PROGRESS, GAPS AND CHALLENGES TOWARDS UNIVERSAL HEALTH COVERAGE

IA-EGM_Third UN Poverty Decade, May 10 2023

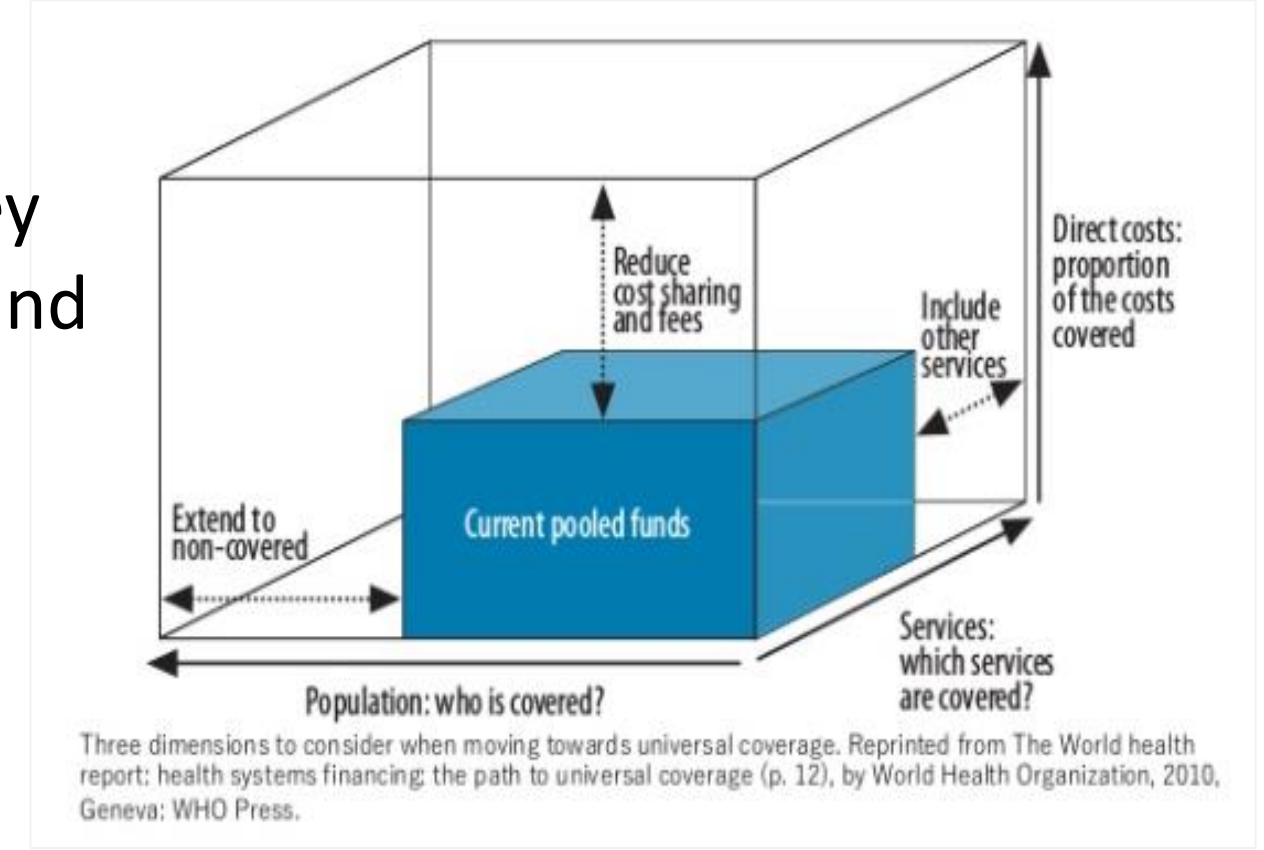
Gabriela Flores, Senior Health Economist, WHO

World Health Organization

Universal Health Coverage (UHC) – definition / conceptual dimensions

All people have access to the full range of quality health services they need across the life course, when and where they need them, without financial hardship

Dimensions of UHC



Three dimensions to consider when moving towards universal coverage. Reprinted from The World health report: health systems financing: the path to universal coverage (p. 12), by World Health Organization, 2010, Geneva: WHO Press.

World Health Organization

Tracking progress towards Universal Health Coverage (UHC)

