PURPOSE OF THE MEETING

Universal Health Coverage (UHC) is defined as the ability of all persons to access quality care when they need without facing financial impoverishment. Since the World Health Report 2010, UHC has gained universal acceptance in the global development discourse as both a means to the high level goal of improved health as well as a desirable end in itself. At the same time, it is clear that there is much that is not known about how UHC can be achieved in practice, given the diversity of country levels of economic development, health system organization and epidemiological challenges. The World Health Report 2013 identified the need for research and sharing of country experiences in order to operationalize UHC. It also noted that if UHC is to become a reality, it is essential to develop sound definitions and metrics to measure progress. Without these, it will be impossible to put in place the accountability systems to make sure people’s needs are addressed and their rights fulfilled.

The purpose of the meeting was to bring together experiences from a wide diversity of countries in order to:

- Synthesize lessons learnt from country experiences of measuring and monitoring UHC;
- Develop global guidance for measuring and monitoring UHC, including core indicators and measurement strategies;
- Develop a set of papers for inclusion in a peer-review journal in order to stimulate and contribute to broader discussions.

ORGANIZATION AND PARTICIPANTS

The meeting was organized by the World Bank and World Health Organization and hosted by the Government of Singapore. Participants were drawn from 14 countries and included representatives of ministries of health, institutes of public health and policy, academia and researchers, NGOs, and staff from the World Bank and WHO (Annex I, List of participants).

PRESENTATIONS

Participants brought to the meeting analytical descriptions of the current situation in their countries with regard to UHC, focusing particularly on the challenges of measuring and monitoring progress. These include the identification of suitable indicators, data sources and measurement approaches, and development of analytical techniques for summarizing and presenting the
data to policy-makers and the public. Key aspects to be addressed were ways of dealing with equity in UHC, and how to incorporate a quality dimension into the measurement of coverage (effective coverage).

**DISCUSSION**

The ensuing discussions focused around several issues:

*Purpose and function of UHC measurement*

- Aggregate measures including UHC are essential to enable the health community to reference and benchmark whether policies are having the desired effects.
- UHC is conceptually appealing and intuitive but its application will necessarily vary from one setting to another. It is important to identify ways of measuring UHC across countries that are comparable but adaptable to local contexts.
- UHC should be positioned within the broader context of health system performance, using common principles and standards and country applications.
- In defining indicators, targets and measurement approaches, it is important to ensure that they resonate with policy makers as well as being technically sound.
- Several participants noted the challenges of defining essential packages of care to be covered under UHC. Health interventions considered to be public good such as immunization are generally covered under UHC schemes and a free of charge. By contrast, chronic conditions requiring long-term treatment, such as most noncommunicable diseases, may not be included in essential packages of care. The need for epidemiologically relevant packages to be covered in UHC was emphasized.

*Indicators for UHC*

- Countries use multiple and diverse indicators for monitoring UHC and it is important to retain a breadth of indicators covering a range of interventions. Several presentations made the case for using the full range of indicators covering inputs, outputs, outcomes (prevalence of risk factors as well as effective coverage) and impact as measured by health status and financial risk protection. The importance of positioning UHC within a wider assessment of health system performance was widely endorsed.
- Many presentations –Cote d’Ivoire, Ethiopia, Ghana, Senegal, and Tanzania – noted relative unanimity around indicators related to coverage of interventions for maternal and child health and for the prevention and management of communicable diseases such as HIV/AIDS, TB and malaria. By contrast, countries in which the health transition is well advanced –
including Chile, Estonia, and Singapore—focused on indicators of noncommunicable disease prevention and management.

- Several country presentations—Bangladesh, Brazil, China, India, South Africa, Thailand, Viet Nam—identified the emerging complexity of the disease burden and the need to measure and monitor progress on interventions coverage for both communicable and noncommunicable diseases as well as injuries. Several presentations proposed using available data on burden of disease to identify the relative importance of tracer indicators across the major disease groups.

  - In view of the considerable diversity of country need, it is important to focus on a core set of priority and feasible indicators and to distinguish between indicators for global monitoring and those most relevant for national and subnational monitoring.

