

“LEAVING NO ONE BEHIND”

DELIVERING ON THE PROMISE OF HEALTH FOR ALL

Reflections of the Civil Society Engagement Mechanism for UHC2030 on the Primary Health Care on the Road to Universal Health Coverage 2019 Monitoring Report



“As we embark on this great collective journey,
we pledge that no one will be left behind.
Recognizing that the dignity of the human person
is fundamental, we wish to see the goals and
targets met for all nations and peoples and for
all segments of society. And we will endeavour
to reach the furthest behind first.”

(2030 Agenda for Sustainable Development)¹

Conducted by: Civil Society Engagement Mechanism (CSEM)
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1: UN Sustainable Development Goals Knowledge Platform. Transforming our world: the 2030 Agenda for Sustainable Development.
<https://sustainabledevelopment.un.org/post2015/transformingourworld>

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Executive summary

This paper from the Civil Society Engagement Mechanism for UHC2030 (CSEM) is written in response to an invitation from the UHC2030 Core Team. From the perspective of civil society, and with a focus on vulnerable populations, the paper provides a commentary on the **Primary Health Care on the Road to Universal Health Coverage 2019 Monitoring Report** (hereafter ‘2019 Monitoring Report’) and the existing global UHC monitoring process, and offers recommendations towards realizing the goal of UHC. It is offered in the spirit of deepening the conversation and focuses on the principle of “leaving no one behind”.

To deliver the promise of achieving UHC by 2030, the world first needs to know how far we have progressed on the journey, and how well we are doing on different aspects of UHC. The 2019 Monitoring Report provides just that. This is the first global monitoring report that provides estimates of numbers of people who are covered by essential health services (and those who are not). This data is extremely useful for monitoring the progress.

The 2019 Monitoring Report shares more bad news than good news.

More than half of the world’s population does not have access to essential health services. Neither the interim target of having 1 billion more people covered by 2023, nor the final goal of achieving UHC by 2030, will be met unless efforts are significantly accelerated. With the current level of effort, at least one third of the world’s population will remain uncovered in 2030.

The commitment to provide financial protection has not moved from rhetoric to reality. More people are experiencing financial hardship due to health care expenses than ever before. In excess of 930 million people had to spend more than 10% of their household budget on health care, and 210 million people crossed the 25% threshold. Hundreds of millions of people are

pushed into poverty each year just because they seek health care.

The only good news is that the service coverage index (SCI) is improving, especially in low-income countries (LICs) and lower-middle-income countries (LMICs). However, this improvement was largely the result of the rapid scale-up of infectious disease interventions between 2005 and 2010.

Even with the above impressive increase, coverage of infectious disease interventions is still the lowest among all the components of service coverage, and LICs and LMICs are still the places where services are least available.

Non-communicable diseases raise different concerns as there is almost no progress in this area globally, and also because data is seriously lacking.

Inequity and inequality are widespread

In all World Bank income groups, service coverage is higher than population coverage. This illustrates the fact that service availability does not translate to accessibility and utilization, and signals widespread inequity between income groups.

Another significant gap between income groups is seen with regard to health system capacity, pointing to striking inequality. The gaps have persisted since the beginning of the century.

Lower-income countries are a ground for grave concern.

Unsurprisingly, service coverage is lowest in LICs. LMICs are home to half of the total number of people left without coverage of essential health services in the entire world. Yet, more and more people in these countries are spending at least 10% of their household budget on health care, accounting for 45% of the world’s population who are forced to do this – and the figure is on the rise.

While the 2019 Monitoring Report presents a very useful overall picture of UHC progress in the world, it fails to identify the people who are left behind.

There is almost no data disaggregation by the key dimensions of equity such as gender, age, wealth, ethnicity, disability, geographic location, fragile states and conflict situations, nor analyses of inequity due to factors that cause marginalization such as migratory status, sexual orientation, gender identity or identification registration. Chapter 3 on gender and equity is an encouraging attempt to address equity in UHC but falls short of providing an overview of the situation.

The report fails to reflect the provision of financial protection (or lack of it) to vulnerable populations. Having more health care needs but less of their essential health needs covered (due to facing barriers to enrol in a financial protection mechanism and/or encountering obstacles to utilize services eligible to them), vulnerable populations are more likely to experience catastrophic expenditure and more likely to forgo their health care needs.

The existing UHC monitoring processes leave the most vulnerable populations out.

Although they may manage to present the overall picture of UHC progress in the general population. Household surveys and facility data are unlikely to capture data from these populations as the most vulnerable people are often those who are stigmatized, hidden, imprisoned, illiterate, and/or undocumented. The services most essential to each vulnerable population may be different from those the UN and Member States selected as indicators of coverage.

Further, indicators to monitor financial protection can only partially monitor financial hardship due to health care cost. Out-of-pocket expenditure does not account for non-medical costs, which can be steep and become a barrier. The data on people who are pushed into poverty fails to count people who are already in poverty, and who are pushed deeper when they have to pay out-of-pocket for health care. And the people living in so much poverty that they cannot even afford to pay for health care are completely left behind in the monitoring of financial protection.

The CSEM welcomes and appreciates the invitation to provide a commentary to the 2019 Monitoring Report as a concrete action by WHO, the World Bank and UHC2030 to engage civil society and coordinate our efforts in monitoring UHC progress. We regret that a similar partnership-building effort does not happen in many countries around the world, and look forward to this situation changing. The standard process of collecting, collating, validating and analysing data does not typically involve civil society and vulnerable populations, and this must change.

Recommendations

1

The UHC movement should firmly uphold the principle of “leaving no one behind”, which is articulated in the SDG Agenda as “reach the furthest behind first”. To achieve that, at every level, UHC actors should:

- Identify the people who are consistently being left behind;
- Identify their essential health needs, including the needs distinctive from those of the general population;
- Understand the reasons why they cannot access or use services essential to them;
- Enlist them as key partners in advocating for inclusive, rights-based, effective and sustainable UHC policy and programmes; and
- Engage them in the planning, budgeting, implementing, and monitoring of services so these are more appropriate, accessible, acceptable and sustainable, and the interventions are more likely to reach them with satisfactory outcomes.

3

To improve service coverage of UHC, intensified efforts are needed in LICs and LMICs where service coverage is far below the global average level to:

- Significantly increase coverage of both the infectious disease and non-communicable disease components of UHC packages, as infectious diseases are still at the lowest coverage level among all the components of UHC and non-communicable diseases show no progress;
- Continue efforts to expand services for reproductive, maternal, newborn and child health; and
- Thoroughly review the systems that provide essential health services, to have in place and implement plans that mobilize and strengthen the capacities of service providers from different sectors to meet the health needs of all populations, including the distinctive needs of vulnerable populations. Community-based services that mobilize community service providers and engage community participation should be considered for the populations whom the public sector finds hard to reach.

2

The monitoring of UHC, at all levels, should embrace the “leave no one behind” mindset and make every effort to gather the most accurate and up-to-date information about UHC progress among people who are furthest behind. In doing so, UHC monitoring should:

- Be aware that some vulnerable populations are severely marginalized, hidden or appear as hard-to-reach to the people outside their own community, to the extent that the usual monitoring approaches may not be relevant;
- Recognize that health services essential to vulnerable populations may differ from those for general populations and that their living circumstances, culture, and/or values may not be similar to those of the general population; and
- Engage vulnerable communities in the entire process of monitoring – from selecting, developing, reviewing indicators and tools, as well as data collection, analysis, verification and dissemination. Doing so will increase the relevance of the monitoring process and accuracy of information as well as the use of data.

4

To get closer to the targets of covering 1 billion more people by 2023 and to achieve UHC by 2030, the pace of expanding population coverage needs to be significantly accelerated.

