uhc2030

State of commitment to universal health coverage: **Synthesis 2021**

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Glossary

Health-in-all policies approach
Protection of people's health by comprehensively addressing social, economic, environmental and other determinants of health in collaboration with all sectors.

Leave no one behind
The UN approach to "leave no one behind" entails not only reaching the poorest of the poor but also combatting discrimination and rising inequality – and their causes – within and among countries. Leaving no one behind means moving beyond assessing average and aggregate progress to ensuring progress for all population groups at disaggregated levels.

Multisectoral approach
Engagement with one or more government sectors as well as health.

Multi-stakeholder engagement
Engagement of actors outside national governments and governing political parties, including citizens, civil society, nongovernmental and international organizations and entities, development partners, the private sector, local governments, trade unions, parliamentarians and academics. The engagement can take many forms.

Non-state actors
Organizations and individuals that are not affiliated with, directed by or funded through governments but may be involved and engaged in health policies for UHC. They include civil society, the private sector, academia, communities and providers.

Out-of-pocket expenditure
Direct payment to health-care providers by individuals at the time of service use, i.e., excluding prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions, and, when possible, net of any reimbursement to the individual who made the payment.

Social determinants of health
The conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of outcomes and risks for health, functioning and quality of life. They also contribute to wide health disparities and inequities (3).

Universal health coverage (UHC)

Ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, that are of sufficient quality to be effective, while also ensuring that use of those services does not expose users to financial hardship. UHC has three dimensions: health service coverage (what services are covered), financial protection (how much people have to pay to receive the services) and population coverage (who is covered) (1).

Vulnerable population

Vulnerable populations include people who belong to racial or ethnic minorities, children, the elderly and people who are socioeconomically disadvantaged, underinsured or have certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by inadequate health care (2).

Whole-of-government approach

A whole-system approach that helps to address challenges to health and well-being that transcend traditional sectoral boundaries and to promote good governance by building accountability in all sectors, encouraging broader participation in policy, improving the coherence of policy, and strengthening collaborations and partnerships.

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Executive summary

2021: A lesson on the urgency of universal health coverage

Two years since the onset of the pandemic, COVID-19 continues to reveal and exacerbate inequities and to push millions of people into poverty. The 2021 UHC global monitoring report suggests that the pre-COVID-19 challenges combined with additional difficulties arising from the pandemic bring even greater urgency to the quest for Universal Health Coverage (UHC) (4).

"Progress made in service coverage over the past 20 years is likely to be offset by the COVID-19 pandemic, bringing the world further away from the goal of 1 billion more people benefiting from UHC by 2023. While pre-pandemic service coverage increased, reducing financial hardship remained a challenge, with persistent inequalities. Without accounting for the impact of the COVID-19 pandemic, at current rates of progress for both service coverage and financial hardship, only an additional 270 million people were projected to be covered by essential health services and not experiencing catastrophic out-of-pocket health spending by 2023 – that is, a shortfall of 730 million."

The lesson of the pandemic is clear: Health is an investment in the future well-being and safety of all. Achievement of UHC has never been more urgent. Everyone, everywhere should have access to good-quality health services – including vaccines, tests and treatment for COVID-19 – without facing financial hardship. The pandemic has also reinforced the conclusion that, to achieve both UHC and health security, countries must invest in resilient and equitable health systems based on primary health care (PHC). We need a comprehensive, multi-sectoral, inclusive approach that puts communities at the heart of decision-making.

The state of UHC commitment in 2021

The *State of UHC commitment* brings a unique multi-stakeholder view to a simple question: What actions are governments taking to fulfil their UHC commitments? The review shows that countries have made a wide range of commitments to UHC, set national targets and recognized the importance of UHC for achieving Sustainable Development Goal (SDG) 3, Ensuring healthy lives and well-being for all at all ages. Many have prioritized equity in their UHC commitments; however, gaps persist between policy, implementation and results. COVID-19 has brought additional challenges, as health services have been disrupted and countries face huge economic shocks. Findings point out the importance of developing clear strategic approaches to achieve UHC based on resilient and equitable health systems, increasing the participation of non-state actors, using multidimensional approaches to identify and reach vulnerable communities and enhancing collaboration with non-health sectors.

The UN High-level Meeting on UHC to be held in 2023 will be a significant milestone: At the mid-point of the deadline to attain the SDGs, Heads of State and Government will undertake a comprehensive review of what has been done so far to identify gaps and means to accelerate progress towards the achievement of UHC by 2030. Before the meeting, leaders have a crucial, urgent opportunity to convert the lessons learnt from the COVID-19 pandemic into concrete action to protect people, particularly the most vulnerable, and to safeguard the right to health. The findings from the State of UHC commitment in 2021 provide a useful basis for further building equitable and resilient health systems that truly leave no one's health behind, in crisis or in calm.

Key finding 1: Most countries have agreed on strong national commitments and targets for UHC, and an increasing number are reviewing their progress. To achieve UHC by 2030, governments must act on their commitments.

Key finding 2: Country commitments and reporting on UHC are often not linked to a clear strategy to achieve UHC. Governments should develop and communicate clear pathways to achieve UHC in national health strategies based on resilient and equitable health systems.

Key finding 3: Government plans and reporting on UHC often focus on specific diseases or services in a fragmented manner. UHC is an opportunity to accelerate outcomes across health priorities, based on a comprehensive approach to strengthening health systems.

