State of commitment to universal health coverage: synthesis, 2020

Urgent action for health systems that protect everyone – now

uhc2030

Key targets, commitments and actions in the political declaration on UHC

Ensure political leadership beyond health

Commit to achieve UHC for healthy lives and well- being for all at all stages, as a social contract.

Leave no one behind

Pursue equity in access to quality health services with financial protection.

Legislate and regulate

Create a strong, enabling regulatory and legal environment responsive to people's needs.

Uphold quality of care

Build quality health systems that people and communities trust.

Invest more, invest better

Sustain public inancing and harmonize health investments.

Move together

Establish multi-stakeholder mechanisms for engaging the whole of society for a healthier world.

Gender equality

Emphasize gender equality, redress gender power dynamics and ensure women's and girls' rights as foundational principles for UHC.

Emergency preparedness

Promote strong and resilient health systems for enhancing health emergency preparedness and response.

UN high-level meeting on universal health coverage, multi-stakeholder hearing

Photo Credit: @UHC2030 - Akihito Watabe

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Abbreviations and acronyms

ACT-A	Access to COVID-19 Tools Accelerator
CSEM	Civil Society Engagement Mechanism
COVAX	The Vaccines Pillar of the Access to COVID-19 Tools Accelerator
CSO	Civil Society Organization
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer (or Questioning) and Others
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UHC2030	International Health Partnership for UHC2030
UN	United Nations
VNR	Voluntary National Review
WHO	World Health Organization

Foreword

> **"COVID-19 has shown that universal health coverage, strong public health systems and emergency preparedness are essential to communities, to economies, to everyone."**
>
> António Guterres, the Secretary-General of the United Nations (Policy brief: COVID-19 and UHC (1))

2020: A global reckoning for universal health coverage

The world looks very different today from how it did one year ago, just before the first cases of COVID-19 were reported to the World Health Organization (WHO).

Mere months earlier, in September 2019, world leaders gathered to endorse the most ambitious, comprehensive political declaration on health in history. The day of the UN high-level meeting on universal health coverage (UHC) was filled with optimism, as leaders reaffirmed their commitments to achieve UHC and ensure healthy lives and well-being for all by 2030.

The ongoing COVID-19 crisis is an unprecedented challenge to global health and a fundamental threat to human security. It has been an extreme stress test for the world's health systems. As countries face the dual challenges of managing the spread of the virus and sustaining other health services, it has tested every country's ability to reach everyone with high-quality essential health services without a financial burden. Leaders around the world and at every level of government have been faced with countless difficult decisions. In many places, COVID-19 has exploited and exacerbated deep inequities and gaps that were holding people back long before the virus hit.

About this synthesis

This first synthesis of the state of UHC commitment and country profiles published in the lead-up to International UHC Day in 2020, is based on diverse stakeholder perspectives of current country situations and commitments and summarizes challenges and opportunities for advancing UHC in a world coping with the COVID-19 pandemic. It draws on many sources, including an online stakeholder consultation and survey, a literature review, media analysis, political statements of UN Member States in various global forums and a review of actions taken by global initiatives. The report is structured on the eight areas of commitment in the political declaration on UHC (2), which are based on the "Key Asks" of the UHC movement on which stakeholders agreed before the UN high-level meeting in 2019 (3).

At the time this report was being finalized in November 2020, the pandemic—and the responses to it—are still unfolding, which means that it remains to be determined which approaches have been the most successful. However, key findings and lessons are already emerging.

Messages for political leaders

UHC is not just a long-term initiative that can be "put on a back-burner" until the pandemic is over. It is an urgent priority for ending this crisis and building a safer, healthier future. The State of UHC Commitment review asks a simple question: Are governments taking action towards meeting their UHC commitments? This synthesis presents findings and trends from around the world in people's lived experiences during this trying time. **The current state of UHC presents huge challenges.** In many countries, poor and vulnerable groups are once again being left behind, and inequities are widening due to the COVID-19 crisis. People are anxious about their health, their finances and their futures, and trust in government and political leaders is eroding in some countries. The COVID-19 pandemic is also exposing and exacerbating weaknesses in health systems, showing that many governments neglected to invest in health, social safety nets and emergency preparedness when it really mattered: before a crisis struck. Even countries with stronger health systems could have been better prepared for this emergency. There is still much to be done to ensure adequate support to front-line health workers, to meaningfully engage all stakeholders in decision-making and to ensure gender-equitable responses. Furthermore, many countries have not adopted measurable national targets, and public awareness of governments' commitments remains limited.

However, there is also hope. Countries that have performed better so far on COVID-19 tend to have leaders who interact with the scientific community, heed advice from public health officials and take rapid, decisive action to protect everyone.

We call on all leaders and other stakeholders across society to take urgent action for health systems that protect everyone – now.

Co-chairs of the UHC2030 Steering Committee and members of the UHC Movement Political Advisory Panel

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Specifically, we call on all national political leaders to:

Prioritize UHC to tackle and recover from the COVID-19 pandemic, allay anxiety and rebuild trust. Public health, economies and societies suffer when people are anxious about their health, finances and futures and lose trust in government and political leaders.

Address the systemic inequities that are widening with COVID-19 by creating stronger social and financial safety nets and prioritizing equity every step of the way. The poor and vulnerable communities that were struggling even before the pandemic are being hit hardest by the health and economic impacts.

Expand and strengthen UHC legislation and regulations, set clear targets, and communicate better to bring people together. Many countries have not adopted measurable national UHC targets, and public awareness of government commitment to UHC remains limited.

Support, protect and care for health workers, and innovate to improve and maintain quality during emergencies. Front-line health workers have not been supported adequately during the pandemic, adversely affecting the quality of their service.

Invest in public health and primary health care as a joint effort of health and finance ministers, and local governments, to ensure the continuity of essential health services and provide first-line defence against outbreaks. People want more government spending on health but tend to overlook public health and preparedness, which are essential public goods.

Build partnerships through genuine civil society engagement. Civil society has often considered that they are consulted only to comply with requirements. This is a mistake. Civil society is a crucial bridge between governments and the people left behind in an emergency response.

Empower women, who are proving to be highly effective leaders in health emergencies. UHC processes are still gender-blind, and COVID-19 has shown that women and girls are still being left behind.

Give UHC principles more weight in every crisis response, and build emergency preparedness into all health system reforms. Some countries have performed well in responding to the pandemic, and UHC approaches have been crucial, but many countries have underinvested in preparedness.

Going forward, we urge all global leaders and other stakeholders come together, to ensure coherent action and to build trust and accountability by widening participation in health governance at all levels.

Executive summary

We call on all leaders and other stakeholders across society to take urgent action to ensure health systems that protect everyone – now.

Just over one year on from the UN high-level meeting on UHC, the State of UHC Commitment review examines a simple question: Are governments taking action towards meeting their UHC commitments?

The key findings are that, in many countries, poor and vulnerable groups are once again being left behind, and inequities are widening due to the COVID-19 crisis. People are anxious about their health, their finances and their futures, and trust in government and political leaders is eroding in some countries. The COVID-19 pandemic is also exposing and exacerbating weaknesses in health systems, showing that many governments neglected to invest in health, social safety nets and emergency preparedness when it really mattered: before a crisis struck. Even countries with stronger health systems could have been better prepared for this emergency. There is still much to be done to ensure adequate support for front-line health workers, to meaningfully engage all stakeholders in decision-making and to ensure gender-equitable responses. Furthermore, many countries have not adopted measurable national targets, and public awareness of governments' commitments remains limited.

However, there is also hope. Countries that have performed better so far on COVID-19 tend to have leaders who interact with the scientific community, heed advice from public health officials and take rapid, decisive action to protect everyone.

As fear and mistrust are likely to increase in the coming months, as the pandemic intensifies, political leaders must take decisive action now to tackle the pandemic in order to have a rapid, demonstrable impact on people's lives.

As many people's fears are associated with the adverse health and economic impacts of the crisis, an obvious policy to be considered is scaling up health system reforms towards UHC, to benefit health and financial security simultaneously by protecting people against the costs of health care. The fact that UHC can allay people's fears about the financial consequences of ill health was recognized by Aneurin Bevan, the architect of the United Kingdom's health reforms, who called his book on the success of the creation of the National Health Service "In Place of Fear".

Many of the world's great health systems were put in place by leaders in the aftermath or even in the middle of national crises, often in an attempt to reduce fear, lower social tensions and rebuild trust in the State. These include the transitions to UHC in France, Japan, New Zealand, Rwanda, Sri Lanka and Thailand, where health system reforms followed devastating malaria epidemics (4).

With the world now gripped by the greatest health crisis in more than a century, today's leaders may be advised to use this strategy and, even in the face of fiscal restriction because of the economic impact of COVID, invest heavily and rapidly in health system reforms not only to tackle this crisis but also to protect everyone from future public health and other crises. This would also rebuild trust in the State and strengthen the case for stronger social contracts to sustain universal services, not only in health but also in other vital social sectors. This is likely to prove one of the best strategies for recovering from the COVID-19 crisis and getting back on track to achieving all the Sustainable Development Goals (SDGs).

Messages for national political leaders

Political leaders who are responsible for fulfilling their country's commitment to UHC are unlikely to engage with detailed findings and recommendations. It is therefore important to bring the details together and translate them into key messages for political leaders to consider as they plan and implement their COVID-19 responses and their longer-term UHC strategies. The following messages and key findings, reflecting the COVID-19 crisis, have been identified for the 2020 synthesis in a multi-stakeholder consultation and survey, a literature review, media reports and from the political commitments made in several international forums. The state of UHC commitment review is structured around eight "commitment areas" in the political declaration on UHC, based on the Key Asks from the UHC movement, which stakeholders agreed on before the UN high-level meeting in 2019.

Ensure Political Leadership Beyond Health

Prioritize UHC to tackle and recover from the COVID-19 pandemic, allay anxiety and rebuild trust. Public health, economies and societies suffer when people are anxious about their health, their finances and their futures and lose trust in government and political leaders.

Fear is rising in populations around the world, in both rich and poor countries. People fear for their own and their families' health (including fear of death and long-term health impacts), for unemployment and loss of income, poverty, hunger, isolation and discrimination. Fear is also induced by the health inequities that have been exposed by the pandemic and are likely to widen. It is worth noting that, in many countries, those who fear unemployment and loss of income or poverty are also those who are unable to access care.

Such individual and collective fear is also increasing mental illness – notably anxiety and depression –resulting in significant loss of well-being. Increasing fear is also dividing populations, such as younger and older age groups and groups of differential vulnerability to COVID-19. These divisions represent a significant threat to social cohesion, which must be sustained in what could be a long crisis.

Fear is also fuelling growing dissatisfaction with the responses of some governments to COVID-19 and eroding trust in some governments and their leaders. This is undermining compliance with public health measures, such as restrictions on social gatherings and the wearing of face masks, and is also fuelling scepticism about the safety and efficacy of vaccines, exacerbated by online disinformation campaigns. Some protests against government policies to combat COVID-19 are becoming violent and therefore posing a threat to social stability (5).

Erosion of trust in the State could have profound long-term consequences, not least for advancing UHC, if it undermines social contracts in which people are prepared to pay higher taxes for universal public services. Leaders should recognize the importance of UHC in preparedness and response to COVID-19 and advance the UHC agenda when building resilience in the recovery phase of the pandemic.

It is already clear that failing trust in political leaders who are perceived as having performed poorly in response to the pandemic has negative political consequences for them, reflected by falling approval ratings (6,7) or potentially impacting election outcomes (8–10).

Therefore, it is in the interests of politicians themselves to make a priority of alleviating the fears of their populations about COVID-19, to rebuild trust in their leadership and to find quick, effective ways to do so. Reform of health systems towards UHC could be an effective way; now is a good time for civil society organizations (CSOs) and their partners to emphasize the health, economic and social benefits of UHC to political leaders.

Leave No One Behind

Address the systemic inequities that are widening with COVID-19 by creating stronger social and financial safety nets and prioritizing equity every step of the way. The poor and vulnerable communities that were struggling even before the pandemic are being hit hardest by the health and economic impacts.

At the UN high-level meeting on UHC, global leaders agreed to reach UHC equitably and made a specific commitment to "Ensure that no one is left behind, with an endeavour to reach the furthest behind first..." (11).

Global surveys of people's experiences and media reports (12) indicate that this commitment is not being fulfilled in responses to the COVID-19 pandemic, and the poor and vulnerable are being hit hardest by the direct and indirect effects of the pandemic. The groups that are suffering disproportionately include the elderly, poorer members of society, women and girls, people with disabilities and chronic health conditions, people living in remote areas and migrant populations.

Even in high-income countries, vulnerable groups are being left behind, notably elderly people living in residential care homes, people requiring palliative care, migrant populations living in poor housing with inadequate workplace protection and homeless people, who are slipping through social safety nets.

As unemployment levels have been rising and income levels falling, more and more people have been struggling to access effective health services, particularly in health systems dominated by out-of-pocket payment and employment-based insurance schemes. These threaten to reduce both service coverage and financial protection from health costs and to increase health inequality between the rich and the poor. Not only does this undermine progress towards UHC, it threatens collective health security, reflecting the statement by WHO that: "No-one is safe until everyone is safe" (13).

Regulate and Legislate

Expand and strengthen UHC legislation and regulations, set clear targets, and communicate better to bring people together. Many countries have not adopted measurable national UHC targets, and public awareness of government commitment to UHC remains limited.

One of the key findings from the 2020 UHC Survey (14) is that stakeholders are unclear about what constitutes a UHC commitment and what, if any, commitments their governments have made recently or in the past. In referring to commitments, survey respondents often mentioned references to health in their country's constitution or laws or vague policies or statements made in meetings or in the media.