- LICs and LMICs should be the focus ground for acceleration as they have the highest concentration and numbers of people who are left without coverage of essential health services in the world;
- Vulnerable populations in all settings are left furthest behind and should be prioritized for any effort to increase population coverage; and
- Primary health care has been rightly identified and recommended by the 2019 Monitoring Report as “the route to UHC” and should receive the investment and attention it deserves.

5

The recent deterioration of financial protection is unacceptable and is the biggest failure of the UHC promise, and this necessitates immediate attention. The governments, UN, the World Bank, WHO, relevant UN agencies and all stakeholders should make every effort to cut down out-of-pocket expenditure. Greater reliance on public spending on health coupled with so-called progressive universalism, i.e. taking steps to benefit the most disadvantaged people first, should be the main strategy.

6

Engagement of and investing in civil society as a key stakeholder is essential to achieving UHC that leaves no one behind. Civil society is often best placed to gain access to vulnerable populations, to represent and prioritize their messages for equitable access to quality health services. Civil society helps to ensure that they are informed of health policies, that their voices are heard and that they can participate in improving their countries' health systems and budget. Civil society also has a proven track record of being a very effective, reliable and resilient advocacy force, and is well placed to ensure social accountability.

Preamble

The Civil Society Engagement Mechanism for UHC2030 (CSEM) is the civil society constituent of the International Health Partnership for UHC2030 (UHC2030). The CSEM raises civil society voices in UHC2030 to ensure that universal health coverage (UHC) policies are inclusive and equitable, and that systematic attention is given to the most marginalized and vulnerable populations so that no one is left behind.

We do this through:

- Influencing policy design and implementation;
- Lobbying for participatory and inclusive policy development and implementation processes;
- Strengthening citizen-led social accountability mechanisms;
- Promoting coordination between civil society organization (CSO) platforms and networks working on health-related issues at the national, regional and global levels; and
- Enabling civil society to have a voice in the UHC movement at subnational, national, regional and global level.

The UN High-Level Meeting on Universal Health Coverage is a critical opportunity for the world to come together, to make commitments and identify actions to achieve UHC by 2030. The CSEM, in line with “Key Asks from the UHC Movement” released by the UHC2030 platform² in consultation with broad civil society constituents, upholds the principle and goal to “leave no one behind”. In April 2019, the CSEM issued its “Civil Society Priority Actions for the UN High-Level Meeting on Universal Health Coverage” statement,³ calling on all Member States to fulfil the right to health for all:

1

Increase public health financing and financial protection

- Decrease, then eliminate, out-of-pocket private spending on health.
- Increase public financing through progressive taxation or other mandatory and fair contributions and take concrete action to eliminate tax avoidance that deprives countries of crucial resources to invest in health.
- Increase public domestic financing towards a minimum of 5% of GDP as government health spending and other appropriate targets based on the country and/or regional context (such as the Abuja Declaration’s 15% annual budget allocation for health sector improvements).
- Improve transparency and accountability in health planning, budgeting and expenditure tracking, especially for communities that have been left behind.
- Ensure financial protection to allow all people to access quality UHC services that cover the full spectrum of care: promotion, prevention, treatment, rehabilitation and palliative care.
- Prioritize primary health care services when allocating health resources and access to affordable quality health commodities.
- Create adequate regulatory safeguards and accountability to communities for private sector delivery of health products and services to prevent conflict of interest, poor health outcomes and mitigate potential excessive focus on profit motives when addressing the needs of vulnerable communities.

2

Leave no one behind

- Provide quality, affordable essential health services, prioritizing those populations that have been “left behind”,⁴ or are often excluded from universal health coverage in their countries, as committed to in the SDGs.
- Address the compounding effects of poverty – gender inequalities; discrimination based on ethnicity, disability, sexual orientation and gender identity – on those left behind when developing and/or updating policies and budgets.
- Countries need to address legal and policy barriers, as well as harmful social, traditional and cultural norms that prevent women and girls, as well as marginalized and criminalized groups, from receiving health services.
- Create health facilities with environments that are free of stigma and discrimination.
- Ensure that tracking of UHC-related indicators includes disaggregated data collection and analyses include cross-cutting issues such as gender, age, income, race, ethnicity, migratory status, disability, sexual orientation, gender identity, and geographic location.

3

Focus on health workers

- Finance community health workers (CHWs) as integral parts of the health workforce and provide proper remuneration for their work. It is important to recognize that over 80% of health workers are female. Two WHO reports⁵ indicate that policies which address the underlying causes of gender inequities must be adopted to achieve UHC as well as to unleash broader socioeconomic gains and spur women's economic empowerment.
- Set minimum standard targets, including gender equity, for training and professional opportunities, quality assurance and adequate supervision and support, for health workers at all levels, including CHWs. While volunteers at the community level are an important resource, they are not and should not be considered as a sufficient substitute for trained and adequately remunerated professional health workers.

The 2019 Monitoring Report captures the progress made and the issues that need to be addressed on the road to achieving UHC by 2030. This paper on behalf of the CSEM offers reflections on that report and provides a commentary encompassing the perspectives of civil society and focusing on the UHC goal to “leave no one behind”.

This paper does not purport to be a systematic review of recent scientific literature, nor is it a critique of the 2019 Monitoring Report; rather, it is designed to discuss key issues of concern to civil society. It is offered in the spirit of deepening the conversation and focus on the principle and goal to leave no one behind.

4

Engage civil society and community in UHC implementation to ensure accountability

- Create mechanisms to promote community participation in health governance to ensure transparent decision-making and accountability, as well as effective monitoring and evaluation mechanisms to guide the development of policies and strategies towards achieving UHC.
- Develop and expand the use of social accountability frameworks in partnership with civil society that monitor country progress towards UHC with a particular focus on the poor and marginalized populations. This will help governments, donors and partners be more aware of, and be held accountable to, the needs of all communities.
- Develop plans to address health needs in emergency and humanitarian settings.

The 2019 Monitoring Report captures the progress made and the issues that need to be addressed on the road to achieving UHC by 2030.

1: Moving together to build a healthier world: key asks from the UHC movement. UN High-Level Meeting on Universal Health Coverage. https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/UN_HLM/UHC_Key_Ask_Final.pdf

3: Civil society priority actions for the UN High-Level Meeting (UN HLM) on Universal Health Coverage (UHC). https://csemonline.net/wp-content/uploads/2019/04/CSEM-Priority-Actions_FINAL-3.pdf

4: Populations who are increasingly left behind are those communities who are displaced, living in fragile, humanitarian, urban poor or rural remote contexts and those living with stigma and discrimination.

5: WHO. Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. Human Resources for Health Observer No. 24; and Boniol M, Mclsaac M, Xu L, Wuliji T, Diallo K, Campbell, editors. Gender equity in the health workforce: analysis of 104 countries. Health Workforce Working Paper 1. See https://www.who.int/hrh/news/2019/gender_CSW/en/

Introduction

What would it look like when universal health coverage (UHC) is achieved around the world? The World Health Organization defines UHC as “All individuals and communities receive the health services they need without suffering financial hardship. UHC should include the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care”.⁶

The WHO Constitution (1946) envisages “... the highest attainable standard of health as a fundamental right of every human being”. The Sustainable Development Goals (SDGs) build on this foundation with pledges of “no one will be left behind” and the right to health: “A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity”.⁷

Vulnerable populations have the greatest health burdens and are least able to cope with and recover from illness and the associated expense of it. Consequently, vulnerable populations have the most to gain from health interventions. People can become vulnerable at certain points over the course of their life including as newborns, children, adolescents, and older people.

