uhc2030
Taking action for universal health coverage

State of commitment to universal health coverage:

Synthesis 2023

State of commitment to universal health coverage:

Synthesis 2023

Cover image credit: © WHO / Fanjan Combrink

Contents

Foreword

Progress in achieving universal health coverage (UHC) – ensuring that everyone, everywhere can access the full range of health services they need without financial hardship – is far off track. According to the Tracking Universal Health Coverage: 2023 Global Monitoring Report, more than half of the world's population – 4.5 billion people – are unable to access affordable, quality care when they need it; 2 billion people face financial hardship, including impoverishing health spending for 1.3 billion people due to out-of-pocket spending on health. For too many, access to health care depends on whether they have resources. Women and girls in particular still struggle to access the health services they need because of structural barriers, including financial hardship, lack of transport and lack of time. Health should not be a privilege: it is a right. And the fundamental right to health is not being delivered.

This report on the state of UHC commitment in 2023 summarizes the current state of UHC commitment around the world. Despite high-level commitment to UHC, reiterated at the United Nations (UN) high-level meeting on UHC in September 2023, countries are not adopting targets or milestones that will translate their political commitments into concrete actions. What is urgently needed from world leaders is faster progress towards building strong, equitable, resilient health systems and implementing the lessons learnt from the COVID-19 pandemic. UHC based on primary health care (PHC) is the essential foundation for effective pandemic prevention, preparedness and response and for ensuring equitable access to essential, affordable health services in times of both crisis and calm.

Before the UN high-level meeting, UHC2030 launched the Action Agenda from the UHC Movement, which outlines the critical steps that countries should take to accelerate progress towards achieving UHC. We invite countries to use this agenda to prioritize action in areas that cannot be neglected and to guide implementation by adopting national and local laws and regulations. Countries should involve all stakeholders and all spheres of government in decisions around our health systems and implementation, track milestones and strengthen accountability with independent assessments of progress. We also encourage leaders, stakeholders and UHC advocates to use this report and the UHC Action Agenda to ensure that achieving UHC remains high on political agendas and to hold leaders accountable for acting on the commitments they made during the UN high-level meeting on UHC. Failing to prioritize UHC will imperil millions of lives and economies, undermine health emergency preparedness, and jeopardize the entire 2030 Agenda for Sustainable Development. This is a risk we cannot afford to take. The stakes have never been higher and the consequences of inaction are dire. The time for action is now.

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

Gabriela Cuevas, Co-chair

Justin Koonin, Co-chair

Vytenis Andriukaitis, Political Advisor

María Fernanda Espinosa Garcés, Political Advisor

Ilona Kickbusch, Political Advisor

Sania Nisthar, Political Advisor

Joy Phumaphi, Political Advisor

Emilia Saiz, Political Advisor

Elhadj As Sy, Political Advisor

Keizo Takemi, Political Advisor

Acknowledgements

UHC2030 extends its appreciation to the United Nations (UN) for preparing and organizing the UN high-level meeting on UHC and the multistakeholder hearing for its preparation in 2023, particularly for listening to multistakeholder voices, sharing evidence, good practices, challenges and lessons learnt (A/RES/73/131) and revitalizing and promoting strong global partnerships with all relevant stakeholders to ensure collaborative support for the work of Member States through technical support, capacity-building and strengthening advocacy (A/RES/78/4).

We thank Gabriela Cuevas Barron and Justin Koonin, Co-Chairs of the UHC2030 Steering Committee, for their strategic guidance. The project was coordinated by Shohei Okamoto, Technical Officer, Akihito Watabe, Programme Manager (until May 2023), and Laetitia Bosio, Programme Manager, under the leadership of Marjolaine Nicod, Lead of the UHC2030 Secretariat.

We extend our appreciation to the UHC Movement Political Advisory Panel for their guidance in strengthening political support for UHC: Vytenis Povilas Andriukaitis, María Fernanda Espinosa Garcés, Ilona Kickbusch, Sania Nishtar, Joy Phumaphi, Emilia Saiz, Elhadj As Sy and Keizo Takemi.

This synthesis and the country profiles were updated by the State of UHC Commitment task team and contributing partners of UHC2030, with research support from the Swiss Tropical and Public Health Institute of the University of Basel, Switzerland. UHC2030 warmly thanks everyone for their commitment to the work.

The task team provided overall guidance, supported dissemination of the UHC survey and collection of stories, consulted stakeholders, and reviewed draft versions. Those from the task team were: Jose Álvarez, Amaya Ana, Emily Bigelow, Kathryn Boateng, Lucas Chambel, Jonathan Cushing, Poonam Dhavan, Xin Guo, Ilze Kalnina, Kalkidan Lakew, Eliana Monteforte, Patricia Monthe, Margot Nauleau, Waiswa Nkwanga, Vanessa Peberdy, Joana Perez, Laura Philidor, Ben René and Ani Shakarishvili. Those from the Swiss Tropical and Public Health Institute were: Daniel Cobos, Katarina Dudová and Anna Socha, project and technical leads; Katarina Dudová and Dell Saulnier, data collection and analysis coordination; Daniel Cobos, Katarina Dudová, Salma Elgamal, Jana Gerold, Laura Monzon, Dell Saulnier, Anna Socha, Fabrizio Tediosi and Jinxiu Wang, contributors to the report. Lujain Alchalabi, Khin Sandar Bo, Sana Khan, Rose Nadege Mbaye, Kirubel Mussie, Kyaw Htun Naing, Carmen Libertad Ballester Otero, Anindita Rochili and Metti Girma Temesgen also collected and analysed data. Luis Felipe Patiño Velasquez was the Microsoft Power BI expert who developed the country profile dashboards.

This work could not have been done without the contributions of the many stakeholders who provided input to the 2021 UHC survey and stories. We greatly value their comments and time. In particular, we thank the Civil Society Engagement Mechanism for UHC2030 and the following partners for conducting civil society focus groups on the state of UHC in countries: the Asia Pacific Council of AIDS Service Organisations, the Global Health Council, the International Federation of Red Cross and Red Crescent Societies, Living Goods, the NCD Alliance, the People's Health Movement, Save the Children and the Joint UN Programme on HIV/AIDS.

We also express our gratitude to Bronwyn McBride and Neena Joshi for review, to Paloma de la Cruz and Pete Martin for strategic communications, Elisabeth Helsetine for proofreading and Matt Hanns Schroeter for design and layout.

We thank all the UHC2030 partners who endorsed the global compact for progress towards UHC for their collective commitment and work towards UHC by 2030.

Abbreviations

COVID-19	coronavirus disease 2019
IDP	internally displaced people
LGBTQ+	lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other identities
PHC	primary health care
SDG	Sustainable Development Goal
UHC	universal health coverage
UN	United Nations
VNR	voluntary national review

Glossary

Leave no one behind

The UN approach to “leave no one behind” entails not only reaching the poorest of the poor but also combating 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.

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. Their engagement can take many forms.

Out-of-pocket expenditure

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

Sustainable Development Goals

The 2030 Agenda for Sustainable Development, adopted by all UN Member States in 2015, provides a blueprint for peace and prosperity for people and the planet, now and in the future. It comprises 17 Goals, which represent an urgent call for action by all countries – developed and developing – in a global partnership. They recognize that ending poverty and other deprivations must include strategies to improve health and education, reduce inequality and spur economic growth, while tackling climate change to preserve our oceans and forests (1).

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 (the services covered), financial protection (the cost of the services) and population coverage (who is covered) (2).

Vulnerable populations

Vulnerable populations are people who are at greater risk of poor physical and social health. They are considered vulnerable because of poorer physical, economic and social health status than the dominant population. Vulnerability refers to the likelihood of contracting disease or illness. Vulnerable populations may be less able to anticipate, cope with, resist or recover from the impacts of a hazard (3).

Whole-of-society approach

A whole-of-society approach embraces all relevant stakeholders, including civil society, local communities, the private sector and academia, in seeking a generalized agreement across society about policy goals and the means to achieve them (4).

Executive summary

2023: The urgency of action for UHC

The year 2023 provided a unique opportunity to raise health high on political agendas when world leaders convened during the UN General Assembly for three high-level meetings on UHC; pandemic prevention, preparedness and response; and tuberculosis, as well as Sustainable Development Goal (SDG) Summit. During the three health-related high-level meetings, heads of state and government and ministers renewed their countries' commitment to making progress towards UHC and emphasized the importance of health systems strengthening, with PHC as the foundation to achieve UHC. The political declaration adopted by Member States (5) provides a road map of specific actions to get progress towards 2030 back on track and will provide the basis for the work of UHC2030 in reviewing the state of UHC commitment.

Action is more urgent than ever, with 4.5 billion people (half the world's population) not having access to essential health services and 2 billion facing financial hardship due to out-of-pocket health spending. The 2023 Global Monitoring Report on UHC suggests that progress in health service coverage has stalled in recent years and financial protection has continued to deteriorate (6).

The State of UHC commitment review in 2023

This review provides a multistakeholder answer to a simple question: What actions are governments taking to fulfil their UHC commitments? The review provides an alarming answer, with insufficient progress in service coverage and setbacks in financial protection. The review nevertheless shows that, since 2015, countries have made various commitments to UHC, prioritizing equity and recognizing the importance of UHC for achieving SDG 3, Ensuring healthy lives and well-being for all at all ages. Urgent action is needed, however, to translate the commitments into action, as gaps persist between policy, implementation and results. COVID-19 has brought additional challenges, as health services have been disrupted and countries faced huge economic shocks. Evidence shows that the focus should be on implementation, adoption of specific targets and timelines and greater accountability for results, with the involvement of all stakeholders.

Overall trends in the state of UHC commitment

After the 2019 UN high-level meeting on UHC, annual country commitments to UHC almost doubled between 2019 and 2021. Yet, in 2022, the trend stagnated and even reversed in some countries. Although the majority of countries recognize UHC as a goal, which is reflected in laws and national plans, there are few concrete operational steps and lack of adequate public financing for health, setting UHC targets for 2030 further off track. Countries'

commitments do not address all three dimensions of UHC: service coverage, population coverage and financial protection. Most commitments address service coverage (43%) and population coverage (42%), with relative lack of commitment and clear targets for financial protection (15%), which is a crucial, integral component of UHC. Reducing financial barriers to health care was systematically under-prioritized, including under-investment.