Key finding 4: Non-state actors lack opportunities to participate in government-led planning, progress reviews or implementation towards UHC. Governments alone will not achieve UHC, and they must create space for non-state actors to participate meaningfully in relevant government processes.

Key finding 5: The importance of equity is strongly acknowledged in governments' UHC initiatives, but it needs to be operationalized comprehensively. Governments must identify and reach all groups in society that are at risk of neglect, including groups at the intersection of multiple vulnerabilities.

Key finding 6: Governments have committed to multisectoral action to address factors outside the health sector. Collaboration with non-health sectors could be significantly improved to ensure systematic, collective action to address the social, economic, environmental and commercial determinants of health.

About the State of UHC commitment review

All countries committed themselves in the SDGs to achieve UHC by 2030. They reinforced this commitment at the United Nations (UN) High-level Meeting on UHC in September 2019 and agreed on the most ambitious political declaration on health in history. It is crucial – especially in the light of COVID-19 – that countries be accountable for that commitment and realize their obligation to leave no one's health behind.

This year's review is based on 45 updated country profiles, which may be accessed through the UHC data portal. The synthesis draws on many sources, from online surveys and policy reviews to media monitoring and consultations with non-state actors. It provides an overview of key findings in 45 countries, consolidates diverse perspectives and summarizes progress, gaps, challenges and opportunities in achieving the commitments and actions for UHC.

Find out more about your country's state of UHC commitment
The UHC data portal is a single interface for obtaining an overview of the state of UHC commitments in every country, for accessing data on UHC and health systems and for visualizing official statistics on the SDGs and selected sources from UHC2030 partners.

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Introduction

In 2019, world leaders endorsed the most ambitious, comprehensive political declaration on health in history at the United Nations High-level Meeting on Universal Health Coverage (UHC): Moving together to build a healthier world (5). In that endorsement, they committed themselves to ensuring that, by 2030, everyone, everywhere will be able to receive quality health services without suffering financial hardship. Countries have also committed themselves to cover one billion more people in 2023 than in 2019 with high-quality essential health services and safe, effective, affordable essential medicines, vaccines, diagnostics, and health technologies (6).

The aim of this review was to curate the diverse views of a range of stakeholders on the current situation and on commitments to progress towards UHC by 2030. **We asked a simple question: What actions are governments taking to fulfil their UHC commitments?** The review is political, country-focused and action-oriented and therefore complements the more technical global UHC monitoring reports, which address indicators of service coverage and financial protection.

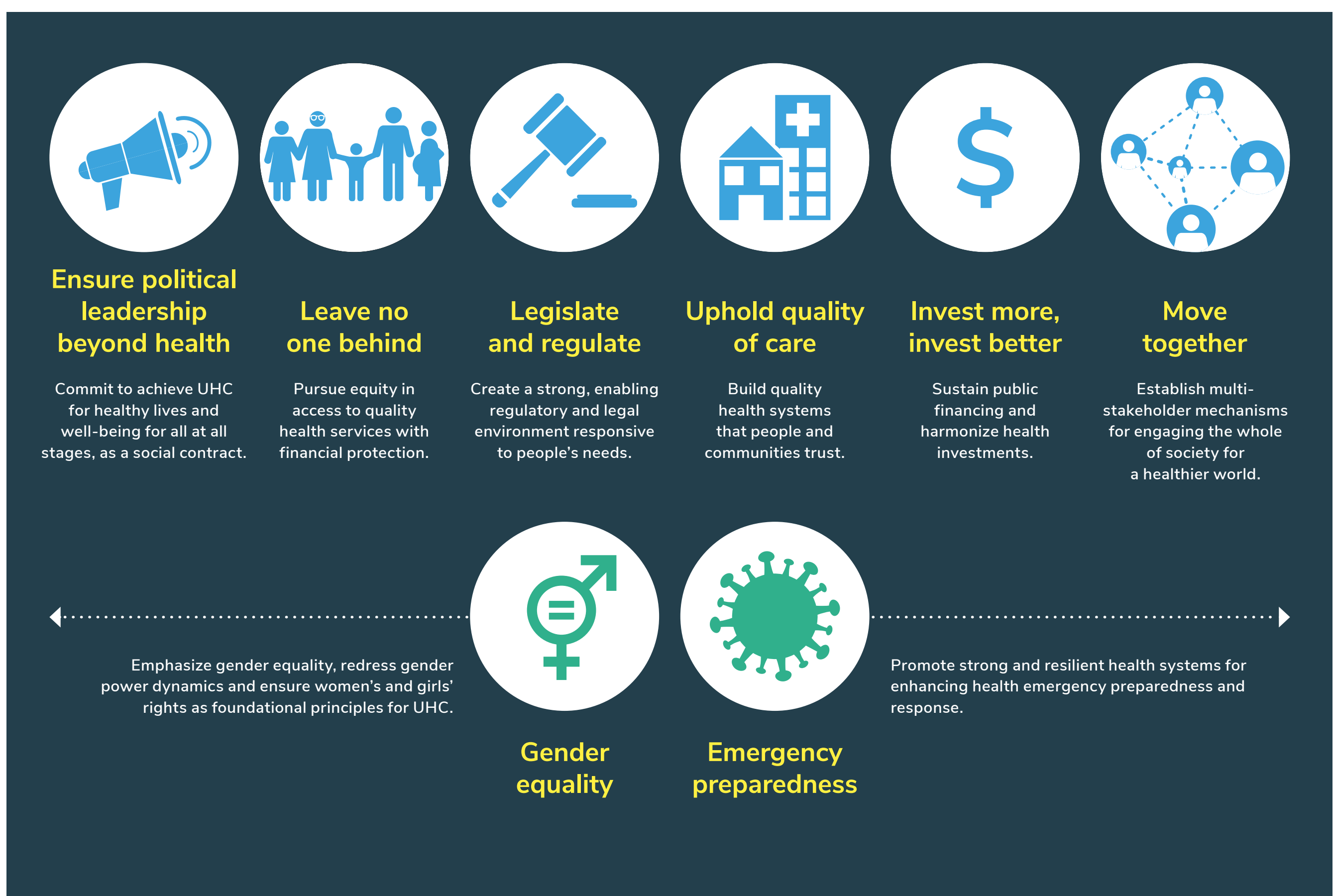
The COVID-19 pandemic has added urgency to building resilient and equitable health systems that meet communities' needs (7, 8, 9). Throughout the pandemic, countries across the globe and at different income levels have struggled to ensure adequate health care and enough medical commodities, diagnostic testing and specialized care. Those with weak health systems, significant health disparities and inadequate social and financial safety nets have been faced with even greater challenges (9, 10). The first State of UHC commitment review, published in December 2020 (11), found that poor and vulnerable groups were further left behind in many countries, and the inequities increased with the COVID-19 crisis. The pandemic exposed and exacerbated weaknesses in health systems, highlighting lack of investment in health, social safety nets and emergency preparedness.

