PROGRESS, GAPS AND CHALLENGES TOWARDS
UNIVERSAL HEALTH COVERAGE

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Gabriela Flores, Senior Health Economist, WHO
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

Tracking progress towards Universal Health Coverage (UHC)

UHC is SDG target 3.8 for the health sector

Global monitoring reports co-produced with the World Bank
Before COVID-19 struck, the world had made substantial progress in service coverage, from an index of 45 in 2000 to 68 in 2019...

Progress was mainly driven by improvements in the coverage of interventions tackling infectious diseases.
• National income growth is a driver of progress in service coverage and life expectancy at birth

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

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

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)

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

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

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%).

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

An increase in health service coverage is better

SDG 3.8.1 UHC Service Coverage Index, score

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

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.

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.

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.

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.

Methodology

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

Make health budgets work more effectively:
- too many budgets serve buildings not patients

Additional measures
- 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

- 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

- 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.
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 available 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.
THANK YOU