Why is equity in access important to Universal Health Coverage?

The Government of Uganda (GOU) is committed to pursuing UHC, providing everybody with quality promotive, preventive, curative, rehabilitative and palliative health services in a way that ensures that the user is not exposed to financial hardship (WHO 2019). Pursuing universal health coverage (UHC) requires three inter-related foci: improving equity in access to health services, increasing the quality of those services, and protecting people from financial risk due to high out of pocket payments.

Equity in access means that everyone who needs specific services is able to access services, regardless of ability to pay (WHO 2019). Equity in access to health services has three dimensions: physical accessibility, financial affordability, and acceptability. The World Health Organization (WHO) defines equity as “the absence of avoidable or remediable differences among groups of people (WHO 2019).” These groups are defined in different ways, such as gender, age, and economic status, and many others. The ultimate goal in the pursuit of UHC is to narrow the equity gap between socioeconomic and demographic groups in their physical and financial ability to seek quality services.

Introduction

The Activity conducted a voucher beneficiary study in August 2018 in 26 districts. The study sought to assess the status of the Activity’s central aims of increasing financial protection, access to services, and service quality. These aims are important not only to the Activity, but also to USAID and the Government of Uganda’s broader objectives related to UHC.

Purpose of this brief:

To provide an overview of the Voucher Plus Activity’s findings from the beneficiary study in improving equity in access. This includes providing financial protection for poor women to receive the service package, thereby expanding their access to facility-based obstetric care, newborn care, and postpartum family planning (PPFP). The findings provide lessons for future considerations to design health purchasing mechanisms to enable poor beneficiaries to seek out, access, and afford facility-based health services from contracted providers.
Voucher beneficiary study methods

The voucher beneficiary study employed a cross-sectional, descriptive study design that employed quantitative data methods. The research team conducted the study in Eastern and Northern Uganda, covering 26 of the 33 districts where the Activity was active at the time. The study population consisted of clients who had purchased and redeemed their voucher for at least three ANC services. We did this to ensure better understanding of client satisfaction issues and attitudes toward price, given that clients had had several contacts with the providers. The team also restricted the population to those who had used services within the four months prior to the study. At a 5% level of statistical significance, we calculated the required sample size using the Kish Leslie formula for simple random sampling, assuming a 60% satisfaction rate for aspects of the services. The team used a stratified, multi-stage sampling approach to select respondents.

We administered the 75-question client satisfaction survey instrument to 399 voucher clients, with a final response rate of 99.7%. The AIDS Support Organization's (TASO) Research Ethics Committee and the Uganda National Council of Science and Technology approved the study. We included robust quality assurance (QA) processes to ensure quality data collection, processing, and analysis.

Findings on expanding financial protection for quality facility based obstetric, newborn, and PPFP

Overall, the findings from the client beneficiary study indicate the Activity is improving equity in access to health services by reaching poor vulnerable women in the Activity’s priority districts with quality obstetric and newborn care. It is reaching young women and those in rural areas with little or no education. The findings indicate that qualifying mothers see the voucher as providing financial protection, allowing them to use services they would not have been able to afford otherwise.

The socio-demographic characteristics of clients purchasing the vouchers

- **Age**: One in five younger than 19 years, 6 out of 10 were 20-29 years with a mean age of 25 years
- **Education Level**: Clients had primary as the highest level of education 71%
- **Rural versus urban**: Almost eight of every ten clients were residing in rural areas 78%
- **Livelihood activity**: 69% were either farmers or involved in agriculture, 21% were full-time housewives not involved in any other economic activity.
- **Religion**: 81% were either Catholic or Anglican
**Clients’ reasons for buying the voucher**

87.1% of the 399 respondents purchased the voucher because they could not afford to pay for the services otherwise. Other reasons cited for purchasing the voucher included a friend or family buying the voucher for the client or a voucher community-based distributor encouraging the client to buy the voucher.

**Clients’ attitudes toward voucher price for obstetric, newborn, and postpartum family planning (PPFP) service package**

For the 294 clients surveyed who had purchased their own vouchers, 72% indicated that the vouchers were affordable at UGX 4,000. 18% felt the voucher cost was too high, and 13% of respondents felt the cost of the voucher was too low.

We asked the 399 respondents if they would be willing to pay UGX 4,000 for the same voucher in the future if they needed the service package again. Approximately 64% were willing to pay the current price of 4,000 UGX. Almost 25% would like to pay less for the voucher, and 11.5% of respondents were willing to pay more than UGX 4,000 for the vouchers.