Countries continue to rely on disease- and service-specific programmes and interventions instead of operationalizing UHC commitments through comprehensive reforms for comprehensive health benefits and integrated service delivery.

Key findings for eight areas of UHC commitment covered in the 2023 review

The findings on national progress in the eight areas of commitment are provided below, with suggestions for translating commitments into action and greater accountability of governments for UHC according to the Political Declaration adopted at the UN high-level meeting on UHC in 2023 (5).

1. **Ensure political leadership beyond health:** Most countries recognize UHC as a goal but have not taken concrete operational steps to achieving UHC. Governments at all levels should determine their own path towards achieving UHC, in accordance with national contexts and priorities. They should strengthen national efforts, international cooperation and global solidarity at the highest political level and should sustain national political leadership for achievement of UHC (Paragraphs 2, 9, 46, 47).

2. **Leave no one behind:** Vulnerable individuals and groups continue to face financial and structural barriers to accessing the health services and commodities they need. Governments should respond to unmet health needs and eliminate financial barriers to access to quality, safe, effective, affordable essential health services, medicines, vaccines, diagnostics, and other health technologies. Governments should implement interventions that are people-centred, gender-, race- and age-responsive, disability-inclusive, and evidence-based to meet the health needs of all throughout the life course and particularly those who are vulnerable or in vulnerable situations. They should ensure protection against financial risk for all throughout the life course, especially for those who are poor and in vulnerable situations (Paragraphs 46, 49, 51, 83).

3. **Legislate and regulate:** While 89% of countries have made UHC a central goal in their national health policy plans and strategies, 41% have enacted UHC laws to ensure equitable, affordable access to health services. Governments should strengthen their legislative and regulatory frameworks and institutions and enhance policy coherence to support equitable access to quality service delivery for achievement of UHC, including through engagement with their communities and stakeholders (Paragraphs 44, 47).

4. **Uphold quality of care:** The global shortage of health and care workers, lack of support for the health and care workforce and inadequate health-care resources remain challenges to providing effective, safe, people-centred care for all. Governments should accelerate action to address the global shortfall of health workers and develop nationally-costed health workforce plans by investing in education, employment and retention, strengthening the institutional capacity for health workforce governance, leadership, data and planning. It should provide incentives to secure the equitable distribution of qualified health workers, including community health workers (Paragraphs 91-93).

5. **Invest more, invest better:** Despite continued increases in overall health expenditure for the COVID-19 response, governments' current investment commitments and public spending for health are inadequate to achieve UHC. Governments should prioritize and optimize budgetary allocations to health by investing in PHC and ensure adequate financial resources for a nationally determined package of health services for UHC. They should mobilize domestic public resources as a major source of financing for UHC and ensure sustainable financing and investment in UHC and health systems strengthening (Paragraphs 83-87).

6. **Move together:** Few countries have a formal, effective accountability mechanism for UHC, with inadequate multistakeholder engagement. Governments should promote participatory, inclusive approaches to health governance for UHC, including by enhancing a meaningful whole-of-society approach and social participation. All relevant stakeholders should be involved in the design, implementation and review of UHC, so that policies, programmes and plans better respond to individual and community health needs and foster trust in health systems (Paragraph 104).

7. **Gender equality:** Although women represent the majority of the health and care workforce, there is lack of commitment to achieving gender equality in the health and care workforce and to increasing women's representation in overall political leadership for health. Governments should mainstream a gender perspective into the design, implementation and monitoring of health policies and provide better opportunities and decent work for women in order to achieve gender equality and increase the empowerment of women and girls. They should ensure effective participation and leadership of women in health policies and health delivery (Paragraphs 61, 95).

8. **Emergency preparedness:** Countries do not invest sufficiently in health systems strengthening based on PHC to achieve UHC and health security. Governments should reaffirm the link between UHC and pandemic prevention, preparedness and response, recognizing that health system resilience and UHC are central to effective, sustainable prevention, preparedness and response to pandemics and other public health emergencies. Governments should strengthen the resilience of their health systems by ensuring that PHC, referral systems and essential public health functions, including prevention, early detection and control of diseases, are among the core components of prevention of and preparedness for health emergencies (Paragraphs 28, 41, 96).

Introduction

In September 2023, political leaders around the world convened at the UN General Assembly high-level meetings on health and reaffirmed their resolve to taking action for UHC. Building on the 2019 Political Declaration on UHC (7), which was the most ambitious, comprehensive political declaration on health in history, the 2023 declaration provides a useful roadmap to accelerate implementation to achieve UHC. It acknowledges the importance of health systems strengthening based on a PHC approach, which is critical not only for people-centered systems but also for effective health emergency prevention, preparedness, and response.

Given that half the world's population is unable to access essential health services and two billion people are facing financial hardship due to out-of-pocket health spending, greater focus on concrete steps is critical to address gaps in translating UHC political commitments into action. The need for urgent action could also be observed as UN Member States were delivering their statements during the UN high-level meeting on UHC (Box 1). Analysis of the recurrence of selected UHC aspects provides a useful basis of what issues matter most for Member States.

Box 1. Analysis of statements made by Member States during the UN high-level meeting on UHC

To get a sense of Member States' priorities to achieve progress on UHC, we analyzed the occurrence of several key aspects of UHC which enable or impede its realization, as shown in the first column of the table. We looked at whether countries made general references to the importance of each of these issues, described recent national achievements or announced new commitments or plans for implementation of new interventions in these areas. As an overall trend, general references to the importance of some selected UHC aspects were more common than mentions of concrete forward-looking actions and recent achievements.

Coming out as a central concern, equity was referenced by 77 Member States during their interventions. In addition to equity, health systems strengthening and/or its link to pandemic prevention, preparedness, and response, PHC and financial protection were the next top three areas that countries highlighted. More countries referred to recent achievements in the field of PHC and financial protection, going beyond general references to their importance. This is an interesting finding that could suggest that countries are taking tangible action on these critical areas.

Table 1 below summarizes patterns and themes in how Member States highlighted selected UHC aspects in their interventions at the UN high-level meeting on UHC which were grouped in the three categories below:

General reference: Any generalized acknowledgement, affirmation, or verbalization regarding selected UHC aspects which are not specific to any country or group's present or future plans/projects/activities.

Forward-looking announcements/new implementation plans: Specific references to future plans/projects/activities (not yet initiated), or recently initiated plans/projects/activities for which there are no results yet, at the national level.

Recent achievements: Specific references to projects/activities which have already been carried out, or projects/activities which are currently underway/being carried out, or references to specific outcomes or statistics related to such projects/activities.

Key aspect of UHC	General reference/ recognition of importance	Recent achievements	Forward-looking announcements/new implementation plans
Leave no one behind / equity in general/vulnerable populations	77	37	24
Health systems strengthening/ link to pandemic prevention, preparedness and response	46	17	14
Primary health care	44	52	22
Financial protection	43	44	20
Right to health	42	7	2
Health workforce	37	25	24
Prevention/health promotion	21	21	15
Gender equality	20	4	2
Social participation/ multistakeholder engagement/ whole-of-society	17	11	10
Climate change	15	1	3
Digital health	10	11	14

Table 1. Number of Member States mentioning selected UHC aspects across 119 Member States/groups that delivered verbal or written/transcript interventions at the UN high-level meeting on UHC on 21 September 2023.

While the UN high-level meeting and the resulting political declaration provided a strong signal, with political leaders reaffirming their commitment to UHC, the outcome of a high-level meeting alone is not enough to deliver on the commitments to protect and improve rights and access to health services for all, especially girls, women, sexual- and gender-diverse people and many other vulnerable groups. What matters now is to ensure real work in countries, with a focus on implementation and accountability and political will to turn global commitments into local action, with clear strategies, targets and timelines.

Regular monitoring of progress is critical to ensure accountability for UHC. The aim of this review is to determine whether countries are acting on their stated commitments to UHC in the action areas for health systems identified in the 2019 Political Declaration on UHC. It complements the more technical UHC global monitoring reports and provides an overview of national commitments made in policies and government documents; progress in implementing and acting on UHC commitments; and insights from state and non-state actors on countries' progress in achieving UHC. The findings of the review will be useful for policy-makers in preparing UHC progress reviews, including national voluntary reviews (VNRs), for reporting to the UN on achievement of the SDGs and other reports. The findings will also be a powerful tool for non-state actors to use in identifying gaps in UHC commitments for advocacy and to hold governments accountable.

The main objective of this report is to describe gaps in action on UHC commitments in 153 countries since the state of UHC commitment review conducted in 2020, including overall trends in action on UHC commitments and results in action areas.

UHC2030 began reviewing the state of UHC commitment in 2020 to consolidate a multi-stakeholder view of global and national commitments to achieving UHC by 2030. Its aim is to support national accountability and advocacy, ensuring that political leaders are held accountable for translating their commitments into action. It includes the UHC data portal, which provides dashboards of national UHC commitments and progress over time (Fig. 1), with downloadable profiles for 139 countries; and this synthesis of findings on UHC commitments and actions. The dashboards provide an overview of national commitments made in policies and government documents, progress in action on UHC commitments and insights from state and non-state actors on the country's progress towards UHC for each country. A User guide is available for guidance on how to use the dashboards.

The review addresses the targets, commitments and follow-up actions agreed at the 2019 UN high-level meeting on UHC and the resulting Political Declaration. More details on the methods used for this review are provided in the Appendix of this report and the Research protocol of the State of UHC commitment 2021–2023.

In the future, the 2023 Political Declaration will provide the basis for the contribution of UHC2030 to greater accountability for UHC commitments, with the Action Agenda from the UHC Movement as a reference framework.

