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POLICY BRIEF

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Healthcare coverage and equity – Towards Universal Health Care in Uganda

Executive summary

*Universal Health Coverage (UHC) is a popular global health policy agenda and particularly in Uganda, the health ambition is now aligned to the UHC target. This brief provides an understanding of UHC progress in Uganda, by examining healthcare coverage and equity based on reproductive, maternal, new-born, and child health (RMCH) intervention areas. Evidence shows that coverage improved marginally over the reviewed period, although the Composite Coverage Index remained low, and regional and socio-economic disparities in coverage remained. Improving healthcare coverage is important since it corresponds to better health outcomes. To scale up healthcare coverage; interventions should aim at maintaining immunization successes and addressing existing gaps in lagging intervention areas as well as addressing inequity in coverage. Accelerating UHC is feasible if the country institutes and effectively implements a coherent set of health sector policy reforms, regarding health financing, for instance, while drawing lessons from observed successful policy efforts. The brief is from the paper "**Universal health coverage in Uganda: The critical health infrastructure, healthcare coverage and equity**". It demonstrates Uganda's progress towards UHC and equity in coverage, based on healthcare intervention areas of Reproductive, Maternal, and Child (RMC) healthcare. Composite Coverage Index (CCI) and Coverage Gap Scores (CGS) were computed using the Demographic & Health Survey data, and country comparison was conducted to draw policy lessons.*

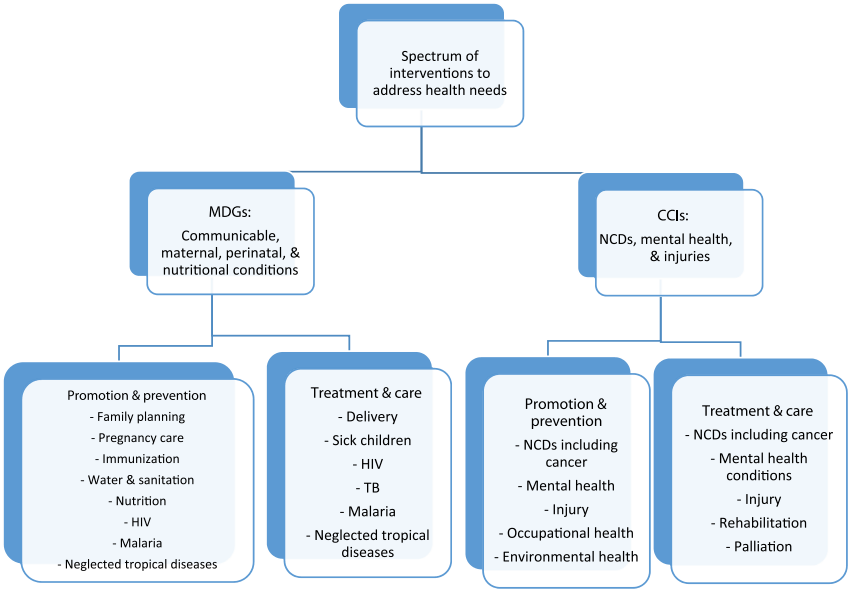
Introduction

Global movement towards Universal Health Coverage (UHC) has gained momentum. The increased interest in the need for UHC was driven by the post-2015 development agenda established under the Sustainable Development Goals (SDGs), a continuation of the unfinished health objectives of the Millennium Development Goals (MDGs). In the SDGs, the world is committed to ensuring UHC, among other objectives. However, limited access to basic health care remains a global challenge. Indeed, the UHC agenda stems from the fact that more than one billion people worldwide still lack access to basic healthcare (Nicholson et al.; 2015) . In the efforts to realize UHC, international development agencies (e.g. WHO, World Bank) urge countries (especially developing nations) to address; coverage of quality essential health services, financial risk protection, and equity in coverage.

