annual estimates, as well as to identify the groups of households with repeat versus new expenditures. This information on specific population groups can guide policy making.

In the meantime, both global entities such as WHO and countries should take into account that existing estimates of FRP should not be considered annual if they are based on data that have a reference period of less than a year. Annual estimates are some factor larger than measures based on data with a shorter time horizon.

## Equity in financial risk protection?

Equity in financial risk protection reflects an explicit recognition that access to health care is a right. Financial risk protection should therefore be universally guaranteed to all citizens and residents of a country.

FRP indicators should therefore be assessed, ideally, in the most dis-aggregated way possible-by socio-economic and demographic or population group-in order to identify and design policies to respond to the needs of those at greater risk. This is particularly important for health systems with a relatively small proportion of public health expenditure, that lack targeted policies to protect the poor or otherwise vulnerable groups, or are unable to respond to people in need of more expensive treatments.

GNHE also suggests that governments disaggregate FRP indicators to the extent that data allow. For example, along the lines of inpatient versus outpatient care and

private versus public facility utilisation, as well as across the different levels of care (first level hospitals compared to referral hospitals). This would enable a deeper understanding of the major 'micro' level drivers of lack of financial risk protection. Evidence shows that household groups at greater risk of incurring catastrophic spending or impoverishment include those that use inpatient services, those with more children or elderly family members, and households living in rural areas, among others.

## How should FRP measures be used to assess a country's progress towards UHC?

The world has adopted UHC, and with it the responsibility to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need. These need to be of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

Partial achievement of UHC is not synonymous with achieving UHC. Covering only a part of a population does not equate to UHC, nor does the provision of a package that ignores any of the components of health care that are essential and outlined in the definition.

GNHE argues, in accord with the WHO definition of UHC, that even when financial risk protection is relatively high, UHC is not necessarily achieved or guaranteed. UHC requires that each of its components be achieved; thus, FRP is an essential but not sufficient goal.

Monitoring progress towards UHC thus also requires monitoring the use of health services, as discussed in GNHE's companion policy brief on measuring health service use. When health care use is insufficient, monitoring financial risk protection is one step on the way to understanding why. In countries where the health financing system functions as a barrier to particular groups, re-design and reform of the system are essential to accelerate progress towards UHC.

## Implications for policy makers

The greatest concern related to the use of the conventional indicators for financial risk protection is that many at-risk

households and those who do not use services become invisible. Only through an effective exercise to estimate unmet need and to identify those households that forego care due to financial or other barriers, can an effective FRP response be developed.

Measuring financial risk protection with conventional or traditional indicators can engender complacency by governments when they see they apparently have low proportions of catastrophic and impoverishment health spending. It can also lead to further neglect of vulnerable groups who should in fact be prioritised.

Even countries with relatively high levels of financial risk protection through public prepayment funding and near universal coverage, should not assume that low estimates of OOP or impoverishing or catastrophic spending households mean that households are not refraining from using health services due to financial or other barriers.

Monitoring unmet need is both a recommendation for achieving UHC and financial risk protection, as well as an ethical obligation and matter of urgency for governments across the world to respond to the most deprived segments of their populations.

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## More about GNHE ...

GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

GNHE is coordinated by three institutions collaborating in this project, namely: the Mexican Health Foundation (FUNSALUD); the Health Economics Unit of the University of Cape Town in South Africa; and the Institute for Health Policy based in Sri Lanka.

More information on GNHE, its partners and its work can be found at <http://gnhe.org>.

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