Gaps, challenges & progress towards universal health coverage, global health security & the 2030 Agenda for Sustainable Development

Context

Health is considered a precondition for, and outcome and indicator of, sustainable development. Investments in health systems are needed not only to achieve SDG 3, but will also have an impact on SDG 1, 2, 5, 6, 8, 9, 10, among others. The world is confronted by multiple global challenges: climate change, pandemics, war, inequality. Consequently, despite many health gains over the past several decades, global trends have not been moving at the scale or speed necessary to achieve the health-related SDGs. In some cases, such as financial protection for accessing health services, we are moving in the wrong direction entirely.

COVID-19 has reinforced the existing evidence that investments in health have long-term returns, while underinvestment has potential large-scale global social and economic effects. The COVID-19 pandemic has disrupted essential health services in all countries, undermined progress towards the SDGs, and laid bare inequities within and between countries. It has become clear that sustained recovery will require more than reinvesting in existing services and systems. Rather, we are at a critical juncture, with the opportunity to reinvent the system, based on shifting priorities, lessons learned, and smarter execution to deliver the SDGs.

Universal Health Coverage (UHC)

Progress on universal health coverage is measured by two indicators: SDG indicator 3.8.1 measures service coverage, based on 14 tracer indicators across reproductive, maternal, newborn and child health, infectious disease control, noncommunicable diseases, and service capacity and access; and SDG indicator 3.8.2 measures financial protection, based on two thresholds (10% and 25%) of total household expenditure or income.

Since 2000, service coverage has increased globally, as average income has grown, but not without inflicting financial burden to many people (Figure 1). Trajectories on the path to UHC, as tracked by related SDG indicators on service coverage and financial hardship, vary substantially across WHO regions and countries.

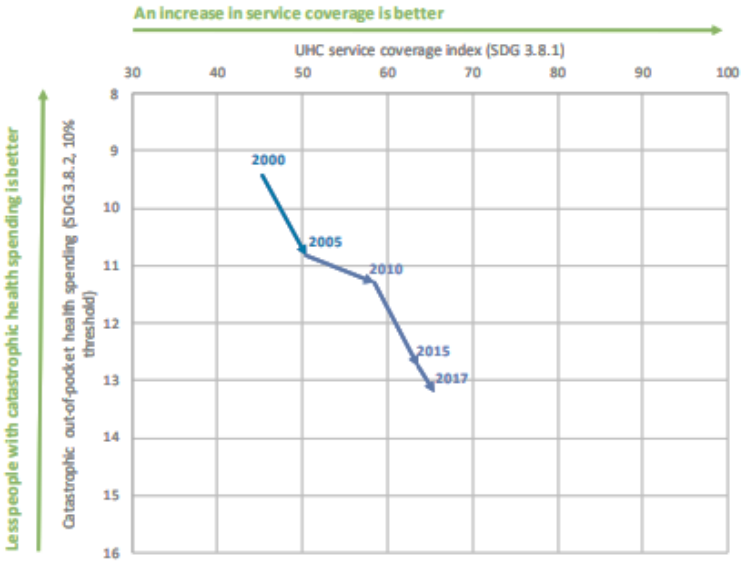
Service Coverage[1]

WHO's data shows that service coverage improved globally over the last two decades. According to the WHO service coverage index (SCI), coverage increased from a population weighted average of 45 in 2000 to 68 in 2019. The infectious disease sub-index improved the fastest with a pronounced acceleration around 2005, followed by the reproductive, maternal, newborn and child health (RMNCH) sub-index. Conversely, the noncommunicable diseases and the service capacity and access sub-indexes experienced slower gains. However, the progress observed over the period 2000–2019 was not sufficient to achieve a minimum of 80 by 2030.

Significant health gains accompanied these improvements in worldwide service coverage. The global average life expectancy at birth increased from 66.8 years in 2000 to 73.3 years in 2019. Between 2000 and 2019, the African Region had the fastest growth in both measures with an increase of 22 index points in the UHC SCI and a gain of 11.7 years of life expectancy.

