ABSTRACT

Background

Universal Health Coverage (UHC) reflects the ability of all people to use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality, without financial hardships. Despite having a free healthcare system, the available scarce Sri Lankan literature points towards the potential presence of suboptimal service coverage and financial risks to clients. However, a larger scale research on those two components of UHC, covering a total district has not been done. A focused study paves a pathway for a better analysis and description of UHC in determining priority areas for action.

Objective

To assess selected components of Universal Health Coverage: health care access and health-related financial risk protection (FRP) among residents of Kalutara District in 2019.

Methods

The study consisted of three main components. The first component was a descriptive cross-sectional study with geo-spatial mapping of the allopathic-healthcare institutions including private hospitals and General-Practitioners (GPs) with a mobile-application and subsequent analysis with arcGIS10.3-software. Component 2 was a descriptive cross-sectional study with an analytical component to assess the financing and morbidity-profile as well as the factors associated with them. A sample of 1005 patients attending out-patient settings was recruited using a two-staged stratified-cluster sampling technique. An interviewer-administered questionnaire was used. Descriptive analysis was done. Factors associated with the selection of the institutions were assessed. Component 3 included a community-based cross-sectional study among 1737 households in assessing the financial-profile and Financial Risk Protection (FRP) using an interviewer-administered questionnaire including a section on five scenarios: fever for 3 days, dengue fever, minor surgery, emergency by-pass graft and a cataract surgery. Descriptive statistics were derived followed by the calculation of Catastrophic Health Expenditures (CHE) and three other financial risk-protection indicators: Mean-Positive-Catastrophic-Overshoot (MPCO), incidence-of-impoverishment (IoI) and poverty-gap-index (PGI).

Predictors of CHE were assessed using OR, with 5% significance level using bivariate analysis followed by logistic regression.

Results

General practitioners (GPs) covered the highest fraction out of all primary care settings covering 87.8% and 98.1% of the population within areas of 2km and 4km radii respectively.

While the commonest (33.7%) age group seeking Outpatient Department (OPD) care was above 50 years of age and gender patterns were different in GP settings. The commonest symptom category (39.1%) was respiratory in all levels of facilities. More than half (57.6%) sought treatment within the first three days of sickness with earlier presentation to the GPs. Nearly 50% were with a comorbidity. More than two fifths (44.2%) were with some kind of disability. A majority (77.1%) had to remain at work during illness with compromised financial gains. The government sector was selected by a significantly higher number of people above 30 years of age, females, those who had had formal education up to ordinary level and with a duration of the presenting complaint more than three days ($P<0.05$).

Median-income and expenditure of households at community-level were Rs. 68,625 and Rs. 65,225. Households exceeding CHE threshold were 8.41% and 1.79% respectively, for cut-offs of 10% and 25%. Number of family members with heart disease ($p<0.001$), hypertension ($p=0.003$), diabetes ($p<0.001$), cancer ($p=0.004$), kidney disease (0.048) and arthritis ($p<0.001$) were found to be independently associated with the occurrence of the CHE at 10% cut-off level. MPCO ranged from 14-16%. The IoI increased from 4.8% to 6.7% due to Out of Pocket (OOP) health-expenditure. The PGI was 1.2% and 1.65% before and after the total health payments.

Conclusions:

Increased coverage at primary healthcare level is only obtained by obtaining the services from the GP settings. Except for few similarities, the morbidity profile showed variations across the different levels of healthcare facilities. Once indirect costs were added to the health-expenditure, which does not happen in routine reporting sources, the financial risk was higher than the reported. The assessed components of UHC: Health care access and FRP for the clients would be benefited by healthcare reforms that will include better collaboration between the primary care settings and specialized institutions and an enhanced/ extended service profile including extended working hours. More operational

research into the area of Primary Health Care (PHC) and UHC including healthcare quality and safety as well as adherence to standard treatment protocols is recommended.

Keywords

Universal health coverage; Healthcare Accessibility; Financial Risk Protection; Catastrophic Health Expenditure; Out of Pocket Health Expenses; Healthcare Quality and patient satisfaction