Commitments to UHC in each country are influenced by the national context and policies, approaches to governance and accountability mechanisms (12). Although the reality of "many paths, one direction" towards UHC poses some challenges to assessing progress in meeting commitments, it must be adopted for meaningful advances in understanding and approaches to UHC.

Health is a political choice (13), and it is crucial that political leaders be accountable for their UHC commitments. Inadequate political leadership and financial constraints remain the major obstacles to equitable progress (14). To maintain the momentum on UHC and ensure accountability, political commitments must be measured and tracked, with corresponding action, as has been done for diseases such as HIV/AIDS and for issues specific to certain population groups, such as women's, children's and adolescents' health (14–18). Furthermore, given the complexity of health systems and their wider ecosystem, filtering data through the perspective of a single group will not ensure accountability. Decision-making, monitoring, review and remedial actions must involve all stakeholders, including non-state actors, to ensure legitimacy and shared ownership of the decisions made.

UHC2030 began reviewing the State of UHC commitment in 2020 in order to provide a consolidated, multi-stakeholder view of global and national commitments to achieving UHC by 2030. Its aim is to support national accountability and advocacy, thus ensuring that political leaders are held accountable for their commitments to UHC. Specifically, the review follows up on the targets, commitments and follow-up actions agreed at the UN High-level Meeting on UHC and the UHC Political declaration (5). UHC2030 summarized relevant paragraphs contained within the Political Declaration, in relation to the Key Asks from the UHC movement, which provides an outline for strategic multi-stakeholder advocacy and accountability to help translate UN High-level Meeting commitments into action (Fig. 1).

Fig. 1. Key areas of commitment to universal health coverage (6)



The *State of UHC commitment* has two main elements. The first element is the UHC data portal, which provides a dashboard that showcases national UHC commitments and progress over time. The 2020 UHC dashboard set a baseline for UHC commitments for all 193 UN Member States. The 2021 UHC dashboard displays progress in meeting the commitments in 45 selected countries[1] that submitted, or were due to submit, a "voluntary national review" (VNR) of their progress in 2021. VNRs are a country-led, multi-stakeholder initiative to follow up and review achievement of the 2030 Agenda for Sustainable Development.

The second element of the State of UHC commitment is this global synthesis of key findings on UHC commitments and actions. The purpose of the synthesis is to:

- share high-level findings on the state of UHC commitment in 2021 in the 45 countries;
- showcase country examples of gaps and progress in moving towards UHC; and
- complement the country profiles on the UHC data portal by providing the stories behind the data on the dashboard.

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1 Afghanistan, Angola, Antigua and Barbuda, Azerbaijan, Bahamas, Bhutan, Bolivia, Cabo Verde, Chad, China, Colombia, Cuba, Czechia, Cyprus, Denmark, Democratic People's Republic of Korea, Djibouti, Dominican Republic, Egypt, Germany, Guatemala, Indonesia, Iraq, Japan, Lao People's Democratic Republic, Madagascar, Malaysia, Marshall Islands, Mexico, Myanmar, Namibia, Nicaragua, Niger, Norway, Pakistan, Paraguay, Qatar, San Marino, Spain, Sierra Leone, Sweden, Thailand, Tunisia, Uruguay and Zimbabwe

Methods

The aim of the State of UHC commitment is to answer the following question: What actions are governments taking to fulfil their UHC commitments?

The process brings together a range of data sources and the perspectives of non-state actors and governments to assess the state of commitments to UHC in 2021. This includes i) the extent to which action on commitments has been initiated in the countries in this review; and ii) the areas of commitment to UHC that have been prioritized to make progress.