UHC is SDG target 3.8 for the health sector

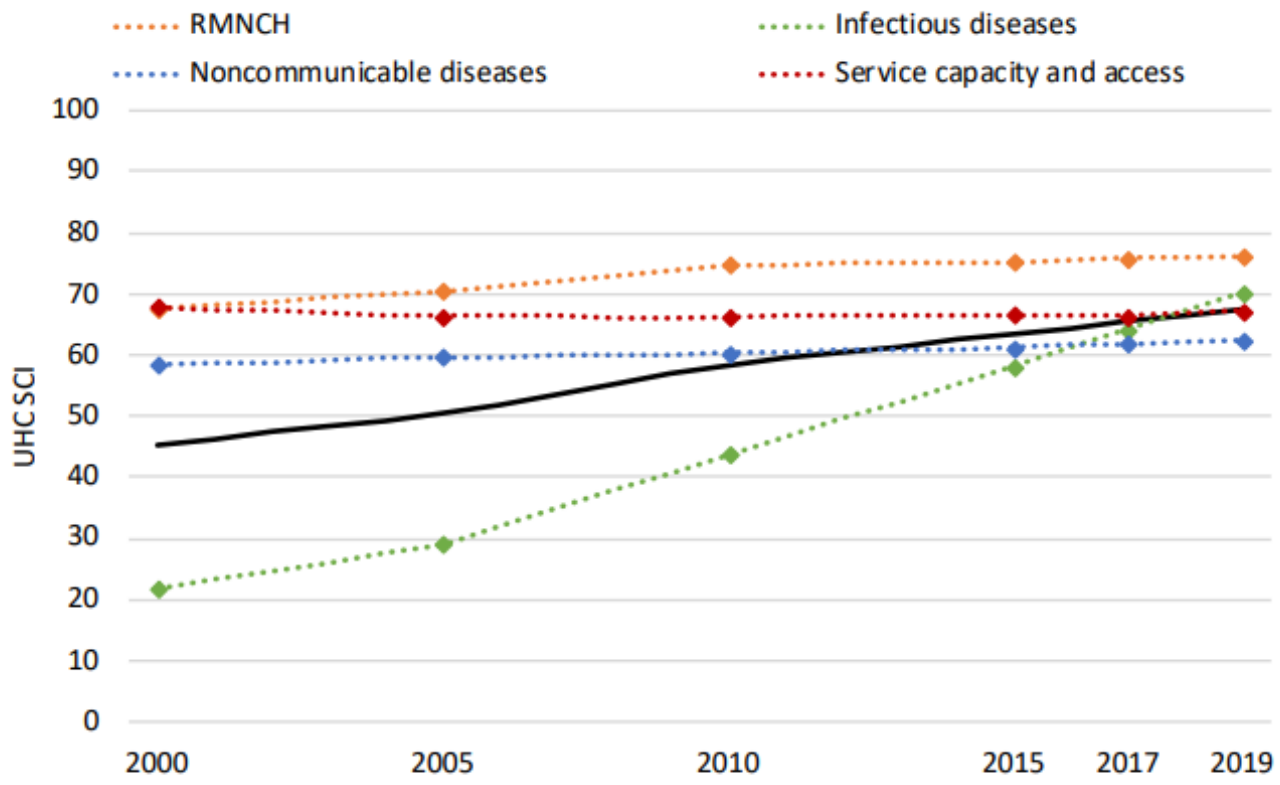
SDG 3.8.1 Service coverage

SDG 3.8.2 Financial hardship

Global monitoring reports co-produced with the World Bank

World Health Organization

Before COVID-19 struck, the world had made substantial progress in service coverage, from an index of 45 in 2000 to 68 in 2019…



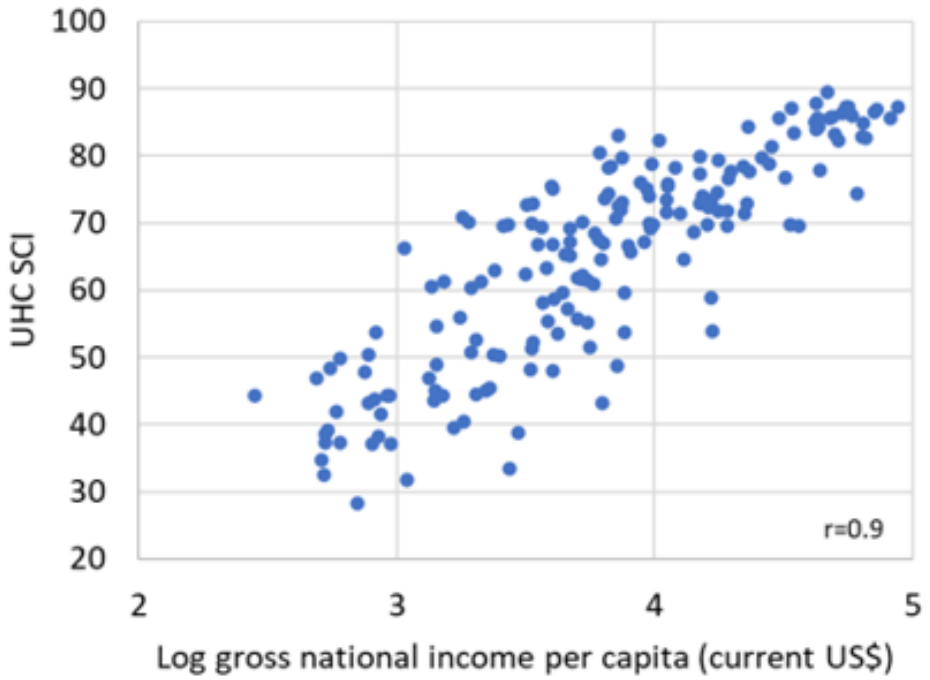
Note: The dark bold trend line corresponds to the overall index.

Progress was mainly driven by improvements in the coverage of interventions tackling infectious diseases

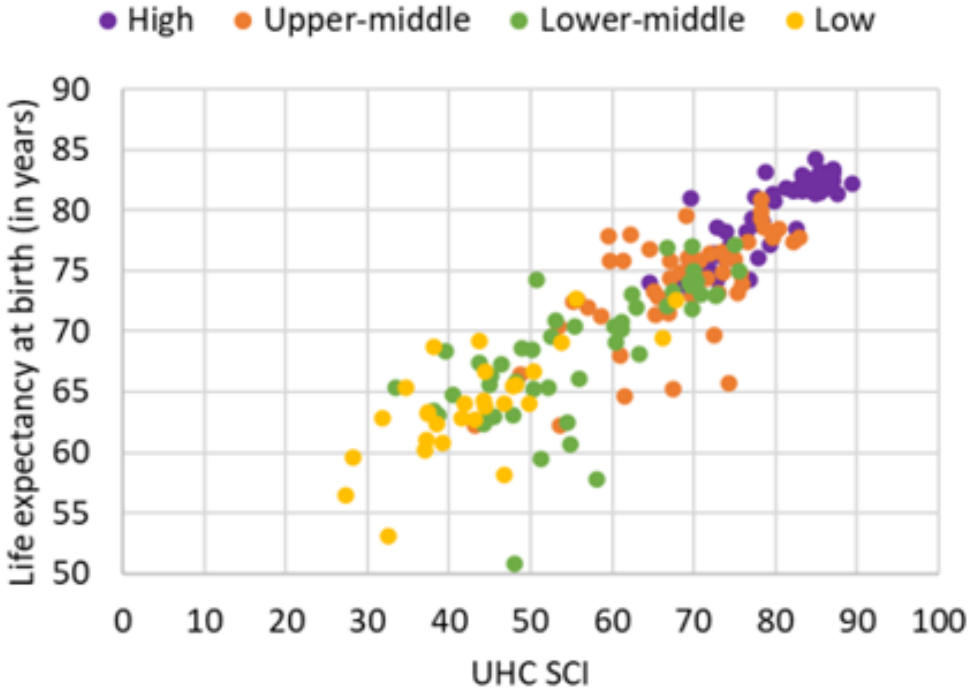
World Health Organization

• National income growth is a driver of progress in service coverage and life expectancy at birth