  - There is also a need to strike a balance between indicators that can be readily measured frequently (using routine administrative data sources) and those that can be measured at population level but less frequently due to reliance on household surveys.

  - All the presentations described the need to monitor different aspects of financial risk protection but noted the difficulties inherent in measurement on a regular basis, especially in settings without on-going systems of national health accounts.

  - Which indicators to use for equity analyses was the subject of much discussion. Participants agreed that in addition to disaggregation by sex and age group, disaggregation by household wealth and geography—urban/rural, subnational administrative levels—would be essential.

  - Several presentations tackled the issue of how to determine need for care, particularly when need is not defined as a total target population in a particular age group (as is the case for immunization coverage) but only those with a specific health problem such as hypertension or diabetes. Indicators that reflect self-perceived need only were agreed to be inadequate because the poorest groups in a given population are least likely to self-report need. More objective measures, including bioclinical tests, are needed to accurately the proportion of the population in need for a defined health intervention.

  - There was some discussion on how to identify indicators of quality of care; several participants argued that UHC should aim to reflect effective coverage (the extent to which the people who need health services obtain them in a timely manner and at a level of quality necessary to obtain the desired effect) rather than simply use of services. Patient satisfaction is one measure but is too subjective in nature for monitoring purposes. Given the challenge of identifying specific quality of care indicators, several participants proposed
that systems of health care facility accreditation be introduced in order to improve quality of care.

Data sources for UHC indicators

- All presentations concurred that currently the most widely available data sources, such as household surveys and routine health management information systems (HMIS), do not generate all needed UHC indicators. A pragmatic approach was proposed, starting with the collection of indicators that are available using common data sources and identifying what kinds of additional information sources or data collection methods could be introduced to fill gaps.

- Most countries use household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) to generate indicators of service coverage (or use). However, participants pointed out that not only are surveys too infrequent for real-time monitoring, but they also are inadequate when it comes to monitoring inequities at subnational level or among disadvantaged and hard-to-reach populations who should be the target of UHC efforts.

- There was considerable discussion around the need to reconcile data from different sources – especially from household surveys and administrative sources – in order to track coverage of key indicators such as immunization coverage.

- The challenge of using the various non-integrated information systems surveys was noted by many presenters. The weakness of routine information systems, information gaps in relation to private sector care, and the general lack of data on noncommunicable diseases and financial risks were identified as important barriers to the effective measurement of UHC.

Analytic requirements

- Participants agreed that it would be essential to strengthen analytical capabilities in countries in order to collect and interpret data on UHC progress. A major challenge is how to build a complete picture based on incomplete data from different sources, including population-based and administrative data.

- There were different views on the appropriateness and feasibility of developing a single index of UHC. In terms of an index of coverage, participants suggested that while there was value in developing a single indicator, the different components should be equally weighted in order to avoid disruptive and inconclusive arguments about how the various components should be weighted.

- While there was a broad measure of support for the construction of summative indices for communicable and noncommunicable diseases, participants urged that any index be presented as a summary measure
capable of decomposition into its constituent parts. This would be essential for the purposes of programme targeting towards those areas performing least well.

- The idea of combining into a single index the multiple aspects of coverage along with financial risk protection was less enthusiastically received. Most participants favoured a cautious approach, retaining the ability to identify the individual components.
- Participants agreed on the need to come up with targets for UHC in order to stimulate advocacy and permit benchmarking and tracking of progress.

SHARED CHALLENGES

Presenters identified some particular challenges, including:

- The geographic characteristics of the country impose difficulties in reaching the rural and extremely isolated population.
- The difficulties in addressing some increasingly important diseases, such as coverage of care for dementias and mental health problems.
- The limited availability of disaggregated data (especially at the health results level).
- Information systems are not configured to meet the data needs for UHC, with limited data availability, quality and consistency problems (especially for routine administrative data sources), lack of coordination between various producers of data (such as vertical programmes) and weaknesses in data sharing and dissemination.