The review is based on various data sources and methods, including policy and document reviews, surveys of government stakeholders and non-state actors, collection of UHC-related indicators from global datasets, media monitoring and consultations with non-state actors in selected countries. A separate annex describes the methods in full. In summary, we analyzed 113 government health policy documents from the 45 countries, conducted consultations with non-state actors in nine countries, and analyzed 12 VNR "shadow reports", which are SDG reviews led by non-state actors. 76 non-state actors and seven governments responded to the tailored UHC survey, respectively, and 759 media sources (social media and news) were included in the analysis. The review, therefore, has a good basis for identifying common challenges and progress in diverse countries and from diverse perspectives, while acknowledging that the findings cannot represent progress towards UHC in all countries.

At an early stage of this year's review, participants noted the importance of unpacking a continuum of "commitment", from high-level political will to institutional reforms and implementation. In Box 1, we show how we categorized three types of commitment in considering countries' progress towards UHC and presenting data in the country profile timeline dashboard.

Box 1. A continuum of UHC commitments[a]

Rhetorical commitment (political will)
Forward-looking statement (verbal or written) made by members of a government who recognize the importance of UHC and that action is necessary and forthcoming. A rhetorical commitment may be a "symbolic gesture" or may reach a government's "decision agenda" and be converted into action through directives for governmental and societal action of one of two types of commitment.

Institutional commitment (institutional reform)
Conversion of a rhetorical commitment into substantive policy infrastructure, including making institutions responsible for coordinating actions and adopting enabling legislation, policies and policy instruments.

Operational commitment (implementation)
Conversion of rhetorical and institutional commitments into on-the-ground action, which may include sustained allocation of human, technical or financial resources, effective coordination of actors along national to subnational implementation pathways and the commitment of programme managers and implementation teams.

[a] Adapted from (19)

Findings

We found wide diversity among the countries in terms of the state of commitment to UHC. Most have strong national commitments and targets for UHC. An increasing number are reviewing progress. Fewer countries have articulated a clear vision and strategy for achieving UHC, especially in the face of the COVID-19 pandemic and its effects on health and economies.

The clear overall message is that countries will not achieve UHC by 2030 unless they act on their commitments. Translating political will into health impacts must be accelerated to achieve UHC by 2030.

Although there is no one-size-fits-all approach to UHC, the findings point out the importance of: developing clear strategic approaches to achieving UHC, based on resilient and equitable health systems; increasing the participation of non-state actors; using multidimensional approaches to identify and reach vulnerable communities; and increasing collaboration with non-health sectors. These are elaborated on below.

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Key finding 1: Most countries have agreed on strong national commitments and targets for UHC, and an increasing number are reviewing their progress. To achieve UHC by 2030, governments must act on their commitments.

Countries have made a wide range of commitments aligned with the Political Declaration on UHC (5), setting national targets and including UHC in their review of achievement of the SDGs. Most of the countries in this review have made commitments in line with the key UHC commitments (Fig. 1). The area to which most countries have made commitments is to leave no one behind, suggesting clear understanding among governments that equity is at the centre of UHC.

In 2021, a larger proportion of VNR reports reviewed UHC descriptively, numerically and with the official SDG indicators of UHC (3.8.1 and 3.8.2) compared to previous years. Reporting on progress in achieving UHC is critical to understanding and filling gaps. Analysis of all VNR reports in 2021 shows a positive trend as compared with previous years. UHC was reviewed descriptively by 90% of reports and numerically by 55%, and 25% of reports reviewed SDG 3.8.1 or 3.8.2 in 2021. From 2016 to 2020, 71% of VNR reports reviewed UHC, 37% had done so quantitatively, and only 13% of reports had reviewed either 3.8.1 or 3.8.2 (10). An improvement was also seen in "shadow reporting" on SDG implementation by civil society and non-state actors, as 25% of VNR reporting countries' civil society included UHC review in their shadow reports in 2021, compared to only 13% in 2019 and 2020.

Many countries are acting on their high-level political commitments through institutional reforms and implementation. In all 45 countries, UHC commitment appears to have progressed past rhetorical, high-level, visionary statements to development of policy infrastructure. According to the typology of commitment described in Box 1, UHC commitments are now largely at the institutional stage and moving towards operational commitment. Specifically, in the 45 countries reviewed by UHC2030 in 2021, 20% of UHC commitments were rhetorical, 44% were institutional and 36% were operational. Therefore, most government statements on UHC referred to developing or existing policy infrastructure for UHC rather than providing evidence of implementation of UHC or rhetorical statements about their UHC vision for the future. This can be interpreted as promising progress in the relatively short time since the global commitments were made in 2019. Institutions and policies may, however, be underpowered and inadequately resourced and therefore have limited impact. A high level of institutional commitment could also indicate superficial rebranding of existing policies as UHC commitments (further discussed under key finding 3). In fact, consultations with national non-state actors and the VNR shadow reports showed clear gaps between policy and reality. Therefore, governments must accelerate work to meet their UHC commitments: making institutional commitments does not mean acting on them.

