Foreword

The right to health is well established in principle but not yet in practice. The COVID-19 pandemic is the most disruptive event in a century with significant health, social and economic consequences, including shortening healthy life expectancy. It has also demonstrated that investing in Universal Health Coverage (UHC) is the foundation of social, economic, and political stability and global health security.

This report is yet another reminder that our world is way off track to reach the Sustainable Development Goal target on UHC. In 2018, the World Health Assembly adopted the “triple billion” targets, including the target to see 1 billion more people benefiting from UHC by 2023. Even before the pandemic, the world was still 730 million people short of that target; now we estimate that shortfall to be between 800 and 840 million.

Only with a significant increase in ambition will we be able to change the trajectory to progress towards UHC in every country, built on the foundation of primary health care.

UHC is a political choice. At the United Nations General Assembly in September 2019, just a few months before the pandemic struck, all countries made that choice by endorsing the Political Declaration on Universal Health Coverage. The pandemic has only illustrated why that commitment is so important, and why, as the world responds to and recovers from the pandemic, we must all pursue it with more determination, innovation and collaboration.

COVID-19 is a devastating reminder that when health is at risk, everything is at risk, and that health is not a luxury, but a human right; not a cost, but an investment in sustainable development.
Joint statement

Health is a fundamental human right, and Universal Health Coverage (UHC) is critical for achieving that right. UHC represents the aspiration that good quality health services should be received by everyone, when and where needed, without incurring financial hardship. This ambition was clearly stated as a target in the United Nations Agenda 2030 for Sustainable Development and reaffirmed when world leaders endorsed the Political Declaration of the United Nations High-level Meeting on Universal Health Coverage in September 2019, the most comprehensive international health agreement in history. Beyond health and wellbeing, UHC also contributes to social inclusion, gender equality, poverty eradication, economic growth and human dignity.

This report reveals that pre-pandemic, gains in service coverage were substantial and driven by a massive scaling up of interventions to tackle communicable diseases, such as HIV, tuberculosis and malaria. And while impoverishing health spending has decreased in recent years, the number of people impoverished or further impoverished by out-of-pocket health spending has remained unacceptably high. These trends are exacerbated by substantial and persistent inequalities between and within countries.

The COVID-19 pandemic has subsequently led to significant disruptions in the delivery of essential health services. Rising poverty and shrinking incomes resulting from the global economic recession are likely to increase financial barriers to accessing care and financial hardship owing to out-of-pocket health spending for those seeking care, particularly among disadvantaged populations. The pre-COVID challenges, combined with additional difficulties arising from the pandemic, brings an even greater urgency to the quest for UHC.

Strengthening health systems based on strong primary health care (PHC) is crucial to building back better and accelerating progress towards UHC and health security. Effective implementation of PHC-oriented health systems enables greater equity and resilience, with greater potential to deliver high-quality, safe, comprehensive, integrated, accessible, available and affordable health care to everyone, everywhere, but most especially the most vulnerable. Substantial financial investments in PHC-oriented building blocks of health systems, particularly in the areas of greatest expenditure (health and care workforces, health infrastructure, medicines and other health products) should be supported, carefully planned and informed by health system performance data to address critical gaps, particularly in low-income and lower-middle income countries.

There is also an urgent need to remove remaining barriers in order to enable access to health care for all. Key barriers to UHC progress include poor infrastructure, with limited availability of basic amenities, weaknesses in the design of coverage policies to limit the harmful effects of out-of-pocket payments particularly for the poor and those with chronic health service needs, shortages and inefficient distribution of qualified health workers, prohibitively expensive good quality medicines and medical products, and lack of access to digital health and innovative technologies.

Maintaining progress towards UHC is likely to be challenging. UHC is first and foremost a political choice. It is also a moral imperative to guarantee the right to health for all. More than ever before, strong political commitment from world leaders and partners organizations is the essential ingredient for overcoming barriers.

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Executive summary

Universal Health Coverage (UHC) means that everyone receives quality health services, when and where they need them, without incurring financial hardship.