In Uganda, the health sector plan has been refocused on the need "to accelerate movement towards Universal Health Coverage". This renewed focus on UHC is in line with Uganda's second National Health Policy, whose overriding aim is to improve access to the National Minimum Health Care Package. Thus the existing health-related strategies and policies indicate that UHC is not a very new initiative in the country, as the government has made some efforts towards universal access. Nevertheless, many gaps that have plagued the health system still exist. For example, the health system delivery mechanism is weak and inadequate for delivering UHC (Kiwanuka et al.; 2008 ; Kaija and Okwi, 2014).

The joint WHO/World Bank Group framework for monitoring UHC progress (Figure 1), was used to conceptualize analysis of two aspects of health system performance in relation to UHC that is; the level of coverage of health interventions and equity, focusing on RMC healthcare.

Figure 1: Indicator framework for monitoring service coverage – progress towards UHC



Intervention coverage indicators among population in need with "effective coverage – equity & quality"

Source: Adopted from WHO/World Bank (2013)

Table 1: Composite Coverage Index (CCI), Coverage Gap Scores (CGS), and Equity in Coverage

	Composite Coverage Index – CCI (%)		Coverage Gap Score – CGS (%) 2011
	2006	2011	
I. Region			
Uganda	51.79	57.91	42.09
Central1	52.83	58.96	41.04
Central2	56.03	60.45	39.55
Kampala	69.11	70.13	29.87
East Central	49.00	55.63	44.37
Eastern	53.52	55.02	44.98
South West	47.67	53.03	46.97
Western	50.1	60.14	39.86
North	49.82	57.35	42.65
West Nile	49.88	58.09	41.91
Karamoja	44.71	54.39	45.61
II. Rural – Urban Locale			
Urban	64.16	69.14	30.86
Rural	50.17	55.96	44.04
III. Wealth Quintile			
First Quintile (Poorest)	47.4	51.78	48.22
Second Quintile	46.8	54.37	45.63
Third Quintile (middle)	49.3	56.86	43.14
Fourth Quintile	55.4	59.53	40.47
Fifth Quintile (Highest)	63.4	68.64	31.36

Source: Author's computation based on UDHS 2006 & 2011.

Healthcare coverage

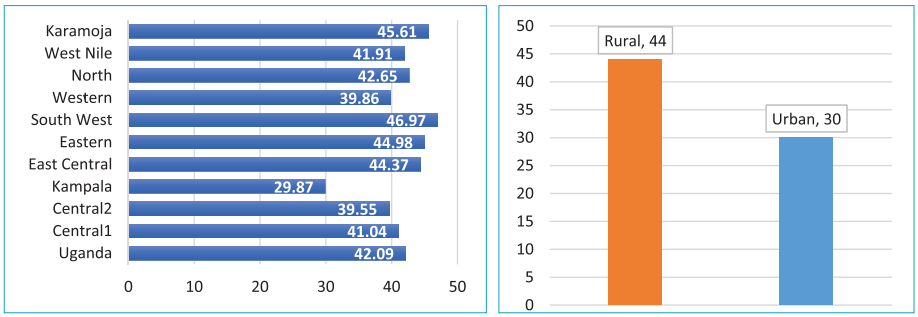
Table 1 shows an overall improvement in healthcare intervention coverage over the reviewed period at the national level, by approximately 6 percentage points. General improvement was also observed during the same period across regions, rural-urban locales, and wealth quintiles. Results based on service coverage reveal that immunization interventions are the key drivers of the observed increase in coverage at both the national and regional levels. This is partly attributable to notable contributions from interventions such as the National Expanded Programme on Immunization and the Global Vaccines Alliance Initiative. However, the low overall population coverage (based on CCI) is due to modest performance in skilled birth attendance, family planning, child healthcare (e.g., oral rehydration therapy (ORT) and pneumonia treatment (CPNM)), and intermittent presumptive treatment for malaria (IPT2).