Populations are vulnerable for many and varied reasons, such as:

- a. physical, cognitive or psychosocial disabilities;
- b. the location where they live, such as an isolated area or with quasi-legal status in an urban slum;
- c. their living environment, such as being homeless, being displaced or living in a fragile state or conflict situation;
- d. social, cultural, structural and legal factors including discrimination against women and girls, refugees, migrants, LGBTIQ+, persons with disabilities among others;
- e. their legal status, such as people who are incarcerated or people who do not have the legal right to be a particular territory;
- f. discriminatory laws and criminalization of people’s behaviours, such as using drugs or selling sex;
- g. health conditions, such as people who are HIV-positive or those experiencing mental illness; and
- h. harmful social norms and practices, including gender inequality, homophobia and transphobia.

The term “vulnerable populations” used in this commentary encompasses populations that are marginalized, disadvantaged and the “key populations” defined by some global health programmes such as HIV or zero dose by immunization programmes.

The movement to achieve UHC has garnered increasing political momentum and support across a diverse range of stakeholders. However, implementation has stalled and many social, cultural, structural and legal barriers to access and use of health services stand in the way of those who are most vulnerable.

Civil society is often best placed to gain access to vulnerable populations to represent and prioritize their messages for equitable access to quality health services. Civil society helps to ensure that they are informed of health policies, that their voices are heard and that they can participate in improving their country’s health systems and budget.⁸

Following the publication of CSEM’s commentary on the second GMR in 2017, CSEM was offered a similar opportunity to preview the 2019 Monitoring Report and publish a commentary as the report is launched. We appreciate this gesture of collaboration and coordinated action.

To prepare this commentary, the CSEM Secretariat formed a task force to work alongside a consultant. Given the tight time frame between the availability of the draft and the launch of the 2019 Monitoring Report, the task force was not able to hold consultations with CSEM members. Instead, it called for submission of evidence to inform the commentary.

This commentary shares (a) reflections on the 2019 Monitoring Report, examining both the content and the ways in which the data were collected and presented; and (b) recommendations to accelerate the UHC movement inclusive of vulnerable populations.

6: WHO. Key facts: universal health coverage. January 2019. [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

7: WHO. Key facts: human rights and health. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>

8: UHC2030. Civil society engagement. <https://www.uhc2030.org/what-we-do/civil-society-engagement/>

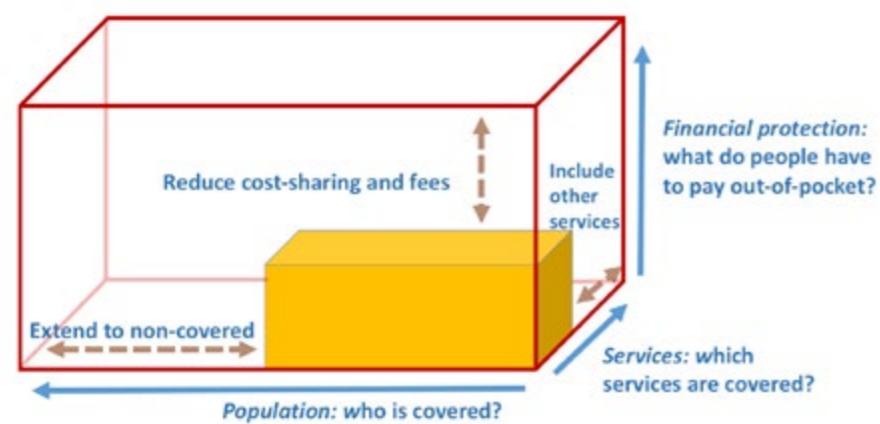
PART 1

Reflections on the 2019 Monitoring Report

The GMR 2019 presents an overview and analyses of progress towards achieving UHC across the dimensions of (1) service coverage; (2) population coverage; and (3) financial protection, by country, region, income group and globally. This commentary reflects on the global progress of UHC by reflecting on these three dimensions of UHC.

A. Examining the three dimensions of UHC

Figure 1: The three dimensions of UHC



Source: https://www.who.int/health_financing/topics/benefit-package/UHC-choices-facing-purchasers/en/

A1. Coverage of essential health services – progressing, but uneven improvement

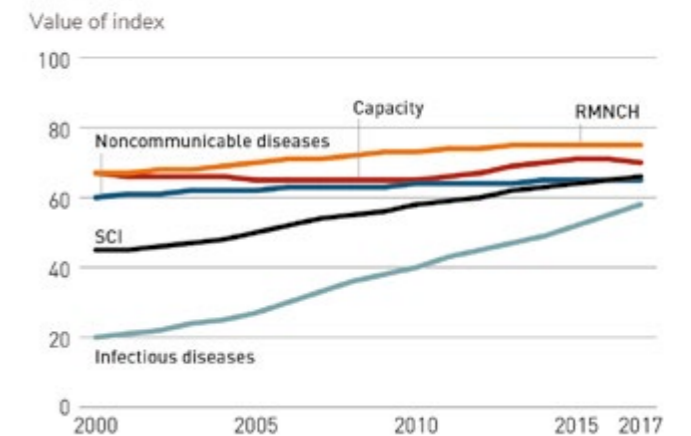
SDG 3.8.1 indicator: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).

Coverage of essential health services is moving in the right direction although improvement is uneven. At first glance, the 2019 Monitoring Report presents an optimistic picture: between 2000 and 2017, the service coverage index (SCI, as defined in SDG 3.8.1 indicator, with four components) at the global level increased from 45 to 66. The increase of service coverage, indicating that more services became available and were being used, was observed in all regions, by all income groups. However, a closer look reveals uneven improvement between countries. The overall progress has been slowed or even stalled in some countries and there is stark inequity between income groups in all aspects of service coverage, especially in health system capacity.

A2. Progress on service coverage – a glory of the past, made by a few

The biggest gains in SCI values were in the period 2005–2010, due to the increase of the infectious disease component of SCI, as the world focused efforts on scaling up ART for HIV, and on treated bed net coverage for malaria. These surges made the biggest contribution to the SCI although there had been some improvement in all SCI components. The index value of the infectious disease component almost tripled between 2000 and 2015 – from 20 to 59, compared to a few points in each of the other three components.

Figure 2: Of the index's four components, infectious disease coverage improved the fastest globally

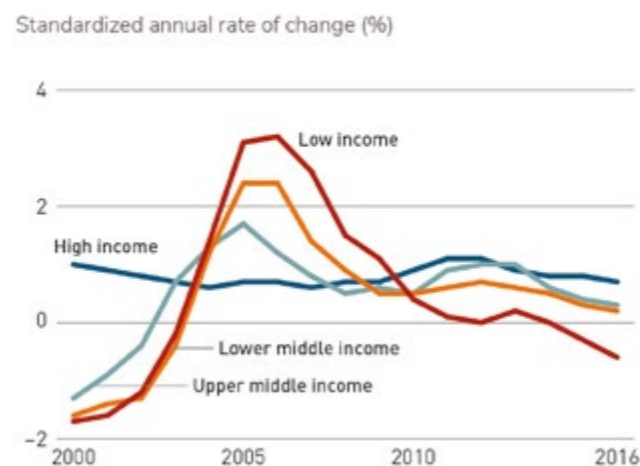


Note: SCI – service coverage index; RMNCH – reproductive, maternal, newborn and child health; NCD – non-communicable disease.

Source: 2019 Monitoring Report, page 15.

Most of the gains in SCI in low-income countries (LICs) and lower-middle-income countries (LMICs) happened during the aforementioned period of significant improvements in the infectious disease component (almost five-fold in both groups), as well as to some extent in reproductive, maternal, newborn and child health (an increase of almost 20 points). In recent years, change has been much slower for the LMIC group, and even stalling for the LIC group.