Relationship GNI and SCI, 2019



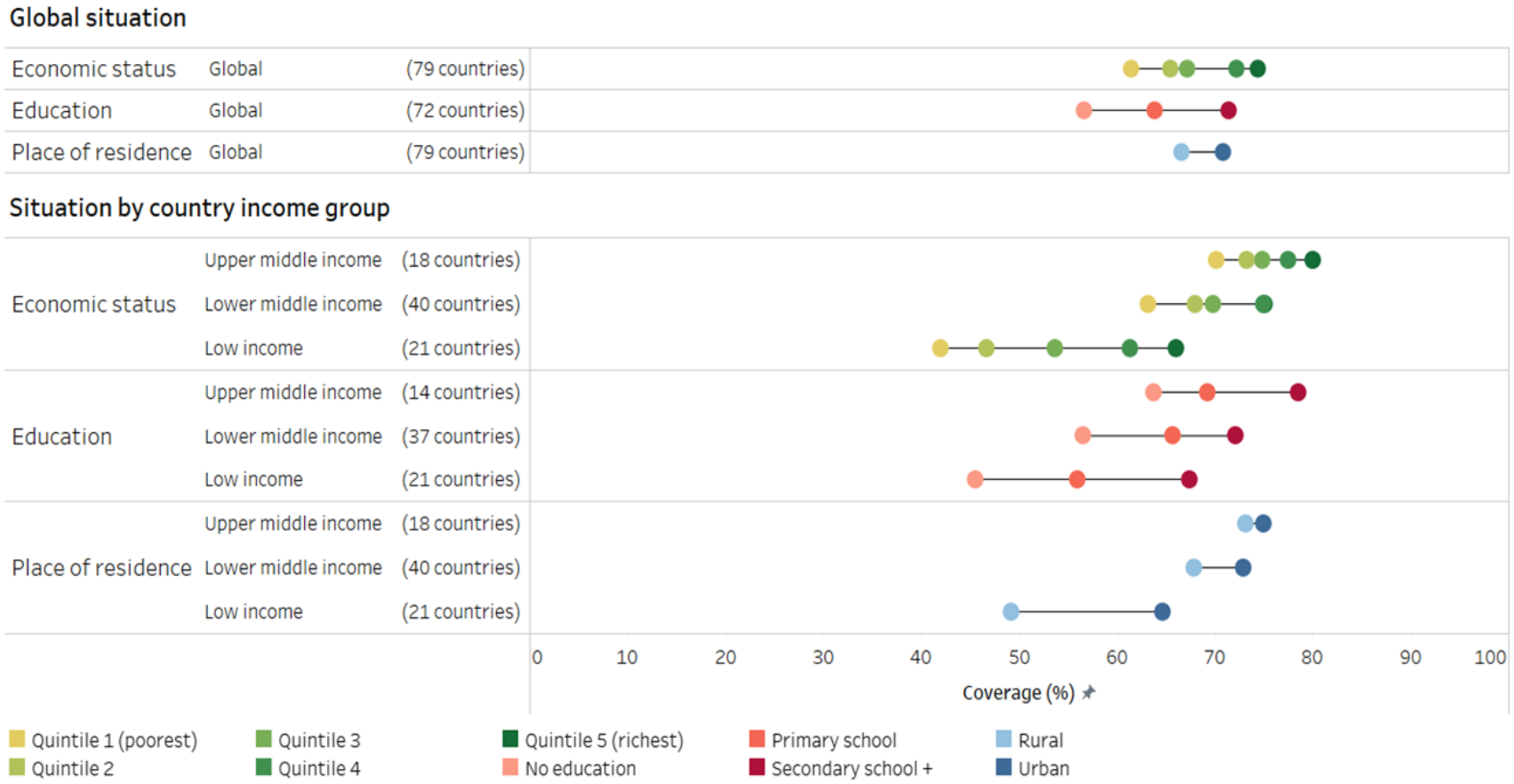
Relationship SCI and life expectancy, by income group, 2019



Source: Tracking Universal Health Coverage 2021 global Monitoring Report, WHO

• But large inequalities existed within countries, especially in relation to economic status

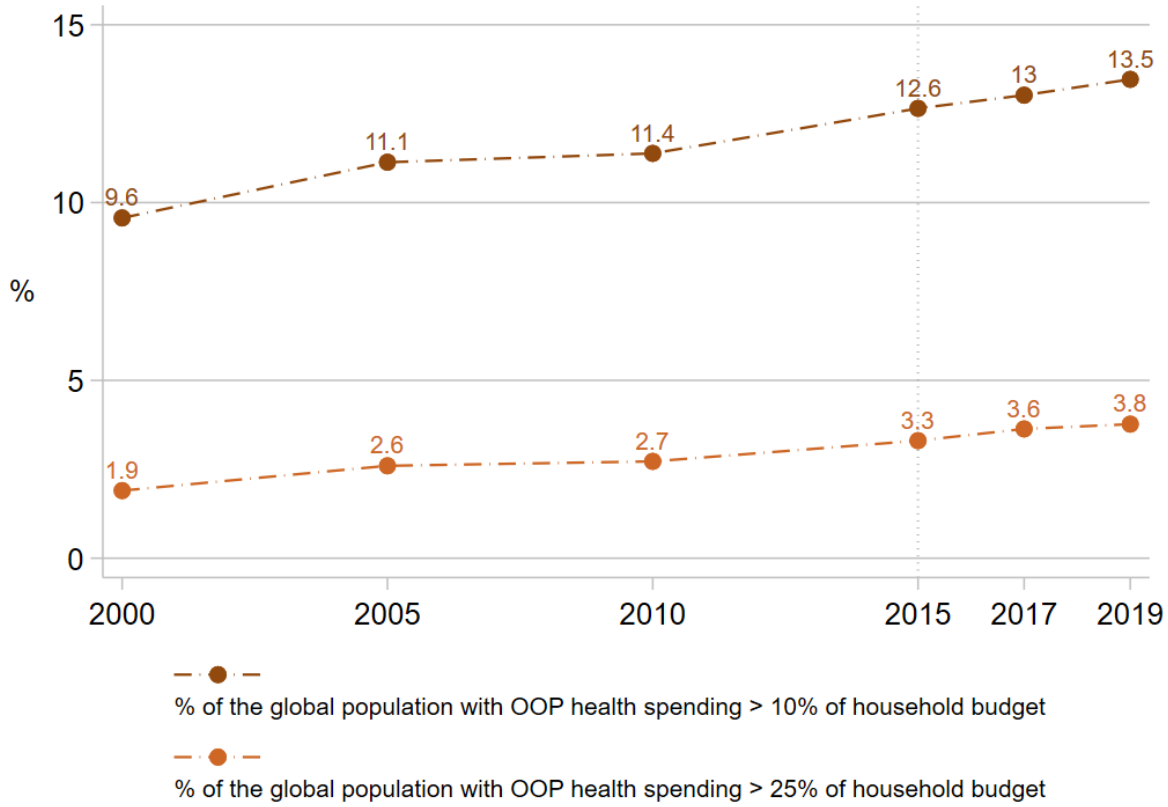
RMNCH composite coverage index by multiple dimensions of inequality, 2010-2019