Furthermore, few countries have set explicit UHC targets to increase coverage of essential health services or to increase financial protection or have failed to communicate those targets to stakeholder groups, including CSOs. Although all countries agreed to monitor progress towards UHC with two specific indicators – SDG indicators 3.8.1, coverage of essential services, and 3.8.2, financial protection – most have not yet set explicit national targets to improve those indicators or have never reported on them. The UHC-related targets that exist tend to be focused on specific population groups, increasing the uptake of selective disease-specific services or the availability of key inputs such as health facilities and health workers, increasing enrolment in insurance schemes or pledging to increase public financing. These targets often fail to materialize in the ultimate goal of ensuring that everyone, everywhere has access to high-quality essential health services without fear of a financial burden.

This leads to confusion in the population about what commitments they should hold their governments accountable for and what, if any, progress is being made to meet them.

Parliaments, civil society and other stakeholders can not only ask governments to share more information about legislation and regulation but can act on their own, learning about legislation or the lack thereof and sharing the information with the population. UHC is more likely to advance if people are proactive in pursuing it and holding their government to account for providing it.

Uphold Quality of Care

Support, protect and care for health workers, and innovate to improve and maintain quality during emergencies. Front-line health workers have not been supported adequately during the pandemic, adversely affecting the quality of their service.

In virtually all countries, the COVID-19 pandemic has put front-line health workers under immense pressure and exposed shortcomings in the numbers of health workers, their distribution, their levels of remuneration and the inadequacy of the resources available to them

to provide high-quality services. A major failing has been in providing health workers with adequate personal protective equipment.

In some areas, greater efficiency is required in ensuring human resources. Countries should make sure that front-line health services are optimally staffed to meet population needs.

While this crisis has generated many challenges, it has also created opportunities to innovate and improve health care delivery, as in rapid scaling-up of tele-health and tele-medicine services to maintain and even increase access to vital services, particularly for people living in remote areas and for those who are self-isolating to avoid infection.

Invest More, Invest Better

Invest in public health and primary health care, as a joint effort of health and finance ministers and local governments, to ensure the continuity of essential health services and provide first-line defence against outbreaks. People want more government spending on heath but tend to overlook public health services and preparedness, which are essential public goods.

When stakeholders were asked on what aspects of their country's health system their governments should increase spending, there was a clear tendency to prioritize services that benefit individuals (e.g. health facilities, medicines and front-line health workers) over collective public health services; very few referred to strengthening pandemic preparedness. Given the devastating impact of COVID-19, it is hoped that populations will begin to demand better performance from their public health systems and that these be given greater priority in UHC processes. As governments across the world are now investing huge sums in surveillance, contact tracing and testing systems, there are some signs of greater public accountability for how those resources are being spent (15). Even with constrained finances to rebuild from the economic effects of the pandemic, countries should prioritize both UHC and pandemic preparedness in health system reforms, with greater collaboration between health and finance authorities. This commitment was made by G20 leaders at their summit in Osaka, Japan, in 2019 (16).

One of the key lessons of 2020 has been that health and economics are not mutually exclusive but are inextricably interconnected. The pandemic therefore provides a compelling reason to prioritize investments in health now, for both health and economic reasons. The costs of inaction vastly outweigh those of investing in public health functions and outbreak preparedness (17). The costs of responding to the pandemic and the resulting economic recession have been and will continue to be immense, undermining progress in reducing the poverty and inequity of past decades. Therefore, health policies should prioritize public financing and remove financial barriers to services at the point of use. It is undeniable that parliamentarians are facing hard choices, navigating between controlling the outbreak and protecting other essential health services, mitigating the "indirect" effects of COVID-19 and restoring the economy. However, experience shows that effective epidemic control and protecting the most vulnerable benefit the economy.

Move Together

Build partnerships through genuine civil society engagement. Civil society has often considered that it is consulted only to comply with requirements. This is a mistake. Civil society is a crucial bridge between governments and people left behind in emergency response.

The advice of and requests by CSOs are often not considered in high-level policy decision-making. In some areas, only selected nongovernmental actors are included in policy-making consultations, and other key stakeholders are left out, as reported by patient groups in France (18). Our research confirms that the voices of people and community organizations are not always heard in decision- and policy-making spaces for UHC and in the COVID-19 response, and, when people's concerns are voiced, there is limited or no uptake by policy-makers.

An equitable response to COVID-19 requires that civil society maintain its role and give voice to the communities most likely to be left behind in a public emergency response. The crisis is making it harder for civil society to respond, as closure of civic space, constraints on movement and increasingly authoritarian policies in many countries make it extremely difficult to conduct advocacy and to demand accountability. Governments should create mechanisms for engaging civil and civic society to enable them to take up opportunities.

Gender Equality

Empower women, who are proving to be highly effective leaders in health emergencies. UHC processes are still gender-blind, and COVID-19 has shown that women and girls are still being left behind.

The COVID-19 pandemic, like previous pandemics and infectious disease outbreaks, is exacerbating gender inequality in many ways. Globally, women make up a significant proportion of front-line health workers, who are at increased risk of infection. Thus, some have deliberately stayed away from their children to reduce the risk of infecting them. Women who do not work in the health sector have also been disproportionately affected by the pandemic. In many countries, women work in sectors that have been heavily impacted by the pandemic or in the informal sector and have thus been more likely to experience economic loss. Furthermore, curfews and lockdowns have been instituted in many countries without consideration of the continuity of maternal health services, putting pregnant women at risk. In addition, gender-based violence has been reported to increase during lockdowns in several countries.

The patriarchal nature of global and public health systems received increasing attention during 2020. Recent research (19) showed that 85.2% of COVID-19 national task forces are men, and an average of about 25% of participants in the first three committees on International Health Regulations Emergency were women. A gender-sensitive response to disease outbreaks is crucial; responses are more likely to be effective for everyone if there is diversity in

leadership panels. In addition, countries with women leaders are reporting fewer COVID-19-related deaths, and strong leadership by women politicians is gaining international attention.

Emergency Preparedness

Give UHC principles more weight in every crisis response, and build emergency preparedness into all health system reforms. Some countries have responded well to the pandemic, and UHC approaches have been crucial, but many countries have underinvested in preparedness.

Whereas it is too early to say definitively which countries and what COVID-19 responses have been better and why, global media reports and international surveys of public perceptions indicate a consensus that some governments have performed better than others. In particular, some countries in South East Asia and Australasia have been praised for their approach, and experts have credited the response in several Asian countries as having been facilitated by their governments' investment in preparedness since their experience with the SARS epidemic in 2003, which affected the region the most (20). A number of African governments and regional bodies have also been praised for their COVID-19 responses that built on lessons learnt from previous outbreaks.

One factor that appears to be common to good performance so far has been the willingness of political leaders to heed scientific, evidence-based advice from their public health officials and to take rapid, decisive action to protect public health. In taking action, they have adopted strategies consistent with the principles of UHC, namely universality, leaving nobody behind and allocating support and services equitably according to need. This is in stark contrast to leaders who have downplayed the impact of the pandemic and often overruled their public health officials in prioritizing economic activity over protecting public health. A graphic published in The Economist in November 2020 (Fig. 1) shows the extent to which scientists around the world in May–June 2020 perceived that policy-makers in their countries had taken scientific advice into account. The lowest scores were given by scientists to countries (21) that have the highest cumulative numbers of COVID-19 deaths in November 2020 (22).

If the world is to tackle future pandemics more effectively, it needs empathetic leaders who make decisions based on science not populist urges. This will be facilitated by a well-informed population that can hold their leaders to account.

The pandemic has highlighted major weaknesses in multilateral response systems and in compliance with the International Health Regulations (2005). Improving global preparedness will therefore require investment in multilateral partnerships and organizations, notably strengthening WHO and ensuring that its funding matches its global mandate and responsibilities.

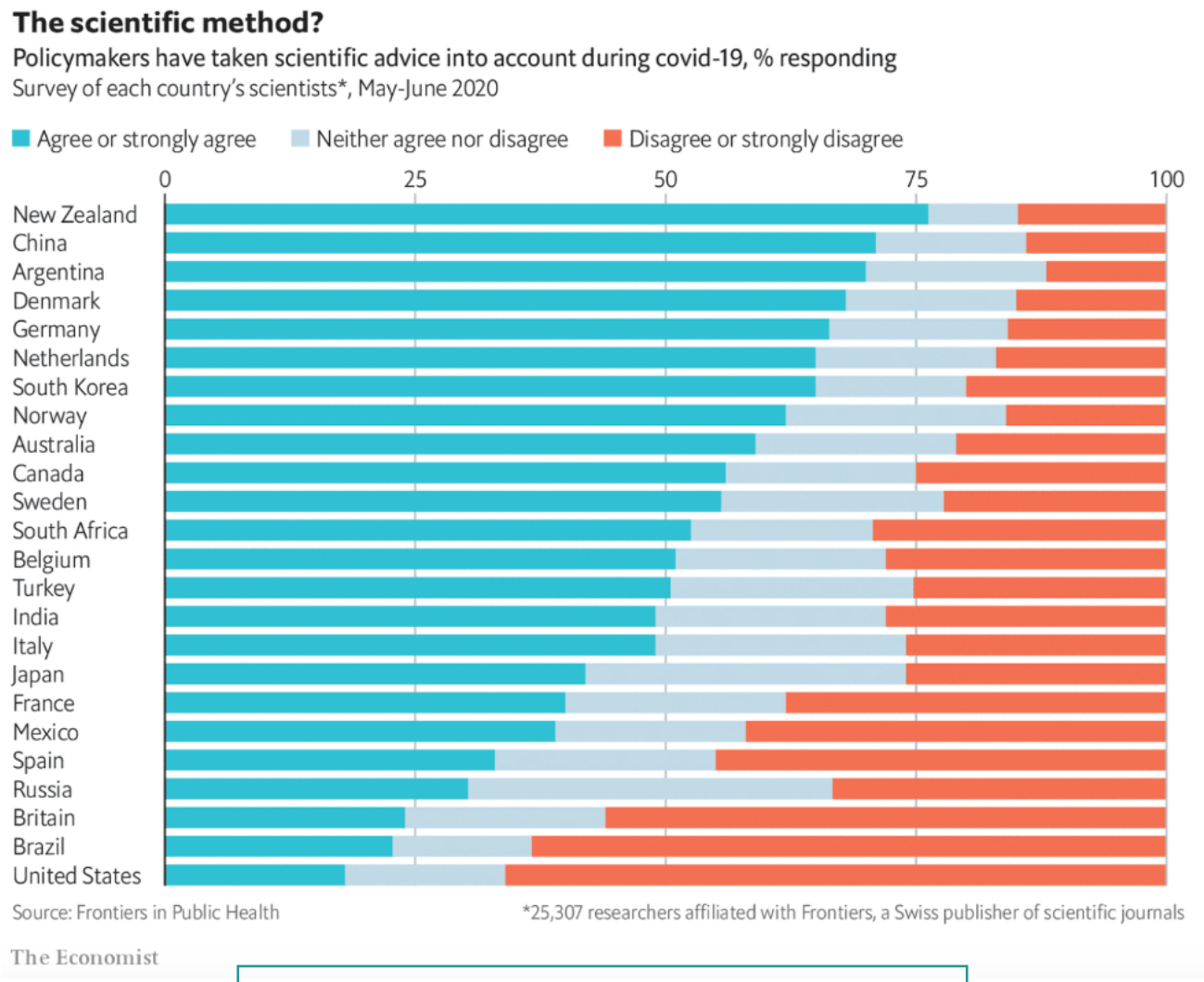


Fig. 1. Are governments following the science on COVID-19? Source: reference 21

Message for global leaders and other stakeholders

We urge all global leaders and other stakeholders to come together to ensure coherent action and to build trust and accountability by widening participation in health governance at all levels.

Civil society has a crucial role to play in accelerating progress towards UHC by influencing agenda-setting, contributing to and monitoring policy implementation and holding governments to account. Although the participation of non-State actors such as the media, patient organizations, research organizations and auditors in global decisions has increased and new models of governance have emerged in which civil society and other non-State actors have formed constituencies, their participation and ability to hold leaders to account are still challenged.

The process of voluntary national reviews (VNRs) should be transformed. Our findings show that, while more countries and civil societies have recently reported progress in UHC, more is required to make SDG review work properly, to ensure more objective, accurate reporting of progress in meeting measurable UHC commitments.

CSO participation is limited by unclear, non-standardized reporting and the lack of measurable

national targets for UHC. Our survey indicated that many CSOs are unaware of global accountability mechanisms and do not know where or how they can participate in decision-making, especially at global level. They also face managerial, technical and funding constraints to their participation.

Improving CSO participation is not the responsibility only of governments and global health institutions. It will also require health-focused CSOs to become more proactive in engaging in accountability processes like VNRs and demanding a seat at the table in such processes.

Without access to global platforms and better understanding of global accountability mechanisms whereby commitments are made and country progress is reported, civil society cannot track implementation of national targets or effectively hold leaders to account for their words and actions. The types of commitments and actions taken by governments should be communicated clearly nationally, regionally and globally. A review of the statements made at the UN high-level meeting on UHC and the Seventy-first World Health Assembly indicates that approximately half the political statements lacked a clear commitment (14) to move UHC forward at national level.

There is concern that the involvement in COVID-19 responses of CSOs, the private sector and other stakeholders has been limited by divergence of funds from regional and national advocacy platforms to the pandemic response.

Multi-stakeholder participation in social and political accountability for UHC must be strengthened at all levels, including making governance mechanisms, platforms, laws and regulations accessible to civil society to ensure its effective participation. Their participation should be institutionalized as an acknowledged, formal relation for monitoring, reviewing and making recommendations and for monitoring the solutions and actions that follow. The process should also be democratized, as recommended in a recent report of the Independent Accountability Panel (23), so that all levels of political leadership, government and other stakeholders listen to and act upon the expressed needs and priorities of the people. Multilateral organizations and multi-stakeholder partnerships must provide scientific guidance and institutional support for active citizenship and bridge science and politics, so that leaders make the right political decisions based on science and evidence (23).