Figure 3: Since 2010, the pace of progress on the service coverage index has slowed or begun stalling, especially for low-income countries

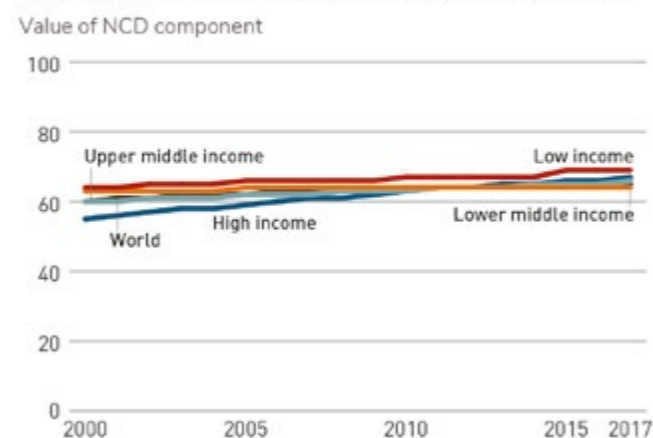


Source: 2019 Monitoring Report, page 19, figure 1.11.

A3. Non-communicable diseases – non-progress

Except for some improvement in the high-income countries (HIC) group, non-communicable disease component of SCI in all other income groups has almost flat-lined since 2000.

Figure 4: While absolute progress on the noncommunicable disease UHC SCI component was not large for any income group, high-income countries saw somewhat faster gains since 2000



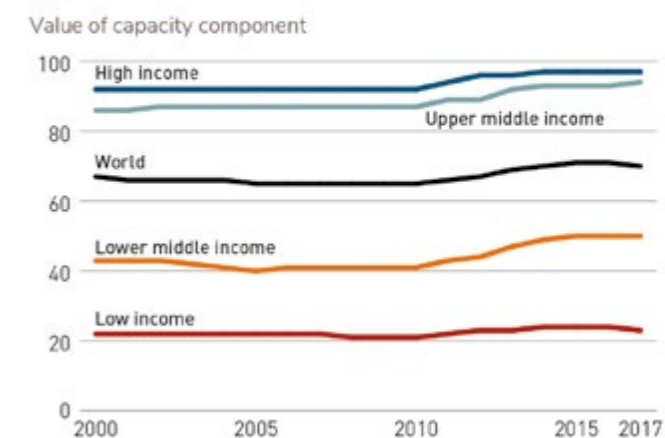
Note: Each circle represents a country and UHC SCI index values (x-axis) are for 2000.

Source: 2019 Monitoring Report, page 16, figure 1.8.

A4. Service capacity – the striking inequality

The disparity of the capacity of health systems between lower-income and higher-income groups is enormous. While the average index value among the LIC group is just above 20 and among LMICs around 50, it is almost 95 among upper-middle-income countries (UMICs) and close to 100 in HICs. As strong health systems will lead to more sustainable health gains over time, particularly for the most vulnerable populations, weak health systems in the lower-income countries – if not improved significantly and rapidly – will continue to fail to deliver.

Figure 5: Large gaps between high-income and low-income countries persisted over time on the service capacity and access component of the UHC SCI



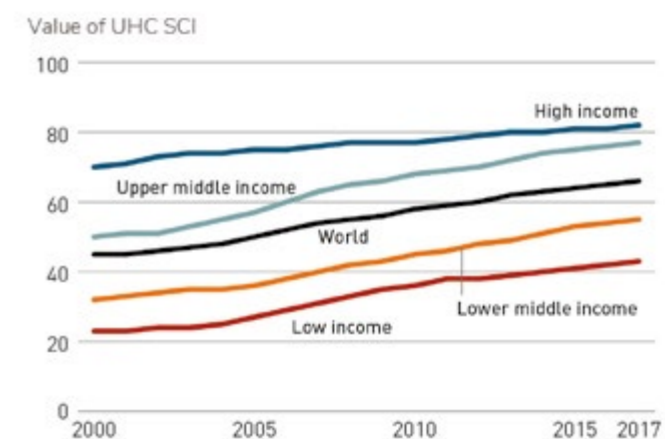
Note: Each circle represents a country and UHC SCI index values (x-axis) are for 2000.

Source: 2019 Monitoring Report, page 18, figure 1.9.

A5. Infectious diseases and low-income countries – the catch-up game

Starting at the lowest level in 2000, LICs as country group and infectious diseases as an SCI component have both made significant progress in catching up with other countries and other SCI components. The SCI in LICs doubled while index values of the infectious disease component tripled. Despite this, the index value of the infectious disease component is remarkably lower than any other component, and the SCI of LICs is far behind other country groups.

Figure 6: The UHC SCI improved from 2000 to 2017 in all WHO regions and World Bank income groups



Source: 2019 Monitoring Report, page 14, figure 1.3.

B. Population coverage – not even half of the world's population

The 2019 Monitoring Report is the first in a series to produce estimates of numbers and percentages of people who are and are not covered by essential health services. This is a step towards more practical monitoring and accountability for impact on people's lives.

Population coverage reported in the 2019 Monitoring Report are estimates of “coverage of essential services among those in need” (2019 Monitoring Report, Statistical Annex 1.3). In this context, “fully covered” signals coverage by at least 70% of essential health services identified by 12 tracer indicators. These 12 tracer indicators are from four domains, similar to but with some distinction from 14 tracer indicators of the SCI. Population coverage focuses on utilization and impact of the services rather than availability of services. The four domains are: (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) non-communicable diseases; and (4) specialized care.

B1. Widespread inequity regardless of income status

In all income country categories by World Bank, population coverage lags far behind service coverage, signalling that the availability of services does not automatically translate into access and use. The service coverage and population coverage are not comparable in all income groups, pointing to the widespread inequity. In the HIC group, while service coverage has gone beyond 80/100, only between 59% and 72% of the populations are fully covered by essential health services. Similarly, in UMICs, service coverage is close to 80 but the population coverage is only about half of the population. Worst are the LICs where only between 1-in-9 and 1-in-3 people are fully covered.

Table 1: Population coverage in 2017 of the world population and by income group

World Bank income group	% covered in 2017	Number of people (billions) in 2017		
		Covered	Not covered	Total population*
World	33–49%	2.5–3.7	3.8–5.0	7.5
High income	59–72%	0.7–0.9	0.3–0.5	1.2
Upper-middle income	42–57%	1.1–1.5	1.1–1.5	2.6
Lower-middle income	21–38%	0.6–1.1	1.9–2.4	3.0
Low income	12–27%	0.1–0.2	0.5–0.6	0.7

*According to World Population Prospects 2019 (United Nations, Department of Economic and Social Affairs, Population Division 2019).