[1] World Health Organization and the International Bank for Reconstruction and Development / The World Bank, 2021. *Tracking universal health coverage 2021 Global Monitoring Report.*

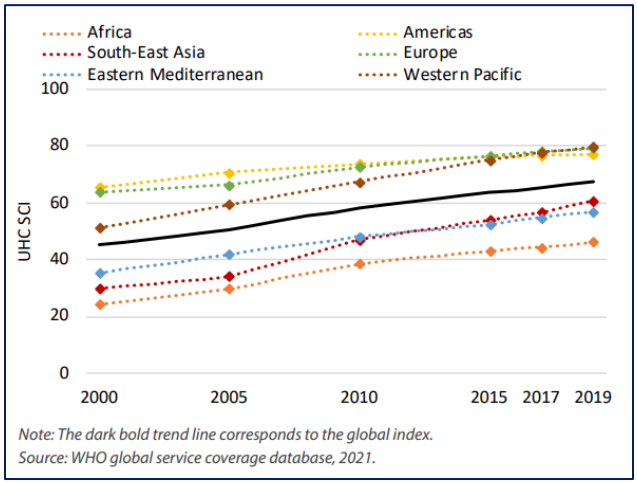
Figure 1. Progress in service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2,10% threshold), 2000–2017



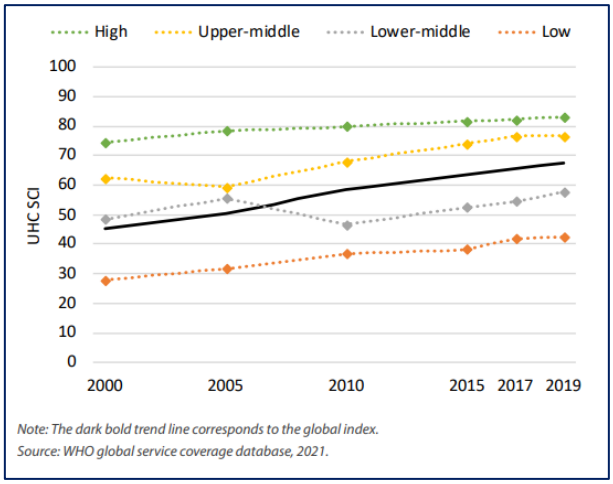
Note: The vertical axis corresponds to the global incidence rate of catastrophic health spending defined as the population-weighted proportion of the population with household out of pocket health expenditure exceeding 10% of household budget (13.2% in 2017). The horizontal axis corresponds to the global population-weighted average UHC service coverage index (65) in 2017.
Source: SDG indicator 3.8.1: WHO global service coverage database, 2021 update; SDG indicator 3.8.2: WHO and World Bank global financial protection database, 2021 update.

Average UHC SCI values were highest in the WHO Western Pacific Region (80), European Region (79) and Region of the Americas (77), and lowest in the African Region (46). Trends in the UHC SCI between 2000 and 2019 showed improvements across all WHO regions and all World Bank income groups, with the South-East Asia Region and Western Pacific Region recording the largest gains (Figure 2). The strong positive relationship between UHC SCI and gross national income per capita (current US$) suggests that service coverage might be driven by income growth. In other words, service use increases when people have more money and face less severe financial barriers to seek care.

Figure 2. Universal Health Coverage Service Coverage Index (SCI), 2000-2019



Note: The dark bold trend line corresponds to the global index.
Source: WHO global service coverage database, 2021.



Note: The dark bold trend line corresponds to the global index.
Source: WHO global service coverage database, 2021.

Financial Protection[2]

Trends in catastrophic health spending were already worsening pre-pandemic, with at least 1.4 billion people facing catastrophic and/or impoverishing health spending.

