

## **WHO Expert Reference Group on the Draft GPW 13**

### **Preliminary Report – May 2018**

The Expert Reference Group on the General Programme of Work 13 (GPW13) continued its work providing input on the measurement and accountability framework for the GPW13 as requested by the Director-General. As part of its work in consultation with the Director-General, a Task Force on Metrics for GPW13 was created. The Task Force co-Chaired by Irene Agyepong and Christopher Murray met 6 times and provided the ERG with a preliminary report which the ERG endorses. The Task Force interim report is attached.

The overall evaluation of the Task Force is in keeping with ERG preliminary report in January 2018 highlighting key areas.

- 1) The Task Force believe that the triple billion target for GPW13 can be measured and provides a very valuable approach to tracking the joint efforts of Member States, the WHO Secretariat and other partners to achieve the GPW13 goals and SDGs. The development of the measurement framework is a major step towards accountability and transparency and is a new approach, which is to be appreciated.
- 2) GPW13 and the triple billion target included in it can be measured but will be improved by efforts by Member States supported by WHO to strengthen measurement systems especially cause of death measurement.
- 3) It will also require refinement of existing WHO approaches for each of the three billions particularly measuring UHC service coverage. The Task Force report outlines these areas in detail and provides suggestions on pathways forward.
- 4) The indicator framework should add as an overall measure for the GPW13 healthy life expectancy (HALE) as an overall integrative measure of population health.

The Task Force will continue meeting to refine recommendations on UHC service coverage and methods for assessing WHO Secretariat's contributions to the triple billion target. The ERG will continue meeting to consider these recommendations. This report is preliminary and has not yet benefited from receiving an institutional response from the WHO Secretariat on the issues that have been raised. Future revisions of the ERG and Task Force reports will reflect careful consideration of any issues raised by the WHO Secretariat in their institutional response.

#### **Task force on Metrics for GPW13 Preliminary Report**

The Task Force met 6 times over the period March 23rd to April 26th to review the methods for measuring the achievement of each of the three billion targets in GPW13. The Task Force is Chaired by Irene Agyepong, Senior Lecturer, Department of Health Policy, Planning and Management, University of Ghana and Christopher Murray, Institute Director, Institute for Health Metrics and Evaluation (IHME). Members include Enis Baris, Sector Manager for Health Nutrition and Population, Europe and Central Asia Region, World Bank; Beth Bell, Consultant and Former Director, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, USA; Majid Ezzati, Professor

and Chair in Global Environmental Health, School of Public Health, Imperial College; Tom Frieden, President and CEO, Resolve to Save Lives; Amanda Glassman, Chief Operating Officer, Senior Fellow and Board Secretary, Center for Global Development; Bruce Hollingsworth, Professor of Health Economics and Head of the Division of Health Research, Lancaster University; Jami Husain, Economist, Centers for Disease Control and Prevention, USA; Anna Korotkova, Federal Research Institute Health Organization and Informatics, Ministry of Health, Russian Federation; Soewarta Kosen, Health Policy Research, National Institute of Health Research and Development, Ministry of Health, Indonesia; Alan Lopez, Melbourne Laureate Professor and the Rowden-White Chair of Global Health and Burden of Disease Measurement, University of Melbourne; Fatima Marinho, Director, NCDs and Health Promotion, Ministry of Health, Brazil; Martin McKee, Professor of European Public Health, London School of Hygiene & Tropical Medicine; Randa Nooh, Field Epidemiology Training Program Faculty Member, King Saud University; Benn Sartorius, Professor at University of KwaZulu-Natal, School of Public Health, University of the Witwatersrand; Joshua Salomon, Professor of Medicine (Primary Care Outcomes Research), Stanford University School of Medicine, Stanford University; and Nikhil Tandon, Professor, Endocrinology and Metabolism, All India Institute of Medical Sciences.

The Task Force compliments the WHO Secretariat for presenting in detail efforts to date on measuring the three billions. The Task Force also usefully reviewed other work on measurement that is relevant to the triple billion target. The work of the Task Force could not be completed in the time frame but at this point we can provide some observations and recommendations to the Director-General. The Task Force will meet immediately after the World Health Assembly to continue deliberations on the detailed indicator framework for measuring UHC and addressing issues of measuring the contribution of the WHO Secretariat to GPW13 goals and targets. The Task Force will also address in subsequent meetings the time frame needed for implementation by the WHO Secretariat and Member States of the recommendations.

## **General**

### **Observations**

- 1) The Task Force believe that the triple billion target for GPW13 can be measured and provides a very valuable approach to tracking the joint efforts of Member States, the WHO Secretariat and other partners to achieve the GPW13 goals and SDGs. The development of the measurement framework is a major step towards accountability and transparency and is a new approach, which is to be appreciated.
- 2) All three billion targets contribute to improved health. This interconnection should be recognized in the measurement framework. Understanding the interconnection will be facilitated through in depth analysis of Member States.
- 3) Measurement of the triple billion target depends on country measurement systems. The pursuit of the triple billion target and its measurement will require improvements in national health information systems. In particular, many of the SDG indicators, GPW13 specific indicators and our proposed approaches for measuring UHC depend on the availability of accurate cause of death data. Efforts to strengthen the measurement of causes of death will be critical to robust measurement of the GPW13.