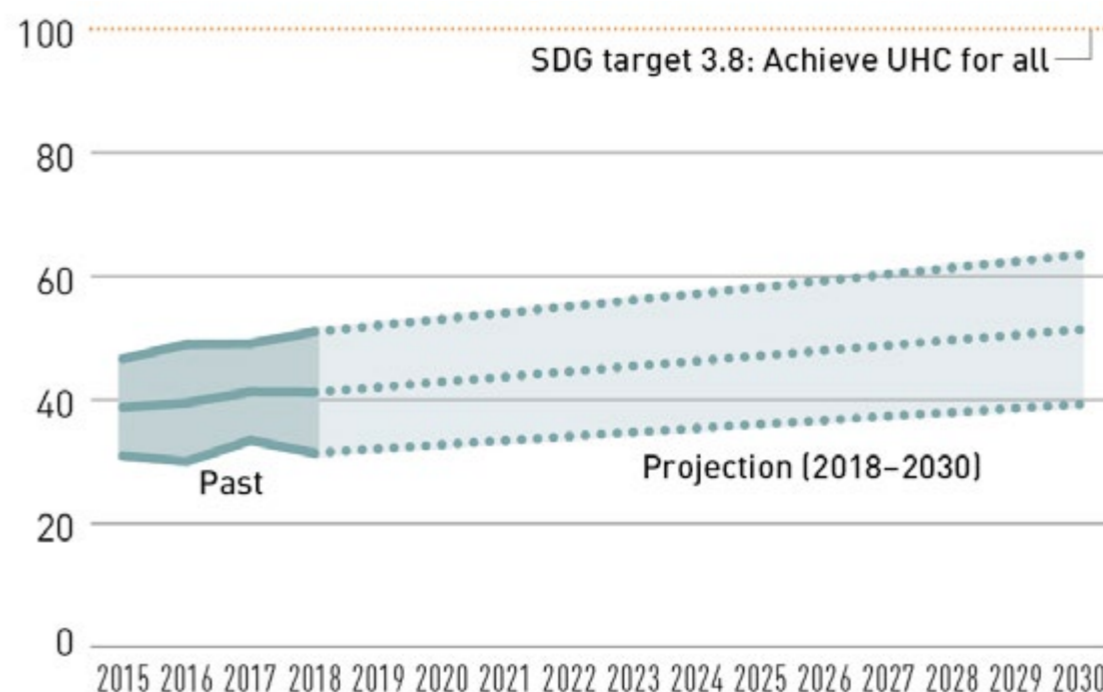
Source: 2019 Monitoring Report, page 21, table 1.1.

B2. UHC by 2030 – a broken promise?

The 2019 Monitoring Report shows a substantial gap between the aspirations of UHC2030 and progress so far. The prospect of not reaching the targets by 2030 is cause for serious concern, and is acknowledged in the report: less than half the world's population is currently covered. The report estimates that if current trends continue and taking into account the offset by population growth, by 2030 less than two thirds of the people in the world or “4.1 to 5.5 billion people, or 49% to 65% of the world's projected population, will be covered by essential health services” and “3.0 billion to 4.4 billion, will still lack such coverage” (2019 Monitoring Report, page 19).

In an effort not to be overwhelmed by the tasks ahead and perhaps make the targets more achievable, WHO set in its Global Program of Work a target of “1 billion more people with coverage of essential health services” between 2019 and 2023. However, only four years from that mid-point, the 2019 Monitoring Report estimates that not more than 40–60% of this target will be met with the current rate of change and rate of out-of-pocket expenditure.

Figure 7: If recent trends continue to 2030, the world is likely fall well below the SDG target of universal health coverage for all



Source: 2019 Monitoring Report, page 21, figure 1.12.

C. Financial protection or financial burden?

C. Financial protection or financial burden?

The 2019 Monitoring Report also covers financing UHC, reminding the reader: “Financial protection means that all individuals can obtain the health care they need without experiencing financial hardship” (page 27).

Financial hardship is monitored by the “SDG indicator 3.8.2, (which) defines catastrophic health spending as out-of-pocket health spending exceeding 10% and 25% of the household budget (total consumption or income)” (2019 Monitoring Report, page 27).

Out-of-pocket health spending that leads people to live in poverty is monitored by impoverishment spending, and is presented in the 2019 Monitoring Report by three different poverty lines: (1) absolute poverty line of \$1.90 a day, (2) absolute poverty line of \$3.20 a day, and (3) relative poverty line of 60% of median daily per capita consumption or income in their country.

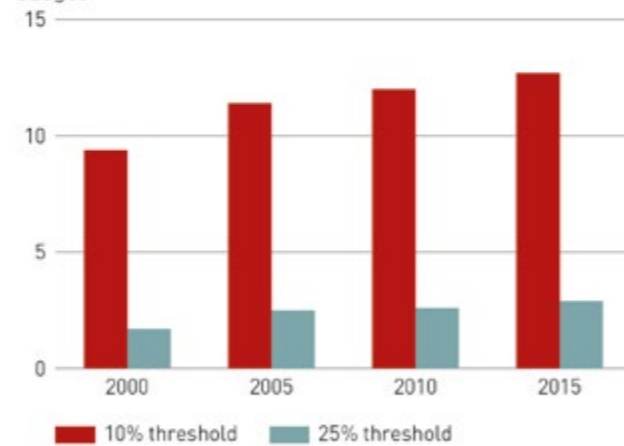
The 2019 Monitoring Report is the first global UHC monitoring report that uses the relative poverty line to estimate impoverishment due to health spending which is a more appropriate measure given the rapid increase of health care costs .

C1. Deterioration of financial protection

Financial protection, as stressed by the 2019 Monitoring Report, is “going in the wrong direction”. The report points out that “A growing number of people and share of the population incurred catastrophic health spending, as tracked by SDG indicator 3.8.2 – and impoverishment due to out-of-pocket health spending increased as measured by a relative poverty line” (2019 Monitoring Report, page 25).

Figure 8: Globally, financial protection against out-of-pocket health spending decreased continuously between 2000 and 2015, as tracked by Sustainable Development Goal indicator 3.8.2 on catastrophic health spending

Percentage of the population (SDG indicator 3.8.2) with out-of-pocket health spending exceeding 10% or 25% of the household budget



Source: WHO, World Bank (2019). Global monitoring report on financial protection in health 2019. World Health Organization and International Bank for Reconstruction and Development/ The World Bank; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Source: 2019 Monitoring Report, page 32, figure 2.3.

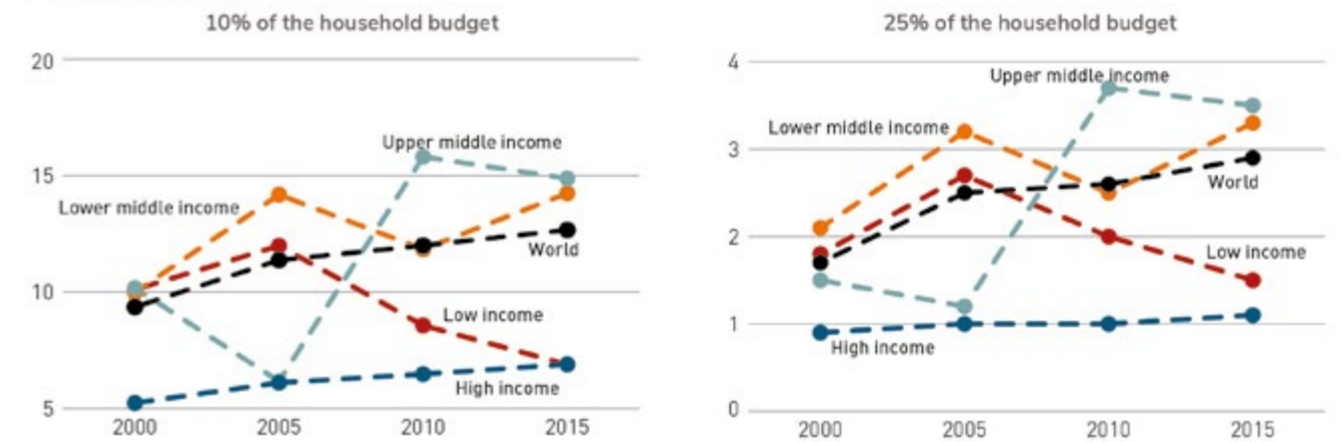
Financial protection trends indicate an increase in people who encounter catastrophic expenditure: on average 2.4% per year at the 10% threshold and 3.2% per year at the 25% threshold. In excess of 930 million people had to spend more than 10% of their household budget on health care and 210 million people crossed the 25% threshold.