UN high-level meeting on universal health coverage, multi-stakeholder hearing

Photo Credit: @UHC2030 - Akihito Watabe

Introduction

Photo Credit: @WHO - Fanjan Combrink

Photo Credit: @WHO - Jim Holmes

Introduction

On 23 September 2019, the world's leaders came together at the United Nations (UN) General Assembly and made the most comprehensive commitment to health ever, to achieve universal health coverage (UHC) by endorsing a political declaration (11). In doing so, they reaffirmed the promises made in agreeing to the Sustainable Development Goals (SDGs), which include the goal of ensuring healthy lives and well-being for all at all ages. The political declaration represents a significant milestone in the global UHC movement, because, in addition to pledging to achieve UHC by 2030, leaders also committed themselves to a wide range of actions and investments in their health systems to accelerate progress and leave no one behind. WHO hailed the agreement as "the world's most comprehensive set of health commitments to be adopted at this level." (24).

The political declaration makes clear reference to scaling up investments in preventive health services, including the vital public health functions necessary to tackle the spread of infectious diseases. It was notable how few of the world's leaders mentioned public health services, or even primary care, in their speeches to the UN high-level meeting, despite stern warnings about a potential pandemic in the report of the Global Preparedness Monitoring Board, "A world at risk" (25), published on the eve of the meeting on UHC.

Less than 4 months later, the COVID-19 pandemic – an unprecedented challenge to global health and a threat to human security – took hold. It has provided an extreme test of the world's health systems in terms of their ability to ensure that everyone receives the promotive, preventive, curative, rehabilitative and palliative care services they need without suffering financial hardship: the definition of UHC. Regrettably, the global toll from COVID-19 and the health and economic impacts of the crisis indicate that the world is struggling to meet its UHC commitments. The resilience of systems in the spirit of UHC is seen in the ability to protect vulnerable populations from not only COVID-19 but also the knock-on effects and to maintain essential services for those who need them. The COVID-19 experience has brought to the fore the reality that the health systems of many countries were not adequately prepared to protect the health of their populations from COVID-19 or from routine threats to health. Behind these global figures, however, it would appear, at least at the time of writing in November 2020, that some countries have performed better than others in tackling COVID-19 and in maintaining their progress towards UHC, despite the pandemic. Many reviews are under way to understand the factors that account for this variable experience and the lessons that can be learnt to guide policies in the future in order to strengthen health security within broader health system reform for achieving UHC.

The International Health Partnership for UHC 2030 (UHC2030) is a global movement to build stronger health systems for UHC. It provides a multi-stakeholder platform to convene, build connections and promote enhanced political and financial commitments for UHC, more coherent health systems strengthening by all relevant partners, inclusive approaches and accountability for results, based on a shared vision for health systems that protect everyone and a shared commitment to leave no one behind.

Purpose

The aim of this review of the state of commitment to UHC is to curate the diverse views of a range of stakeholders on the current situation and commitments to making progress towards UHC by 2030. It asks a simple question: are governments taking action to fulfil their UHC commitments? The review is political, country-focused and action-oriented and therefore complements the more technical Global UHC monitoring reports (26), which address UHC indicators of service coverage and financial protection.

Monitoring progress in attaining UHC and holding everyone accountable to take the necessary action may require national data on the political dimensions of rights, governance and equity that are not always collected by national institutions. It also involves going beyond the face value of policy reports of what ought to be happening by providing empirical assessments of the experiences of people, especially the vulnerable, in accessing health services.

Recognizing that health system reform is inherently political, the profiles of individual countries in this review are presented to provide national stakeholders with information to be used in inclusive, participatory assessments of progress in UHC and commitments over time. The profiles provide the basis for feeding into regular country preparatory processes for regional summits and the UN High-level Political Forum on Sustainable Development, such as in voluntary national reviews (VNR). Brief syntheses of key political messages and findings from the multi-stakeholder review are provided for input to the UN high-level meeting on UHC in 2023 and beyond, including the UN Secretary-General's progress report.

This inaugural synthesis includes challenges and opportunities for advancing UHC seen through the lens of how well the world has coped to date (November 2020) in addressing the COVID-19 pandemic. As UHC is a political choice to be made by every nation and its achievement depends on the emerging priorities of political leaders and people, the synthesis also seeks to contribute to and influence the debate on how the world can recover lost ground and recover better.

Methods

This review of the state of UHC commitment consolidates stakeholder perspectives of global and country progress towards UHC by 2030 and includes information from academic sources and the media. Mixed methods were used to triangulate data from UN systems, governments and non-State actors. Fig. 2 outlines the approach taken, which combines an online survey, quantitative data analysis, a literature review of VNR reports and additional sources, including a Wakelet repository (27) of over 700 articles, input from the civil society engagement mechanism (CSEM) for UHC2030, country consultations and articles on the constituencies of UHC2030 submitted by its partners.

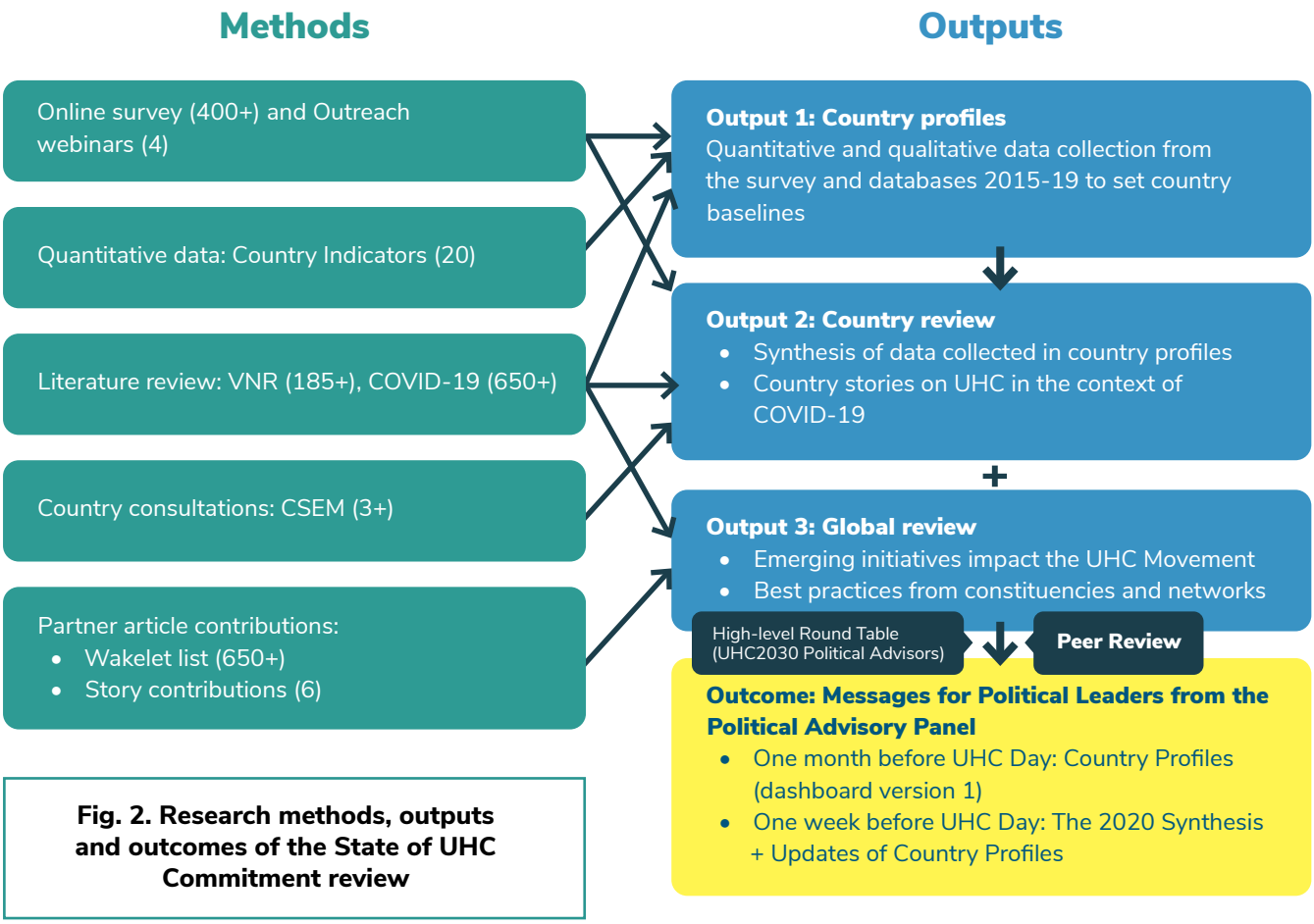


Fig. 2. Research methods, outputs and outcomes of the State of UHC Commitment review

The survey was structured to elicit information on the key targets, commitments and follow-up actions of the political declaration of the UN high-level meeting on UHC. The participants included stakeholders beyond health experts and governments, such as CSOs, academia, parliamentarians, the private sector and the media. The review will be conducted annually to update the profiles of selected countries, with a brief synthesis of key political messages and findings from a multi-stakeholder review. This first review includes analyses of data from 2015 to the present and other sources of information in order to establish a baseline for country profiles of the state of UHC commitment in all 193 UN Member States, regardless of data availability. This first synthesis includes only a limited number of country stories that are

publicly available or extracted from the survey. After 2021, the review will indicate progress. Each year, the focus will be on countries that provide VNRs to the UN high-level political forum, allowing our assessments to support and feed into country-led multi-stakeholder dialogue on a comprehensive review of sustainable development, rather than creating a parallel accountability mechanism for UHC.

We collected stakeholders' perspectives on how countries are performing in eight areas of commitment in the 2019 political declaration on UHC (2) (Fig. 3), which were selected on the basis of the "Key Asks" from the UHC movement.

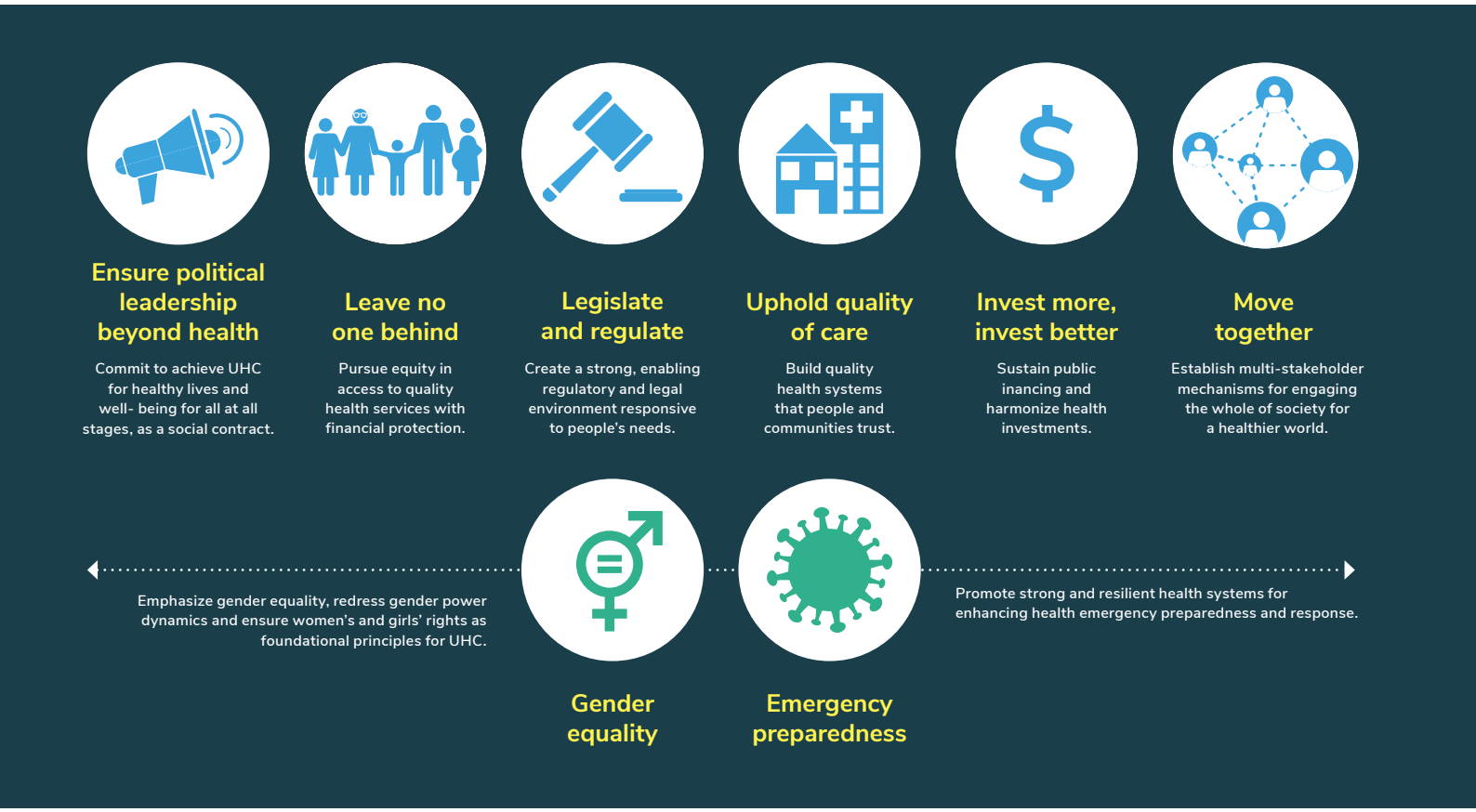


Fig. 3. Key targets, commitments and actions in the political declaration on UHC

Country progress towards UHC during a global health emergency

Photo Credit: @WHO - Lisette Poole

Photo Credit: @WHO - Fabeha Monir

Country progress towards UHC during a global health emergency

Ensure Political Leadership Beyond Health

Message for national political leaders

Prioritize UHC to tackle and recover from the COVID-19 pandemic, allay anxiety and rebuild trust.