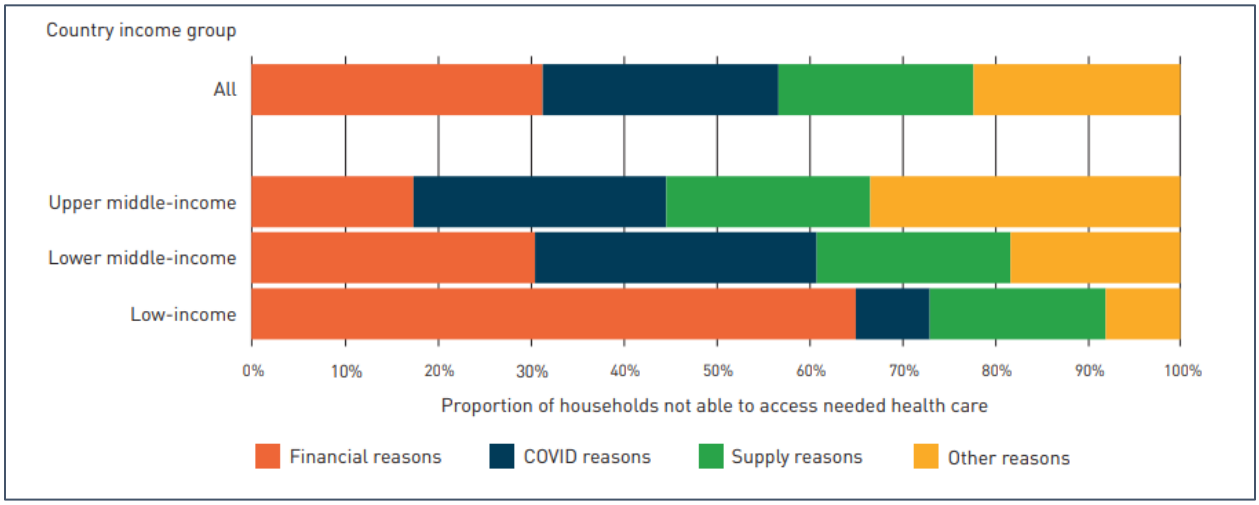
Prior to COVID-19, almost one billion people spent in excess of 10% of their household budget on health (out of pocket) of which, 290 million spent at least a quarter of their household budget on health (out of pocket). Even when people are devoting less than 10% of their household budget to health, out-of-pocket health spending can also be a source of financial hardship. This is particularly true for the near-poor and the poor who incur impoverishing health spending. Based on the extreme poverty line, an estimated 70 million people were impoverished by out-of-pocket health spending.

Between 2015 and 2017, the number of people with out-of-pocket health spending exceeding 10% of their household budget rose from 940 million to 996 million per year. The increase was driven by two factors: (1) an increase in the amount people spent out of pocket per person for health; and (2) a higher rate of growth of out-of-pocket health spending relative to growth in private consumption. On average, as households' income increased, so too did their demand for services. This demand manifested in high out of pocket health spending.

COVID-19 has resulted in a deep global economic contraction and is likely to significantly worsen financial protection globally, particularly among low- and middle-income countries and lower-income households. Millions of people have been forced into poverty, with the poor and most vulnerable populations bearing the economic brunt of the pandemic. This means that, on average, households have fewer resources to pay for health care (Figure 3).

In the face of these health and economic pressures, governments worked to buttress households and the overall economy through large increases in overall government expenditure. Higher government spending combined with lower government revenues implied higher levels of deficit financing and a jump in levels of public debt across most countries, which will have long-term effects on debt servicing payments, placing additional pressure on constrained fiscal envelopes. The confluence of these factors means that public spending on health will face constraints in the years to come. These constraints raise even more concerns about financial protection, particularly for the increased number of poor households, given the protective role of public spending.

Figure 3: Main reasons reported by households for not accessing health care when needed, multi-country evidence



Source: World Health Organization and the International Bank for Reconstruction and Development / The World Bank, 2021. Global monitoring report on financial protection in health 2021.

[2] World Health Organization and the International Bank for Reconstruction and Development / The World Bank, 2021. *Global monitoring report on financial protection in health 2021.*

Trends in financial barriers to care emphasize the need to focus urgent policy attention of how health systems are financed. Out-of-pocket (OOP) health spending is an inefficient and inequitable way of financing health and should be reduced as much as possible. While there are different ways of organizing the financing of health systems to ensure a population is financially protected, it is clear that health systems need to predominantly rely on public revenue sources: mandatory, pre-paid and pooled, rather than voluntary pre-payment mechanisms.