The vast majority of people who experience financial hardship because of health care live in MICs, home to 86–88% of people who experience catastrophic spending. Between the two middle-income country groups, LMIC fares worse and is where 45% of the world’s population experiencing catastrophic spending at both thresholds live (and this trend is rising), while in UMIC there is sign of it declining.

Out-of-pocket spending is also responsible for pushing hundreds of millions of people into poverty or driving them deeper into poverty. In 2015, it is estimated that out-of-pocket spending pushed 89.7 million people under the poverty line of \$1.90 a day, 98.8 million under the poverty line of \$3.20 a day, and 183.2 million people at the relative poverty line of 60% of median daily per capita consumption or income in their own country.

Figure 9: Progress on financial protection, as tracked by Sustainable Development Goal indicator 3.8.2, varies across country income groups

Percentage of the population



Source: Global monitoring report on financial protection in health 2019 (4).

Source: 2019 Monitoring Report, Chapter 2, page 33, figure 2.5.

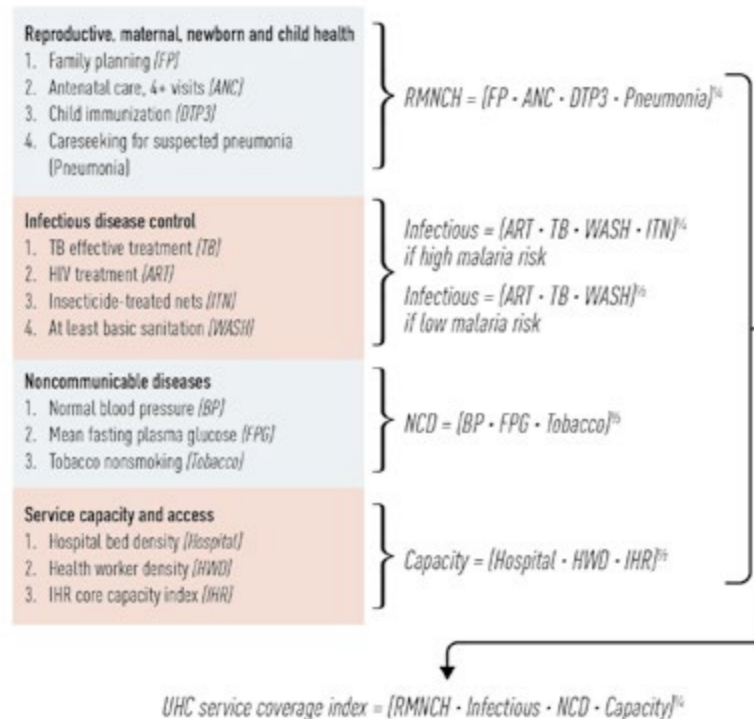
PART 2

Left behind in UHC monitoring

A. Where are the vulnerable populations in service and population coverage monitoring?

The UHC service coverage index (SCI) – constructed from 14 tracer indicators – was agreed by Member States to monitor the progress on service coverage. According to the 2019 Monitoring Report, SCI “meant to provide a strong signal on coverage for health services needed by most, if not all, populations across socio-demographic settings” (page 12).

Figure 10: The UHC service coverage index (SCI): summary of tracer indicators and computation



Note: For more detail on UHC SCI calculation methods, see Annex A1.2.

Source: 2019 Monitoring Report, page 12.

A1. Essential health services to whom and provided where?

While it can provide an overall picture of essential health services coverage in specific geographic areas for the general population, the SCI falls short of shedding light onto the coverage of services essential to the populations that are left furthest behind as certain services may be more essential to them than those of the tracer indicators, and the system that covers the general population may fail to cover them. Three examples follow:

- Among 15–19 year-old adolescent males, road injury, interpersonal violence, and self-harm are three leading causes of deaths, which kill more than 250,000 adolescents per year, representing 21% of mortality among the 10–19 year-old population.⁹ All these deaths are preventable and relevant prevention services should be considered essential to them. However, regular prevention programmes which are usually developed by and for adults may not be effective for this particular population.

- Before the Gender Identity Law was passed in 2012, the life expectancy of the transgender population in Argentina was unacceptably low in comparison to the general population: 35 years versus 76.3 years.¹⁰ This is despite service capacity in Argentina scoring maximum on the SCI (100/100) for numbers of hospital beds and health workers (2019 Monitoring Report, Annex Z), and so points to the reality that the existing health system does not meet the health needs of the country’s transgender population. We are grateful to Argentina though, for being serious about not leaving transgender people behind and making efforts to collect data from this population as an important step to address their needs.

- Persons with disability, whose essential health services include rehabilitation and assistive devices, may not find tracer indicators reflecting their most essential health needs. Health facilities and health workers, even when available where they live, may not be accessible nor compelling to them.

The tracer indicators do not include mental health services, needed by almost a quarter of the world’s population, and by higher proportions of many vulnerable populations.¹¹

9: WHO. More than 1.2 million adolescents die every year, nearly all preventable. News release; 16 May 2017. <https://www.who.int/news-room/detail/16-05-2017-more-than-1-2-million-adolescents-die-every-year-nearly-all-preventable>

10: ATTA and Huesped. Gender identity law and transgender access health services in Argentina. 2014. <https://www.huesped.org.ar/wp-content/uploads/2018/03/Ley-de-Identidad-de-Genero-y-acceso-a-la-salud-de-personas-trans-ING.pdf>

11: WHO. Mental disorders affect one in four people. News release; 7 October 2001. https://www.who.int/whr/2001/media_centre/press_release/en/

A2. Coverage for whom?

Most data for tracer indicators are provided by governments, UN agencies or interagency groups, from household surveys or facility information systems (2019 Monitoring Report Annex X, Chapter 1).

The way data are collected is likely to leave behind the most vulnerable populations. Household surveys are likely to leave out the homeless, and undocumented migrants and refugees, together with people who are not registered or not officially recognized. Data from UNICEF show that, by November 2017, 29% of all the children under the age of five in the world (not including China), and 44% of those in the poorest countries, were not registered.¹² The World Bank's Identification for Development estimate that about 1 billion people, including one in every two women in LICs, do not have official proof of identity.¹³ Children and adults with disability, and illiterate people are also less likely to be registered and included in such surveys. Facility information systems could, at best, collect data from people who use services, leaving non-users unaccounted for.

A3. Availability to the general population versus accessibility and utilization by vulnerable populations

Chapter 4 of the 2019 Monitoring Report presents primary health care as the route to UHC and discusses the removal of barriers for access to health care. Availability of health services does not translate to access and use. For example, the 2019 Monitoring Report points out "Even when facilities are physically accessible, barriers related to language, literacy, culture, employment status and various special needs can impair access" (page 87). Vulnerable populations often face multiple challenges to access and use, even when services are available. Population-focused interventions delivered through community-based outreach can mitigate geographic barriers to access and enhance equity, but do not eliminate barriers.

The 2019 Monitoring Report makes the link between spending and impact on the population: "[H]igher total spending is strongly associated with service coverage, whereas higher public spending in particular is associated with financial protection" (page 98).

A4. Who are left behind? Needs for data and understanding of data

Chapter 3 of the 2019 Monitoring Report explains the distinct health needs of men and of women and the gender factors relating to each gender's health risks and health-seeking behaviours. It also mentions the WHO "Country Support Package for Equity, Gender and Human Rights in Leaving No One Behind in the Path to Universal Health Coverage".¹⁴ The first module in the package is "Knowing who is being missed and why", and step 1 is to "have data collection practices that facilitate data disaggregation by relevant dimensions of inequality and across a wide selection of health topics".