During the COVID-19 pandemic, some governments have given less priority to maintaining essential health services at affordable costs. The UHC country consultations[2] and VNR civil society shadow reports (20) indicate that COVID-19 has reduced access to health care and government subsidies. Many governments have shifted their focus to the pandemic response,

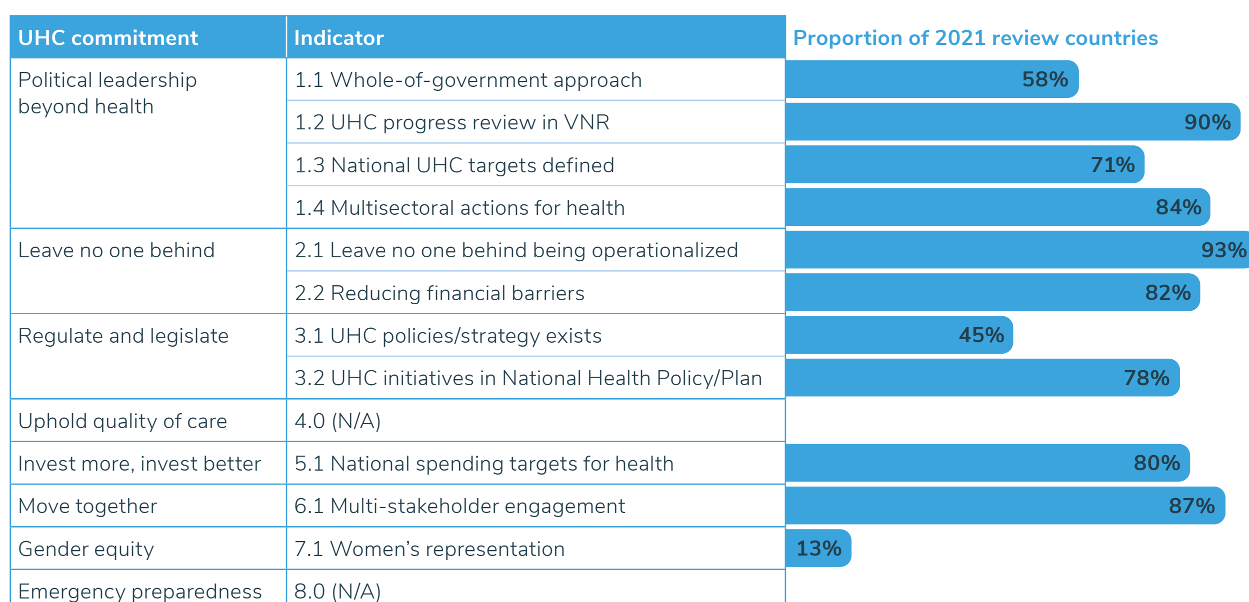
2 A synthesis of country consultations on UHC is forthcoming: Civil Society Engagement Mechanism (CSEM) Online.

postponing work on UHC, which has further exacerbated health inequalities and personal financial hardship. The country consultations and shadow reports describe reduced health services for non-COVID-19 conditions and diseases, making already vulnerable communities and populations more vulnerable. In some countries, diverting staff to COVID-19 care has resulted in closure of public health centres where treatment and services such as HIV testing, mental health counselling and sexual and reproductive health services were accessible to vulnerable groups free of charge.

Governments are not adequately addressing gender equality in their UHC commitments, especially women's representation in health and political leadership. In the 45 countries reviewed, there are strikingly few government commitments to increase women's empowerment and representation in political and health leadership in line with the UHC Political Declaration: only a stark six governments have made this commitment. It should be in the interest of every government to promote women's, and non-binary persons', representation and leadership to ensure inclusive decision-making that addresses their needs (21). Although there are many UHC efforts focusing on reproductive, maternal, newborn, and child health, a more comprehensive approach would be needed to address the health needs of women and girls. Women comprise 70% of the global health care workforce, but are still being left out of leadership roles (22, 23).

Fig. 2 shows the proportion of countries that have made specific commitments in line with selected areas of UHC commitment: political leadership beyond health; leave no one behind; ensure the quality of care,[3] regulate and legislate; invest more, invest better; move together; and gender equality.

Fig. 2. Overview of specific UHC commitments made by countries reviewed in 2021



UHC commitment	Indicator	Proportion of 2021 review countries
Political leadership beyond health	1.1 Whole-of-government approach	58%
	1.2 UHC progress review in VNR	90%
	1.3 National UHC targets defined	71%
	1.4 Multisectoral actions for health	84%
Leave no one behind	2.1 Leave no one behind being operationalized	93%
	2.2 Reducing financial barriers	82%
Regulate and legislate	3.1 UHC policies/strategy exists	45%
	3.2 UHC initiatives in National Health Policy/Plan	78%
Uphold quality of care	4.0 (N/A)	
Invest more, invest better	5.1 National spending targets for health	80%
Move together	6.1 Multi-stakeholder engagement	87%
Gender equity	7.1 Women's representation	13%
Emergency preparedness	8.0 (N/A)	

3 Indicators for the UHC commitment area "Ensure the quality of care" are listed in the UHC dashboard 2021 update; however, the quality and amount of data were insufficient to be included in this report.

Key finding 2: Country commitments and reporting on UHC are often not linked to a clear strategy to achieve UHC. Governments should develop and communicate clear pathways to achieve UHC in national health strategies based on resilient and equitable health systems.