WHO's Triple Billion Targets[3]

WHO's 13th General Programme of Work is defined by 3 bold targets, aligned with the 2030 Agenda, intended to promote health, keep the world safe, and serve the vulnerable. These include:

1. One billion more people to benefit from universal health coverage
2. One billion more people better protected from health emergencies
3. One billion more people enjoying better health and well-being

For Universal Health Coverage, progress is less than 1/4 of that required to reach SDGs by 2030. Current projections suggest that an additional 280 million people will be covered by health services without experiencing financial hardship by 2023, compared to the 2018 baseline, leaving a shortfall of 720 million people. WHO pulse surveys reported that 94% of countries experienced disruption to essential health services due to the pandemic. Taking COVID-19 into account, the shortfall rises to up to 840 million.

WHO's initial projections anticipated the target billion to be better protected from health emergencies could have been met by 2023; however, COVID-19 revealed that no country is fully prepared for a pandemic of such scale. The *Prepare indicator*[4] shows country-level preparedness capacities have increased since the 2018 baseline. Some activities central to health emergencies protection have been disrupted by the COVID-19 pandemic, with the *Prevent indicator*[5] showing more countries experiencing decrease in vaccine coverage for priority pathogens than in the previous year. The *Detect, Notify and Respond indicator*[6] shows a different trend: countries improved the timeliness for detecting events and strengthened critical public health functions such as surveillance. COVID-19 highlighted limitations in current metrics and prompted the evolution of assessment methods and systematic processes to ensure they are more predictive, dynamic and holistic.

Prior to COVID-19, estimates suggested 900 million more people would be enjoying better health and well-being in 2023 compared to 2018. This includes improvements in access to clean fuels, safe water, sanitation (WASH), and tobacco control; however, in other areas like obesity and malnutrition, the situation is stagnant or even worsening. WHO estimates that to keep pace for reaching the health-related SDGs, the healthier populations target should be almost 4 billion for every 5-year period.

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[3] WHO, 2022. "For a Safe, Healthier and Fairer World: Results Report Programme Budget 2020-2021".

[4] The *Prepare indicator* is the average of the 13 core capacities of the International Health Regulations (IHR), which helps countries build their capacities to detect, assess and report public health events. (The Triple Billion targets: A visual summary of methods to deliver impact)

[5] The *Prevent indicator* measures the average vaccine coverage for selected diseases. For each country, the indicator uses only those vaccine coverages that are relevant. Vaccination coverage measures the percentage of the target population that has received the recommended dose of vaccine (The Triple Billion targets: A visual summary of methods to deliver impact)

[6] The *Detect & respond indicator* comprises three components related to events with serious public health impacts. They monitor the timeliness of detection, notification and response. (The Triple Billion targets: A visual summary of methods to deliver impact)

Impact of COVID-19

To better understand the extent of essential health service disruptions caused by the COVID-19 pandemic, WHO has conducted three rounds of the *Global pulse survey on continuity of essential health services during the COVID-19 pandemic*. The 3rd round, released in February 2022, found that two years into the pandemic, COVID-19 continues to disrupt health services in almost all countries, at all income levels, including:[7]

- Increased disruptions were reported to potentially life-saving emergency care, likely resulting in substantial near-term increased mortality from both COVID-19 and other time-sensitive conditions;
- Almost half of countries reported disruptions to both routine facility-based and outreach immunization services;
- 40% or more countries reported increased backlogs in multiple essential health services during the second half of 2021, including: care for cancer, other noncommunicable diseases and rehabilitation;
- 54% of countries reported disruption in nutrition services;
- 1/3 of countries reported disruptions to sexual, reproductive, maternal, newborn, child and adolescent health services.