Policy recommendations

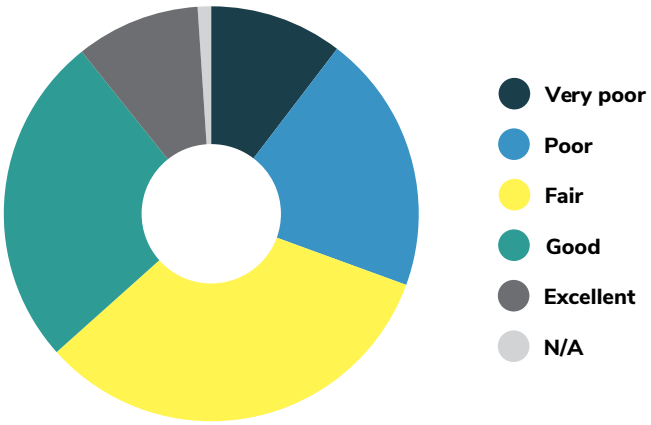
- Tackling COVID-19 and recovering better call for a genuine, effective, multi-sectoral approach by governments, including local, municipal and regional governments, and not health ministries alone.
- Governments should be proactive rather than reactive and adopt inclusive COVID-19 strategies that bring people together in national solidarity, working towards a common goal.
- Clear messages, transparent data and evidence-based decision-making are critical for building trust and ensuring compliance with vital public health measures. Governments must urgently halt the spread of misinformation and false rumours about COVID-19 and vaccine safety.
- Beyond their immediate COVID-19 responses, governments must clearly communicate on progress and the actions they are taking to achieve UHC, including setting clear targets to improve service coverage and financial protection and communicating them to all stakeholders.
- Governments should strengthen their health security systems within their longer-term UHC strategies and recover better with a view to accelerating progress in achieving all the SDGs.

Findings

- **Across the world, people at all income levels are fearful and anxious about the COVID-19 crisis,** especially its possible impact on their health and economic well-being. Recognizing that the pandemic is not only a public health crisis but that the implications go beyond the health sector, they are turning to their heads of government to solve the crisis

and alleviate their fears. People have recurrently feared going to health services during the pandemic because of concern about contracting the virus. Anxiety, stress and fear were commonly mentioned in our survey. Stigmatization was another barrier to accessing health services. Our survey and international media reports indicate that, whereas some leaders are perceived to have performed well, others have been slow to respond or even dismissive of the pandemic, which has eroded trust in their leadership.

- **Government performance has been variable.** With regard to the performance of their governments in tackling recent epidemics, survey respondents expressed a broad variety of opinions, the most frequent (33%) response being "fair", roughly similar numbers reporting "good" (26%) and "poor" (20%) and 10% each for the more extreme responses of "very poor" and "excellent". Interestingly, these responses were fairly independent of income level, with a roughly even distribution of "excellent" and "very poor" ratings from high- and low-income countries. Critical comments on the response of political leaders included concern about lack of preparedness, unclear or even confused messages, corruption and poor transparency, politicization of COVID-19 and neglect of other (non-COVID-19) health services and diseases.



- **The survey indicated that lack of clear, evidence-based messages from governments incites fear and mistrust in the population.** Health care workers also expressed fear of COVID-19, and in many cases health workers have protested about their working conditions and lack of personal protective equipment; some have refused to treat patients. Such situations clearly exacerbate people's fear and undermine trust in the health system, the government and its political leaders.

- **There has been considerable variation in the extent to which political leaders have implemented public health measures to curb the spread of the coronavirus and have initiated emergency economic policies to protect businesses, jobs and people's living standards.** Wide variation was also seen in how quickly leaders have acted, some being accused of being slow and others of being too hasty in enacting draconian measures that have imposed hardship on people forced into lockdown or having to relocate (Box 1).

- **Responses within countries have also varied.** In some countries in which subnational and local governments have considerably devolved powers, the approaches of national and subnational leaders have differed significantly, which has fuelled heated political debates about which strategy is in the best interests of the people. Political leaders are therefore under close scrutiny and are increasingly recognizing that, in view of the enormous stakes involved, their performance in tackling COVID-19 may make or break their political careers.

Box 1. Evidence-based, inclusive communication is the key to building trust.

The political leadership of New Zealand's Government has received plaudits during the COVID-19 crisis, both domestically and internationally. In February 2020, when the first cases appeared in the country, the Government responded to advice from public health advisers and implemented a "go hard, go early" lockdown to stop the spread of the virus. The Government also used an inclusive communications strategy, referring to the population as "the team of 5 million" and using clear messages to explain why the public health measures were necessary for the long-term welfare of the people. The strategy was widely accepted and complied with, which has been credited as a major factor in New Zealand's early containment of the virus, with only 35 deaths reported by the end of October 2020.

In contrast, the early response of the federal government in the USA was to play down the significance of the threat posed by COVID-19. Divisiveness has been recognized as a feature of the US response, and the population has been polarized on issues such as wearing face masks. The lack of uniform adherence to public health measures and the divisions in society are widely acknowledged as having contributed to the country's struggle to control transmission of the virus.

Sources: references 8–10, 28–30

Leave No One Behind

Message for national political leaders

Address the systemic inequities that are widening with COVID-19 by creating stronger social and financial safety nets and prioritizing equity every step of the way.

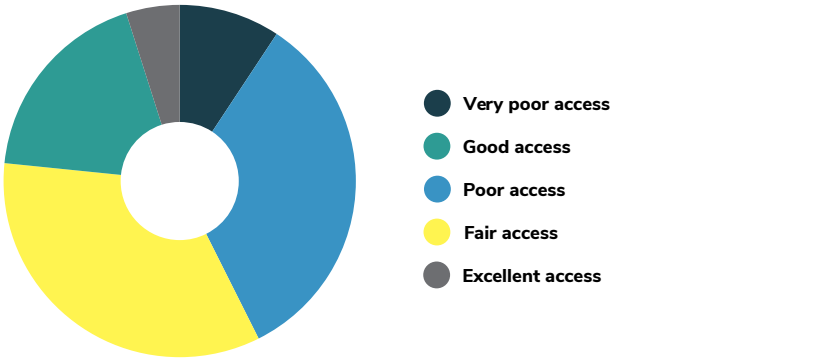
Policy recommendations

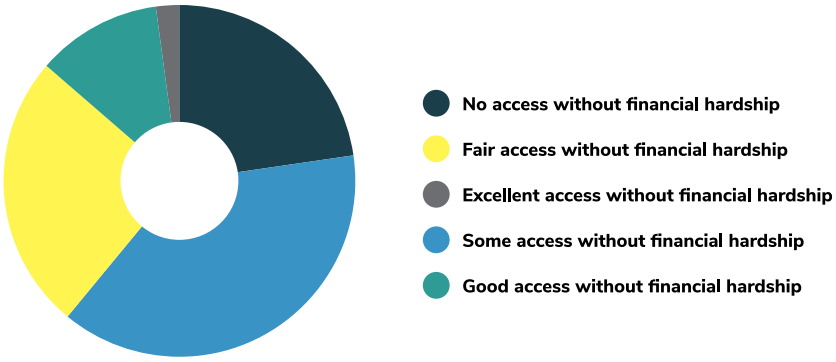
- UHC is by definition universal: nobody should be left behind in accessing vital health services, especially in a pandemic of an infectious disease that threatens us all. As access to health services should be determined by need and financed according to ability to pay, more attention should be paid to achieving UHC equitably, prioritizing the needs of the most vulnerable.
- Governments should heed the advice of the UN to suspend health service user fees during the pandemic and to move away from selective health insurance schemes to guaranteeing universal entitlement to publicly financed health services (1).

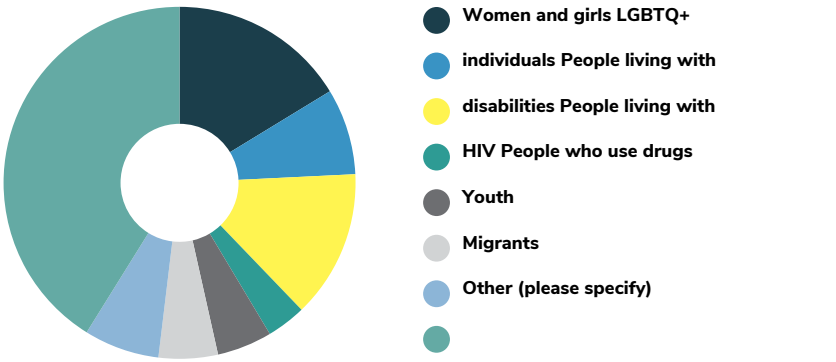
- No one should face financial, geographical or cultural barriers to access to essential COVID-19-related services, including testing, treatment, palliative care and vaccines, once they become available. Special measures should be taken to ensure equity and protect the most vulnerable at greatest risk, including front-line health workers. As these principles also apply to other vital health services, achieving universal access to COVID-19-related services should be seen as a springboard for accelerating progress towards UHC worldwide.
- Ensure adequate safety nets, beyond health services, to protect the livelihoods and welfare of vulnerable groups, including the poor, the elderly, people with disabilities, migrant populations, the homeless and people living in remote communities.
- Governments and the international community should seize the moment to protect the health and welfare of the most vulnerable; we are not safe unless everyone is safe.

Findings

- **One third of survey respondents said that people had poor access to health services in their country.** Furthermore, 10% of respondents claimed that access was very poor. Less than 25% considered that access to services was good or excellent.
- **People are suffering significant financial hardship in accessing health services.** Only 14% of respondents said that access without financial hardship was "good" or "excellent", the majority said it was "fair" or "some access", whereas 23% said there was no access without financial hardship.
- **COVID-19 has magnified inequities.** The global survey concords with other analyses in showing that the most vulnerable are hardest hit by the direct and indirect effects of COVID-19. Specific groups identified by respondents as being left behind







were women and girls, people living in remote and rural settings, the poor, people suffering from HIV and tuberculosis, people with rare diseases, LGBTQ+ individuals, migrants, people with noncommunicable diseases and people with disabilities.

- **Even in high-income countries, vulnerable groups are being left behind,** notably elderly people living in residential care homes, people requiring palliative care, migrant populations living in poor housing with inadequate workplace protection and homeless people, who are slipping through social safety nets (Box 2).

Box 2. Migrants and refugees are vulnerable groups being left behind

Across the world, migrants and refugees have been shown to be particularly vulnerable to the health and economic impacts of COVID-19. This is often due to higher rates of transmission of the virus in populations living in overcrowded accommodation with poor access to health and sanitation services, which limits their ability to follow public health measures, including hand-washing, social distancing and self-isolating if they have symptoms. In addition, because of their often precarious legal and employment status, migrants and refugees find it harder to access health services (as reported in our survey), which undermines their ability to be tested for the virus and treated appropriately. This not only poses a threat to their health and well-being but represents a threat to collective health security by reducing the ability of communities and governments to reduce transmission of the virus.

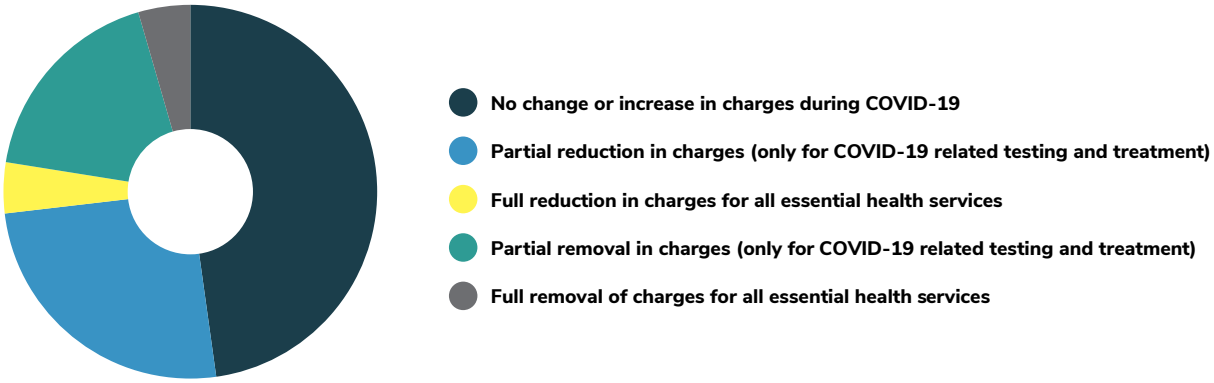
Even in wealthy countries that have performed relatively well in containing COVID-19, such as Germany and Singapore, outbreaks have flared up in migrant communities with poorer health and less social protection. Large populations of migrant workers and their families have suffered considerable economic hardship and heightened health risks, such as in lockdown measures that forced urban workers to return to rural villages in India.

Sources: references 31–33

Front-line health workers are not always given the protection they need. In view of their vulnerability, front-line health workers should be protected by governments as a priority. But, evidence of higher mortality rates (34) and numerous media stories of inadequate personal protective equipment for health workers have shown this not to be the case.

- **Large numbers of people are left behind in countries that have selective health insurance schemes.** In some regions, notably South Asia, Latin America and some countries in Africa and North America, people must be members of a health insurance scheme linked to their employment or a beneficiary of a scheme for the poor in order to access health services. This leaves hundreds of millions of people without effective health coverage, and the numbers are set to rise as unemployment rates increase as a consequence of the pandemic.

- **Countries are doing little to reduce financial barriers.** Almost half the survey respondents reported that there had been no change or even an increase in user charges during the COVID-19 pandemic. Some countries (e.g. the Islamic Republic of Iran and Turkey) have, however, removed or reduced health care user fees to increase the uptake of vital health services (Box 3).



Box 3. Some countries are removing user fees to improve access to services

It is now widely acknowledged that health service user fees are the worst way to finance a health system and are incompatible with UHC because they prevent poor and vulnerable people from accessing services. As it is particularly important that everyone access the health services they need during a pandemic, WHO has issued a recommendation to all countries to suspend user fees for COVID-19 and other essential health care. Few countries that charge fees have heeded this advice, and international donors are doing little to help. In research by Oxfam, only 8 of 71 World Bank country projects on COVID-19 country included any plan to remove health care user fees, even though out-of-pocket spending on health in 80% of the countries is above the WHO safe level, accounting for 20% of total health expenditure. Examples of countries that have removed user fees include:

Islamic Republic of Iran, which has announced that it will extend free COVID-19-related health services to all migrants and refugees in the country; and

Turkey, which is providing universal free COVID-19 services, including to people not covered by the national health insurance programme, and is providing free face masks to its population.