- 4) In addition to global targets, it will be important for the WHO in close consultation with Member States to develop regional and country-specific targets that rolled up equal to the global billions goals. This is essential so that improvements will not leave behind areas of greatest need.

#### Recommendation

- 1) As noted in the GPW 13, “. WHO will explore measuring this foundation of its work using healthy life expectancy, which could serve as one overarching measure aligned with SDG 3, complemented by the triple billion goal, which leads to three more specific priorities, each with overlapping one-billion people goals.” We recommend including in the indicators framework the measurement of healthy life expectancy (HALE) in each Member State as the integrative measure of the three billions combined. This is an over-arching indicator that complements the “triple billion” target, as anticipated in para 15 of GPW 13. HALE is reported annually as part of the Global Burden of Disease so estimates are already available and some countries already can report on HALE through their own efforts.

#### Measuring the UHC Billion

##### Observations

- 1) The two components of measuring UHC: service coverage and financial risk protection are intimately linked. UHC service coverage should in principle include the main services that households for which they decide to use leading to catastrophic health expenditure. These can be based on outpatient services but can also often be hospital-based services.
- 2) Health promotion is part of the WHO definition of UHC and multi-sectoral actions to promote health such as taxing tobacco products can be considered part of the broader construct of UHC. In line with the GPW13, however, the pragmatic definition of UHC service coverage in GPW 13 should be based on the SDG 3.8 indicator definition. Broader efforts for health promotion through multi-sectoral action for health should be considered for GPW13 measurement to be covered under the healthier populations billion.
- 3) Ideally, measures of UHC service coverage should capture the construct of effective coverage which includes both access to care and quality of care. Effective coverage is also defined as the fraction of potential health gain through a service or intervention that is actually delivered to the population.
- 4) The principle of the tracer indicator method described in the UN SDG indicator 3.8 definition is that tracer indicators are highly correlated to a larger bundle of services. This correlation needs to be demonstrated statistically in settings with high quality data. Small area spatial correlations of indicators may be a useful source of information on the correlations of tracers with broader service bundles. A toolkit for tracer indicator selection based on explicit criteria would be useful.
- 5) The existing methods for measuring UHC need to be improved for the GPW13 UHC measurement. For example, the WHO measure of UHC uses as a key indicator of NCD service delivery smoking prevalence and the prevalence of elevated blood pressure. These measures of risk are not measures of service delivery. Smoking does not measure access to smoking cessation services and blood pressure can vary considerably between population for many

reasons not related to UHC service coverage such as diet or physical activity levels. The existing GBD measure of UHC while much broader than the existing WHO measure is also missing tracer indicators for some critical service areas such as palliative care and rehabilitation.

- 6) The package of interventions that would be included in UHC will vary across Member States because of differences in epidemiology, health system organization and financial resources. Although within broader groups of countries such as low-income or middle-income categories, the packages may have much in common.
- 7) A consensus emerged that more use of health outcomes in measuring the breadth and depth of UHC would be appropriate. Health outcomes should be risk-adjusted for factors that are not influenced by UHC. Methods for risk-adjustment should be transparent and reflect the available science on non-UHC determinants of the outcomes. The advantage of outcomes is that they allow comparable measurement while recognizing that different Member States will choose different modalities and technologies to address important outcomes. For example, using maternal mortality to measure the package of prenatal care and emergency obstetrical services would be an effective way to capture an UHC sensitive outcome. A challenge in using health outcomes in the service coverage measure is to translate observed counts or rates of events (e.g. mortality rates) into headcount measures of UHC coverage.
- 8) Equity of UHC service coverage and financial risk protection is a very important topic. Measuring equity in the lowest quintile or in certain disadvantaged groups would be a first step in the right direction. Given that disadvantaged groups vary widely across countries, comparability of measures will remain challenging.

## Recommendations

- 1) UHC measurement for monitoring GPW13 should be based on the service areas that address the needs of major population groups through different service platforms such as outpatient care, district hospital care and referral care. These service areas should be widely identified as relevant to the majority of Member States' approaches to defining their national UHC packages. Annex 1 provides a mapping of these service areas and population groups. The matrix identifies combinations of population group and service area. To provide context, the matrix maps GPW13 indicators to the relevant areas and the tracer indicators proposed in the WHO UHC measure from 2017 and the GBD 2016 measure of UHC. Populating this matrix with indicators will be a key goal for ongoing efforts of the Task Force.
- 2) For each of these areas, one or several tracer indicators should be developed that fulfill the following criteria. a) the tracer should be correlated with the broader set of interventions that provide health gain in that area; b) the indicator should be measurable; c) the tracer indicator should in its own right be important for UHC and thus improving health; d) variation in the indicator to the extent possible should reflect variation in UHC coverage and not factors that are beyond the scope of UHC such as social or environmental determinants; and e) existing GPW13 indicators should be used if they fulfill the previous criteria. Many tracer indicators may address more than one of the areas.
- 3) In addition, the criteria for selecting tracer indicators for the set of service platform-population group areas, the overall set of indicators should provide a balanced representation of where UHC can provide health gain across the spectrum of communicable diseases, non-communicable