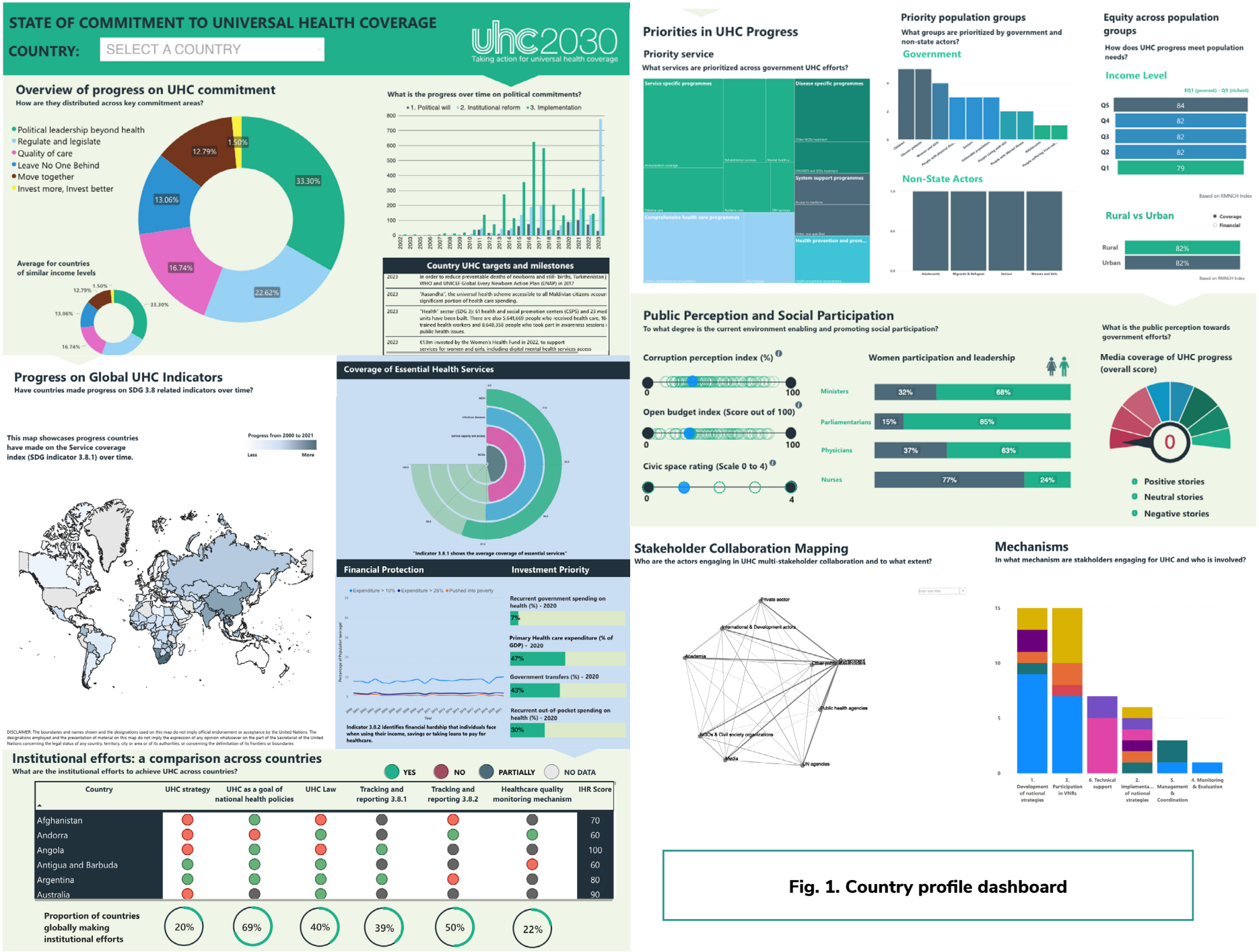


Fig. 1. Country profile dashboard

Findings

The path to achieving UHC is marked by both promises and challenges. Between 2019 and 2021, the number of countries that had expressed unwavering commitment to UHC increased consistently, and the volume of countries' UHC commitments also increased, with a significant increase from approximately 250 to around 600 individual commitments worldwide (Fig. 2). The increase in commitments mirrored a similar trend observed after adoption of the SDGs in 2015, when UHC became an integral part of SDG 3.

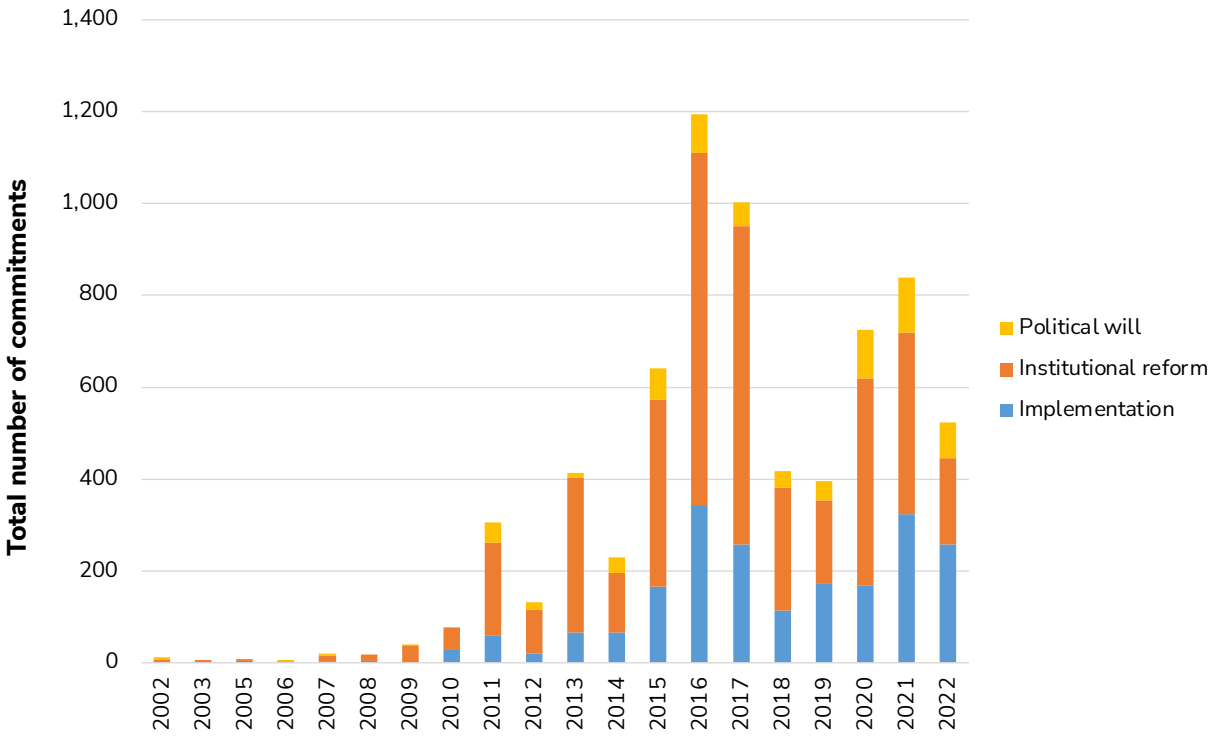


Fig. 2. Commitments to UHC by year

In 2022, however, the once-promising momentum towards UHC showed signs of slowing down and even reversing in some countries. In the midst of competing policy priorities, certain governments have not given health and UHC the priority they demand and have focused instead on other areas, such as education, infrastructure and defence (8). The recent Global Monitoring Report on UHC indicated that the world is not making the progress necessary to achieve UHC by 2030, as improvements in health service coverage have stagnated since 2015, and the proportion of the global population facing catastrophic out-of-pocket health spending has increased (6). The pursuit of UHC requires persistent political dedication to convert promises into meaningful actions. In this crucial period, advocacy at global, regional, national and grassroots level becomes essential to maintain UHC as a top priority and to hold political leaders accountable for their UHC commitments.

Many countries do not commit to addressing issues across all health care coverage dimensions: service coverage (43%), population coverage (42%) and financial protection (15%) (Fig. 3).

Current commitments focus mainly on service and population coverage, leaving gaps in explicit targets and obligations for financial protection. The consistent underemphasis and lack of adequate investment in addressing financial barriers to health-care delivery pose a substantial challenge to achieving UHC by 2030 (8).

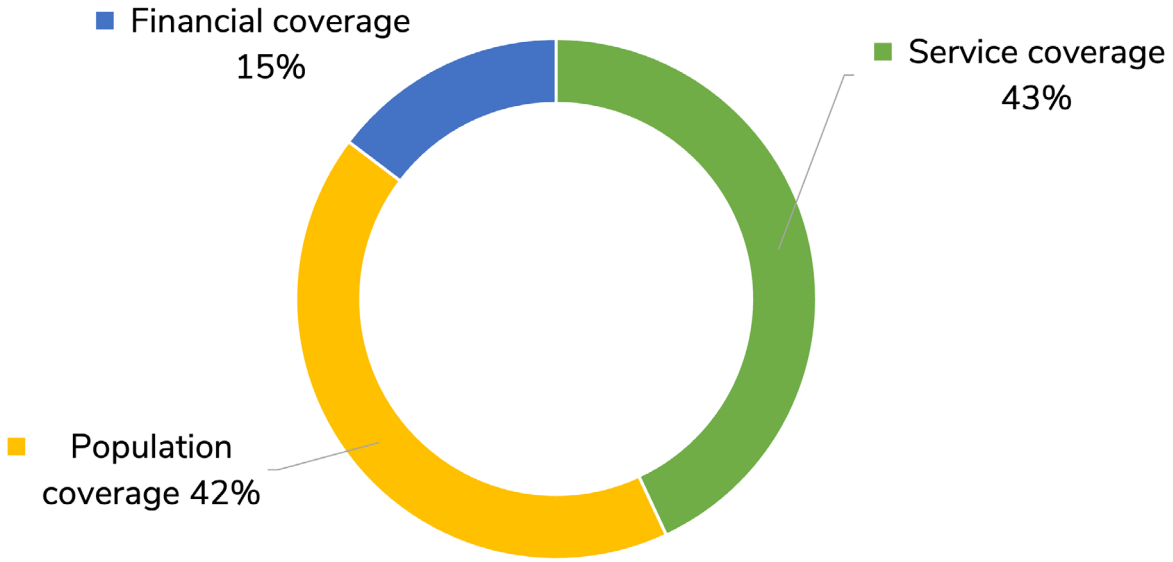


Fig. 3. Distribution of commitments across health care coverage dimensions

Most governments' commitments to UHC comprise fragmented implementation plans for specific diseases, while achieving UHC requires an integrated approach to planning and service delivery based on PHC. The design, implementation and review of health policies and programmes aimed for achieving UHC must ensure inclusive approaches to health governance through a whole-of-society approach and meaningful social participation of all relevant stakeholders, including local communities, health and care workers, volunteers, civil society organizations, the private sector and academia. A whole-of-society approach is crucial for addressing the complex interplay of health determinants and health needs effectively and ensuring that health services are of high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone, everywhere (9, 10). The findings of this review of the key action areas, however, show that governments have still not taken operational steps to achieving UHC and ensuring that no one is left behind.