Inequity in healthcare coverage

Regional disparities in coverage exist. As expected, the central and Western regions have higher coverage rates above the national coverage (Panel I Table 1 and Figure 2). The South Western, Eastern, and Northern regions experienced the lowest coverage and are therefore associated with the highest Coverage Gap Scores (CGS) of 47%, 45%, and 43%, respectively. This regional disparities contrast with the principles of equity in coverage. Considering rural-urban locations, rural areas are associated with a higher CGS (44%) than the CGS of 30% in urban areas (Figure 2), which also reflects inequity in coverage along rural-urban disaggregation of the population.

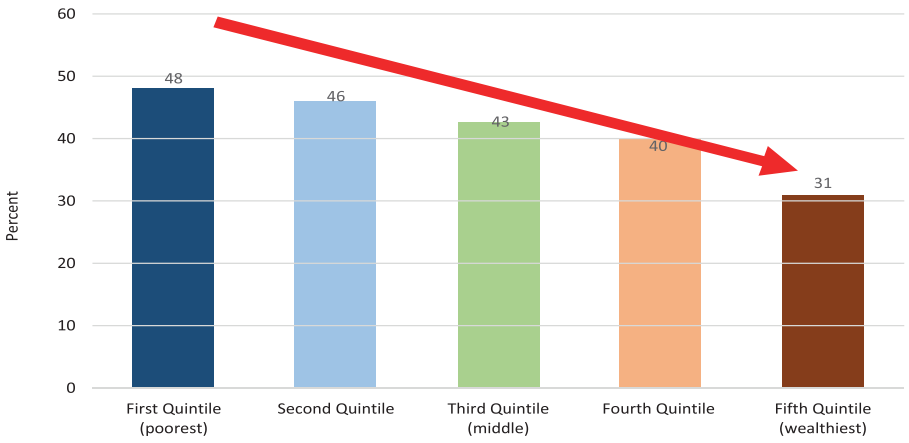
Regarding wealth group categorization, coverage is lowest among the poorest segment of the population (52%) and highest among the richest (69%) (Panel III – Table 1). Accordingly, coverage index rises with increase in wealth quintile. In other words the CGS decreases with increases in wealth quintile (Figure 3); for instance the CGS for the poorest quintile is approximately 48%, while the corresponding values for the second richest and richest are 40% and 31%, respectively. The richer segment of the population is therefore more covered in terms of healthcare than the poor, indicating inequity.

Figure 2: Coverage Gap Score by region and rural – urban location, 2011



Source: Author's computation based on UDHS data (2011)

Figure 3: Coverage Gap Score by Wealth Quintile



Source: Author's computation based on the UDHS data (2011).

Table 2: Trends in healthcare coverage and health outcomes

Indicator	Country	Period			
		2000/01	2005/06	2010/11	2014/15
Coverage indicator					
Composite Coverage Index (CCI - %)	Uganda	-	52	58	-
	Rwanda	-	48	68	72
Health outcome indicators					
Maternal Mortality Ratio (Deaths @ 100,000 live births)	Uganda	505	418	438	-
	Rwanda	1071	750	476	210
Infant Mortality (Deaths @1,000 live births)	Uganda	88	76	54	-
	Rwanda	-	73	50	32
Under-five Mortality (Deaths @ 1,000 live births)	Uganda	152	137	90	-
	Rwanda	-	133	76	50

Source: DHS (2000/01 – 2014/15) and authors' computation based on DHS data (2005/06 – 2014/15)

Linking coverage to health outcomes: Country comparison

Over time, Uganda experienced slow progress in coverage of RMCH, with improvement of only about 6 percentage points between 2005/06 and 2010/11 (Table 2).

In Rwanda, accelerated progress is evidenced by steady improvement in coverage by 20 percentage points over the same period. This made Rwanda to surpass Uganda, with coverage of 68% in 2010/11 compared to Uganda's 58%. Rwanda's steady progress has culminated in an impressive level of coverage of RMCH care, which is currently 72%[1].

