Reaching the Unreached is UHC enough?

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Historically, richer groups tend to capture more of the social benefits of increased economic growth.....

Proportion of children 0 – 59 months old who are stunted, by household wealth quintile

Note: Prevalence trend estimates are calculated according to the NCHS reference population, as there were insufficient data to calculate trend estimates according to WHO Child Growth Standards. Estimates are age-adjusted to represent children 0–59 months old in each survey.

Information on household wealth quintiles was not originally published in the 1992–1993 and 1998–1999 National Family Health Surveys (NFHS). Data sets with household wealth quintile information for these surveys were later released by Measure DHS. For the analysis here, the NFHS 1992–1993 and 1998–1999 data sets were reanalyzed in order to estimate child stunting prevalence by household wealth quintile. Estimates from these two earlier rounds of surveys were age-adjusted so that they would all refer to children 0–59 months old and would thus be comparable with estimates from the 2005–2006 NFHS.

Leading to widening disparities in health outcomes.....

U5MR = 72

U5MR = 42

Source: Social & economic policy brief, UNICEF, August 2010
... and growing inequalities within most countries

- Two-thirds of the countries that have made strong progress in reducing the under-five mortality rate have shown worsening inequalities since 1990.

- In short, gaps between better off and worse off have increased.

- This suggests that the delivery, financing, and use of essential health services for children favor the better off.

Source: DHS, various years (reanalysed by UNICEF, 2010). PROGRESS FOR CHILDREN, Achieving the MDGs with Equity, Number 9, September 2010, UNICEF
Some Potential drivers of these inequities are found in current UHC efforts

• Supply-side
  – Hub-to-spoke expansion of services; the poor are the last to receive investments & to be reached
  – The scope and quality of services supplied is lower in the periphery, and in rural and poorer areas
  – Institutional & informal discrimination, beyond financial

• Demand-side
  – Urban & rich: more aware of services, and have more powerful networks to capture benefits.
  – Poor face proportionately greater opportunity costs
  – Avoidance of care can be due to fear of discrimination as well as fear of impoverishment
There are multiple causes of deprivation hidden within national aggregates

(\textit{deaths per 1,000 live births})

\begin{itemize}
  \item \textbf{by wealth quintile}:
    \begin{itemize}
      \item Poorest 20% - 121
      \item Second 20% - 114
      \item Middle 20% - 101
      \item Fourth 20% - 90
      \item Richest 20% - 62
    \end{itemize}

  \item \textbf{by mother's education}:
    \begin{itemize}
      \item No education - 146
      \item Primary - 91
      \item Secondary or higher - 51
    \end{itemize}

  \item \textbf{by residence}:
    \begin{itemize}
      \item Rural - 114
      \item Urban - 67
    \end{itemize}
\end{itemize}

\textit{Children from poorer households, from rural areas, and whose mothers have less education are at higher risk of dying before age five}

39 countries with most recent DHS surveys conducted after 2005 with further analyses by UNICEF for under-five mortality rates by wealth quintile, 40 countries for rates by mother’s education and 45 countries for rates by residence. Source: Levels & Trends in Child Mortality Report 2011; Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation.
MDG 1: Eradicate extreme poverty and hunger

Iodized salt consumption is higher among the richest households than the poorest households in countries with available data

Percentage of households consuming adequately iodized salt among the richest 20% of households as compared to the poorest 20%, by country

How to read this chart: This chart is based on 50 countries with available disparity data. Each circle represents data from one country. The size of a circle is proportional to the size of a country’s population. The horizontal axis represents the percentage of the poorest 20% of households consuming adequately iodized salt, while the vertical axis represents the percentage of the richest 20% of households. Circles along the green line represent countries in which the likelihood of consuming adequately iodized salt is similar among the richest and the poorest households. Circles above or below the green line suggest disparity. The closeness of circles to the upper-left corner indicates greater advantage for the richest households in that country (greater disadvantage for the poorest households).

Source: MICS, DHS and national nutrition surveys, 2003–2009, with additional analysis by UNICEF.
Health inequities are often linked to multiple deprivations: e.g. Education marginalization

Source: SOWC 2012
An alternative: shifting the curve towards pro-equity strategies

A shift would avert many preventable deaths

Ideal uptake for the poorest 20%

Typical uptake for the poorest 20%

Source: adapted from M. Chopra, UNICEF
Research areas on how to shift the curve, and move towards UHC with Equity

3 research areas

Specific context of different populations

Factors affecting coverage
- Current coverage: lower in more deprived populations
- Bottlenecks: larger and more evident in more deprived populations

Factors affecting impact
- Fertility, morbidity, mortality: higher rates and burdens in more deprived populations
- Causes of mortality: easier to address in deprived populations

Factors affecting cost
- Epidemiology: more illness episodes in deprived populations
- Geography: deprived populations living in more dispersed and remote settings

Cost and financing context
- Direct and indirect out-of-pocket spending: higher in more deprived populations

Policy choices
- Selection of a strategic approach
  Mainstream vs equity focus
- Selection of interventions
  High-impact intervention packages

Modelling of interactions
- Supply and demand bottleneck reductions
- Estimation of coverage increase of selected interventions
- Estimation of impact
  Mortality and undernutrition rates and numbers
- Estimation of incremental cost
- Cost effectiveness
- Estimation of out-of-pocket spending

Source: *The Lancet* 2012; 380:1341-1351 (DOI:10.1016/S0140-6736(12)61378-6)
Assessing health system bottlenecks to access for children & other at-risk groups

Gap

- Quality of coverage
- Continuity & appropriateness
  - Initial utilization
  - Accessibility – physical access of services
  - Availability – human resources
  - Availability – essential health commodities
- Population needing a service

Adapted by T O'Connell from Tanahashi T. Bulletin of the World Health Organization, 1978, 56 (2)
Resolving inequities requires data on inequities in access faced by each group.

Analysis of services delivered at primary health facilities in Ethiopia

Source: UNICEF 2011 reanalysis of DHS. MICs data.
Strategies to shift the curve

Reducing the gap

1. Delivery system

2. Demand Empowerment

3. Legislation & Policy changes

Reorienting towards pro-equity delivery & demand

Source: The Lancet 2012; 380:1341-1351 (DOI:10.1016/S0140-6736(12)61378-6)
Delivery Platforms

**Community-based promotion and case management:**
- 160% significant increase in the use of oral rehydration solution
  - 80% increase in use of zinc in diarrhoea
  - 13% increase in care-seeking for pneumonia
  - 9% increase in care-seeking for diarrhoea.
- 75% significant decline in inappropriate use of antibiotics for diarrhoea
- 40% reduction in rates of treatment failure for pneumonia.

**Reduction of financial barriers**
- Promote increased coverage of child health interventions
- Pronounced effects achieved by those that directly removed user fees for access to health services.
We can and should get to UHC

• An equity-focused approach has real potential to avert many more child and maternal deaths and episodes of stunting than the current path, and do so effectively.

An optimistic note

• We are getting real movement towards UHC,
• Yet, in the majority of countries we could accelerate progress by shifting the curve, through greater use of explicitly pro-equity UHC strategies and policies

Thank you!