Sources: references 35–37

Regulate and Legislate

Message for national political leaders

Extend and strengthen UHC legislation and regulations, set clear targets, and communicate better to bring people together.

Policy recommendations

- Governments should increase awareness among their populations about UHC laws, regulations and accountability mechanisms. This is essential in order for people and electorates to hold their governments to account in meeting their UHC commitments.
- Governments must commit themselves to setting national UHC targets and communicating them clearly to multi-stakeholder audiences at local, national and global levels. Accountability requires a common understanding of the commitments made. Very few governments provide clear, measurable UHC targets in their VNRs or in global political statements. National targets should therefore be publicized openly and made understandable and accessible for populations across the world.
- Where UHC laws and regulations are lacking, parliamentarians will have a key role in translating the commitments made at the 2019 UN high-level meeting on UHC and the expectations of the electorate into appropriate legislation.
- Governments should institutionalize and mandate social and political accountability mechanisms and implement concrete plans to monitor the impacts of laws and policies on UHC.
- In planning and implementing emergency measures to combat COVID-19, governments should ensure that legislation and regulations are compatible with the principles of rights and equity of UHC.
- Governments should improve regulation of private health providers and insurance companies in particular, to ensure that vulnerable individuals are not exploited.
- The COVID-19 crisis may give governments an excellent opportunity to pass legislation for accelerating progress towards UHC.

Findings

- **In our survey, people's awareness of UHC laws, policies and accountability mechanisms was limited.** This is a concern if people are to hold their governments accountable for achieving UHC, as what will they hold them accountable for and through which mechanisms? Asked if they were aware of a specific national law or policy on UHC, only 35% responded "yes", while 65% responded either "no" or "unknown" or did not answer the question.

- **When giving examples of UHC-related laws, survey respondents often referred to references to health in their constitutions and relatively old laws, rather than to recent legislation to extend health coverage.** Respondents at all income levels commented that, although UHC laws and policies existed on paper, they were not implemented adequately. A lack of awareness was even more striking with regard to accountability and monitoring mechanisms for UHC: only 18% of respondents said that they were aware of any such mechanism in their country.
- **Awareness of specific UHC targets was marginally better:** 30% or respondents reported that they were aware that their governments had set measurable, specific UHC targets.
- **In 2020, virtually all countries introduced emergency public health measures, including new legislation, with the intention of stopping the spread of COVID-19 and therefore protecting the health of the population.** These include travel bans, compulsory wearing of face masks, restricting social gatherings, closing workplaces and schools and requiring people who test positive and their close contacts to self-isolate. These policies have been accompanied by economic measures, including legislation, to reduce financial hardship associated with reduced economic activity. In general, there has been good compliance with these types of regulations across the world, which, as they are universal and needs-based, are also compatible with the ideals of UHC.
- **Some countries have implemented or announced new legislation** specifically for accelerating progress towards UHC (Box 4).

Box 4. Countries that have accelerated UHC reforms during the COVID-19 pandemic

On 1 June 2020, Cyprus launched the second phase of its national health insurance system, adding hospital services, including private providers, to the publicly financed benefits package. In a national address, the President said that the COVID-19 crisis represented the best moment to launch the reforms, calling them “the biggest reforms in the history of the Republic of Cyprus”.

Throughout the COVID-19 pandemic, the President of South Africa has signalled his intention to accelerate reform of the Government’s national health insurance. Early in the crisis, the Government enacted new legislation that requires private providers to enter into contracts with public purchasers to improve access to services for previously uninsured citizens. This represents a “trial run” for the reforms envisaged in a bill being debated by Parliament. If this public–private partnership proves successful, the Government plans to reach full population coverage with national health insurance by 2025.

Sources: references 38, 39

- **Inadequate regulation of private providers has been highlighted as an area of concern in some countries**, especially during the COVID-19 crisis, with evidence that private providers have charged excessive fees to patients requiring intensive treatments (Box 5).

Box 5. Poor legislation and regulations make health care overly expensive.

In recent months, there have been numerous media stories of exploitative charging for COVID-19-related services by private health care providers in health systems dominated by privately financed hospitals. This has particularly been the case in India's poorly regulated private insurance and hospital system, whereby patients reported having been overcharged for treatments and insurance companies have refused to cover their bills, leaving families facing crippling out-of-pocket payment. In a number of instances, the disputes have resulted in lengthy, costly legal battles. Some Indian states have brought in emergency legislation to cap hospital prices for expensive COVID-19 services (for example day rates in intensive care units), but the media still report hospitals that continue to overcharge.

Likewise in the USA, there have frequently been stories of excessive charging of vulnerable COVID-19 patients by the predominantly privately financed health system. During the early stages of the pandemic, uninsured Americans could face bills of up to US$ 74 310 if they were hospitalized with COVID-19, and those with insurance who used in-network providers could still face out-of-pocket costs of up to US$ 38 755, depending on their health plan. Although the Families First Coronavirus Response Act was passed on 18 March 2020, guaranteeing free testing regardless of insurance status, many still face high out-of-pocket costs for testing because of loopholes in the legislation.

Sources: references 40–43

Uphold Quality of Care

Message for national political leaders

Support, protect and care for health workers, and innovate to improve and maintain quality during emergencies.

Policy recommendations

- Increase public spending on a spectrum of health services – from preventive to palliative care – to maintain and improve the quality of services, to respond to the additional

demands of the COVID-19 pandemic and to sustain existing services. This will require investment in all the building blocks of health systems that are the foundations of a universal, high-quality health system.

- Invest heavily in strengthening human resources for health, as these represent the most important asset in combatting COVID-19 and maintaining good-quality health services. This will involve recruiting and training more health workers, increasing their remuneration and providing them with the resources they need to do their vital work safely.
- Implement special measures to improve access to essential medicines, particularly for people with noncommunicable diseases whose lives are threatened if they do not receive their medicines. The measures could involve removing all user fees for essential medicines, providing larger prescriptions to give patients longer supplies or introducing digital prescribing systems.
- Improve communication both within the health system and among the population. This should include issuing operational guidance for maintaining essential health services and ensuring access to high-quality essential health services for all.
- Strengthen accountability, and tackle corruption. Citizen engagement is essential to ensure that resources are allocated efficiently and equitably and are spent appropriately and effectively. This should involve the participation of social actors and enabling citizens to request information as part of freedom of Information and to report on irregularities in procurement of treatment for COVID-19. Encourage open, transparent reporting of public funds allocated for health care suppliers, contracts and emergency procurements, and ensure that health care data are in formats that allow complex analysis, comparison and reuse.

Findings

- **COVID-19 has exposed the fragility of health systems and other sectors in most countries.** Baseline capacity was already low in many countries, with understaffed services, poor infrastructure and lack of health products. Many survey respondents mentioned that underfunded, poorly governed health systems were struggling before the pandemic.
- **Access to health services and medications has been significantly impaired in nearly all countries.** Restrictions on movement (e.g. lockdowns, border closures) were the most commonly mentioned source of difficulties in accessing health care services. For example, many survey respondents mentioned the closure of outpatient health services, postponement of procedures and appointments and inability to access medications for various reasons (e.g. supply chain interruptions).
- **Front-line health workers have not been supported adequately, which is adversely affecting service quality.** In virtually all countries, the COVID-19 pandemic has put front-line health workers under immense pressure and exposed shortcomings in their numbers, their inefficient and inequitable distribution, their levels of remuneration and the inadequate resources available to them to provide high-quality services, including major failure in providing adequate personal protective equipment.

Box 6. Under-investment in human resources affects the quality of services.

Malawi has always provided free universal health care to its population. Those services are, however, under considerable strain because of low levels of public financing and now the pressure of COVID-19, which are clearly affecting service quality.

During the pandemic, vital health services have been interrupted in most parts of the country, the burden tending to fall on under-resourced front-line health workers. Early in the pandemic, health workers did not receive agreed payments for risk and overtime and lacked vital personal protective equipment to ensure that they worked safely. As a result, many took strike action, which further reduced the availability and quality of front-line services. Staff complained that vital maternal and child services were being compromised by withdrawal of funds to finance COVID-19-related services. The disruption of these services is undermining sexual and reproductive rights and highlights the need for a crisis-resistant national UHC strategy in the country.

These challenges are not unique to Malawi and have been recorded in countries at all income levels, including France, Nigeria and Peru.

Sources: references 40–43

- **Poor communication has led to confusion and limited access to services.** Survey respondents noted that communities were often not informed about COVID-19-related disruptions to services or were unclear about where they could access services. Poor communication also fuelled the spread of misinformation about COVID-19. Respondents reported that: “People are confused.” (Burundi); “People lack information that, when the hospital closed, where they can check their health safely, or access to health service if needed.” (Viet Nam); and “People in my country don’t believe in the pandemic. They said it’s fake. They go about with their normal lives. Nothing has changed, and it’s as it used to be.” (Nigeria).
- **Survey respondents had different definitions of good-quality health services and the indicators to be used to monitor it.** Most referred to factors in WHO’s health system building blocks, namely: human resources, availability of medicines, infrastructure, equipment, geographical access to services, rural–urban divides, long waiting times, access depending on ability to pay and the governance of health systems, including corruption (Box 7). Poorer quality has been reported by regular users of health services, including tuberculosis patients, HIV patients, users of sexual and reproductive health and rights and family planning services and patients with noncommunicable, chronic and rare diseases.

Box 7. Corruption undermines the delivery of high-quality care.

When corruption drains away limited public financing, quality inevitably suffers. This manifest itself in dilapidated infrastructure, inadequate numbers of health workers, shortages of medicines and unofficial payments making care unaffordable for some. This increases inequalities and undermines the population's trust in public health services.

Brazil has had a universal, free, publicly financed health system since 1988, which guarantees free access to all levels of health services, from primary care to specialized services. According to a survey respondent, "Although the quality of public health services is not always good, its wide coverage allows most Brazilians to fulfil basic needs and access more complex treatments." Its performance has, however, been undermined for years by corruption, which has continued into the COVID-19 pandemic, with evidence of violation of people's right to free access. Transparency International's Global Barometer 2019 revealed that 5% of those interviewed paid bribes to access health services in hospitals and health centres. Nearly 1500 federal criminal judicial proceedings have been opened into coronavirus-related corruption cases, reaching all levels of the Government. They include investigations into misuse of federal funds, fraud, overpricing and money laundering.

Investigators in Bolivia, Colombia, Ecuador and Peru have also alleged that officials have benefitted from pandemic-related graft schemes. Although there are official mechanisms to combat corruption (e.g. federal, state and municipal councils and, in Brazil, an ombudsperson), they have not popularized social oversight so that citizens could denounce such practices and contribute to a better health care system.

Sources: references 48, 49

- **While the crisis has generated many challenges, it has also created opportunities to innovate and improve health care delivery.** This has been seen in the rapid scaling up of tele-health and tele-medicine services to maintain and even increase access to vital services, particularly for people living in remote areas or who are self-isolating to avoid infection (Box 8).
- As countries struggle to access equipment and products on international markets, the crisis has also incentivized countries to invest in local manufacture of health commodities. For example, Kenya is scaling up the production of personal protective equipment (50).

Box 8. Innovation in response to COVID-19 is improving quality

The Australian Government was quick to use virtual health care in response to COVID-19. On 10 July 2020, the federal Minister for Health announced a number of temporary Medicare services to ensure that health care practitioners could deliver tele-health services by phone or video conferencing. The goal was to protect health care professionals, their staff and patients from unnecessary risks of infection while performing business as usual in the new remote environment.

The country was also quick to adopt and change legislation to allow medical staff temporarily to create a digital image of a patient's prescription to ensure a supply of their medicines. In this interim arrangement, the health worker converts a paper prescription into an "image-based prescription" that can be sent to his or her preferred pharmacy. The Government is now working with providers on clinical software to be introduced in early 2021 to support fully electronic prescribing.

There has also been considerable local innovation in Australia's health system to sustain and improve quality. In Victoria, the state with the largest outbreak, Monash Health and The Alfred Hospital, in partnership with Deakin University, are testing use of artificial intelligence to triage patients, with continuous monitoring via an app. The Royal Prince Alfred Hospital in Sydney has opened the first virtual ward in Australia. It is too early to determine whether these innovations will translate into systemic change at state or national level.

Sources: references 51, 52

Invest More, Invest Better

Message for national political leaders

Invest in primary health care as a joint effort of health and finance ministers and local governments, to ensure the continuity of essential health services and provide first-line defence against outbreaks.

Policy recommendations

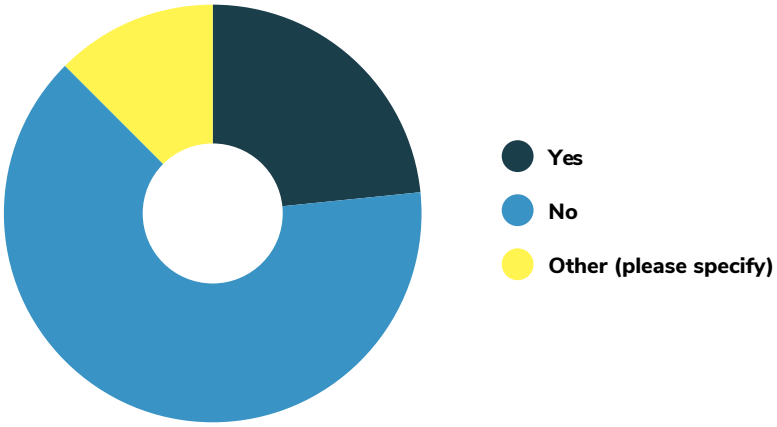
- In the midst of the worst global health crisis in more than a century, governments should respond to the expressed needs of their people and invest heavily in health. In particular, as people are so fearful about their health and that of their loved ones and about potential

financial hardship associated with the pandemic, this is the ideal opportunity for increasing public spending to accelerate health system reform to improve access to vital health services and reduce the financial burden on households.