Most of the national health policies and VNRs did not include references to clear strategies for achieving UHC. Many VNR reports and government health policies listed various distinct UHC initiatives, indicating that the countries reviewed have either not made clear, strategic plans to achieve UHC or are not communicating their plans effectively. Even though many institutional commitments are identified, countries may be superficially rebranding existing health policies and vertical programmes as UHC commitments rather than developing clear, coherent plans for achieving UHC. In terms of communicating plans, UHC initiatives were not always described explicitly as such, and policies had to be closely scrutinized and interpreted in order to identify planned initiatives to achieve UHC. Many national non-state actors described lack of clear, transparent planning, budgeting and evaluation of UHC initiatives. Similarly, the country consultations and the non-state actor survey indicated more emphasis on UHC as a goal than on implementing and evaluating schemes for achieving it. A key finding of the 2020 UHC synthesis was that stakeholders were unclear about what constitutes a UHC commitment and what, if any, commitments their governments had made recently or in the past (11). This year's review reiterates that better reporting on UHC is necessary, with clear, explicit, coherent outlines of strategic plans for UHC. Countries should communicate clear, effective policies to ensure accountability and greater transparency in UHC actions.

According to some non-state actor respondents to the UHC survey, **some governments appeared to prioritize global targets and global partners over local ones in designing and implementing UHC initiatives**. Governments may prioritize global frameworks and targets that skew prioritization of UHC initiatives in their countries (24, 25). This perspective is supported by VNRs that show how governments report on the inclusion of UHC in their policies, which appear to focus on disease areas that are prioritized in the global indicator framework for UHC,[4] a composite of indicators agreed upon by UN Member States for reviewing and reporting on progress in achieving UHC. Although a standardized global indicator framework is essential for global reviews of UHC and international comparisons, it should not adversely affect country priorities for UHC.

4 https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.8

Key finding 3: Government plans and reporting on UHC often focus on specific diseases or services in a fragmented manner. UHC is an opportunity to accelerate outcomes across health priorities, based on a comprehensive approach to strengthening health systems.

Governments' UHC commitments and reports are often based on multiple programmes and specific disease initiatives without clear alignment. This is possibly a result of the absence of coherent strategies to achieve UHC, which inevitably lead plans and reports to focus on specific diseases or services (key finding 2). This is also a legacy of international cooperation during the Millennium Development Goals era, which often created vertical structures focusing on specific diseases or interventions, and resulted in sub-systems that function independently of the rest of the health system and can duplicate responsibilities, compromising efficiency in resource use and sometimes effective case management (25).

In 35 of the 45 countries, the national health policy extended UHC through one of its dimensions of service coverage, financial protection or population coverage. Analysis of plans, reporting and feedback from diverse stakeholders suggests **few countries are taking a comprehensive approach across these dimensions**. Governments are reporting progress and initiatives in UHC in a fragmented manner, according to disease-specific programmes, with actions on health service delivery for specific diseases rather than a comprehensive, systemic, life-cycle approach that will ensure coverage for all disease areas and population groups.

In government reporting on UHC, the majority of UHC commitments focused on disease-specific areas over comprehensive approaches to health, such as focusing on PHC or extending essential health service packages. Of all the UHC commitments focusing on health services, only 14.5% (96 out of 662 commitments reviewed) related to cross-cutting PHC or essential health service packages; the remaining were targeted towards specific health services. Non-state actor voices in country consultations and VNR shadow reports highlighted a lack of integration across health services, insufficient coverage by PHC, and a lack of comprehensive approaches and planning for UHC.

This is a missed opportunity. **UHC reflects a comprehensive and systemic approach to ensuring coverage for all disease areas and population groups across the life-course**. Reporting on individual disease programmes and/or 'tracer' services – for example, indicators from national malaria or immunization programmes, or proportion of women who attend a minimum number of antenatal visits – is not of itself problematic, and these programmes and services are, of course, important. However, this type of reporting may also reflect (or worse still, incentivize) siloed planning, budgeting and implementation. There similarly remains a tendency to articulate "no UHC without…" for any given disease area, rather than seeing the benefits across multiple disease areas of a more comprehensive and aligned approach.

Countries that have made the fastest progress towards UHC have shown that a comprehensive approach benefits outcomes across multiple health and disease areas. This requires a coherent focus on strengthening health systems, linked to expanding service coverage and financial protection across health and disease areas and for different population groups.

Key finding 4: Non-state actors lack opportunities to participate in government-led planning, progress reviews or implementation towards UHC. Governments alone will not achieve UHC, and they must create space for non-state actors to participate meaningfully in relevant government processes.

Our results strengthen previous findings (11, 28) of limited participation of non-state actors in government UHC actions and indicate overall lack of progress in meeting the UHC commitment to "Move together". Whole-of-society engagement through social participation mechanisms is the basis for holding governments accountable for their UHC obligations. It is key to improving the responsiveness and legitimacy of UHC policies by ensuring civil society participation in UHC policy formulation and implementation (28). In the 45 countries that submitted reports in 2021, the main opportunity for most non-state actors to participate in government-led UHC actions was in implementing policy. One positive example of strong social participation in UHC policy development and implementation, however, is the Thai's Government decision to engage and involve other stakeholders in UHC policy. Civil society representatives were thus granted seats on the national health security board, where they contributed to drafting the National Health Security Act and submitting it to Parliament as early as 2001 (29).