Source: Tracking Universal Health Coverage 2021 global Monitoring Report, WHO

While service coverage improved, financial hardship due to large out-of-pocket health spending as tracked by SDG indicator 3.8.2 worsened

Trends in SDG 3.8.2: proportion of the population with large household out-of-pocket health spending as a share of household budget (AKA incidence of catastrophic health spending)



World Health Organization

https://www.who.int/data/gho/data/themes/topics/financial-protection

Out-of-pocket health spending is a source of financial hardship for those living in extreme poverty even when it is "small"

% of the global population living in extreme poverty* incurring any out-of-pocket health spending

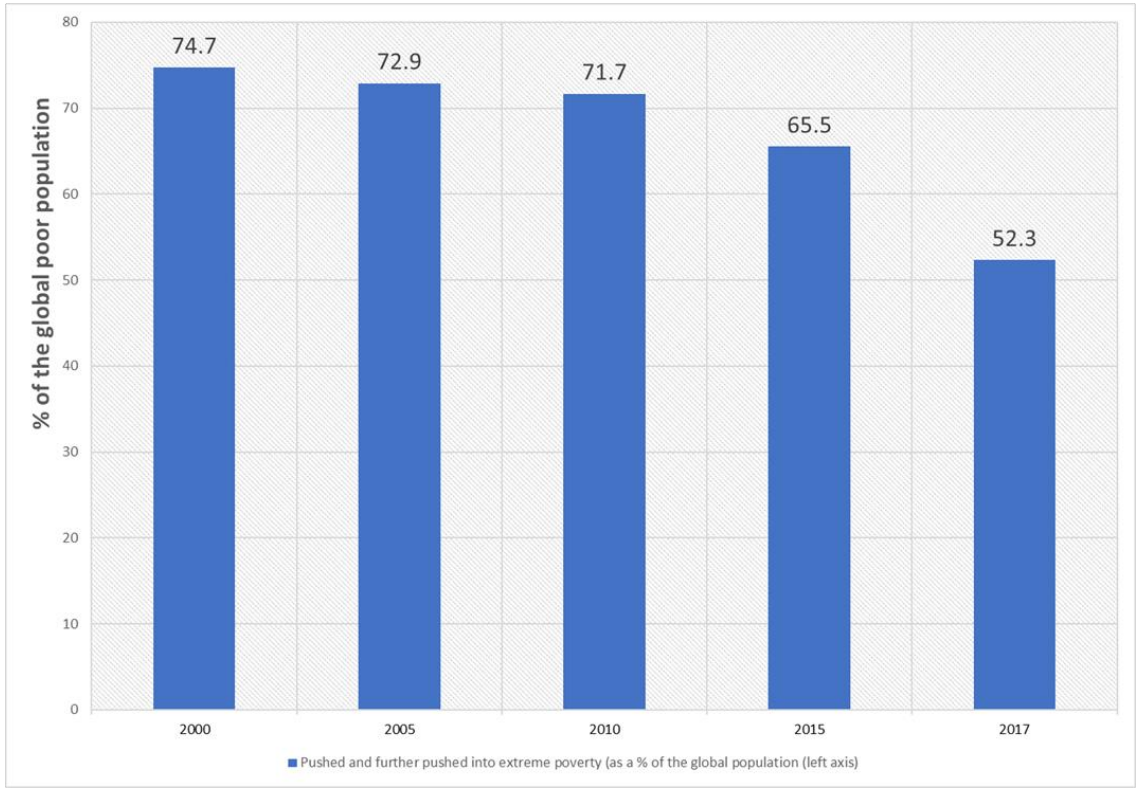
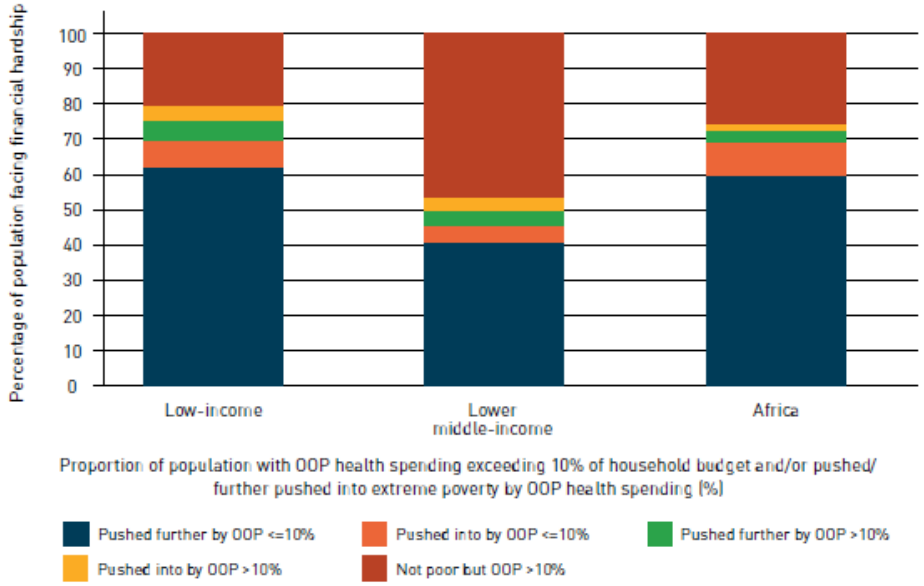