Following that line of thought, at all levels UHC data should adhere to the Fundamental Principles of Official Statistics embedded in SDG 17.18, building capacity to disaggregate for income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in the national context.

In addition to regular household surveys or facility records, additional efforts should be made to collect UHC-related data from hidden, marginalized, and criminalized populations whose information is not usually included in the general population databases.

This WHO country support package also encourages a deeper understanding of the situation: "Qualitative sources are particularly powerful to understand the 'why' behind differences in exposure to risk factors, access and outcomes, including those due to enduring forms of discrimination and human rights violations. They help unpack the demand-side barriers that subpopulations face, including in relation to gender, and the supply-side bottlenecks impacting equitable coverage".¹⁵

Unfortunately, there is very little data disaggregation in the 2019 Monitoring Report beyond income groups or WHO regions. Even Chapter 3 on gender-responsive and equitable health systems does not provide any data disaggregation on gender or any other equity factor relating to the three dimensions of UHC.

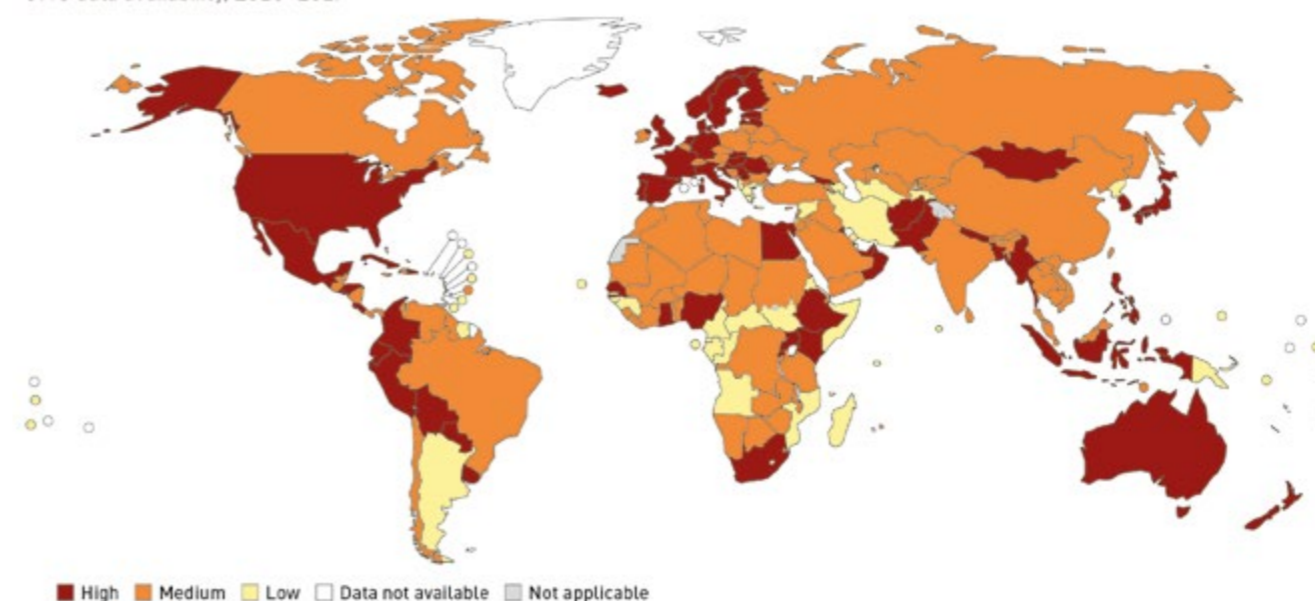
For data to be disaggregated, it first needs to be collected, and shared. The 2019 Monitoring Report shows a disheartening situation of data reporting from countries. Only 60% of the 184 Member States provided primary data for seven or more of the 14 tracer indicators and only 5% provided 10 or more for the period 2015–2017, and no country provided primary data for at least 12 of the 14 indicators in this period. Except for indicators reported by (vertical) global health programmes such as HIV, TB, vaccination or water, sanitation and hygiene (WSAH), most other indicators are poorly reported.

While data collection should be selective and with clear purpose, data used for indicators that Member States have committed to should be made available, on time.

First and foremost, accountability starts with knowing the situation and being transparent about it. Member States need to improve their efforts in collecting, analysing and sharing data, within stakeholders in the country and with global institutions.

Figure 11: From 2013 to 2017, countries had data for an average of 40% of the 14 UHC SCI indicators

UHC data availability, 2013–2017



Note: This map has been produced by the World Health Organization (WHO). The boundaries, colours or other designations or denominations of the World Bank or WHO, any opinion or judgement on the legal status of any country, territory, city or area or of its authorities, or any endorsement or categorization, data availability is considered to be low if it is less than 35%, medium if it is 35%–44%, and high if it is more than 44%.

Source: 2019 Monitoring Report, page 13, figure 1.2.

12: UNICEF. Birth registration, <https://data.unicef.org/topic/child-protection/birth-registration/>

13: World Bank. ID4D data, <https://id4d.worldbank.org/global-dataset>

14: <https://apps.who.int/iris/bitstream/handle/10665/325057/WHO-FWC-GER-17.1-eng.pdf?ua=1>

15: Ibid

B. A serious underestimate of financial hardship due to health care

Catastrophic and impoverishment spending reported in the 2019 Monitoring Report only presents a partial picture of financial hardship due to health care costs.

B1. Incomplete account of out-of-pocket spending

The 2019 Monitoring Report explains that “Out-of-pocket health spending is defined as household spending on medicines, health products, outpatient and inpatient care services (including dental care) and other health services (such as medical laboratory services) that are not reimbursed by a third party (such as the government, a health insurance fund or a private insurance company). It excludes household spending on health insurance premiums” (page 27).

The definition of “out-of-pocket health spending” should be expanded to incorporate some of the other significant costs that people have to pay out-of-pocket for their health care.

Health insurance premiums often cost a significant portion of people’s income. In some places, health insurance premiums are so high that they alone could constitute a catastrophic payment.

In many developing countries, the costs of health care are way beyond the actual payments made to health service providers and usually include transportation, food, costs associated with lost earnings for family members who are caregivers, and other expenditures. A study on the financial burden of TB on patients in the Western Pacific Region found that even before starting treatment, the out-of-pocket non-medical costs (transportation, accommodation, food) that patients and families had to pay were as high as the out-of-pocket medical cost.¹⁶ Many vulnerable populations face the vicious circle of the “cheaper” the service, the more discriminatory it is, the more likely that people will have to wait for longer, that they will have to travel more frequently to facilities, that they will have less care provided to them, and will then incur more out-of-pocket costs...

The definition of “out of pocket” used in the 2019 Monitoring Report reflects a “crippled” version of UHC, where health promotion, prevention and rehabilitation are ignored and their costs – usually paid out of pocket – are excluded.

Taking into account this expenditure, the rate of catastrophic payment will be much higher than it is already.

B2. Incomplete account of impoverishment

Impoverishment due to out-of-pocket expenditure is defined as people being pushed under a certain poverty line after out-of-pocket health care. This measurement does not take into account the people who are already under the poverty line and made poorer because of out-of-pocket health spending. WHO Europe is the only region that collected data on “further impoverished”. Data available for countries in this region (2019 Monitoring Report, Annex 2.8) show that in most countries, the proportion of the population that are “further impoverished” is significantly higher than the rate of “impoverished”. For example, in Spain in 2015, the impoverishment rate was 0.2% while 2.2% was considered as “further impoverished”, and in Albania, the rates were 1.5% and 6.7% respectively. Countries and global institutions working towards UHC should include this segment of the population in their regular monitoring exercises.