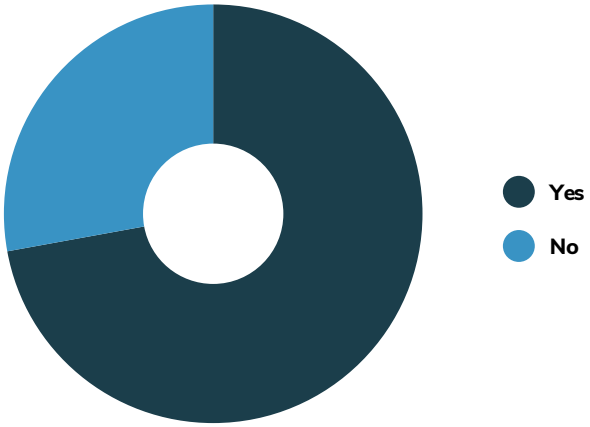
- Increasing public spending will not, however, be sufficient. Both additional and existing resources should be spent better. This will be facilitated through health system reforms for UHC that prioritize spending on cost-effective primary health care, including community services.
- More public financing should be allocated to collective public health services (including for pandemic preparedness) to ensure that they are well integrated in overall health system reform. For too long, strengthening of health systems has consisted almost exclusively of services for individuals (through health centres and hospitals). This must change; public health functions must be given greater prominence and more public financing.
- Governments should show greater commitment to reducing inefficiency in health systems and, especially, tackling corruption in public health spending. Corruption scandals during the COVID-19 crisis are attracting much unfavourable media coverage and are seriously undermining the credibility of the commitment of some governments to tackle the pandemic and achieve UHC.

Findings

- **When asked "Is your government spending enough on health services and is this increasing?" almost two thirds (64%) of our survey respondents said "no", and only 24% responded "yes".** The responses indicated that governments were failing to meet the levels of public financing they had set themselves publicly, indicating a clear breach of their UHC commitments.



- **People have to pay for their health care out of pocket.** As a consequence of underinvestment in health by governments, about three quarters of survey respondents reported that people had to pay directly for health services in their countries.



- **Governments have been increasing public health budgets, but some have reduced them.** Whereas there has been little research on changes in public health expenditure during 2020, the media have reported increasing health budget allocations in response to the pandemic (Box 9).

Box 9. Taking advantage of COVID-19 to prioritize health spending

Ireland increased its health budget by 12% during the current financial year in response to COVID-19, and, in October 2020, announced that next year's budget would be increased by 24% – the largest rise in the country's history. In addition to emergency funding to tackle the pandemic, the resources will be used to accelerate the country's UHC strategy (Sláintecare), with large increases in funding for mental health services and health promotion.

Morocco has substantially increased public health spending in response to the COVID-19 pandemic and has allocated about one third of a US$ 1.1 billion special fund for COVID-19 established in March 2020. This represents an increase of 19% in the annual health budget. Furthermore, the Government has announced that next year's national health budget will rise by 11%, specifically to advance equitable access to health services, including covering an additional 22 million people with compulsory health insurance by the end of 2022.

Sources: references 53–56

- **When survey respondents were asked where governments should be spending more, a broad range of services were cited**, including health facilities, health workers, medicines, primary health care (notably prevention), health promotion, health education and community services.
- **Only a few respondents mentioned public spending in the private sector and for secondary and tertiary level services, indicating a preference for primary health care rather than hospital services.** Some called for local responses to COVID-19 and investment in strengthening community capacity to respond to outbreaks of infectious diseases.
- **Interestingly, very few respondents specifically mentioned investment in vital public health functions to control infectious diseases**, although some references to "prevention" may have included this aspect. The overall response would suggest that people (and therefore electorates) prefer greater government expenditure on visible health services that they and their families use as individuals to vital collective public health services that benefit everyone.

- **A number of respondents referred to improving the efficiency of public health spending and the vital importance of eradicating corruption, which directly undermines UHC reforms.** Corruption in public health spending was flagged as a significant problem in Brazil, Kenya, Mozambique, South Africa and the United Republic of Tanzania.

Move Together

Message for national political leaders

Build partnerships through genuine civil society engagement.

Policy recommendations

- UHC reviews should involve multiple stakeholders. People, communities, CSOs and the private sector should have formal opportunities to contribute to decisions about health.
- The role of civil society in pushing forward the UHC agenda and promoting effective health, social and political measures during the COVID-19 pandemic should not be underestimated. Civil society serves as a bridge and facilitator between governments and the public and acts as a barrier in protecting civil space from repressive State intervention.
- Civil society should be included in accountability for UHC. It is time to democratize accountability as a process that values and responds to people's lived experience.
- CSOs representing every sector of the population, including minority groups and those discriminated against because of gender, ethnic group, age, sexual orientation, religious beliefs or socio-economic status, should be included in social participation to advance UHC and tackle COVID-19. Their involvement should be properly resourced and conducted in a consistent, measurable way and not be considered a "tick-box exercise".
- Governments should work with CSOs and stakeholders from all sectors and strengthen their relations with them, as they can be important, instrumental actors in reaching populations during a health crisis.
- Transparent and participatory processes should be formalized for making decisions that affect communities. CSOs should be engaged in debates on key issues and in priority-setting. The private sector should be sensitized to the needs and issues that affect communities.

Findings

- **Approximately 40% of survey respondents considered that people, communities, organizations and the private sector in their country had formal opportunities to contribute to health policy decision-making**, while about 30% considered that this was not the case; 7% of respondents replied that they did not know, and 15% did not answer

the question. Professional CSOs and international organizations are more likely to be invited to contribute to policy-making.

- **Private sector organizations significantly influence health policies and participate in health service provision**, especially during COVID-19, whereas organizations that represent the people most affected by health policies have less chance of influencing them.
- **About 10% of respondents, most in low- and middle-income countries, reported poor or no multi-stakeholder engagement in health planning**. A further 9% indicated that community engagement is deficient. Others pointed out that, when consultations with civil society occur, they do not necessarily result in implementation of specific policies.
- **Very few VNRs include engagement with civil society or the private sector**. VNR "shadow reports" present an opportunity for civil society to engage in tracking UHC; however, only a few reports have been submitted: from 6 of 47 (13%) VNR countries in 2020 and 2019.
- **Countries with a vibrant, active civil society are more likely to interact with health legislators and policy-makers**. Even in countries with strong involvement of nongovernmental actors, however, there are gaps in accountability in the health sector.
- **CSOs often have the impression that they are talking to themselves and that they are consulted only to fulfil a requirement or formality**. The advice and requests of CSOs are often not considered in making high-level policy decisions. Sometimes, only some nongovernmental actors are consulted in policy-making (Box 10). Our research confirms that the voices of people and community organizations are not always heard in decision- and policy-making for UHC and in the COVID-19 response, and, when people's concerns are voiced, they are considered by policy-makers to only a limited extent or not at all.

Box 10. Limited engagement of CSOs in COVID-19 responses

Evidence from many sources shows that CSOs and communities have not been involved in their governments' COVID-19 responses, with the risk that national response plans do not take adequate stock of the disproportionate impacts of the pandemic.

For example, in France, the Government has not called on CSOs, despite a long tradition of civil society representation in national and regional health agencies. Patient associations were not invited to join either of the two official expert committees of the country's COVID-19 Scientific Council and were not consulted on the conditions for imposing or lifting lockdowns. This occurred despite offers from the associations of their services to improve communications and overcome the public's mistrust of Government decisions.

Sources: references 18, 57

- **Health services provided by the private sector often do not reach the poorest levels of society**. Survey respondents consistently noted that public health sector budgets should be increased to ensure that all people, including the poor, receive health services.
- **An equitable response to COVID-19 requires that civil society maintain its role and give a voice to the communities most likely to be left behind in the public emergency response**. The crisis is making it harder for civil society to respond, as closure of civic space, constraints on movement and increasingly authoritarian policies in many countries make advocacy and accountability extremely difficult (58).
- **CSOs and volunteer organizations have come to the forefront during the COVID-19 pandemic and are covering many basic community needs, such as providing food, water and sanitary products**. They have also alerted governments to the increased risks of populations, such as increasing gender violence and mental health issues (see Boxes 11 and 12).
- **When the status of CSOs is appropriately recognized and supported by other actors (national governments, international agencies), they can act as a bridge between governments and the people**. They are a voice for the most vulnerable and an ear for society's concerns.

Box 11. Participation of civil society in health policy-making

In Argentina, CSOs and other stakeholders, such as medical associations, are weighing into debates on establishing a health system that is more equitable and universal. Civil society representatives from all regions of the country met with Government officials in 2019 to discuss strategies for the next UN high-level meeting on UHC and to present the Government with demands for concrete, measurable commitments to UHC, to identify challenges and achievements in implementation of UHC and to advocate for participation of civil society in UHC reform.

During the pandemic, CSOs have continued to push for inclusion in decision-making and for the protection and the fulfilment of rights of the most vulnerable and disadvantaged groups, such as those working in the informal economy. They have also been working closely with community leaders, providing them with information on prevention measures against COVID-19 and other diseases, legal information pertaining to compulsory lockdown, guidance on institutional or gender-based violence and safety measures in public places.

Sources: references 59–65

Box 12. Effective collaboration between government and CSOs

Collaboration between the Government and CSOs has been effective in Fiji, with a swift, comprehensive response. The Fiji Ministry for Disaster Management explicitly requested the assistance of civil society in the country's COVID-19 response. The Fiji Council of Social Services and its subnational counterpart, the District Council of Social Services, are active in the country's disaster management system. The Government also requested Partners in Community Development Fiji to assist in the response, and their staff work with and report back to the Government divisional office daily. The COVID-19 CSO Alliance for COVID-19 Humanitarian Response (a partnership of various Fijian charities) has been providing humanitarian support to families and communities across Fiji and has set up a centre to distribute food rations and seedlings, facilitate training and provide counselling and legal services to those impacted by COVID-19.

Sources: references 66–73

Gender Equality

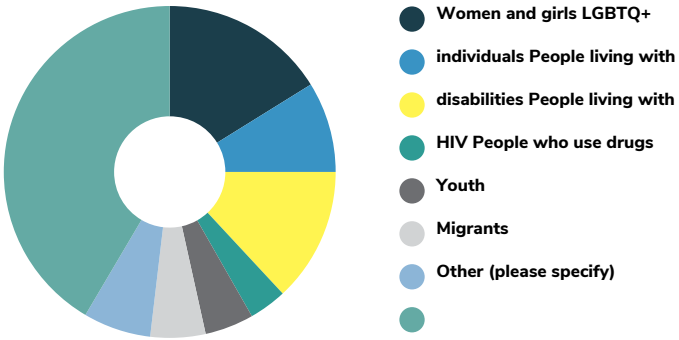
Message for national political leaders

Empower women, who are proving to be highly effective leaders in health emergencies.

Policy recommendations

- Gender-diverse representation and inclusion of experts on gender should be ensured on relevant national health committees for COVID-19 responses.
- Gender should be considered in preparedness, response and relief to ensure an equitable, inclusive approach to health emergencies.
- Intersectional and sex-disaggregated data should be collected and published by national authorities to inform preparedness, response and relief efforts.
- Public knowledge about barriers to accessing health services because of gender or sexual orientation or identity should be increased.
- Sexual and reproductive health services, including family planning (such as access to contraceptives and abortions), are essential services and cannot be disrupted due to COVID-19 restrictions.

Findings



- **Women and girls are still struggling to access health services**. When asked what group might struggle to access to health services, "women and girls" was the most common answer[1], 15.6% of survey respondents choosing this option.
- **Women and girls are disproportionately affected by barriers to accessing and using health services**. Survey respondents highlighted the structural barriers that women and girls experience, including financial hardship, lack of transport (especially if they live in rural areas) and lack of time because of a care burden or other unpaid labour. Our results indicate that much must be done to communicate the importance of gender as a barrier to access. The existence of specialized sexual and reproductive services for women (often provided free of charge in countries without UHC) gives the impression that women and girls receive beneficial treatment. This is misleading and does not reflect the huge structural barriers that women and girls across the world experience in accessing health care (Box 13).

Box 13. Disruption of sexual and reproductive health services during COVID-19

Many respondents to our survey described disruption of sexual and reproductive health services during the pandemic. A participant in Kenya explained the power structures that prevent women and girls from accessing health services:

[...] she often needs to ask a male family member for permission to go to the clinic and pay for services. Additionally, as the care takers of the home and family, it is difficult for women to leave without planning in advance. Accessing services like family planning is difficult for girls under the age of 18 who need permission.

In addition to social barriers such as that described above, countries failed to take into consideration the sexual and reproductive needs of women when responding to the pandemic, thus severely limiting access. This is particularly harmful in countries where abortion is illegal. Other countries deliberately closed abortion clinics by classifying them as non-essential – an ideological decision rather than one based on science. Lack of access to abortion services does not stop abortions; it just makes them unsafe and potentially lethal for the mother. In previous health emergencies, the unmet need for sexual and reproductive health needs has resulted in a 70% higher maternal mortality rate.

Sources: references 74–78

[1] The response options were: women and girls (15.6%, n=64), people living with disabilities (13%, n=53), LGBTQ+ individuals (8.1%, n=33), migrants (6.6%, n=27), young people (5.1%, n=21), people who use drugs (4.9%, n=20), people living with HIV (3.4%, n=14), other (please specify) (39.9%, n=163), no response (3.4%, n=14).