disease and injuries. Likewise, the set of indicators should be combined into the overall UHC service coverage measurement reflecting the magnitude of health gain that can be achieved through UHC in each area.

- 4) Financial risk protection should be measured through the fraction of households facing catastrophic health spending in a year measured in household surveys. We agree with using the threshold of 10 percent of total household expenditure to define catastrophic spending as proposed by the WHO Secretariat. Sensitivity of results to alternative assumptions such as 30% of non-food household expenditure should also be evaluated.
- 5) If a single measure of UHC coverage is desired, one option is to combined service coverage and financial risk protection by subtracting from the estimated number of people in a country with UHC service coverage the number with catastrophic spending.

## **Measuring the health emergencies billion**

### **Observations**

1. Analysis indicates that self-reported IHR functions are in general higher than those assessed through expert reviews such as the JEE exercise. Efforts to increase the accuracy of the IHR reporting based on a range of measures including expert or independent assessment (JEEs, after action reviews, simulation testing) in the future as presented by the WHO Secretariat was welcomed.
2. The assessment of countries IHR core capacities do not directly capture the outcome and impact of better preparedness. In addition other factors, such as immunization coverage, have a potentially significant impact in emergencies on population health.
3. The choice of a 10 percentage point increase in average IHR functions used to define safer is arbitrary. The choice of the threshold increase should be justified through some principled exercise including exploring linkages between changes in IHR functions and measurable outcomes such as the average duration of outbreaks.

### **Recommendations**

1. If monitoring of the health emergencies billion is to use both self-reported IHR functions and observed functions, the self-reported functions will need to be corrected for self-report bias. In places with both self-reported and observed IHR functions, the difference between these can be used as a measure of bias. Using whichever function is available and lower will lead to false trends in the analysis. Ideally, only measured or observed measurements should be used.
2. Statistical analysis of the relationship between each of the IHR functions, improvements over time and real outcomes such as the duration and impact of outbreaks should be undertaken to generate a weighting scheme that is empirically based. This statistical analysis will need to take into account the variation in outbreak duration as a function of specific pathogen.

## Measuring the Healthier populations billion

### Observations

- 1) The Task Force welcomed the clarification that the healthier populations billion was focused on health improvement through multi-sectoral action, determinants of health, and health in all policies and was not meant to include services delivered through UHC.
- 2) There are two very different approaches in use to combine the quite varied types of indicators included in the healthier populations billion. The first is the lives touched approach, namely counting the number of individuals affected by achieving each of the component indicators. This approach has the advantage that is based simply on the addition of different individuals affected by each indicator. The disadvantage is that quite disparate impacts on individuals are giving equal weight such as avoiding death from air pollution or getting access to a pit latrine or having reduced sodium in process foods. The second approach is to convert each of the indicators of multi-sectoral action for health into the equivalent health gain. Health gain should be measured in a way that is consistent with the measurement of HALE as the overarching framework for the GPW13. Since HALE and DALYs in the GBD framework use the same conceptual approach, DALYs averted would provide a coherent approach to measuring this indicator. The latter has the advantage that it is conceptually appealing providing a principled basis for aggregation across disparate efforts. The disadvantage is that it requires considerably more effort to communicate how the calculations are implemented and does not map as directly to the 'billion-persons' heuristic..
- 3) As with UHC measurement, given that different Member States may choose to pursue different indicators with different degrees of resourcing and policy priority, a focus on measures that are grounded in health outcomes rather than process measures or risk measures can be useful.

### Recommendations

- 1) We recommend that in addition to the lives touched calculation that another integrative indicator be added to the framework to reflect the combine effects of multi-sectoral action, determinants of health, and health in all policies: the DALYs averted through multi-sectoral action for health. This would be related to the measurement of healthy life expectancy as described above.
- 2) Given the need to exclude in the third billion indicators that are captured under the measurement of UHC essential services, we applaud the shift proposed by the WHO Secretariat of indicators from the healthier populations billion to the UHC rubric for maternal mortality, neonatal preventable deaths, HPV coverage, and others.
- 3) We recommend that countries in assessing which components and indicators of multi-sectoral action for health and health in all policies should use principles grounded in the quantification of the social, economic, cultural, and environmental determinants of health. As with the selection of UHC tracer indicators, these indicators of the healthier populations should fulfil criteria of importance, measurability, comparability and balance.