Before COVID-19 struck, the world was far short of reaching the Sustainable Goal (SDG) 3.8 targets and the goal of 1 billion more people benefiting from UHC by 2023.

Since 2000, service coverage has increased as average income has grown, but at an undue cost to many people (Figure ES.1). Trajectories on the path to UHC, as tracked by related SDG indicators on service coverage and financial hardship, vary substantially across WHO regions and countries. Country-level analysis of coverage policy is needed to identify gaps in health coverage, understand their causes and develop appropriate policy responses.

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


Without accounting for the impact of the COVID-19 pandemic, at current rates of progress for both service coverage and financial hardship, only about an additional 270 million people were projected to be covered by essential health services and not experiencing catastrophic out-of-pocket health spending by 2023 – that is, a shortfall of about 730 million people.

Service coverage was improving but not fast enough.

SDG indicator 3.8.1 on service coverage, as measured by the UHC service coverage index (SCI), improved globally from a population-weighted average of 45 in 2000 to 67 in 2019. The infectious disease sub-index improved the fastest with a pronounced acceleration around 2005, followed by the reproductive, maternal, newborn and child health (RMNCH) sub-index. Conversely, the noncommunicable diseases and the service capacity and access sub-indexes experienced slower gains. However, the progress observed over the period 2000–2019 was not sufficient to achieve a minimum of 80 by 2030.
Average UHC SCI values were highest in the WHO Western Pacific Region (80), European Region (79) and Region of the Americas (77), and lowest in the African Region (46) (Figure ES.2a). Trends in the UHC SCI between 2000 and 2019 showed improvements across all WHO regions, with the South-East Asia Region and Western Pacific Region recording the largest gains (over 30 index points) (Figure ES.2b).

The strong positive relationship between UHC SCI and gross national income per capita (current US$) suggests that service coverage might be driven by income growth. Low-income countries had lower average index scores compared to high-income countries (42 versus 83) in 2019, though the pace of progress was faster. In other words, service use increases when people have more money and face less severe financial barriers to seek care.

Figure ES.2 Level of and change in UHC SCI (in index points) by country, 2000–2019

a. UHC SCI, 2019

b. Change in UHC SCI (in index points), 2000–2019

The expansion of service coverage, along with other factors, has accompanied the significant health gains made over the last two decades. UHC SCI increased from 45 in 2000 to 67 in 2019, while the global average life expectancy at birth increased from 66.8 years to 73.3 years over the same period. Between 2000 and 2019, the African Region had the fastest growth in both measures with an increase of 22 index points in the UHC SCI and a gain of 11.7 years of life expectancy.

**Trends in catastrophic health spending were already worsening pre-pandemic.**

The population incurring catastrophic out-of-pocket health spending as tracked by SDG indicator 3.8.2 increased continuously between 2000 and 2017 (Table ES.1). Most recently, between 2015 and 2017, the number of people with out-of-pocket health spending exceeding 10% of their household budget (that is, catastrophic health spending) rose from 940 million to 996 million per year. The increase was driven by (a) an increase in the amount people spent per person out of pocket for health; and (b) a higher rate of growth of out-of-pocket health spending relative to growth in private consumption. On average, as households’ income increased, so too did their demand for services. This demand manifested in high out-of-pocket health spending.