Steady progress in coverage of RMCH translates into better maternal and child health (MCH) outcomes, as shown in Table 2. There is consistent and rapid improvements in MCH outcomes over the period in which Rwanda registered impressive progress in coverage of RMCH (2005/06 - 2014/15). For example, when there was a remarkable increase in coverage from 48% to 68% (2005/06 - 2010/11), the Maternal Mortality Ratio (MMR) decreased by approximately 37%. In the subsequent period (2010/11 – 2014/15) when coverage notably improved to 72%, the MMR decreased by more than half. Rwanda's advances in healthcare coverage are also associated with faster reduction in infant and under-five mortality.

For Uganda, slow progress in coverage is associated with poorer/slower performance in MCH outcomes. In 2000/01, Uganda was better-off than Rwanda in terms of maternal health outcomes, with a lower MMR of 505 deaths per 100,000 live births compared to Rwanda's alarming rate of 1071 deaths per 100,000 live births. However, from 2000/01 to 2010/11, Rwanda experienced reduction in MMR by more than half; meanwhile, Uganda registered a marginal reduction from 505 to 438. Indeed we observe regress in MMR in Uganda, over a period characterized by low coverage (2005/06-

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2010/11). We also observe sluggish progress in infant and child mortality reduction in Uganda, given the low progress in coverage.

Policy lessons and conclusion

Accelerating progress towards UHC requires policy efforts that have proven to be cogent. Lessons on such policy efforts can be drawn from Rwanda's deliberate interventions for establishing a robust and/or resilient health system capable of accelerating UHC. Systematic reforms that Rwanda implemented addressed critical areas including health infrastructure development, Human Resources for Health, health financing, and effective leadership and governance (Bucagu *et al.*, 2012)[2]. For instance, regarding health financing, Rwanda's progress is strongly dependent on the high level of government commitment and spending on healthcare. Public spending on health by the Rwandan government is as high as 20%, compared to Uganda's less than 10% of the national budget. Rwanda pursued health financing reforms based on effective implementation of the health financing policy, a policy framework that is lacking in Uganda. The health financing policy in Rwanda tackles healthcare funding in a comprehensive manner - including the use of government tax revenue and health insurance schemes that are capable of covering both the formal and informal sectors of the economy.

To scale up healthcare coverage for RMCH, interventions should aim to maintain successes obtained for immunization and address existing gaps in lagging intervention areas while considering strategies to promote equity in coverage. The areas include family planning services, maternal health services (e.g., skilled birth delivery), and child health services (such as ORT and CPNM). Drawing policy lessons from Rwanda, to accelerate UHC, Uganda should aim to institute a coherent set of health sector policy reforms that are effectively implemented, for instance, a health financing policy that is comprehensive enough to cover both the formal and informal sectors.

Endnotes

1. Country comparison was done between Uganda and Rwanda, to draw lessons from successful policy case scenarios in Rwanda. "The lessons from Rwanda's success should inform the work of those around the world who seek to deliver on the commitment of comprehensive and equitable healthcare for all" – (Farmer et al; 2013).
2. Nicholson, D; Yates, R; Warburton, W; Fontana, G. (2015). Delivering Universal Health Coverage: A guide for policy makers. Report of the World Innovation Summit for Health (WISH) Universal Health Coverage Forum 2015.
3. Kiwanuka, S.N; Ekirapa, E.K; Peterson, S; Okui, O; Rahman, M.H; Peters, D; Pariyo, G.W. (2008). Access to and utilization of health services for the poor in Uganda: A systematic review of available evidence. Transactions of the Royal Society of Tropical Medicine and Hygiene Vol. 102, pg 1067-1074.
4. Kaija, D.O; Okwi, P.O. (2014). Quality and demand for health care in rural Uganda: Evidence from 2002/03 household survey. AERC research paper, 214.
5. Rwanda's current level of coverage (as of 2014/15) could not be compared to Uganda's coverage (as of 2014/15) because the most recent DHS data for Uganda at the time of analysis was from 2011.
6. Bucagu, M; Kagubare, J.M; Basinga, P; Ngabo, F; Timmons, B.K; Lee, A.C. (2012). Impact of health systems strengthening on coverage of maternal health services in Rwanda, 2000-2010: a systematic review. Reproductive Health Matters. 2012; 20(39):50–61.

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