Figure 7. Composition of the population incurring financial hardship

b) SDG 3.8.2, 10% threshold and PPP$ 1.90 poverty



Notes: Catastrophic health spending is defined as OOP health spending exceeding 10% of their household budget. In panel a impoverishing health spending is idenfied using the relative poverty line of 60% of median per capita consumption, while in panel b the extreme poverty line of PPP$1.90 a day is used.

Source: Authors' calculations using the 709 surveys for 141 countries or territories from the Global database on financial protection assembled by WHO and the World Bank, 2021 update *(27,28)*. See also Annex A3.

World Health Organization

Sources: Global database on financial protection assembled by WHO and the World Bank, 2023 update (forthcoming)

In 2017, 1.4 billion people were facing catastrophic and/or impoverishing health spending

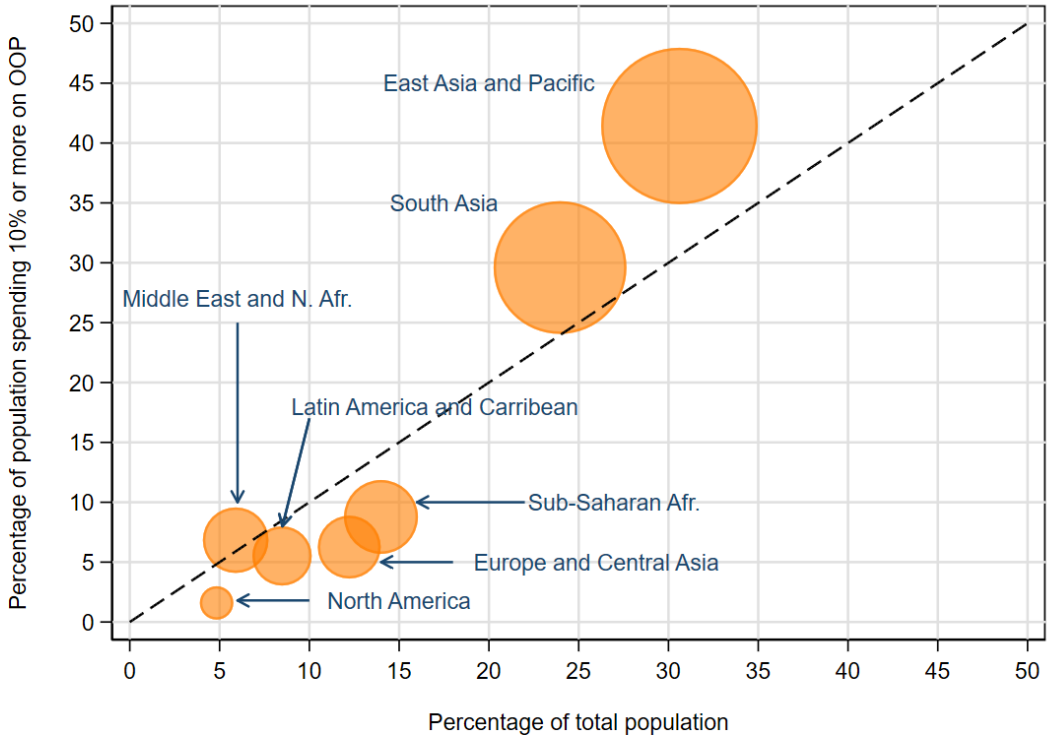
1. **31% of the 1.4 billion were living in extreme poverty**
2. **The population facing catastrophic payments is concentrated in EAP (42%) and SAR (30%)**

- People living in older households face the highest incidence of catastrophic health spending as tracked by SDG indicator 3.8.2 at the 10% threshold across all income groups and UN regions

World Health Organization

2

The population facing **catastrophic payments** is concentrated in **EAP** (42%) **and SAR** (30%)



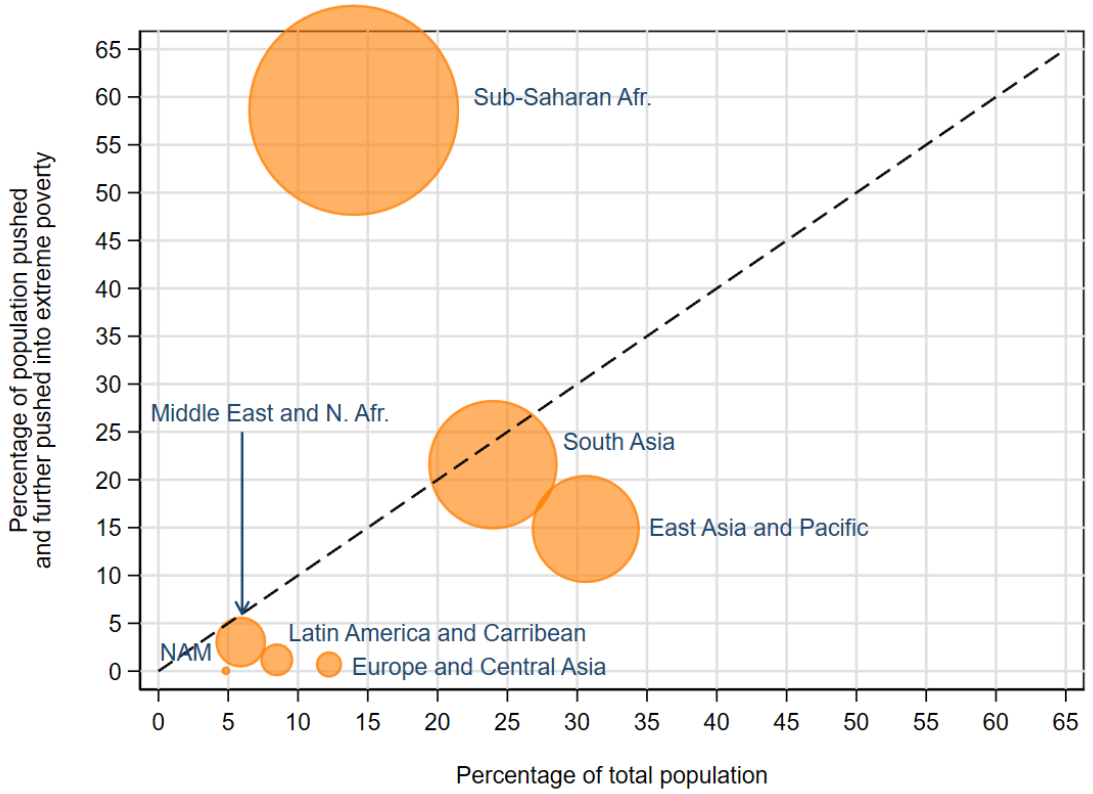
Reason: Population much larger and incidence higher in EAP and SAR than elsewhere