An additional WHO survey on the impacts of COVID-19 on mental health, neurological and substance use services found that 93% of the 130 countries participating in the survey experienced disruptions in one or more services for mental, neurological and substance use disorders, while the demand for mental health services is increasing due to the pandemic.[8]

Countries have also reported facing critical challenges, notably around lack of funding; the health workforce; supply and equipment challenges; lack of clear strategy, guidance, or protocols; lack of distribution capacity; and lack of data and information.

It's important to note that reported COVID-19 cases and deaths do not provide a full picture of the impact of the COVID-19 pandemic on countries, health systems and individuals. Reported numbers miss those who died without testing as well as the increases in other deaths that have occurred because of overwhelmed health systems or patients avoiding care. New estimates from the World Health Organization (WHO) show that the full death toll associated directly or indirectly with the COVID-19 pandemic (described as "excess mortality") between 1 January 2020 and 31 December 2021 was approximately 14.9 million.[9] Measurement of excess mortality is an essential component to understand the impact of the pandemic. Shifts in mortality trends provide decision-makers information to guide policies to reduce mortality and effectively prevent future crises. Because of limited investments in data systems in many countries, the true extent of excess mortality often remains hidden.

Lessons Learned, Progress and Solutions

UHC and health security are two sides of the same coin – two complementary health goals towards which all countries should strive: continuity of essential services for all, when they need them, including during emergencies, without suffering financial hardship.

While chronic underfunding is common in many countries, there are countries where resources are not the only barrier. The cost of ensuring UHC and health security in 67 countries, as calculated by WHO, is extremely low compared with the cost of a crisis such as the current pandemic or future threats, including climate change.[10]

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[7] World Health Organization, 2021. *Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021.*

[8] World Health Organization, 2020. *The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment*

[9] Global excess deaths associated with COVID-19, January 2020 - December 2021 (who.int)

[10] World Health Organization, 2021. *Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond.*

Further estimates concur that improving emergency preparedness is very affordable, with estimates ranging from less than US$ 1 per person per year in low- and middle-income countries to between US$ 1 and US$ 5 per person per year – considerably less than any health emergency response.[11] It means that countries can build resilience by investing in governance, key preparedness and response capacities and PHC as the foundation for addressing the population's essential health needs, while protecting the population from emergencies. In the end, the synergies gained by addressing UHC and health security simultaneously leave us collectively better off, from both a financial and a health point of view.

In light of lessons learned during the pandemic, WHO has published 7 recommendations for building resilience and seeking integration between the promotion of UHC and ensuring health security.[12]

1. Leverage the current response to strengthen both pandemic preparedness and health systems
2. Invest in essential public health functions including those needed for all-hazards emergency risk management
3. Build a strong Primary Health Care foundation
4. Invest in institutionalized mechanisms for whole-of-society engagement
5. Create and promote enabling environments for research, innovation and learning
6. Increase domestic and global investment in health system foundations and all-hazards emergency risk management
7. Address pre-existing inequities and the disproportionate impact of COVID-19 on marginalized and vulnerable populations

Despite the ongoing and persistent health system challenges that have been further exacerbated by the pandemic, countries are adopting short-term strategies and innovations, to not only overcome disruptions and recover services, but also to solve bottlenecks to scale up of essential COVID-19 tools. They are also devising longer-term strategies and making important investments to build health service resilience and strengthen their preparedness for future health emergencies. Already, 70% of countries have allocated additional government funding for longer-term recovery and/or health service resilience and preparedness. Access to medicines and supplies and workforce capacities are the most common areas of investment.

Health worker recruitment, retention and training, surge procurement for availability of essential COVID-19 tools, financial planning and risk communication and community engagement were the most common areas of technical assistance identified by countries. These health system areas are also a main focus of frequently reported strategies being used to overcome service disruptions.

Documentation and learning from national levels to points of care on the best strategies and approaches for catching up and restoring services, reducing the impact of prolonged disruptions, overcoming bottlenecks to scale up essential COVID-19 tools and building longer-term health service resilience and preparedness are also needed to help countries as they begin to transition to a recovery phase.

[11] Ibid.
[12] Ibid.