**Clients’ attitudes toward the regular price of obstetric, newborn, and PPFP services**

The study asked the 399 mothers surveyed how easy or difficult it would be for them to pay for the most recent service they consumed if they did not have a voucher. The voucher clients graded the cost as very easy, easy, difficult, or very difficult to pay. **Underscoring the voucher’s achievements in equity in access, the majority of respondents (95% on average) felt the most recent service they received would be “very difficult” or “difficult” to pay for on their own.** Respondents felt the most ease in paying for postnatal care (PCN) (5,000 UGX) and PPFP services (10,000 UGX) than for any of the other services. Yet, even for these two services, only 16% or fewer of respondents cited ease in paying for these services.

We asked the clients if they were willing to pay the full cost of the most recently consumed service if vouchers had not been available. Service costs presented were an average of the negotiated rates from our providers. The majority of the respondents indicated “no” for the services consumed. Notably, up to 16% of those who had consumed delivery services were willing to pay UGX 61,000 for delivery at a facility in the absence of vouchers. Please see Table 1.

**Table 1: Client attitude on price of services for obstetric, newborn, and PPFP services**

<table>
<thead>
<tr>
<th>Most recent service received</th>
<th>Cost of Service</th>
<th>Willing to pay the full cost if vouchers are not available</th>
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<tr>
<td></td>
<td></td>
<td>Yes (n, %)</td>
</tr>
<tr>
<td>ANC 3 (N=13)</td>
<td>18,000</td>
<td>1 (10%)</td>
</tr>
<tr>
<td>ANC 4 (N= 19)</td>
<td>17,000</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Delivery (N= 119)</td>
<td>61,000</td>
<td>19 (16%)</td>
</tr>
<tr>
<td>PNC (N= 208)</td>
<td>5,000</td>
<td>36 (17%)</td>
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<tr>
<td>PPFP (N= 31)</td>
<td>10,000</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Severe malaria (N= 2)</td>
<td>70,000</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Simple malaria (N= 5)</td>
<td>32,000</td>
<td>2 (38%)</td>
</tr>
<tr>
<td>UTI (N= 3)</td>
<td>28,000</td>
<td>1 (42%)</td>
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</table>
Lessons Learnt for Future Health Financing Mechanisms

The results from the survey indicate that the Activity is achieving equity in access by reaching poor vulnerable women that likely would not have sought the obstetric, newborn and PPFP services from the private sector facilities otherwise. The demographic data indicate that voucher clients are indeed poor vulnerable women, including those with little to no education and those engaged predominantly in subsistence farming. Only 61% of women surveyed had never received obstetric, newborn, and PPFP services from a facility before the voucher. Of the 39% who had received facility based services, over half received free services, likely in public facilities. If not for the vouchers, these mothers would risk not having a skilled attendant at birth.

Given the level of poverty in pockets of Northern and Eastern Uganda, to achieve UHC, the GOU will need to provide targeted subsidies to cover those in poverty to receive quality facility-based health services, including vulnerable pregnant women. Simultaneously, the GOU will need to stimulate demand for facility-based services to change behaviors among the poor who may be accustomed to receiving services in a more informal manner, such as using traditional birth assistants or pharmacies for service support. A voucher mechanism could allow the GOU to simultaneously target specific vulnerable populations for services, accredit and contract with providers, and monitor for quality service delivery.

Willingness to join a national health insurance scheme, if established

Respondents were given a description of the national health insurance scheme (NHIS) and how it operates. Almost nine out of ten mothers (87%) indicated a willingness to join the NHIS scheme.

Prior service utilization

The research team asked respondents if they had previously received the facility-based services they had accessed through the voucher package. Only 39% reported that they had ever previously received the service, indicating that the Activity has likely improved equity in access for poor women in Uganda to access facility based obstetric, newborn, and PPFP services.

Of those who had ever received the services prior to accessing vouchers, 51% did not pay any money for the services. This is of interest given that women paid UGX 4,000 for services under the voucher program despite an awareness that free services were available elsewhere. The driver for this could be a desire to obtain better services than free public services which are often perceived to be poor quality. It may also suggest that the voucher covered other items that are not typically provided free in public facilities, such as some illnesses during pregnancy and lab services. As expected, delivery was the most common service previously paid for, and also the highest priced, with some of the mothers paying up to UGX 220,000 for delivery services.