In 2017, 1.4 billion people were facing catastrophic and/or impoverishing health spending

3. Population facing impoverishment into extreme poverty (pushed & further pushed) is concentrated in SSA (21%), SAR (34%) & EAP (39%)

3

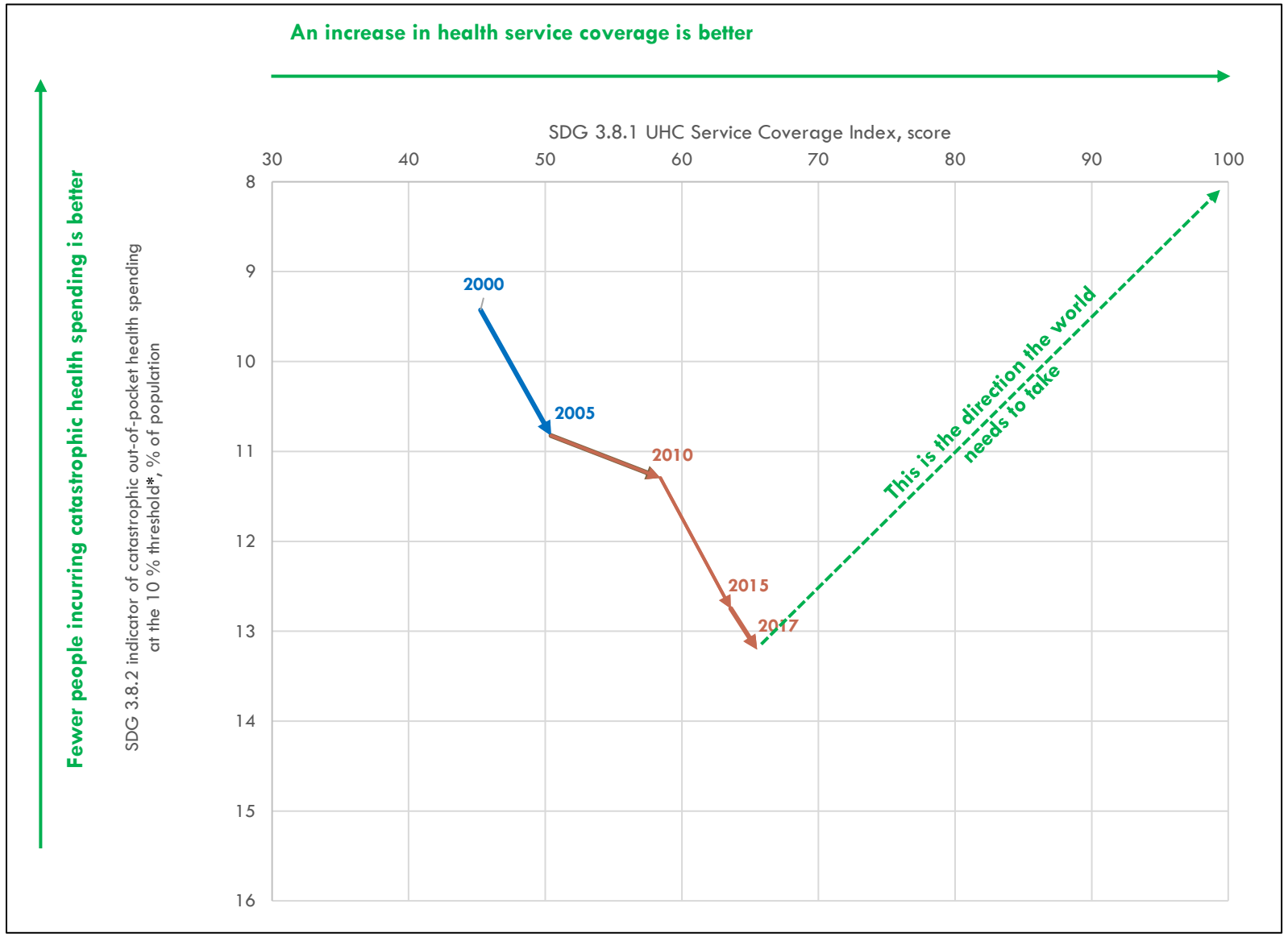
Population facing **impoverishment into extreme poverty** (impoverished & further impoverished



Reason: Very high **incidence in SSA**, **large population in SAR and EAP**

World Health Organization

OVERALL GLOBAL PROGRESS ON UHC HAS BEEN MIXED



- Increase in service coverage driven by progress in coverage of infectious diseases
- Incidence of large OOP health spending (AKA catastrophic) worsening
- Number of people living in extreme poverty facing OOP health spending decreasing but still high

Note: 3.8.2 based on households spending more than 10% of their budget on health as OOPs

• Understanding the past to guide the future

Historical patterns of service coverage and financial hardship are consistent with:

- Overall income growth
- Income inequality
- Inadequate public finance and health financing policies