Ensure political leadership beyond health

Most countries recognize UHC as a goal but have not taken concrete operational steps to achieving UHC.

Political leadership is indispensable for firmly establishing health as an unequivocal human right in the policy of every country. Political will is necessary for governments to allocate resources and make policy decisions to place UHC at the centre of local, national, regional and global political agendas. Although most countries acknowledge the significance of UHC as a goal in their national health policies (89% of 153 countries), many fewer have translated the goal into tangible operational steps towards achieving UHC. Of 153 countries for which data are available, only 19% have adopted a road map or strategy for achieving UHC in their country; the efforts of most countries towards UHC were limited to institutional reforms. In the global pursuit of achieving UHC by 2030, although political commitment is the cornerstone, it is not enough. To achieve UHC by 2030, governments must urgently move towards implementation and concrete action.

> ...while policies and strategies around UHC do exist, the problems lie with the implementation. Many people do not understand the UHC concept and there is often not a complete framework for UHC implementation and resources for health are insufficiently allocated. (Report, country consultation, Kenya, 2021).

For a country to implement UHC, it must be able to track and report on progress on achieving SDGs 3.8.1 and 3.8.2 effectively. The UHC Global Monitoring Report 2023 contains indices on achievement of SDG 3.8.1[1] from 194 Member States in 2021 and on achievement of SDG 3.8.2[2] in 2019 from 167 Member States. Only 36% of 153 countries have comprehensively evaluated achievement of SDG 3.8.1 in their policy documents or VNRs, and only 49% have monitored and reported on progress in achieving SDG 3.8.2. Lack of comprehensive monitoring and reporting creates a gap in alignment between political rhetoric and actionable, concrete strategies. Efficient, transparent monitoring of indicators 3.8.1 and 3.8.2, as illustrated in the examples from national reports below, is essential for evaluating countries' progress in increasing access to essential health-care services, improving protection against financial risk and enhancing quality of care.

For SDG 3.8.1:

> There are now 335 health facilities distributed across the country (comprising hospitals, health centres, health stations, and clinics) – a nearly fourfold increase from 1991. At present, approximately 80 percent of the population lives within a 10 km radius of a

[1] SDG 3.8.1: Coverage of essential health services is defined as the average from tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access for the general and the most disadvantaged populations (11).

[2] SDG 3.8.2 is defined as the proportion of the population with large household expenditure on health as a share of total household expenditure or income (12).

health facility and 70 percent within a 5 km radius, representing major improvements from just a few decades ago. (Eritrea, VNR 2022)

Pursue and provide universal healthcare through a combination of projects, primarily the projects of Quality Healthcare Services, Ending Non-Communicable Chronic Diseases, and Enhancing Hospitals' Capacity. Completion Status of Projects Aimed at Providing Universal Health Coverage: Quality Healthcare Services= 60%; Ending Non-Communicable Chronic Diseases = 40%; Enhancing Hospitals' Capacity = 70%] (Kuwait, VNR 2019)

Public coverage of basic health services started from 24.50% in 2016, increasing to 28.99% and 34.17% in 2017 and 2018 respectively. Then, it verified a decrease to 31.00% in 2019, to finally end at 25.56% in 2020. It is estimated to increase to 50% in 2025, reaching 75% as a final goal in 2030. (Argentina, VNR 2022)

For SDG 3.8.2:

With a significant increase in access to State-supported healthcare, the out-of-pocket expenditure as a percentage of total health expenditure has declined from 64.2 percent in 2013-14 to 58.7 percent in 2016-17. (India, VNR 2020)

Social health protection schemes [...] mechanism includes health insurance schemes (e.g. SASS – health insurance for civil servants) and safety net arrangements (e.g. health equity funds). Out of pocket health expenditure for the fiscal year 2009-2010 was about 46% according to the recent national health accounts study; thus revealing the limited level of financial risk protection of the population. (Lao People's Democratic Republic, Health Sector Reform Strategy And Framework Till 2025)

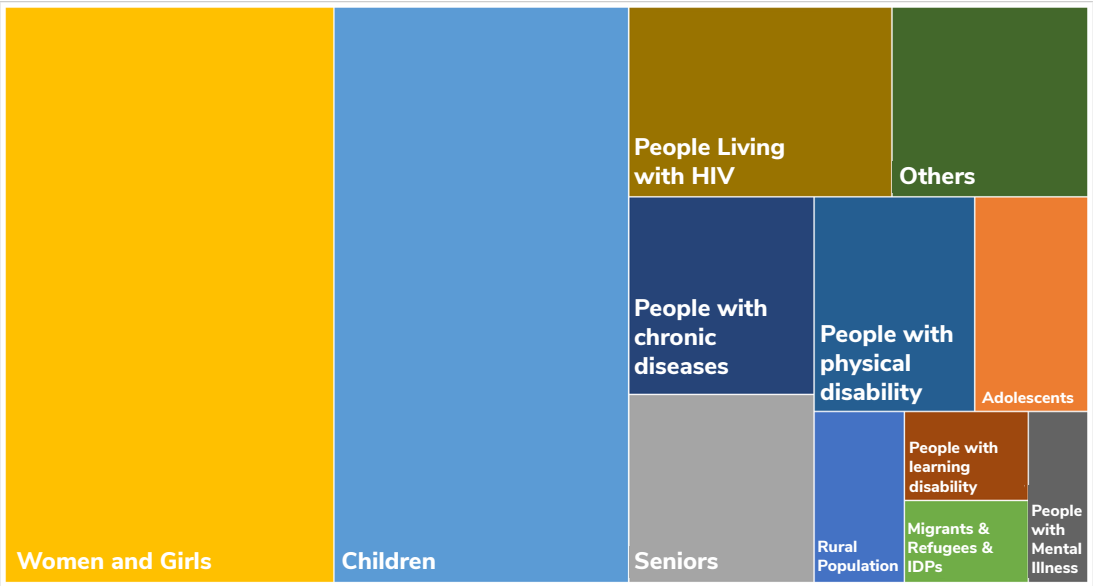
Family out of pocket health expenditure on average: in 2018 9.9% Increased to 10.4% In 2020 (Egypt, VNR 2021)

Leave no one behind

Vulnerable individuals and groups continue to face financial and structural barriers to accessing the health services and commodities they need.

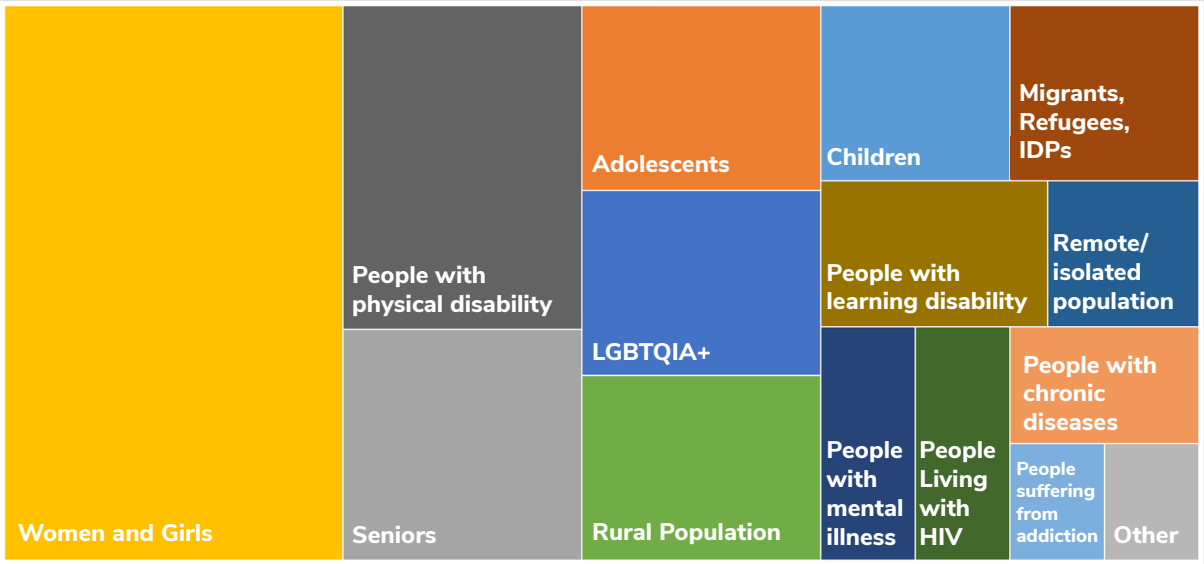
It is essential for UHC to "Leave no one behind", by guaranteeing equitable, affordable access to high-quality health services for everyone, irrespective of their demographic, socio-economic or geographical circumstances. This is both a critical goal and a powerful symbol of a government's dedication to fairness and inclusivity in its health systems.

Despite progress towards UHC, vulnerable individuals and marginalized groups still face significant, inequitable financial barriers to essential health services. While most countries (90% of 153 countries) have implemented policies to reduce some of these barriers, financial protection remains the dimension within UHC with the least commitment (Fig. 3), leaving vulnerable individuals without protection. Health insurances coverage is often unequal and insufficient, with marginalized populations less likely to have coverage (13). Examination of countries' financial commitments shows that women and girls, children and individuals living with HIV are the priority population groups in official governmental documents (Fig. 4), while non-state actors and communities call for broader financial coverage for all vulnerable groups, including lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other identities (LGBTQ+), migrants and refugees, people with disabilities and others (Fig. 5). Many participants in consultations with non-state actors and shadow VNRs stated that health insurance in their country usually does not cover all health needs and population groups. For instance, in Malaysia, participants reported that health-care insurance was restrictive and expensive and was therefore inaccessible to some population groups, such as people with intersecting disabilities. Civil society groups in Ghana and India also raised concern about their health insurance schemes, describing them as "ineffective and dysfunctional", with limited coverage. These disparities highlight the critical need for ensuring that financial barriers are systematically dismantled to ensure equitable access to health care for all.