- **Health systems should be intersectional and gender-responsive**. Gender is not binary, and not all women or men experience the same problems. Many survey respondents mentioned financial hardship as a barrier to accessing health services; others raised the issue of discrimination against the LGBTQ+ community in the health system. During the pandemic, and especially in conjunction with the Black Lives Matters protests in the summer of 2020, the disproportionate suffering of Black, Asian and minority ethnic communities rose up the political agenda. Age has been shown to be an important predictor of the severity of COVID-19 symptoms. This diversity should be reflected in a truly intersectional, gender-responsive health systems approach, which is inclusive not only of gender but also of race, sexual identity, socio-economic status and geography, reflecting the UHC commitment of leaving no one behind.

- **Many responses to COVID-19, as to previous health emergencies, have been gender-blind**. The COVID-19 pandemic has exacerbated gender inequality in the same way as previous pandemics and infectious disease outbreaks. Primary and secondary health effects differ by gender identity. A gender-blind response cannot be adequate to address the different experiences and hardships of women, men and non-binary genders (79). Gender-blind responses ignore crucial information necessary to assess transmission patterns of the disease appropriately. The gendered impacts of the COVID-19 pandemic have been numerous. Globally, women comprise vast numbers of front-line health workers, thus increasing their risk of infection. Women working in other sectors have also been disproportionately affected by the pandemic, as, in many countries, women work in sectors heavily impacted by the pandemic or in the informal sector and have therefore been more likely to experience economic loss. Furthermore, the pandemic has entrenched gender norms whereby it is predominately women who take up unpaid care burdens, often at the expense of paid labour. As most countries having gone into some type of lockdown, many households have had to stay indoors during an intensely stressful period, and the incidence of domestic violence has increased across the globe, often with women victims.

- **Intersectional and sex-disaggregated data to inform responses and measure success are lacking**. Inability to acknowledge the gendered dimensions of health and, in particular, pandemics has led to a lack of intersectional and sex-disaggregated data. Already in 2012, Eklund and Tellier (80) found a profound lack of sex-disaggregated data for evaluating crisis responses. According to Global Health 50/50's COVID-19 sex-disaggregated data tracker (81), 126 countries have published sex-disaggregated data on confirmed cases; only 92 countries had reported sex-disaggregated numbers of deaths as of 19 October 2020, and only about half of all global cases and approximately 70% of global deaths were sex-disaggregated (82). Intersectional data collection systems must be established now and their use and maintenance promised for future health emergencies.

- **Women leaders during the pandemic**. The patriarchal nature of global and public health systems received increasing attention during 2020. van Daalen et al. (19).found that 85.2% of the members of COVID-19 national task forces are men. A similar power dynamic is seen on the global stage. For example, only one fourth of the participants in the first three committees on International Health Regulations Emergency were women. As outlined above, a gender-sensitive response to disease outbreaks is crucial, and responses will be more likely to be effective for everyone if there is diversity in leadership panels.

More positively, increasing evidence is emerging that countries with women leaders are experiencing fewer COVID-19 related deaths, and the leadership of women politicians is gaining international attention (Box 14).

Box 14. Women in leadership roles during the COVID-19 pandemic

Globally, only 19 of 193 countries have a female head of state or government, and only 30% of the chief executive officers of 200 global health organizations are women. Nevertheless, disproportionately more countries with women leaders have demonstrated best practice in handling the COVID-19 pandemic (e.g. Denmark, Finland, Germany, New Zealand, Republic of Korea), with indications of faster, more decisive reactions, based on science. Countries do not necessarily succeed because their leaders are women but because of the culture and institutions that encourage women to be elected to positions of power.

Sources: references 83–87

Emergency Preparedness

Message for national political leaders

Give more weight to UHC principles in every crisis response, and build emergency preparedness into all health system reforms.

Policy recommendations

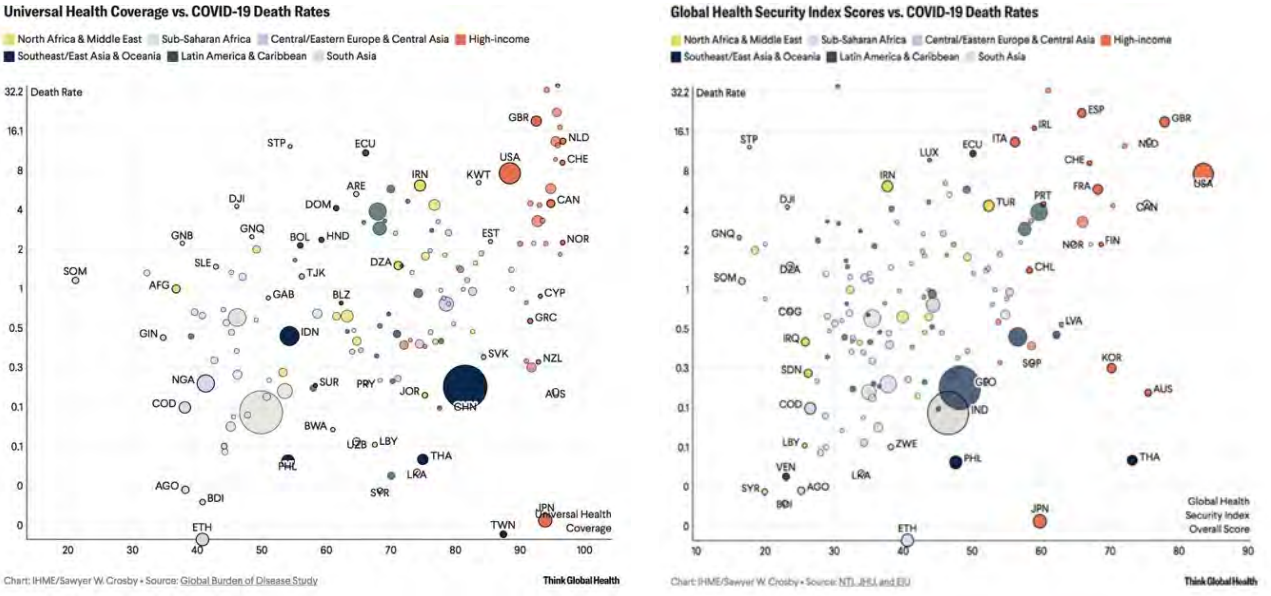
- Decisive, early action by political leaders is essential in responses to emergencies; “speed trumps perfection”(88).
- Government messages on public health interventions during emergencies must be clear and consistent.
- National health security action plans and emergency preparedness should be linked to country strategies for UHC, and public health services should receive greater political commitment and public financing. Global health security and UHC are two sides of the same coin.
- Health systems preparedness for pandemics should include plans for continuation of all the health services provided in non-crisis situations. These should cover the full range of services in primary, secondary and tertiary health care and reinforce the medical workforce and equipment to ensure the continuity of care.

- During the pandemic, governments should waive all health service user fees to facilitate access to essential health services, especially for testing and treating COVID-19.
- National health security action plans and emergency response plans should include references to gender, which could be linked to the UN Resolution 1325 for Women, Peace and Security, to enhance mutually reinforcing goals of participation, protection, prevention, relief and recovery (89).
- Community measures and universal community testing programmes should be initiated and supported to improve the effectiveness of surveillance, case isolation, contact tracing and quarantine.

Findings

- **Political leadership is crucial during an emergency**. Some countries that were ranked highly in pandemic preparedness in the Global Health Security Index have had some of the highest rates of infection and deaths during the COVID-19 pandemic (Fig. 4). While higher case numbers may be partly explained by more testing and deaths are counted differently in different countries, this probably does not entirely explain the numbers, particularly differences in the numbers of reported cases (90,91). Similarly, countries with higher UHC scores have not performed better during the pandemic (92). While these indicators are important for identifying gaps in capacity and for justifying financial or political support, they are not guarantees of performance. The variation in performance is partly a result of political leadership and the consequences of decisions made at the highest level. Political leaders who have ignored expert public health advice have tended to have worse outcomes than those who have followed scientific advice (21).

Fig. 4. UHC vs COVID-19 death rates and Global Health Security Index Scores vs COVID-19 death rates
Source: reference 92



- **Clear communication and messages are crucial during a pandemic**. Our research shows that people find it difficult to access health services because of a lack of reliable information, movement restrictions, fear of seeking health services and lack of access to essential health products. In addition, complicated or ambiguous messages can lead to confusion and non-compliance with emergency preventive measures. Lack of coordination between national and subnational governments has exacerbated the effects of poor communication. This appears to have been a factor in the contrasting performances of China and the United Kingdom in responding to the COVID-19 pandemic.
- **COVID-19 has exacerbated existing challenges in health systems**, exposing shortages in vital inputs, including health workers, medicines, health commodities, equipment and infrastructure (Box 15). Millions of people with health problems have thus been prevented from receiving non-COVID-19-related treatment (93), resulting in many thousands of deaths. UHC by definition must be universal and available at all times, including during emergencies. Preparedness plans must include continuation of non-emergency health services.

Box 15. Financial impact of public health measures on people

Enforcement of public health measures can be accompanied by a significant financial impact on people. If the government does not act to mitigate the impact, it can have unintended effects on people's lives. Public health interventions are intended to protect the health of people.

A survey respondent in Mongolia painted a vivid picture of the pressures on ordinary citizens confronted with high costs in emergency situations:

> **Partial reduction in charges of medical service was needed in my country. Even if the people have health insurance, all the charges came from the citizen's pockets and people who came from abroad felt pressured to pay for medical service and quarantine. Because they have been put in a 21 days quarantine, the hotel and other staff's fee got higher than their salary. For example: A woman named A tried to commit suicide because she could not afford the 21 days quarantine fee. She came from abroad and all her savings were spent on quarantine. The government should have given some support for the people who can't afford the quarantine.**

Sources: Survey

- **Health service user fees remain a major barrier to accessing essential health services**. Despite recent WHO policy advice to waive health care user fees in order to improve access during the pandemic, many countries still charge patient fees, which dissuade people from seeking testing and treatment and lead to financial hardship.
- **Of 409 survey respondents, only 5 explicitly mentioned public health as an investment priority for their country**, while 40 mentioned public health activities and associated services such as health promotion and prevention. Public health is an integral part of UHC, and the international community has a responsibility to raise awareness about the importance of investment to improve public health for future challenges. Investing in preparedness means investing in strong public health systems at national, regional and international levels.
- **The cost of emergency response is far higher than the cost of investing in preparedness and readiness**. The recurrent costs of preparedness are estimated to be US$ 13.8 billion per year for 67 lower- and middle-income countries, while the annual cost of disaster response is more than US$ 500 billion (94). The International Monetary Fund has warned that the COVID-19 pandemic will cost US$ 28 trillion in lost output (95).
- **It is vitally important to form partnerships with CSOs and the wider community to build trust and ensure compliance with emergency public health measures**. This should include engagement at community level, decentralized planning and implementation of emergency public health responses for prevention, care and support.

Contribution of the UHC movement during a global health emergency

Photo Credit: @UHC2030 - Akihito Watabe

Photo Credit: @UHC2030 - Akihito Watabe

Contribution of the UHC movement during a global health emergency

All global leaders and other stakeholders should come together to ensure coherent action and to build trust and accountability by widening participation in health governance at all levels.

Policy recommendations

- Governments, multilateral organizations, civil society and the private sector must work together to transform social and political accountability for UHC. This includes raising access to and awareness among CSOs of existing global accountability mechanisms and platforms both within and beyond the health sector and strengthening opportunities for institutionalized multi-stakeholder engagement.
- The VNR process, a key mechanism for tracking progress towards UHC and other SDGs, should be upgraded by strengthening data collection in countries, with data disaggregation, to provide standardized, detailed guidance for country reviews; strengthening the engagement of the health sector with other SDG-related actors; and supporting civil society in contributing more proactively and effectively to improve UHC reviews in the formal accountability mechanisms of their countries.
- COVID-19 responses are likely to be more effective when response teams comprise a variety of stakeholders. The composition, communications and involvement of CSOs and other non-State stakeholders of country response teams must be transparent.
- Emerging global health initiatives to accelerate collaboration in the COVID-19 response (e.g. the Access to COVID-19 Tools Accelerator and its COVAX facility) must receive adequate financing and support and not be undermined by national, regional or commercial interests, including bilateral and multilateral vaccine deals.

Findings

- **Awareness of global and national UHC targets is low**. Access to and awareness of global platforms and accountability mechanisms, national UHC targets and platforms for UHC are crucial for non-State actors if they are to hold governments and international organizations accountable in progressive realization of UHC by 2030. Without access to global platforms and understanding of global accountability mechanisms in which commitments are made and justified and country progress is reported, civil society cannot

track implementation of national targets or effectively hold leaders to account for their words and actions. This is also true for the types of commitments and actions taken by governments and how well they are communicated at regional, national and global levels. A review of statements at the UN high-level meeting on UHC and the Seventy-first World Health Assembly shows that approximately half the political statements lack clear commitments[2] to move UHC forward nationally.

- **UHC commitments are not captured in VNRs**. All Member States that signed the 2030 Agenda for Sustainable Development have committed themselves to prepare a framework for VNR. Our research (Box 16) indicates that VNR should be transformed to include UHC. While more countries and civil societies have reported progress in achieving UHC in recent years, greater effort is needed to make the SDG review process work properly, to ensure more objective, accurate reporting of progress in fulfilling measurable UHC commitments.

Box 16. Assessment of the VNR process (2016–2020) and knowledge-sharing in UN high-level political forums (2018–2020)

In order to understand the opportunities and challenges that the official SDG accountability mechanism offers for health, we assessed the VNR process and knowledge-sharing in UN high-level political forums in the past 2 years. The key findings are listed below.