COVID-19 brought:

- Lower growth
- Widening inequality, deepening poverty
- More debt service, tighter fiscal space

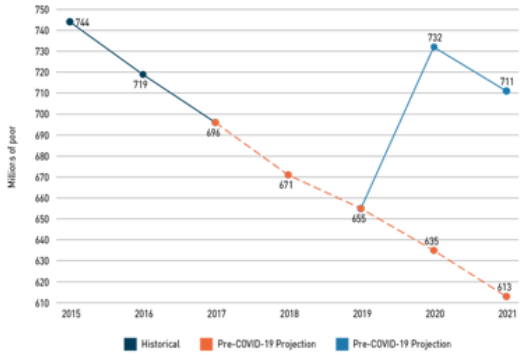
Threatens to derail progress towards UHC…

- Declining GDP overall limits service use and coverage
- Deepening poverty limits use and overall capacity to pay, and more inequality in coverage
- Fiscal constraints limits public spending on health

…Unless we respond

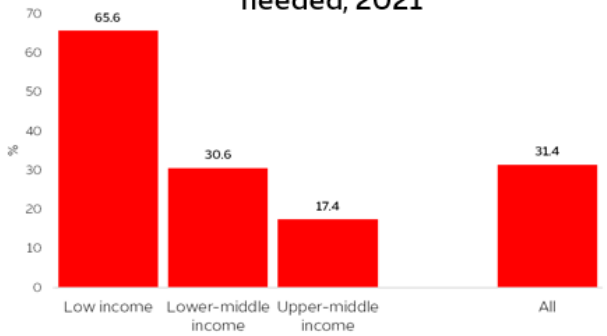
The Economic and Health Impacts of the COVID-19 Pandemic are Leading to a Significant Worsening of Financial Protection

Global Extreme Poverty, 2015-2021



Source: Mahler et al. (2021)

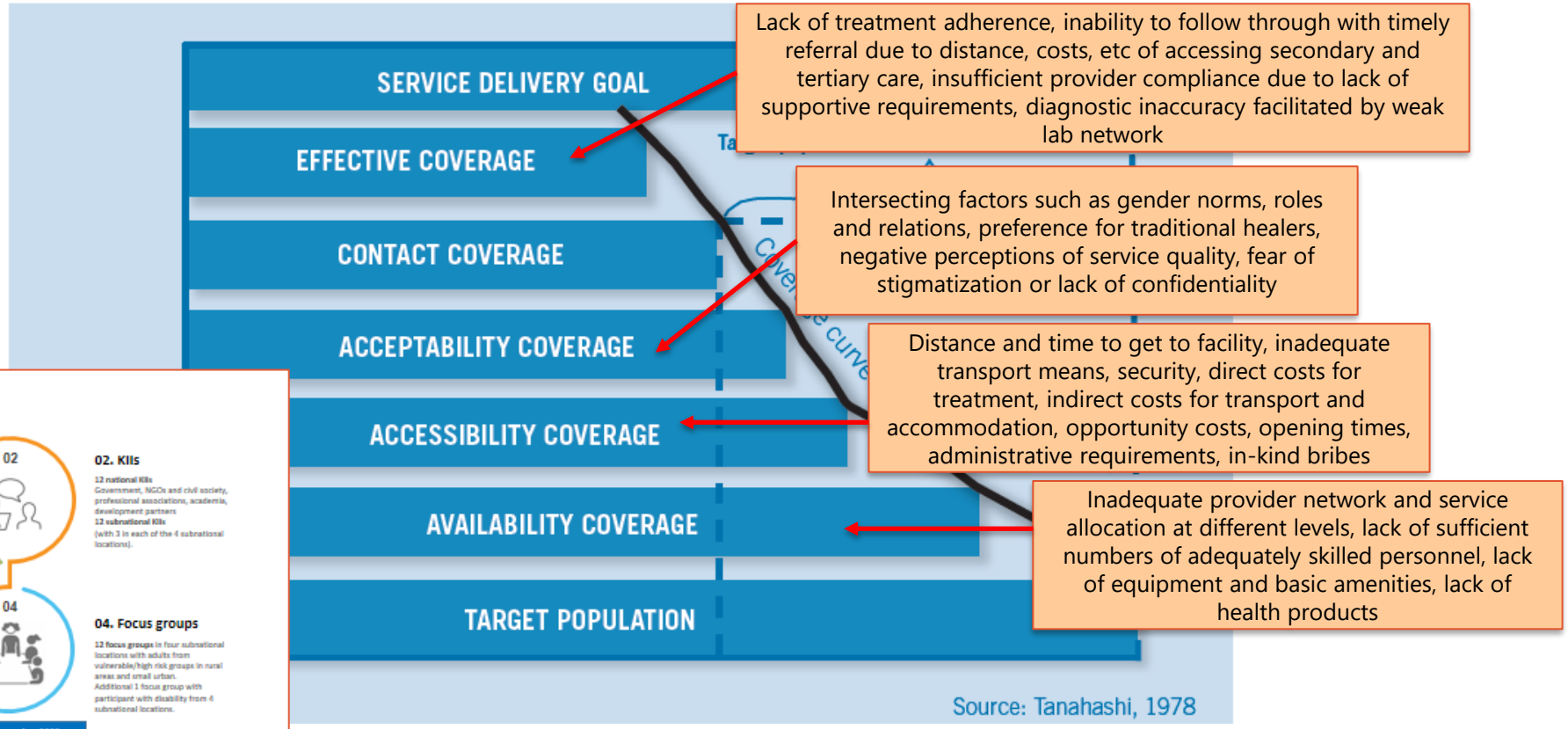
Households reporting affordability as the main reason for not accessing healthcare when needed, 2021



% of those unable to access care

Source: data from the World Bank High Frequency Survey (2021) collected between Apr-20 and Aug-20.