The results of the survey clearly show **lack of government support for social participation overall**. Fewer than half of the 76 non-state actor respondents reported that they had opportunities to develop national health policies; 45 (two-thirds of the respondents) reported that their government did not support or minimally supported participation. Although 43 non-state actors were involved in implementing UHC policy, only 35 reported that they were involved in developing policy. Non-state actor respondents frequently noted that they had no opportunity to formally evaluate policies. A number of civil society organizations (CSOs) have such a capacity and undertake assessments, but often they remain CSO initiatives and are not part of state evaluation processes. In Tunisia, for example, one association has undertaken a rapid assessment of the response by the public sector to COVID-19 impact on the work of midwives, their perceptions and needs as part of the national sexual and reproductive health programme and public health delivery structures across the country.

Decision-making on health policies for UHC appears to be led by governments in top-down structures. Most decisions are developed and made by governments and a minority of influential actors and groups, such as international development agencies and well-established nongovernmental organizations which may not be representative of the full range of non-state actors. For example, it was reported from Sierra Leone that non-state actors take part in discussions on health concerns, but the actual decisions are taken at the level of the state and may not reflect their interests.

Opportunities to engage in government-led activities were described by many as sporadic and superficial. An issue common to many countries at all income levels is limited or shrinking civic engagement. According to global civic space ratings conducted by CIVICUS (30), 21 of the 45 countries in this review are facing a closed or repressed civic space. The replies from non-state

actors in Japan and the country consultation portrayed a government-controlled approach to engaging non-state actors in UHC. This implies that, even in countries where much progress has been made on specific UHC indicators, there may be gaps and challenges in ensuring inclusive, equitable UHC. The government was described as having no permanent or formal mechanism to engage civil society and communities in planning, budgeting, evaluating or reviewing health sector actions for UHC. Instead, opportunities for these groups to engage are temporary, limited and ad hoc.

When opportunities arise, they are “dominated by experts and representatives of industry”, such as medical associations and providers, excluding communities and people who do not conform to notions of professional experts and who do not have the resources to challenge the arrangement. For non-state actors, the consequences of such top-down systems are policies that do not reflect the needs of the population or the most vulnerable groups. None of the non-state actor survey respondents reported official channels for relaying their requests to the national level.

While civil society organizations working at the local level reported local opportunities to develop and implement policy, they had difficulty taking part in national initiatives for UHC due partly to lack of influence, resources and information on how and when to become involved. Nevertheless, some progress was reported. Survey participants from Spain reported public consultations on a new universal health law, and non-state actors in Pakistan referred to advocacy by patient groups as a means of establishing a better culture of social participation.

As mentioned above, these results reinforce previous findings (11, 28) and discussions on the limited space for non-state actors to participate in government UHC action. They indicate that **progress is not being made in social participation for UHC**. This is a concern, as both state and non-state actors must be committed to implementing policies to achieve UHC by 2030. If non-state actors are not included in governance or empowered to engage, achieving UHC will remain a pipedream. This is of particular concern for the groups that are left the furthest behind and most often left out of policy-making, implementation and evaluation of UHC (28).

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Key finding 5: The importance of equity is strongly acknowledged in governments' UHC initiatives, but it needs to be operationalized comprehensively. Governments must identify and reach all groups in society that are at risk of neglect, including groups at the intersection of multiple vulnerabilities.

Health is a fundamental human right, and reaching the most marginalized and vulnerable populations is essential (31). **Specific vulnerable population groups were identified by 31 of the 45 governments, and the second highest overall number of commitments (Figure 2) were made to leave no one behind, signifying that equity is acknowledged as central in government UHC initiatives**. Yet, operationalization of this commitment does not appear to be comprehensive, as countries identified inequalities among specific population groups along traditional, unidimensional lines, which is an approach to addressing health inequalities that has continuously failed (32). Multidimensional approaches to identifying who is being left behind in achieving the SDGs, as suggested in the UN guidance (31), do not appear to be adopted by countries in their policy documents.

One example of the use of a multidimensional approach to identifying and trying to reach vulnerable communities was Egypt's commitment in their VNR (34) to extending health insurance to 42 000 fishermen, who are vulnerable from various perspectives. The determinants of ill health are key to addressing the barriers to equity, as cited by many non-state actors. Multisectoral collaboration for UHC is clearly necessary, as described in key finding 6. Each vulnerable community has specific needs and challenges in accessing and benefitting from health services. Those that emerged as requiring particular attention in the country consultations, VNRs and civil society shadow reports are listed in Box 2.

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Box 2. Responses of non-state actors to the question, Which issues would civil society like to see prioritized in UHC?

Discrimination
Various population groups, including people living with HIV/AIDS, people who use drugs, LGBTQIA+ communities, migrants, victims of domestic violence and sex workers, frequently mentioned that discrimination affected their health. Stigmatization and discrimination during interactions with health-care professionals, lack of confidentiality and discriminatory laws were commonly described challenges. Fear of persecution and difficulties in the criminal justice system were also considered clear barriers to UHC.

Challenges faced by women and girls
Access to abortion, costs related to childbirth and sexual and reproductive health services were the health services most commonly mentioned for inclusion in UHC. Improvements in various non-health services that affect the health of women and girls were also called for, such as health education and family planning, in which restrictive customs and traditions and lack of health literacy are barriers.

Gender-based violence
Victims and survivors of gender-based violence, specifically domestic violence, experienced biased social welfare programmes and gender-based discrimination and stigmatization. There were calls to increase awareness about the available services, promote confidentiality and provide greater overall protection of victims.