**Table ES.1 SDG and SDG-related indicators of financial hardship (millions of people), 2000–2017**

<table>
<thead>
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<tbody>
<tr>
<td>Population spending more than 10% of their household budget on health out of pocket (SDG indicator 3.8.2, 10% threshold)</td>
<td>579</td>
<td>708</td>
<td>785</td>
<td>940</td>
<td>996</td>
</tr>
<tr>
<td>Population spending more than 25% of their household budget on health out of pocket (SDG indicator 3.8.2, 25% threshold)</td>
<td>131</td>
<td>167</td>
<td>189</td>
<td>270</td>
<td>290</td>
</tr>
<tr>
<td>Population with impoverishing health spending at the PPP$1.90 a day poverty line of extreme poverty</td>
<td>1159</td>
<td>1009</td>
<td>826</td>
<td>664</td>
<td>505</td>
</tr>
<tr>
<td>Impoverished by out-of-pocket health spending</td>
<td>124</td>
<td>130</td>
<td>122</td>
<td>115</td>
<td>70</td>
</tr>
<tr>
<td>Further impoverished by out-of-pocket health spending (the poor spending any amount on health out of pocket)</td>
<td>1035</td>
<td>879</td>
<td>704</td>
<td>549</td>
<td>435</td>
</tr>
<tr>
<td>Population with impoverishing health spending at relative poverty line</td>
<td>630</td>
<td>808</td>
<td>1007</td>
<td>1153</td>
<td>1125</td>
</tr>
<tr>
<td>Impoverished by out-of-pocket health spending</td>
<td>91</td>
<td>122</td>
<td>154</td>
<td>182</td>
<td>172</td>
</tr>
<tr>
<td>Further impoverished by out-of-pocket health spending (the poor spending any amount on health out-of-pocket)</td>
<td>539</td>
<td>686</td>
<td>853</td>
<td>971</td>
<td>953</td>
</tr>
</tbody>
</table>

*Note:* The relative poverty line is defined as 60% of the median per capita consumption or income in each country. *Source: WHO and World Bank, 2021: Global monitoring report on financial protection in health 2021.*

The number of people incurring impoverishing health spending decreased in recent years, but remained unacceptably high.

Between 2015 and 2017, all indicators of impoverishing health spending decreased (Table ES.1). The population with impoverishing out-of-pocket health spending at the extreme poverty line ($1.90 a day in purchasing power parity, PPP) fell substantially at global levels (from 664 million in 2015 to 505 million in 2017) but also when considering relative poverty lines, though less markedly (from 1.153 billion to 1.125 billion). Despite higher levels of public spending, the reduction in impoverishing health spending at the relative poverty line did not occur in high-income countries. This underscores the persistent inequalities in coverage and the need for policies to focus on reducing financial hardship among the poor and near poor, even in relatively well resourced health systems.

**Overall, in 2017, the total population facing catastrophic or impoverishing health spending was estimated to be between 1.4 billion and 1.9 billion.**

Among these, most of the population facing catastrophic health payments was concentrated in low- and upper-middle-income countries and the WHO Western Pacific and South-East Asia Regions, followed by the Eastern Mediterranean Region. The population pushed into extreme poverty (at $1.90) was concentrated in low- and lower-middle-income countries and the African, Western Pacific and South-East...
Asia Regions. Based on a relative poverty line definition, however, impoverishing health expenditure was more concentrated in upper-middle-income countries and in the Western Pacific, African and Eastern Mediterranean Regions. Across regions, financial hardship was also increasing. Between 2000 and 2017, the incidence of catastrophic health spending was on the rise (except in the Region of the Americas since 2005) and so was the proportion of the population impoverished and further impoverished into relative poverty by out-of-pocket health spending.

Persistent inequalities in service coverage and financial hardship existed across households within countries.
For instance, coverage of RMNCH interventions tended to be highest among more advantaged groups, such as the richest, the most educated, and those living in urban areas, especially in low-income countries. People living in poor households and in households with older members (those aged 60 and older) were more likely to face financial hardship as a result of paying out of pocket for health care. Monitoring health inequalities is essential to identify and track disadvantaged populations in order to provide decision-makers with an evidence base to formulate more equity-oriented policies, programmes and practices. For example, in order to improve the lives of older people, their families and communities, making progress towards UHC will require extension and improved targeting of benefits to reduce financial hardship and to meet the health needs of people living in older or multigenerational households. To substantially reduce financial hardship, it is critical to protect poor people, and those with chronic health care needs, from out-of-pocket health spending, such as through the effective implementation of exemption mechanisms and related pro-poor health financing measures.

The COVID-19 pandemic is likely to halt the progress made towards UHC over the past 20 years.