When the research team asked the respondents whether they had previously used the facility where they had redeemed for voucher services, only 39% responded in the affirmative. Sixty-four percent of clients surveyed sought care at the facilities solely because they possessed a voucher to redeem for a service. Thus, without the vouchers, these mothers would likely have never have gone to the facilities where they accessed maternal and newborn health services.

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Many results-based financing mechanisms that include a combination of incentives and quality assurance methods have been used to strengthen the quality of health providers’ obstetric, newborn, and postpartum family planning services in Uganda. Lessons learned from the Voucher Plus Activity should be harvested to inform future health financing mechanisms to ensure equity in access and quality service delivery for the poor.

**Lessons learnt include:**

<table>
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<tr>
<th>#</th>
<th>Lessons Learnt</th>
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<tr>
<td>1.</td>
<td>Poor pregnant women want to receive quality facility based care to ensure safe pregnancies, safe deliveries, and better birth outcomes, and they are willing to pay a small amount for facility based care for quality obstetric, newborn, and PPFP services</td>
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<tr>
<td>2.</td>
<td>Poor pregnant women are interested in participating in a National Health Insurance Scheme as a means of ensuring protection against high and potentially catastrophic out-of-pocket payments for health care.</td>
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<td>3.</td>
<td>The private sector plays an important role in reaching UHC, given that many private facilities serve hard-to-reach locations and vulnerable populations where there is no public health facility within five kilometers.</td>
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<td>4.</td>
<td>The Activity’s efforts to ensure that poor pregnant women have access to quality obstetric, newborn, and PPFP shows that it is possible to move quickly towards the goal of UHC by establishing an appropriate financing mechanism that stimulates demand while providing financial protection to the most vulnerable, and that guarantees the supply of quality services.</td>
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**Study limitations**

The first limitation related to the sample of clients interviewed. We chose only those who had attended the third or later with a voucher in the previous four months. While there is clear rationale for this sampling approach, we cannot say that the results are representative for the full population of clients who have purchased vouchers from the Activity. Our satisfaction results are likely higher than either for the broader population of clients who had not redeemed the voucher or for those who did so for only one or two services.

Another limitation relates to relying on client satisfaction to measure domains of quality of care. As the Lancet Global Health Commission article notes, “[a]lthough satisfaction is influenced by the quality of care, it is also influenced by care accessibility, costs, health status, expectations, immediate outcomes of care, and gratitude.” Voucher clients may have a limited understanding of what high-quality care looks like and base their satisfaction on limited expectations.
About the USAID|Uganda Voucher Plus Activity

The USAID|Uganda Voucher Plus Activity (the Activity) is designed to provide quality obstetric, newborn, and postpartum family planning services to poor Ugandan women in Northern and Eastern Uganda. It is funded by USAID and led by Abt Associates. Through the voucher scheme, the Activity improves health equity by ensuring the poor access information and services needed for healthy pregnancies and deliveries. The Activity identifies and accredits private providers to deliver a quality service package. The Activity actively engages the District Health Offices (DHOs) to monitor quality of care through routine supportive supervision to private providers, thus stimulating public-private partnerships for health (PPPH) that ultimately strengthen the district health systems. PPPH is an important avenue for achieving Universal Health Coverage and it is a focus for Uganda’s Health Sector Development Plan (2015/16-2019/20).

The Activity strengthens the capacity of participating private providers through training, on-site clinical mentorship, supportive supervision, and annual clinical audits to improve service quality. The Activity ensures providers contribute to the district health management information system (HMIS) through monthly reporting. The Activity supports providers to learn the necessary skills in managing timely and correct claims submission to enable participation in national purchasing mechanisms.

Simultaneously, the Activity works with community volunteers, including Village Health Teams, who sell vouchers at UGX 4,000 to women who qualify, while also providing safe motherhood information to communities. About 1.5 million Ugandans are pushed below the poverty line due to health care payments (Zikusoka et al 2014). By targeting poor women, the Activity aims to provide financial protection to avoid financial hardship from out-of-pocket payments. The Activity contributes evidence on output-based financing mechanisms to foster policy dialogue as a stepping-stone to Uganda’s long-term health financing strategy. Abt Associates implements the Activity in partnership with Communication for Development Foundation Uganda, PriceWaterhouse Coopers, and BDO East Africa.

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Citations