B3. Incomplete account of financial protection

Financial protection (or lack of it) has so far only been monitored by out-of-pocket spending and its impacts on the household. But if “[f]inancial protection means that all individuals can obtain the health care they need without experiencing financial hardship” (page 27), the monitoring of financial protection should be expanded to include the people whose financial inability makes them forgo needed health care altogether.

In 2016, a survey among 28 country members of the European Union recorded that among the population aged 16 and older, the main reason for not getting medical examination and treatment was that it was “too expensive”, as reported by 1.7% in all the EU, ranging from 0.1% in countries including Austria, UK and the Netherlands to 4.9% in Italy and 12% in Greece.¹⁷ A similar survey in other parts of the world would most likely find much higher rates.

Even for people who manage to participate in a health insurance scheme, for those living in poverty the inability to co-pay prevents them seeking health services.

The people who forgo health care needs due to financial inability are among those who need financial protection the most and who are left furthest behind in UHC. UHC monitoring should keep track of this segment of the population.

B4. Vulnerable populations – layers of vulnerability add up to financial hardship

Financial mechanisms for UHC that are based on public funding or social health insurance are meant to provide financial protection for people. These mechanisms usually prioritize coverage of “essential services” according to a national UHC essential health service package.

Within vulnerable populations, many people face barriers to access public or pooled funding mechanisms in the form of not being registered as citizens, being criminalized, being illiterate, having a disability, being unable to pay insurance premiums, being under the age of consent and so on.

But even for those who are enrolled in a public or pooled funding mechanism, other barriers prevent them accessing and utilizing health services, ranging from lack of information, stigma and discrimination in

health care settings, lack of a caretaker in cases of children or people with severe disability or illnesses, inability to co-pay, inability to afford indirect costs such as transportation and food, fear of confidentiality breach, etc.

Vulnerable populations usually have more health needs, and some of the services essential to them may be different from those of general populations. Unless special attention is paid as a country develops its UHC essential health service package, the services essential to certain vulnerable populations could be neglected.

Having more health care needs but less of their essential health needs covered (due to facing barriers to enrol in a financial protection mechanism and/or encountering obstacles to utilize services eligible to them), vulnerable populations are more likely to experience catastrophic expenditure and more likely to forgo their health care needs.

The 2019 Monitoring Report fails to mention the provision of financial protection (or lack of it) to these populations.

16: Viney K, Islam T, Hoa NB, Morishita F, Lönnroth K. The financial burden of tuberculosis for patients in the Western-Pacific Region. *Trop. Med. Infect. Dis.* 2019;4,94; doi:10.3390/tropicalmed4020094

17: Eurostat. Unmet health care needs statistics. https://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics

C. Questions about accountability, transparency and partnership

The entire process of collecting and collating data and consulting on inputs and calculation is done in the total absence of representatives from civil society and vulnerable populations. "(Once) this existing information on the 14 tracer indicators is collated, WHO conducts a country consultation with named focal points from national governments to review inputs and the calculation of the index." (2019 Monitoring Report. Stastical Annex 1.2. p.116).

While no methodology is perfect, and collecting data from marginalized, hidden, locked up and disadvantaged populations is challenging, mechanisms that engage civil society and vulnerable populations should be set up to supplement and complement the data collection by governments and UN agencies, to give better understanding of the needs of and the service coverage for vulnerable populations.

Doing so will not only increase accountability and transparency of the UHC monitoring process but also build up the partnership between the government, UN agencies, civil society and community, which is critical to achieve UHC by 2030 leaving no one behind.

The invitation of UHC2030 to CSEM to provide a commentary alongside the GMR2019 is good practice, and should be built upon to engage civil society and vulnerable populations in the entire process of monitoring UHC at the country and local level.

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PART 3

Moving forward – recommendations from CSEM towards achieving UHC that leaves no one behind

These recommendations from CSEM are derived from analysis of the 2019 Monitoring Report, as well as from the broad consultation of the CSEM constituency ahead of the UN High-Level Meeting on Universal Health Coverage, and evidence contributed by CSEM members during the process of preparing this commentary.

1

The UHC movement should firmly uphold the principle of “leaving no one behind”, which is articulated in the SDG Agenda as “reach the furthest behind first”. To achieve that, at every level, UHC actors should:

- Identify the people who are consistently being left behind;
- Identify their essential health needs, including the needs distinctive from those of the general population;
- Understand the reasons why they cannot access or use services essential to them;
- Enlist them as key partners in advocating for inclusive, rights-based, effective and sustainable UHC policy and programmes; and
- Engage them in the planning, budgeting, implementing, and monitoring of services so these are more appropriate, accessible, acceptable and sustainable, and the interventions are more likely to reach them with satisfactory outcomes.

The UHC movement should firmly uphold the principle of “leaving no one behind”

2

The monitoring of UHC, at all levels, should embrace the “leave no one behind” mindset and make every effort to gather the most accurate and up-to-date information about UHC progress among people who are furthest behind. In doing so, UHC monitoring should:

- Be aware that some vulnerable populations are severely marginalized, hidden or appear as hard-to-reach to the people outside their own community, to the extent that the usual monitoring approaches may not be relevant;
- Recognize that health services essential to them may differ from those for general populations and that their living circumstances, culture and/or values may not be similar to those of the general population; and
- Engage vulnerable communities in the entire process of monitoring – from selecting, developing, reviewing indicators and tools, as well as data collection, analysis, verification and dissemination. Doing so will increase the relevance of the monitoring process and accuracy of information as well as the use of data.

3

To improve service coverage of UHC, intensified efforts are needed in LICs and LMICs where service coverage is far below the global average level to:

- Significantly increase coverage of both the infectious disease and non-communicable disease components of UHC packages, as infectious diseases are still at the lowest coverage level among all the components of UHC and non-communicable diseases show no progress.
- Continue efforts to expand services for reproductive, maternal, newborn and child health; and
- Thoroughly review the systems that provide essential health services, to have in place and implement plans that mobilize and strengthen the capacities of service providers from different sectors to meet the health needs of all populations, including the distinctive needs of vulnerable populations. Community-based services that mobilize community service providers and engage community participation should be considered for certain services which the public sector finds hard to reach.

4

To get closer to the targets of covering 1 billion more people by 2023 and to achieve UHC by 2030,

the pace of expanding population coverage needs to be significantly accelerated.

- LICs and LMICs should be the focus ground for acceleration as they have the highest concentration and numbers of people who are left without access to essential health services;
- Vulnerable populations in all settings are left furthest behind and should be prioritized for any effort to increase population coverage; and
- Primary health care has been rightly identified and recommended by the 2019 Monitoring Report as “the route to UHC” and should receive the investment and attention it deserves.

5

The recent deterioration of financial protection is unacceptable and is the biggest failure of the UHC promise, and this necessitates immediate attention.

The governments, UN, the World Bank, WHO, relevant UN agencies and all stakeholders should make every effort to cut down out-of-pocket expenditure. Greater reliance on public spending on health coupled with so-called progressive universalism, i.e. taking steps to benefit the most disadvantaged people first, should be the main strategy.

6

Engagement of and investing in civil society as a key stakeholder is essential to achieving UHC that leaves no one behind. Civil society is often best placed to gain access to vulnerable populations, in order to represent and prioritize their messages for equitable access to quality health services. Civil society helps to ensure that they are informed of health policies, that their voices are heard and that they can participate in improving their countries’ health systems and budget. Civil society also has a proven track record of being a very effective, reliable and resilient advocacy force, and is well placed to ensure social accountability.

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in civil society as a key stakeholder
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leaves no one behind



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