IDPs: internally displaced people

Fig. 4. Populations groups prioritized by governments for UHC commitments to financial coverage



LGBTQIA+: lesbian, gay, bisexual, transgender, intersex, queer/ questioning, asexual and other; IDPs: internally displaced people

Fig. 5. Populations groups prioritized by non-state actors and communities for more comprehensive, integrated work towards UHC

Consultations led by civil society and shadow VNRs show the persistent challenge of fragmented, insufficient health services and programmes, which are frequently oriented towards specific diseases or services. This narrow focus results in many evolving unmet patient needs, limiting the delivery of comprehensive care. Limited access to high-quality, patient-friendly health information further limits access to and navigation of health services and health programmes. Notably, the country consultation in Malaysia indicated instances in which people with disabilities were received for consultations in isolation, selectively and sporadically, obviating integrated health services for those with intersecting disabilities. The report from Guatemala noted that the lack of comprehensive care was due to programmes that were driven primarily by political interests rather than to address underlying issues, exacerbating health disparities, particularly among the Indigenous population (Guatemala, shadow VNR, 2021). Governments must prioritize health system strengthening based on a PHC approach to deliver integrated, quality, safe, effective, affordable essential health services, ensuring that diverse patient needs are met and attaining health for all.

Legislate and regulate

While 89% of countries have made UHC a central goal in their national health policy plans and strategies, 41% have enacted UHC laws to ensure equitable, affordable access to health services.

Shielding individuals from financial hardship by legislation to ensure equitable, affordable access to health services is of paramount importance to making UHC a reality. UHC has been integrated as a central objective in the national health policies, plans and strategies of 89% of countries, signifying their strong commitment to health systems that prioritize inclusivity and equity. This high percentage of countries with UHC as a primary goal in local and national strategies combined with the percentage of countries with UHC laws demonstrate worldwide dedication to ensuring that access to quality health services and financial protection are not a privilege but a fundamental human right.

Sound legal and regulatory frameworks and institutional capacity create an enabling environment for implementing UHC reforms and ensuring that health services are accessible to all, irrespective of their socio-economic status (14). Less than half of all countries (41% of 153) have proactively adopted UHC laws. Data from the WHO Global Health Observatory show notable disparities among countries in adoption of UHC legislation (15). Countries categorized as low-income by The World Bank are more likely than wealthier countries to have UHC laws, demonstrating their determination to safeguard the health and financial well-being of their populations. As achievement of SDG 3.8.1 is low in low-income countries (16), this may suggest that they lack the necessary resources, such as funding, to provide an essential health benefits package.

Uphold the quality of care

The global shortage of health and care workers, lack of support for the health and care workforce and inadequate health-care resources remain challenges to providing effective, safe, people-centred care for all.

Ensuring equitable access to safe, quality, effective health services, especially PHC, is fundamental to achieving UHC. Consultations led by civil society and shadow VNRs indicate that the three main themes for ensuring quality of care are people-centred care, sufficient resources for public health facilities and well-trained health-care personnel (Fig. 6).

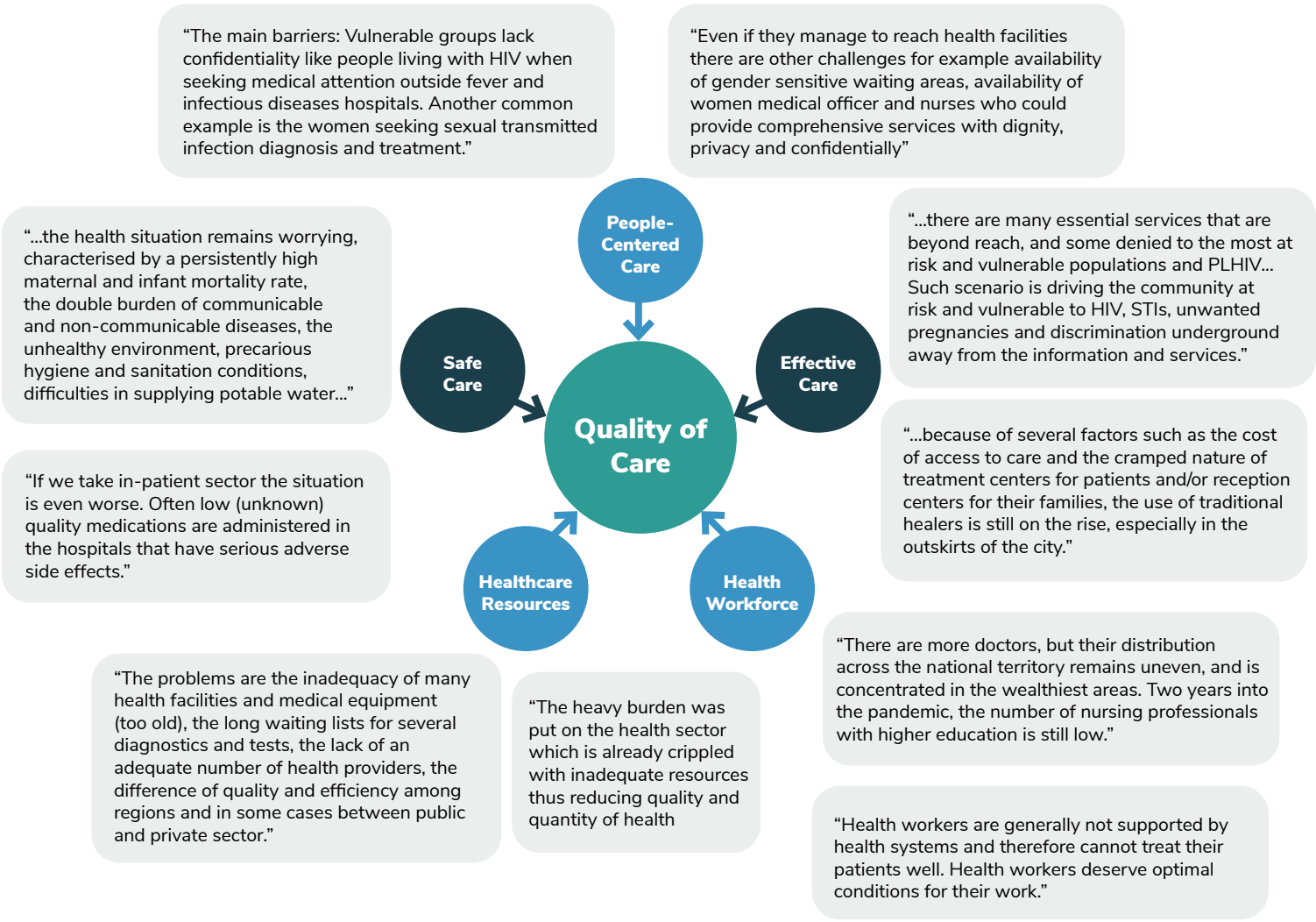


Fig. 6. Statements on quality of care in consultations led by civil society and shadow VNRs

People-centred care is at the heart of UHC, ensuring equitable, quality, efficient health services for all (17). A consistent comment in the consultations and shadow VNRs was that many patients felt disrespected during interactions with health-care providers, and particularly

the poor, women and girls seeking sexual and reproductive health services, members of the LGBTQ+ community, people living with HIV and other neglected population groups. Their voices often remain unheard because of limited engagement and inadequate feedback mechanisms (e.g. in Cambodia, India, Lao People's Democratic Republic). Promotion of patient-centred care means ensuring respectful, dignified care in health-care settings, improving patients' experiences and strengthening health systems to provide quality, equitable care for all and especially for vulnerable populations.

Uneven distribution of essential resources in public health-care facilities, notably health workers, was also highlighted in the consultations and shadow VNRs. The worldwide shortage of health and care workers is a significant challenge, especially in rural areas and public health-care facilities, and must be addressed by strategic planning and interventions (18). Deficiency in training and uneven distribution of health and care workers lead to disparities in care, as noted during consultations in 21 countries, including Brazil, Madagascar, Nigeria and Zambia. Low wages, insufficient incentives and difficult working conditions were identified as the factors that dissuade health-care providers. Inadequate resources in public health-care facilities, particularly in rural areas and primary health care centres, compromise the quality of care.

To advance UHC, governments must improve the quality of care by ensuring that health services are people-centred, including through engagement with communities and stakeholders, and by increasing health-care resources (including the health and care workforce) and investing in innovative care delivery models.

Invest more, invest better

Despite continued increases in overall health expenditure for the COVID-19 response, governments' current investment commitments and public spending for health are inadequate to achieve UHC.

Investment in UHC based on PHC is a smart, cost-effective strategy. UHC is recognized by political leaders as fundamental for achieving the SDG targets not only for health and well-being but also for eradicating poverty; ending hunger; achieving food security and improved nutrition; ensuring inclusive, equitable high-quality education; achieving gender equality; promoting sustainable, inclusive economic growth and decent work for all; reducing inequalities within and among countries; ensuring just, peaceful and inclusive societies; and building and fostering partnerships (5).

In 2020, health expenditure increased to cover the COVID-19 response; however, governments' current investments in public health and especially in PHC still fall short of UHC requirements (8, 19). PHC spending as a percentage of total health expenditure did not increase between 2017 and 2019 (19). Further, a review of government documents revealed limited information on current and planned investments in PHC, only a few countries providing clear plans for budget allocation. While most countries stressed the importance of PHC and its service coverage, only a few had made clear commitments or targets for increasing PHC funding. Guatemala, India and Nigeria, however, are committed to increasing the allocation from their gross domestic product to PHC: Guatemala will allocate 30% of its public health budget to PHC (20); India will increase its PHC allocation to two thirds of all public health expenditure (21); and Nigeria will allocate 35% of its health budget to PHC (22). Limited resource allocation to PHC raises doubt about countries' commitments to advance "UHC based on a PHC approach", as stated by heads of state and of government at the UN high-level meetings in 2019 and 2023 (23). WHO has reported that almost 90% of essential UHC interventions can be delivered through a PHC approach, which would save over 60 million lives and increase average global life expectancy by 3.7 years by 2030 (2, 24). Countries should prioritize investment in PHC and prevention as the foundation of UHC, ensuring access to health services, enhancing the quality of care and eradicating financial hardship due to out-of-pocket spending on health care.