Barriers faced by people living with disabilities
People living with disabilities face difficulty in obtaining financial protection and access to services. Non-state actors cited the importance of reducing out-of-pocket expenditure and the costs of health insurance, in addition to regulatory change, such as non-restrictive insurance policies that do not limit access. Further, to improve access, infrastructure and health systems must be responsive and more appropriate.

UHC for migrants and refugees
In the countries reviewed, insurance schemes excluded or imposed an extreme administrative burden on access to health-care services for migrants (both documented and undocumented) and refugees. Migrant children and unaccompanied migrant children were reported as needing additional protection and access to UHC, as they are at the intersection of many vulnerabilities.

Call to improve mental health services
People with mental health issues face poor-quality care, high costs and stigmatization when accessing mental health services. Standardized, cost-free mental health counselling by specialized personnel and with adequate financing is essential. Additionally, scarce financial and human resources for mental health services have been diverted during the COVID-19 pandemic, leading to further reductions in these services while the demand grows enormously.

From country consultations and VNR shadow reports

Comparison of the population groups targeted for UHC initiatives by governments with those left behind cited by other sources showed clear **general exclusion of sex workers and victims of gender-based violence**. No government source mentioned these groups which were highlighted for additional attention in the non-state actor consultations and the VNR shadow reports. This gap is a concern, as women and girls have been at significantly increased risk of domestic violence during the COVID-19 pandemic (35). Furthermore, governments seldom addressed mental health issues in their UHC initiatives, despite calls from non-state actors to increase access and include mental health in UHC. Alignment was, however, seen in prioritization of people living with disabilities, who were the third most frequently mentioned group by governments, after children and women. Non-state actors identified this group as requiring attention for UHC. The groups left behind by governments and by other sources are compared for each country on the dashboard.

Government initiatives for UHC cannot be limited to delivering specific services to specific populations or focusing only on curative care at the expense of preventive and promotive services. Rather, **governments must commit themselves to policies that promote an integrated, holistic continuum of care for building strong primary health care systems**. Health systems must ensure effective coverage, so that "people who need health services obtain them in a timely manner and at a level of quality necessary to obtain the desired effect and potential health gains" (36, 37) – a people-centred[5] health system that provides high-quality care to all people at all times (37, 38). Across non-state actor country consultations and shadow reports, numerous voices stated a clear lack of attention to integrated health care services and a lack of access to primary health care. In the country consultation in Malaysia, there was a lack of integrated care of people living with disabilities: "Engagement with people living with disabilities communities was done in isolation regarding their disabilities, selectively and sporadically. For example, those with spinal cord injury were only consulted regarding rehabilitation issues, instead of overall healthcare services and facilities. This is also reflected in the mental health sector where many people living with disabilities are suffering in silence due to the lack of engagement in organized programs. This, in turn, prevents an integrated approach in providing healthcare to those with intersecting disabilities."

Country consultations in the Caribbean noted many critiques of the lack of focus on primary health care where "Political motivation favours highly visible infrastructural outputs such as hospitals, rather than a focus on primary care level health systems strengthening" and "Primary Prevention and Health Promotion are not normally seen as important by the Government. Civil society does [the] bulk of that work."

5 In a people-centred health systems approach, care is consciously adapted to the perspectives of individuals, families and communities, who are seen as both participants in and beneficiaries of trusted health systems that respond to their needs and preferences humanely and holistically. People-centred care requires that people have the education and support necessary to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases.

Key finding 6: Governments have committed to multisectoral action to address factors outside the health sector. Collaboration with non-health sectors could be significantly improved to ensure systematic, collective action to address the social, economic, environmental and commercial determinants of health.

Countries acknowledged that they should use multisectoral approaches to advance UHC in their policies. Approximately half of the governments (23 out of 45 countries) made commitments to whole-of-government, health-in-all policies[6], and 36 developed multisectoral approaches for health and well-being. Many of these addressed the systemic determinants of health, including policies for healthy cities to create environments that promote well-being in Qatar and policies to address inequality by increasing social protection in Antigua and Barbuda. Strong examples of multisectoral collaboration for UHC are therefore emerging, although the voices of non-state actors in this review indicate that there are still many barriers to health beyond the health sector.

As evidenced in Key Finding 5, a large number of the barriers to UHC faced by populations relate to challenges outside the health sector. This means health actors must work more closely with non health sectors to operationalize their UHC commitments. An integrated approach is necessary, both within and outside the health sector, to systematically address the social, economic, environmental, and commercial determinants of health.

For example, in the National Health Development Plan, Angola developed a comprehensive, coordinated, intersectoral approach to address the determinants of health, in which the Ministry of Health interacts with other government sectors such as finance, education, family, employment and defence. A multisectoral commission has been created to monitor and evaluate the Plan, with representatives of provincial health structures (39). The Government's National Multisectoral Strategic Plan 2014-2024 to prevent communicable and non-communicable diseases includes institutional and operational commitments to increase road safety and reduce violence, which involve many sectors promoting healthy lifestyles and habits. Other strategies to involve other sectors in developing and implementing health policies were cited, such as collaboration among sectors on mental health policies in the Dominican Republic (40), and an "integrated work model" with a multidisciplinary approach to ensuring equitable access to high-quality health services and effective public health programmes in Colombia (41).

6 Health-in-all-policies protect people's health and comprehensively address social, economic, environmental and other determinants of health by involving all sectors.

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