- Most UN Member States (172 of 193) submitted reports in 2016–2020, and some submitted more than one. Of the 187 VNR reports submitted, 92% (171 reports) reviewed SDG3, and 71% (132 reports) conducted some sort of review of UHC- or health system-related policy. Only 37% (69 reports) included some form of numerical assessment, and most only described their government's policies and strategies.
- Only 13% (25 reports) used the UHC service coverage index and/or UHC financial protection index to review their progress in tracking indicators 3.8.1 and 3.8.2. Although the World Bank and WHO reported on these indicators in the global UHC monitoring reports of 2017 and 2019, the vast majority of countries did not use data in their reviews of progress in SDGs. This may be due partly to the fact that these indicators were not approved as part of the formal SDG monitoring framework until 2017, and data were not available in formal UN statistics systems until 2018.
- Few countries provided disaggregated data on health coverage, which facilitate analysis of equity, and were therefore unable to track progress in improving equity or to determine whether certain population groups were being left behind. Most high-income countries reviewed their contributions to UHC in other countries from the perspective of development cooperation or foreign policy, although some countries mentioned the involvement of civil society in health reviews.
- In the thematic review of SDG3 (2017), UN agencies included global progress in achieving SDG target 3.8 (UHC) with indicator 3.8.1 (service coverage) and 3.8.2 (financial protection); however, the data were rather outdated, and most were not disaggregated.
- No agency, partnership or CSO provided any resources for exchanging knowledge on approaches and tools for VNR reviews (2019 and 2018) or tools for assessing UHC and health systems in preparing VNRs.
- In the VNR "shadow reports", civil society groups from only 13% (6 of 47) of VNR countries reported annually on UHC progress in 2020 and 2019.

Sources: references 96–100

[2] A clear UHC commitment in a global political forum was defined as a statement of actions being taken currently on UHC or clear targets or plans for UHC. Previous achievements and descriptions of a country's health care or health situation were not considered commitments to UHC.

- **Civil society engagement with global health governance and other global governance processes is not effective**. CSOs often participate in international summits, conferences and forums and should therefore be able to influence agenda-setting, policy formulation and implementation of UHC-related policies (101). Governments frequently refer to CSO engagement as evidence that they are fulfilling their commitments to improve monitoring and accountability on health issues (102). The effective participation of CSOs is, however, often constrained by factors such as insufficient power to influence processes and health organizations, lack of financial resources and poor access to platforms and key policy-makers. Although they sometimes contribute to shaping global health governance frameworks by highly effective informal participation, there is a limited formal recognition of their roles in such governance and in international meetings such as the World Health Assembly. While civil society has opportunities to engage in global governance, such as the UN high-level political forum, the UN high-level meeting on UHCs and global and regional summits on the SDGs, they have not effectively introduced the UHC agenda into those processes. To ensure their effective participation, more information is required on how CSOs influence policy and the effectiveness of their strategies.
- **COVID-19 has exacerbated the challenge of effective engagement, as funding for CSO UHC advocacy platforms has been reduced** at country and regional levels when finances have been diverted from civil society to the COVID-19 response. According to the partners in the Civil Society Engagement Mechanism (CSEM) (Box 17), opportunities for advocacy have been constrained by COVID-19-related restrictions, and collaboration has been built virtually through social media and website platforms, with advocacy through virtual consultations.

Box 17. The Civil Society Engagement Mechanism

The CSEM for UHC2030 was created in 2017. It raises civil society voices in UHC2030 to ensure that UHC policies are inclusive and equitable and that attention is paid systematically to the most marginalized and vulnerable populations so that no one is left behind. This is achieved by:

- influencing policy design and implementation;
- lobbying for participatory, inclusive policy development and implementation;
- strengthening community-led social accountability mechanisms;
- promoting coordination among CSO platforms and networks working on health-related issues at national, regional and global levels; and
- giving civil society a voice in the UHC movement.

Since its inception, the CSEM membership has grown to about 1000 individuals representing 900 organizations in more than 100 countries. CSEM is a means for civil society to have its voice heard in UHC processes for effective collaboration. The CSEM engages and mobilizes civil society, supports national CSOs, builds knowledge of UHC in civil society and strengthens UHC2030 as one of its constituencies.

Source: reference 103

- **Civil society is not involved in national COVID-19 responses** (104–107). The CSEM collects evidence of the inclusion of civil society in COVID-19 responses in several ways. A review supported by CSEM found lack of transparency in decision-making by COVID-19 task forces and limited involvement of civil society in national government decision-making and response. Another CSEM survey confirmed that most of civil society was working independently of governments in the COVID-19 response (105). The CSEM has released "civil society calls to action" for COVID-19, to advocate for the inclusion of civil society in national COVID-19 responses.
- **The private sector has played an important role during COVID-19 in protecting supply chains, extending access to COVID-19 testing and treatment and filling gaps in essential services** (Box 18). While this sector focuses on stimulating innovation and

Box 18. Examples of contributions of the private sector to the COVID-19 response

Over the past two years, UHC2030 has brought together private businesses and associations to agree on UHC goals. At the UN high-level meeting on UHC, the UHC2030 private sector constituency also made a joint statement, listing seven principles that will guide private sector contributions to UHC. Two of these principles address access to affordable products and services and innovation; thus, the sector provides additional capacity to keep country health systems functioning while governments increase their capacity to test, trace and treat COVID-19 and maintain essential health services.

Members of the private sector constituency have reported some of the contributions they are making to the COVID-19 response in line with these principles and commitments. These examples show how different organizations can "move together" towards shared health goals.

Maintaining the delivery of critical supplies:

- Ensuring continuous access to the critical medicines, medical equipment and vaccines, harnessing advanced technology for equitable provision and continuity of essential health supplies. .
- Increasing production, maintaining inventories at major distribution centres and working on preparedness plans with external suppliers to maintain supply chains.

Increasing access to diagnostic tests:

- Conducting wide-scale on-site testing of the large underserved population of migrant workers and supporting mass screening in the dormitories of migrant workers in Singapore.

Mobile health and digital solutions:

- Collecting data on health needs and COVID-19 risk factors to guide surveillance and case tracking in rural Asia.
- Applying a risk algorithm to population data in order to identify at-risk patients and working with governments to deliver targeted interventions.
- Developing and supporting applications for remote training of community health workers and dissemination of information to households.
- Facilitating virtual consults for continuum of care.
- Distributing essential medicines through digital supply chains to rural communities that have become even more isolated during COVID-19 lockdowns.

Source: reference 104, 114

improving access to affordable products and services in health (108), several companies also support health system strengthening initiatives. Almost all countries have mixed health systems, and the role of the private sector in health care is significant and wide, including service provision, providing medicines and medical products, health workforce training, technology, innovation, infrastructure and support services. However, private sector involvement in national responses to COVID-19 has been more effective in countries with private sector engagement as a matter of routine management of their health systems, which require well-established regulatory frameworks and strong direct or indirect financing (114).

- **The COVID-19 pandemic has brought health and global health diplomacy to the fore and reinforced the importance of commitments made in the 2019 political declaration on UHC**. For example, the UN Secretary-General issued a policy brief on COVID-19 and UHC that calls for greater investment in UHC. The COVID-19 pandemic has highlighted the importance of strong public health systems and emergency preparedness for communities and economies globally. He urged all Member States and other stakeholders to accelerate and increase investment in UHC and in stronger health systems, starting immediately. With the leadership of the Group of Friends of Universal Health Coverage and Global Health (Box 19), 120 Member States welcomed his recommendations, reaffirmed their commitment to the political declaration of the UN high-level meeting on UHC and recognized the urgency of accelerating action to achieve UHC by 2030.

Box 19. Group of Friends of Universal Health Coverage and Global Health

The Group of Friends of Universal Health Coverage and Global Health is an informal platform for Member States at UN headquarters to promote UHC in the context of the 2030 Agenda. This network of Member States has mobilized its political capital to champion the UHC agenda and supported UHC2030 in playing a key role in global health and foreign policy and has been instrumental in maintaining the momentum of the UN high-level meeting on UHC through a number of initiatives, even during the COVID-19 pandemic, including an event on UHC and COVID-19 during the high-level political forum (July 2020) and the ministerial meeting on UHC during the Seventy-fifth Session of the General Assembly (October 2020), and mobilized 120 Member States to amplify the Secretary-General's policy brief on COVID-19 and UHC and the political declaration on UHC (October 2020).

Sources: references 109–112

- **The COVID-19 pandemic has spurred unprecedented global collaboration in many fields**. A critical example of emerging global health initiatives is the Access to COVID-19 Tools Accelerator (ACT-A) (Box 20). ACT-A was launched as a global solution to accelerating the end of the COVID-19 pandemic, with public and private sector expertise to fast-track the development and production of and equitable access to COVID-19 tools, including tests, treatments and vaccines, while strengthening health systems. Also in this spirit of collaboration, the health systems networks and partnerships that are part of UHC2030 are promoting relevant knowledge and learning in support of UHC goals in the context of COVID-19.

Box 20. An emerging global health initiative: Access to COVID-19 Tools Accelerator

ACT-A is based on the premise that no country can beat COVID-19 alone. By pooling investments globally, ACT-A shapes the market for tools and incentivizes manufacturers to invest in the development and manufacture of critical tools, while enabling governments to access a portfolio, so that the risk of failure of individual candidates is spread. The initiative shares the rewards of complex test, treatment and vaccine development programmes in many regions and on many technical platforms.

ACT-A involves a broad partnership of diverse stakeholders who jointly leverage their comparative advantages and respective constituencies to find collective solutions to COVID-19. It consists of three pillars – vaccines, therapeutics and diagnostics.

The vaccines pillar, the COVAX facility, ensures that all countries have equitable access to safe COVID-19 vaccines, regardless of their capacity or buying power. It includes financial support to ensure that people in the world's poorest countries are not overlooked when COVID-19 vaccines become available. As of mid-November 2020, 187 countries had joined the COVAX facility, including 92 lower-income countries eligible for financial support.

The transversal Health System Connector, led by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and WHO, addresses cross-cutting aspects of health systems to ensure rapid deployment of new tools as they become available, including capacity and infrastructure that should be radically upgraded in order to deploy the COVID-19 tools and system investments that will be required to complement the new tools.

Source: reference 113

Box 21. Health system-related initiatives and non-State actors

The UHC2030-related initiatives are a group of initiatives, networks and platforms that focus on different aspects of strengthening health systems. As the pandemic has developed, the related initiatives have promoted knowledge and learning on health systems' contributions to the response. They provide global platforms for sharing lessons and building collaboration on health systems.

Some of these initiatives bring together constituencies for specific aspects of strengthening health systems. For example, the P4H Network has promoted messages on health financing and the COVID-19 response, including how to budget for the response, how to purchase health services and lessons from countries. The Health Data Collaborative is providing guidance on strong data governance, disaggregated data and trust in data. The Global Health Workforce Network is highlighting the crucial contribution of health workers, informing health professional associations about issues expressed with regard to COVID-19 and supporting dialogue between CSOs and WHO. The Primary Healthcare Performance Initiative has developed messages on why primary health care is a key component of the COVID-19 response,and contributed technical resources and an online community of practice. The Health Systems Governance Collaborative is exploring how better to align global governance for health for collective action towards shared health goals.

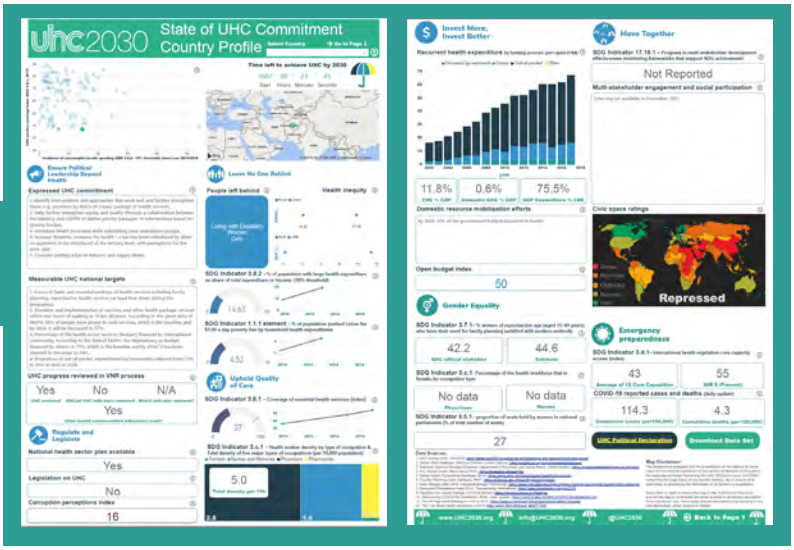
Other related initiatives, including the Joint Learning Network, Health Systems Global and the Alliance for Health Systems and Policy Research, are sharing insights on health policy and systems responses to COVID-19. These endeavours are helping to identify and enhance common approaches to strengthening health systems for both UHC and health security.

Source: reference 107

Country profiles

With the 2020 synthesis, a concise online dashboard of country profiles is provided on the UHC data portal (14) hosted by UHC2030.

An example of country profile



It shows "snapshots" of the state of UHC commitment in countries and facilitates cross-country comparisons. The dashboard (version 1) draws on data available for 2015–2020 to set a baseline for the state of UHC commitment in all 193 UN Member States, comprising quantitative and qualitative data on key areas of commitment in the political declaration on UHC that demonstrate each country's:

- trend and status of UHC service coverage and financial protection;
- trend and status of selected elements of health systems;
- domestic resource mobilization;
- status of health emergency preparedness;
- commitments to UHC expressed by high-level political leaders;
- assessment of UHC progress reviewed in VNRs;
- measurable UHC-related national targets;
- UHC-related legislation and national policy and strategies;
- perceptions of corruption, budget transparency and the availability of civic space;
- progress in UHC with respect to equity, to identify who is left behind and why in terms of access to health services and financial protection;
- challenges to gender equity and women's leadership;
- progress in multi-stakeholder development of frameworks to monitor effectiveness; and
- lessons learnt from multi-stakeholder engagement and social participation in health policy development and accountability.

COVID-19-related statistics are included this year to reflect the current global context. In future years, the country profiles will be updated to help national stakeholders to assess the latest status of UHC commitments and to track progress in translating them into action.

UHC data portal

The aim of the UHC data portal is to provide a single interface for an overview of the state of UHC commitments in every country and to access data on UHC and health systems and data visualizations from official statistics on the SDGs and UHC2030 partners. The background data used in this review of the state of commitment to UHC are also available on the data portal.

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