OPPORTUNITIES

Participants agreed that there is currently an unprecedented opportunity to put UHC at the forefront of global health and development as an integral component for the post-2015 agenda. A sound monitoring and evaluation mechanism is essential to ensure that promises are kept and that donors and governments alike are accountable for progress (or lack of it). Given that UHC is an emerging concept, it will be essential to develop a body of evidence showing how it can be implemented in diverse contexts and to monitor and evaluate progress over time and across countries.

In order to harness the current momentum, global agencies and development partners should:

- Support countries in defining their UHC strategies in a comprehensive manner;
- Identify a limited set of UHC indicators comprising impact, outcome and health system performance indicators. Selection of specific indicators should be guided by programmatic relevance, alignment to with country NCDs
burden and priorities and ability to mobilize political commitment by countries.

- Support capacity building for data generation, analysis, presentation and use.
- Provide incentives for countries moving towards UHC such as the IHP+ initiative.

It was agreed that the lessons learnt from countries would be essential for building an evidence base for UHC implementation. There was broad consensus that all countries face trade-offs in terms of balancing what information is needed and what can be feasibly measured. Decisions on how to prioritize across the various dimensions would have to be taken, remembering that UHC is an evolving concept. The aim should be for the progressive realization of UHC, with modification of indicators and data collection methods in line with evolving needs and capacities.

The possibility of a series of papers in a prestigious, peer-reviewed journal, provides added impetus to the need to learn from country experiences about how UHC can be operationalized.

CONCLUSIONS

There is no single blueprint for interpreting UHC and no ‘one size fits all’. Given that many different interpretations of UHC are possible, measurement and monitoring will depend on country-specific factors including:

- Country level of development, household wealth distribution, overall levels of inequity, income, geographic, and policy commitments to equity.
- Epidemiological context, emergence of multiple and overlapping health problems, including communicable and noncommunicable diseases, injuries etc.
- Health system organization at national, federal, regional, and local levels; balance between public, private, and social insurance care; extent of reliance on primary, secondary, and tertiary care; relative importance of prevention versus care.
- The way UHC is operationalized, whether through tax-based methods, social insurance, government funded basic services, co-payments or other mechanisms.

Despite these many variables, it was agreed that it is important to agree on a global framework for UHC that is adapted according to country needs and circumstances.

There was broad consensus that all countries face trade-offs in terms of balancing what information is needed and what can be feasibly measured. Decisions on how to prioritize across the various dimensions would have to be taken, remembering that UHC is an evolving concept. The aim should be for the
progressive realization of UHC, with modification of indicators and data collection methods in line with evolving needs and capacities.

NEXT STEPS

Participants agreed to further develop the papers and meet the following deadlines:

- October 15 – draft paper shared with editorial group (David Evans, Tim Evans, Carla AbouZahr, Ties Boerma) for initial feedback.
- October 31 – Full paper incorporating comments received from the editorial group.
- First week of November – formal submission of papers to PLOS.

Each paper should follow a standard template, key elements of which include the following:

1. **Introduction**: summary of the country context, background of the topic and the purpose of the review.

2. **General context of UHC**: Development and implementation of UHC over past 10-20 years and current policy discussions; current M&E framework.

3. **Current M&E framework and practices**: overall M&E framework for the health sector (or lack thereof) and the specific approaches to monitor UHC.
   - Health sector progress and performance assessment: current practices including methods and operational issues;
   - UHC monitoring framework including key indicators, data sources; equity dimensions used; targets; analytical approaches (use of tracer indicators, indexes; subnational analyses, benchmarking, comparative performance.

4. **Review of country progress towards UHC**
   - Trends over time: in specific (tracer) indicators, indexes;
   - Inequities, wealth, geography etc.
   - UHC policy impact;
   - Evidence for future UHC priorities.

5. **Implications / discussion /conclusion**
   - Quality of current UHC monitoring and evaluation;
   - Main gaps in documenting UHC situation and trends:
   - How UHC monitoring is embedded in health sector policy context;
   - Communicating UHC monitoring to policy makers and the public.