The consultations and shadow VNRs showed lack of systematic, comprehensive funding mechanisms in the health sector, resulting in short-term, inconsistent funding (e.g. Botswana, Philippines), reliance on development partners or external donors (e.g. Cambodia, Ethiopia, Zimbabwe), diversion of resources from one programme to another (e.g. Burkina Faso), allocation of state funding to highly specialized care and not PHC (e.g. Kazakhstan, Kenya), mismanagement of financial resources (e.g. Kenya) or allocation of very limited funding to research (e.g. Brazil, Bhutan, Botswana). Better investment strategies and more efficient allocation of funds to health systems strengthening are essential to achieve UHC and access to quality, safe, effective, affordable health services for all.

Move Together

Few countries have a formal, effective accountability mechanism for UHC, with inadequate multistakeholder engagement.

Meaningful social participation of all relevant stakeholders in health systems governance and decision-making and promotion of transparency and accountability are critical to ensure that health policies and services are responsive, equitable and effective and that they advance human rights (23, 25, 26).

Only 26% of 153 countries have an accountability mechanism explicitly for UHC. The review of national policy documents and VNRs showed that most such mechanisms consist of monitoring and evaluation of disease-specific indicators (47% of countries) and not more comprehensive measures of UHC for the national population, such as SDG 3.8.1 for service coverage and SDG 3.8.2 for financial protection (25% of 153 countries). Although UHC can be monitored in various ways, reviewing and tracking disease-specific indicators is insufficient for the overview necessary to improve population coverage, service coverage and financial protection. Less fragmentation in programme planning, clear mechanisms and accountability for monitoring and evaluation activities are essential, as confirmed by our findings. Voices from Liberia and Mali civil society-led country Statements made during the consultations included:

> We do not know of any accountability or monitoring mechanism for UHC in Liberia. (Consultation, Liberia, 2022).

> ...the structure [for accountability and monitoring for UHC] is not well built to point out who is to be held accountable. (Consultation, Mali, 2022).

Strong accountability requires not only comprehensive monitoring of policy implementation but also meaningful engagement of non-state actors at various levels. The studies reported here indicated, however, that non-state actors still have few opportunities to engage in government-led UHC initiatives. The country consultations, shadow VNRs from 69 countries and the multistakeholder survey of 286 respondents in 138 countries, civil society and communities consistently highlight the challenges to active engagement of non-state actors in planning, budgeting, reviewing and evaluating health policies. Such difficulties were highlighted in particular in consultations in Argentina, Botswana, Burkina Faso, Cameroon, Colombia, Ethiopia, Georgia, Italy, Japan, Kenya, Malaysia, Mali, Pakistan, Philippines, Uruguay and Zimbabwe. The Political Declaration of the high-level meeting on UHC in 2023 emphasized the need for a meaningful whole-of-society approach and social participation involving all relevant stakeholders, including local communities, health and care workers, volunteers, civil society organizations and youth in the design, implementation and review of UHC (5). Few countries, however, include such provisions, with the notable exceptions of Iceland (27) and Ireland (28). The VNRs of those two countries include assessment by civil society of all areas evaluated in the VNR, including health, education, climate, and community engagement, providing an example of meaningful civil society participation in working towards UHC. All actors must work together for collective action to achieve UHC goals. Meaningful engagement of and clear communication with all relevant stakeholders is essential, as it gives individuals knowledge of their rights and responsibilities, enabling them to make informed decisions and to hold authorities accountable.

Gender Equality

Although women represent the majority of the health and care workforce, there is lack of commitment to achieving gender equality in the health and care workforce and to increasing women's representation in overall political leadership for health.

Gender is a critical determinant of health. Therefore, a gender approach is crucial for strengthening health systems. Gender inequality affects both health outcomes and access to services on both the supply and the demand sides of health services.

Women comprise 67% of global employment in the health and care sector, and nearly 90% of nurses and midwives are women (29-31). Although women are the majority, their representation in the workforce is low, as they hold only 25% of senior roles (31). Globally, women are paid 24% less than men with similar profiles in the health and care sector (32). This "leaky pipeline" extends to the political sphere in which important decisions that affect health are made (33), as women fill only 26% of national parliamentary seats (global average of 147 countries in 2022) and less than 23% of all ministerial positions related to health (global average of 145 countries in 2020). This severe underrepresentation of women in leadership roles not only raises concerns about gender equality but also influences health policies and decisions at various levels, as "UHC is a political choice" (34). A review of the health and development policies of 45 countries in 2021 showed that countries are not making adequate strides towards gender equality in health and leadership. Only 13% of the 45 countries in the review had expressed a commitment to enhancing women's representation in both health and political leadership. Greater emphasis should be placed on the inclusion of women and gender minorities in decision-making. The COVID-19 crisis highlighted the effectiveness of women leaders, who upheld transparency, accountability and a commitment to human rights in their policy responses (35).

Women and girls are prioritized in some work to achieve UHC. They were the targets of most health interventions related to sexual and reproductive services (77%) but to a much lesser extent to HIV/AIDS treatment (6%), malaria treatment (3%) and immunization services (3%). This raises concern that women and girls are not included in more comprehensive work to achieving UHC. Also in this study, women and girls were prioritized for disease- or service-specific programmes and interventions (83%) but not for comprehensive health services, such as PHC and health care throughout the life course, although they face unique barriers to health services and have been neglected and excluded from the medical model for decades (36). These findings indicate that governments should invest in building gender-responsive health systems and incorporating a gender lens in all aspects of health systems.

Emergency preparedness

Countries do not invest sufficiently in health systems strengthening based on PHC to achieve UHC and health security.

Achieving UHC through resilient, equitable health systems based on a PHC approach is the foundation for effective prevention of, preparedness for, response to and recovery from health emergencies (37, 38). Throughout the COVID-19 pandemic, the delivery of essential health services was significantly disrupted (38, 39). Health workers, who were already stretched thinly, had to address a severe additional burden imposed by the pandemic (40). This disproportionally affected women and could lead to a further shortage of health and care workers due to resignations and migration (41).

The crisis in health security represented by COVID-19 demonstrated clearly that underinvestment in resilient health systems results in catastrophic human costs when a crisis strikes, disproportionally affecting the most vulnerable populations and widening health inequality (38, 42). A pivotal lesson from the COVID-19 pandemic, and from previous health crises, is the importance of substantial public investment in strong, resilient, equitable health systems based on PHC (37, 38). Despite this clear insight, tangible action to address critical areas, such as implementing policies that ensure UHC is a central component of and prerequisite for emergency preparedness, has not been taken, as in other action areas. Both funding for PHC and setting of actionable targets for health systems remain insufficient. Governments must affirm their commitment to UHC and health security as two intertwined goals to be achieved within the same national health system and better prepare for future health emergencies and ensure health for all.

References

1. The 17 Goals. New York: United Nations, Department of Economic and Social Affairs; n.d. [cited 2023 10th October]; Available from: https://sdgs.un.org/goals.

2. Universal health coverage (UHC). Geneva: World Health Organization,; n.d. [cited 2023 10th October]; Available from: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

3. Rukmana D. Vulnerable Populations. In: Michalos AC, editor. Encyclopedia of quality of life and well-being research. Dordrecht: Springer Netherlands; 2014.

4. United Nations. The United Nations World water development report 2023: partnerships and cooperation for water. Paris: UNESCO; 2023.

5. Political Declaration of the high-level meeting on universal health coverage (A/RES/78/4). New York: United Nations General Assembly; 2023 [cited 2023 14 November]; Available from: https://www.undocs.org/Home/Mobile?FinalSymbol=A%2FRES%2F78%2F4&Language=E&DeviceType=Desktop&LangRequested=False.

6. Tracking Universal Health Coverage: 2023 Global Monitoring Report. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2023.

7. Political Declaration of the high-level meeting on universal health coverage (A/RES/74/2). New York: United Nations General Assembly; 2019 [cited 2023 14 November]; Available from: https://undocs.org/Home/Mobile?FinalSymbol=A%2FRes%2F74%2F2&Language=E&DeviceType=Desktop&LangRequested=False.

8. Chen S, Cao Z, Wang Z, Wang C. The challenging road to universal health coverage. Lancet Glob Health. 2023;11(10):e1490-e1.

9. Boydell V, McMullen H, Cordero J, Steyn P, Kiare J. Studying social accountability in the context of health system strengthening: innovations and considerations for future work. Health Res Policy Syst. 2019;17(1):34. Epub 20190329.

10. Witt CM, Chiaramonte D, Berman S, Chesney MA, Kaplan GA, Stange KC, et al. Defining Health in a Comprehensive Context: A New Definition of Integrative Health. Am J Prev Med. 2017;53(1):134-7. Epub 20170201.

11. SDG indicator metadata. SDG 3.8.1. New York: United Nations Department of Economic and Social Affairs, Statistics Division; 2015 (Last updated: 2023-01-24) [cited 2023 14 November]; Available from: https://unstats.un.org/sdgs/metadata/files/Metadata-03–08–01.pdf.

12. SDG indicator metadata. SDG 3.8.2. New York: United Nations Department of Economic and Social Affairs, Statistics Division; 2015 (Last updated: 2023-05-15) [cited 2023 14 November]; Available from: https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-02.pdf.

13. Barron GC, Laryea-Adjei G, Vike-Freiberga V, Abubakar I, Dakkak H, Devakumar D, et al.

Safeguarding people living in vulnerable conditions in the COVID-19 era through universal health coverage and social protection. Lancet Public Health. 2022;7(1):e86-e92. Epub 20211211.

14. Perehudoff SK, Alexandrov NV, Hogerzeil HV. Legislating for universal access to medicines: a rights-based cross-national comparison of UHC laws in 16 countries. Health Policy Plan. 2019;34(Supplement_3):iii48-iii57.