WHO work on assessing barriers to health services (example: rural poor)



Lack of treatment adherence, inability to follow through with timely referral due to distance, costs, etc of accessing secondary and tertiary care, insufficient provider compliance due to lack of supportive requirements, diagnostic inaccuracy facilitated by weak lab network

Intersecting factors such as gender norms, roles and relations, preference for traditional healers, negative perceptions of service quality, fear of stigmatization or lack of confidentiality

Distance and time to get to facility, inadequate transport means, security, direct costs for treatment, indirect costs for transport and accommodation, opportunity costs, opening times, administrative requirements, in-kind bribes

Inadequate provider network and service allocation at different levels, lack of sufficient numbers of adequately skilled personnel, lack of equipment and basic amenities, lack of health products

Source: Tanahashi T. Health service coverage and its evaluation. Bull World Health Organ 1978; 56(2): 295-303, with adaptations for barriers experienced by the rural poor laid over by T. Koller based on work on barriers in Mongolia, Moldova, Nigeria, Tanzania, Viet Nam, Indonesia, North Macedonia and global evidence reviews.

NATIONAL POLICY RESPONSES

Develop coherent pro-UHC health financing and coverage policies:

too many countries have a complex patchwork of fragmented and uncoordinated policies

- Establish a universally guaranteed set of essential services, focused on PHC
- Place explicit limits on OOPs for essential services
- Additional measures to support the poor and vulnerable (chronic diseases) & address inequalities

Make health budgets work more effectively:

too many budgets serve buildings not patients

- Introduce budget measures which address misalignment i.e. ensure money flows to priority services & population groups
- e.g. Programme Based Budgeting
- Address the multiple causes of health budget underspend

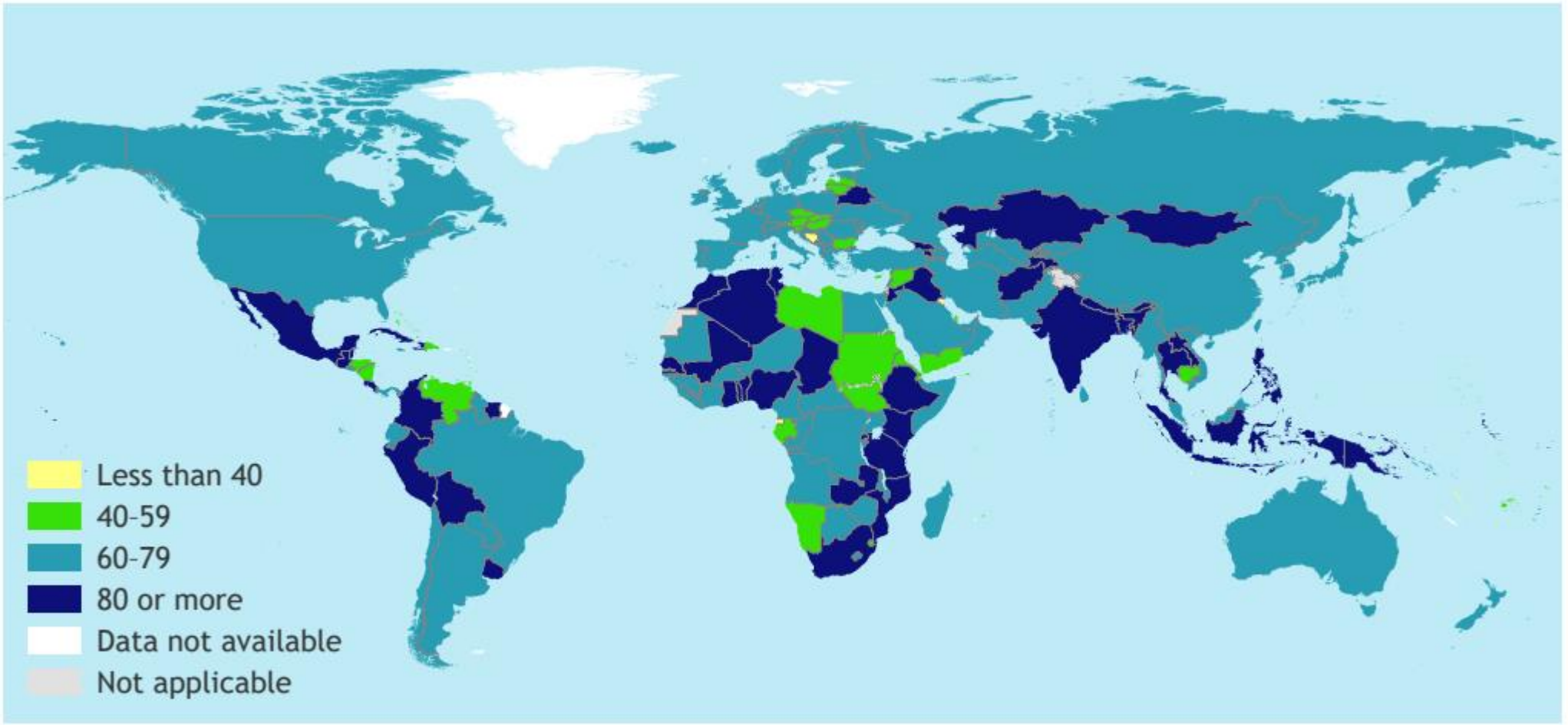
Additional measures

- Intensified country-level UHC monitoring: critical for effective policy development
- Phase-out of fossil fuel subsidies will help to address climate-related ill-health

Data availability is a challenge to track progress towards UHC

Primary data availability of UHC service coverage indicators

From 2015 to 2019 (last 5 years period), countries had primary data for an average of 67% of the 14 UHC SCI indicators.



World Health Organization

Data availability is a challenge to track progress towards UHC

Tracking financial hardship relies on household survey that are infrequent in some regions, were interrupted during COVID and when they are avialable regularly not used for monitoring in most cases due to lack of awareness

- **Requirements:** All indicators (catastrophic and impoverishing) require information at the household level on
  - **OOPs & Household total consumption expenditure (preferred) or income**
- **Source:** All indicators (catastrophic and impoverishing) based on the same type of household surveys:
  - **HBS, HIES, socio-economic or living standards surveys, multipurpose surveys**
- **Frequency & accessibility:**
  - mostly 1 year - 5 years
  - Accessibility at country, regional and global level is different.

World Health Organization

World Health Organization

THANK YOU