15. The Global Health Observatory: Countries that have passed legislation on universal health coverage. Geneva: World Health Organization; n.d. [cited 2023 14 November]; Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/countries-that-have-passed-legislation-on-universal-health-coverage-(uhc).

16. The Global Health Observatory: Index of service coverage by World Bank income group. Geneva: World Health Organization; n.d. [cited 2023 10th October]; Available from: https://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEW-Bv.

17. De Man J, Mayega RW, Sarkar N, Waweru E, Leys M, Van Olmen J, et al. Patient-Centered Care and People-Centered Health Systems in Sub-Saharan Africa: Why So Little of Something So Badly Needed? Int J Pers Cent Med. 2016;6(3):162-73.

18. Liu JX, Goryakin Y, Maeda A, Bruckner T, Scheffler R. Global Health Workforce Labor Market Projections for 2030. Hum Resour Health. 2017;15(1):11. Epub 20170203.

19. Global Health Expenditure Database. Geneva: World Health Organization; n.d. [cited 2023 10th October]; Available from: https://apps.who.int/nha/database/Select/Indicators/en.

20. Secretaría de Planifcación y Programación de la Presidencia Guatemala. III Revisión Nacional Voluntaria 2021. 2021 [cited 2023 10th October]; Available from: https://hlpf.un.org/sites/default/files/vnrs/2023/VNR%202021%20Guatemala%20Report.pdf.

21. Government of India. India Voluntary National Review 2020. 2020; Available from: https://hlpf.un.org/sites/default/files/vnrs/2021/26281VNR_2020_India_Report.pdf.

22. Government of the Federal Republic of Nigeria. A Second Voluntary National Review 2020. 2020 [cited 2023 10th October]; Available from: https://hlpf.un.org/sites/default/files/vnrs/2021/26309VNR_2020_Nigeria_Report.pdf.

23. World Health Organization. Voice, agency, empowerment–handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021.

24. Stenberg K, Hanssen O, Bertram M, Brindley C, Meshreky A, Barkley S, et al. Guide posts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study. Lancet Glob Health. 2019;7(11):e1500-e10. Epub 20190926.

25. Koonin J, Mishra S, Saini A, Kakoti M, Feeny E, Nambiar D. Are we listening? Acting on commitments to social participation for universal health coverage. Lancet. 2023. Epub 20230919.

26. World Health Organization. World leaders commit to redouble efforts towards universal health coverage by 2030. 2023 [cited 2023 10th October]; Available from: https://www.who.int/news/item/21-09-2023-world-leaders-commit-to-redouble-efforts-towards-universal-health-coverage-by-2030.

27. Government of Ireland. Ireland's 2023 Voluntary National Review - Sustainable Development Goals. 2023 [cited 2023 10th October]; Available from: https://hlpf.un.org/sites/default/files/vnrs/2023/VNR%202023%20Ireland%20Report_1.pdf.

28. Government of Iceland, Prime Minister`s office. Voluntary National Review. 2023 [cited 2023 10th October]; Available from: https://hlpf.un.org/sites/default/files/vnrs/2023/VNR%202023%20Iceland%20Report.pdf.

29. Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. Geneva: World Health Organization, 2019.

30. State of the world's nursing report 2020. Geneva: World Health Organization, 2020.

31. Closing the leadership gap: gender equity and leadership in the global health and care workforce. Geneva: World Health Organization, 2021.

32. International Labour Organization, World Health Organization. The gender pay gap in the health and care sector: a global analysis in the time of COVID-19. Geneva: World Health Organization and International Labour Organization; 2022.

33. Global Health 50/50. Gender Equality: Flying blind in a time of crisis, The Global Health 50/50 Report 2021. London: 2021.

34. Ghebreyesus TA. All roads lead to universal health coverage. Lancet Glob Health. 2017;5(9):e839-e40. Epub 20170717.

35. Clark H, Gruending A. Invest in health and uphold rights to "build back better" after COVID-19. Sex Reprod Health Matters. 2020;28(2):1781583.

36. Davidson PM, McGrath SJ, Meleis AI, Stern P, Digiacomo M, Dharmendra T, et al. The health of women and girls determines the health and well-being of our modern world: A white paper from the International Council on Women's Health Issues. Health Care Women Int. 2011;32(10):870-86.

37. Civil Society Engagement Mechanism for UHC2030. Why and how to reflect universal health coverage in the pandemic treaty. Geneva: Global Health Centre, Graduate Institute of International and Development Studies; 2022 [cited 2023 14 November]; Available from: https://www.uhc2030.org/news-and-events/news/universal-health-coverage-and-the-pandemic-treaty-555558/.

38. OECD. Ready for the next crisis? Investing in health system resilience. Paris: OECD Publishing; 2023.

39. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021. Interim report. Geneva: World Health Organization, 2022.

40. E D, HS F, H. C. What the COVID-19 pandemic has exposed: the findings of five global health workforce professions. Geneva: World Health Organization, 2023.

41. Women in Global Health. The Great resignation: why women health workers are leaving. 2023.

42. McGowan VJ, Bambra C. COVID-19 mortality and deprivation: pandemic, syndemic, and endemic health inequalities. The Lancet Public Health. 2022;7(11):e966-e75.

Appendices: Methods

The review provides insights into the UHC commitments of 153 countries derived from a review and analysis of a wide range of sources, providing perspectives from various stakeholders on countries' progress in meeting their commitments to UHC. The data include national health policies and strategies, multistakeholder surveys, secondary data (e.g. from the WHO Global Health Observatory), media (social media and news) and focus group discussions with non-state actors. The analytical framework for the review is based on the "Key asks from the UHC movement", which are requests for governments and political leaders to take action on UHC. Details on the methods used for this review are also provided in the Research protocol of the State of UHC commitment 2021–2023.

Building on the "key asks", the review focused on eight areas of commitment: political leadership beyond health; leave no one behind; legislate and regulate; uphold quality of care; invest more, invest better; move together; gender equality; and emergency preparedness (Table A-1). Three levels of commitment were identified in the theoretical framework adapted from previous work, which reflect the continuum of political commitment, from high-level political will (rhetorical commitment), to institutional reform (institutional commitment) and implementation (operational commitment) in countries' policies (Box A-1).

Table A-1. Eight areas of commitment addressed in this review

Area of Commitment	Milestone by 2023
Political leadership beyond health	Governments incorporate aspirational health-related SDG targets into national planning processes, policies and strategies to ensure that everyone can access high-quality health services without financial hardship.
Leave no one behind	Governments report disaggregated data to SDG official statistics to cover the full spectrum of progress in equity dimensions of UHC monitoring (SDG 3.8.1 and 3.8.2).
Legislate and regulate	Governments introduce legal and regulatory measures to accelerate progress towards UHC.
Uphold quality of care	Access to high-quality essential health services has been provided to one billion additional people (SDG 3.8.1).
Invest more, invest better	Governments adopt ambitious investment goals for UHC, make progress in mobilizing domestic pooled funding, and reduce catastrophic health expenditure (SDG 3.8.2).
Move together	All UN Member States endorse the UHC2030 Global Compact and establish multistakeholder platforms to ensure the involvement of civil society, communities and the private sector in regular policy dialogue and review of progress with the whole government.
Gender equality[a]	N.A.
Emergency preparedness[a]	N.A.

[a]Milestones by 2023 for gender equality and emergency preparedness were not included when the key asks were developed in 2019. These action areas have been added at a later stage based on the growing concern due to the COVID-19 pandemic

Box A-1. Continuum of UHC commitments

Rhetorical commitment (political will):

- Forward-looking statements about recognition and intention to pursue UHC. Can range from symbolic gestures to actionable decisions

Institutional commitment (institutional reform):

- Conversion of rhetorical commitment into policy infrastructure, including coordination mechanisms, legislation and policies

Operational commitment (Implementation):

- Translation of rhetorical and institutional commitments into practical actions. Involves resource allocation, coordination and dedicated programme management.

Adapted from Baker et al. (1).

Commitments were identified and extracted with a data extraction tool designed specifically for this study. This tool facilitated systematic categorization of political commitments into the main areas indicated above. Data were collected by six consultants trained in the study methods and in use of the data extraction tool to ensure the quality of the data extraction and their analysis. Documents were reviewed in their original language, with translation tools used when necessary. Two rounds of quality checks were performed by senior researchers to ensure data accuracy.

Data sources

Publicly available resources from 153 countries were analysed between 2020 and 2023 for this review (Table A-2). The resources included 164 national health plans or strategies, 176 VNRs, consultations with civil society in form of focus group discussions in 35 countries, 34 "shadow" VNRs (reviews prepared by non-state actors on countries' progress in achieving the SDGs), 286 multi-stakeholder survey responses, 759 results of media monitoring, and 17 global repository indicators from publicly available data (Table A-3). National health plans and strategies were reviewed to identify the level of various governmental efforts and strategies towards achieving UHC in the country.

Table A-2. Countries included in the review[a]

Afghanistan, 2021

Andorra, 2022

Angola, 2021

Antigua and Barbuda, 2021

Argentina, 2022

Australia, 2022

Austria, 2022

Azerbaijan, 2021

Bahamas, 2021

Bahrain, 2022

Barbados, 2023

Belarus, 2022

Belgium, 2022

Bhutan, 2021

Bolivia, 2021

Bosnia and Herzegovina, 2023

Botswana, 2022

Brazil, 2022

Brunei Darussalam, 2022

Burkina Faso, 2022

Burundi, 2022

Cabo Verde, 2021

Cambodia, 2022

Cameroon, 2022

Canada, 2022

Central African Republic, 2023

Chad, 2021

Chile, 2022

China, 2021

Colombia, 2021

Comoros, 2022

Congo, 2022

Côte d'Ivoire, 2022

Croatia, 2023

Cuba, 2021

Cyprus, 2021

Czechia, 2021

Democratic People's Republic of Korea, 2021

Democratic Republic of the Congo, 2022

Denmark, 2021

Djibouti, 2021

Dominica, 2022

Dominican Republic, 2021

Egypt, 2021

El Salvador, 2022

Eritrea, 2022

Eswatini, 2022

Ethiopia, 2022

Equatorial Guinea, 2022

Fiji, 2022

Finland, 2022

France, 2022

Gabon, 2022

Gambia, 2022

Georgia, 2022

Germany, 2021

Ghana, 2022

Greece, 2022

Grenada, 2022

Guatemala, 2021

Guinea, 2022

Guyana, 2022

Hungary, 2022

Iceland, 2023

India, 2022

Indonesia, 2021

Iraq, 2021

Ireland, 2022

Italy, 2022

Jamaica, 2022

Japan, 2021

Jordan, 2022

Kazakhstan, 2022

Kenya, 2022

Kuwait, 2022

Kyrgyzstan, 2022

Lao People's Democratic Republic, 2021

Latvia, 2022

Lebanon, 2022

Lesotho, 2022

Liberia, 2022

Libya, 2022

Liechtenstein, 2022

Lithuania, 2022

Luxembourg, 2022

Madagascar, 2021

Malawi, 2022

Malaysia, 2021

Maldives, 2023

Mali, 2022

Marshall Islands, 2021

Mauritania, 2022

Mexico, 2021

Mongolia, 2022

Montenegro, 2022

Morocco, 2022

Mozambique, 2022

Myanmar, 2021

Namibia, 2021

Nepal, 2022

Netherlands (Kingdom of the), 2022

Nicaragua, 2021

Niger, 2021

Nigeria, 2022

Norway, 2021

Oman, 2022

Pakistan, 2021

Panama, 2022

Paraguay, 2021

Philippines, 2022

Poland, 2023

Portugal, 2022

Qatar, 2021

Republic of Korea, 2022

Romania, 2023

Russian Federation, 2022

Rwanda, 2022

Saint Kitts and Nevis, 2022

San Marino, 2021

Sao Tomé, 2022

Saudi Arabia, 2022

Senegal, 2022

Sierra Leone, 2021

Singapore, 2022

Slovakia, 2023

Somalia, 2022

South Africa, 2022

Spain, 2021

Sri Lanka, 2022

Sudan, 2022

Suriname, 2022

Sweden, 2021

Switzerland, 2022

Syrian Arab Republic, 2022

Tajikistan, 2023

Thailand, 2021

Timor-Leste, 2023

Togo, 2022

Tunisia, 2021

Turkey, 2022

Turkmenistan, 2023

Tuvalu, 2022

United Arab Emirates, 2022

Uganda, 2022

Ukraine, 2022

United Kingdom, 2022

United Republic of Tanzania, 2023

Uruguay, 2021

Uzbekistan, 2023

Vietnam, 2022

West Bank and Gaza Strip

Zambia, 2022

Zimbabwe, 2021

[a] Year is that of a major analysis of national health policy plans and strategies and/or VNRs was conducted. For countries reviewed in 2023, only VNRs were analysed.

Table A-3. Data sources

Data source	Number of Sources	Information extracted
National health plans or strategies	164 documents	• tracking and reporting on SDG targets 3.8.1 and 3.8.2 • measurable national UHC targets defined • multisectoral actions for health and well-being • proof of operationalization of equity and leaving no one behind • existence of a commitment to reducing financial barriers to health services • UHC strategy, road map or action plan • existence of national health policy in which UHC is recognized as a goal • existence of a policy, strategy or plan for improvement of quality and safety • existence of national spending targets for health • accountability mechanism for UHC
VNRs	176 reports (137 in 2020–2022, 39 in 2023)	• Same as national health plans and strategies, plus: • multistakeholder engagement in VNRs • existence of a commitment to whole-of-government approach and/or health in all policies in VNRs • recognition of UHC in VNRs
Country consultations	35 consultations	• groups described as vulnerable or “left behind” in health and UHC • health services that are available and are lacking from the perspective of the non-state actor • any measurable UHC target that the shadow report or non-state actors would like the country to achieve • any multisectoral action and/or multi-stakeholder engagement in UHC and the type of mechanism • positive statements about the progress of UHC in the country • negative statements about the progress of UHC in the country • concrete recommendations for the government on UHC commitments
Shadow VNRs	34 reports	Same as national health plans and strategies
Multistakeholder survey	286 responses	• mechanisms for multi-stakeholder involvement in national health policy development,, implementation and evaluation • prioritized groups and health services • public awareness: any communication channels and ways for people to become aware about UHC
Media monitoring (social media and news sources)	759 sources	• positive statements about the progress of UHC in the country • negative statements about the progress of UHC in the country • neutral statements about the progress of UHC in the country

Publicly available data: WHO Global Health Observatory, Transparency International, CIVICUS monitor, International Budget Partnership's Open Budget Initiative, SDG database, World Bank gender statistics	7	• SDG 3.8.1 UHC service coverage index • SDG 3.8.2 Catastrophic out-of-pocket health spending (disaggregated) • health expenditure as percentage of gross domestic product • out-of-pocket expenditure as percentage of current health expenditure • data on reproductive, maternal, newborn and child health equity • existence of UHC law • SDG Indicator 3.c.1 (health worker density and distribution by sex, physicians and nurses) • corruption perception index; • SDG 1.1.1, percentage of households in population pushed below the US$ 1.90 a day poverty line • recurrent health expenditure by funding source • civic space rating • open budget index • SDG 5.5.1: Proportion of seats held by women in national parliaments (percentage of total number of seats) • Proportion of women in ministerial positions • score for achievement of the requirement of the International Health Regulations (2005)

Focus group discussions with non-state actors were conducted to complement the information available in publicly available documents and data on UHC commitment in countries. The discussions involved various civil society and community representatives, who provided the perspectives of civil society advocates, health-care providers, programme implementers, patients and their family members, community leaders, researchers and young people. The survey responses provided insights into opportunities and mechanisms for involvement in UHC work. Social media platforms and news outlets were used to analyse public perceptions about UHC in the country. Publicly available data, such as the WHO Global Health Observatory, were used to assess progress in achieving global indicators of UHC in each country under review.

The countries in which focus group discussions were held were: Bhutan, Burkina Faso, Cambodia, Colombia, Egypt, Georgia, India, Japan, Kazakhstan, Kenya, Lao People's Democratic Republic, Mexico, Nepal, Niger, Pakistan, South Africa and Viet Nam in 2021; and Argentina, Botswana, Cameroon, Dominica, Eswatini, Ethiopia, Ghana, Italy, Jordan, Liberia, Malawi, Mali, Philippines, Senegal, Singapore, Sri Lanka, Switzerland and Uruguay in 2022.

All country consultations for the State of UHC commitment review were conducted by partners in the Civil Society Engagement Mechanism. The findings from consultations in the Caribbean region were difficult to differentiate as they were conducted in several countries.

The questions addressed in the focus group discussions were divided into nine categories according to the UHC areas of commitment (Table A-4).

Table A-4. Country consultations used and questions for focus group discussions[a]

Main Category	Guiding questions for country consultations
Ensure political leadership beyond health	• Does your government have a coordination government agency/mechanism/department that engages across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning? • f you primarily conduct health advocacy, have you engaged with other government ministries or departments beyond health in your advocacy efforts? How so?
Leave no one behind	• Which groups of people in your country struggle to gain access to health services? What are the main barriers for them to access health services? • Considering the needs of the groups identified above, what are the specific health services that are under-prioritized?
Regulate and legislate	• Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented? • Do you know of any accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.
Uphold quality of care	• Do you think that health services in your country are of good quality? Can you elaborate and give examples? • What health services and what communities/population groups experience the gaps in quality?
Invest more, invest better	• Where do you think your government should be spending more in terms of achieving UHC?
Move together	• At the national level: are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? If so, what are those opportunities and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalised populations and communities? • At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? If so, how are they engaged?
Gender equality	• Can you identify some of the major challenges for women and girls in their access to health services? • What kinds of health services are most challenging for women and girls to access? • What are the primary challenges to access health care services for individuals who are non-binary? .
Emergency preparedness	• How has the PHC system been affected by the ongoing COVID-19 pandemic? • How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?

[a] Source: Civil Society Engagement Mechanism for UHC2030 (2).

Only shadow VNRs published before August 2022 were included in the review. The countries for which shadow VNRs were used were: Kyrgyzhtan, Russian Federation and Zambia in 2020; Bhutan, Chad, Cabo Verde, Colombia, Denmark, Democratic People s Republic of Korea, Guatemala, India, Indonesia, Kenya, Lao People's Democratic Republic, Madagascar, Malawi, Malaysia, Mexico, Nepal, Nigeria, Norway, Pakistan, Paraguay, Spain, Uganda and Zimbabwe in 2021; and Argentina, Brazil, Gabon, Italy, Mali, Philippines, Sri Lanka and Switzerland in 2022.

References for Appendices

1. Baker P, Brown AD, Wingrove K, Allender S, Walls H, Cullerton K, et al. Generating political commitment for ending malnutrition in all its forms: A system dynamics approach for strengthening nutrition actor networks. Obes Rev. 2019;20 Suppl 2:30-44. Epub 20190627.
2. Civil Society Engagement Mechanism for UHC2030. Country Consultations on UHC. 2022 [cited 2023 8 November]; Available from: https://csemonline.net/civil-society-perspectives-souhcc-2022/

About UHC2030

UHC2030 is the global movement to build stronger health systems for UHC. It provides a platform to convene and build connections through joint high-level events or gatherings of experts and contributes advocacy, tools, guidance, knowledge and learning. This supports all relevant stakeholders to take more effective and coherent action in support of countries' efforts to achieve UHC, based on a shared vision for health systems that protect everyone and a shared commitment to leave no one behind.

UHC2030 brings together diverse partners, including governments, international organizations and global health initiatives, philanthropic foundations, civil society and the private sector. UHC2030 also brings together partnerships, collaboratives and networks which focus on strengthening different aspects of health systems (Health Systems Strengthening Related Initiatives), greater collaboration and harmonization across health stakeholders and programmes (Coalition of Partnerships for UHC and Global Health), and promote mutually reinforcing action and sharing of information, learning and resources.

Join our mailing list | info@UHC2030.org | www.UHC2030.org

Follow us on: X - Twitter @UHC2030 and LinkedIn