Health systems are facing challenges to ensure the continuity of essential health services.
Additional patient load caused by the COVID-19 pandemic has strained health systems and threatened their ability to provide all essential health services. During the first quarter of 2021, disruptions to essential health services were still widespread across the globe and reported across all service delivery channels and programme-specific areas. Primary care as well as rehabilitative, palliative and long-term care service delivery channels were most affected (Figure ES.3). High-income countries reported fewer service disruptions compared with countries in other income groups. The magnitude and extent of those disruptions decreased in the first quarter of 2021, with countries reporting that, on average, only one third of services were disrupted compared with just over half in the second semester of 2020. Despite a reduction in the magnitude, the continuing disruption may be much more prolonged than the major initial shock, and therefore leading to a stagnation or even a decrease in service coverage.

Figure ES.3 Average percentage of countries reporting disruptions in essential health services across integrated service delivery channels (n=112), January–March 2021

People are struggling to access care due to financial constraints, and financial hardship is likely to worsen further among those seeking care as poverty grows and income falls.

Source: WHO, Second round of national pulse survey on continuity of essential health services during the COVID-19 pandemic.
Lack of data currently precludes a detailed and comprehensive assessment of the impact of COVID-19 on financial protection; nevertheless, the combined macroeconomic, fiscal, and health impacts of COVID-19 point towards the strong likelihood of a significant worsening of financial protection globally – higher rates of foregone care due to financial barriers as poverty grows (Figure ES.4), and, for those seeking care, a higher incidence of catastrophic health spending and worsening impoverishment due to out-of-pocket health spending – resulting from the pandemic, in particular among lower-income households in all countries. This worsening of financial protection will probably be sustained in the medium term unless proactive policy efforts are made, for example, pro-poor focused increases in public spending to reduce out-of-pocket spending on health, enhanced social protection support, removal of co-payments and other fees at the time and place of seeking care, cash transfer payments to enable poor and vulnerable households to meet their basic needs (including for health services), expansion in coverage and strengthening of primary health care – not just to recover but also to accelerate progress towards UHC.

**Figure ES.4** Main reason reported by household for not accessing health care when needed, multi-country evidence

![Figure ES.4 Main reason reported by household for not accessing health care when needed, multi-country evidence](image)

<table>
<thead>
<tr>
<th>Country income group</th>
<th>Low income</th>
<th>COVID-19 reasons</th>
<th>Supply reasons</th>
<th>Other reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper middle income</td>
<td>17.4</td>
<td>27.2</td>
<td>21.9</td>
<td>33.3</td>
</tr>
<tr>
<td>Lower middle income</td>
<td>30.6</td>
<td>30.4</td>
<td>20.9</td>
<td>18.3</td>
</tr>
<tr>
<td>Low income</td>
<td>65.6</td>
<td>8</td>
<td>19.1</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Note: upper-middle-income countries n=1 to 13; lower-middle-income countries n=2 to 17; lower-income countries n=3 to 12. Data collected between April and August 2020.


**Strengthening health systems based on primary health care-oriented systems is crucial to build back better and accelerate progress towards UHC and health security.**

Effective PHC-oriented systems are the bedrock of equitable and resilient health systems that deliver high-quality, safe, comprehensive, integrated, accessible, available and affordable health care to everyone, everywhere, especially the most vulnerable. Building such health systems is the most practical, efficient and effective first step for countries working to deliver UHC.

Primary health care must feature in health system efforts to build back better, including through (a) action on all components of multisectoral policy and action to address the determinants of health, integrated health services emphasizing primary care and essential public health functions, and empowered people and communities; and (b) critical investments in the health and care workforce, physical infrastructure, and medicine and other health products. Investments in these areas should be supported and carefully planned, informed by health system performance information to address critical gaps, particularly in low-income and lower-middle-income countries.

The bulk of the required investments and implementation will come from domestic public resources. The degree to which those resources leads to an effective PHC-oriented health system depends on policy design and implementation. International assistance flows, including global health initiatives, will continue to contribute. To advance the related objectives of health system strengthening (based on PHC) and global health security, initiatives addressing both must be genuinely linked. This need is particularly acute in conflict-affected and fragile settings where numerous external partners play a larger role – requiring renewed commitment to coordinated responses aligned behind the national health sector policies, strategies and plans.

**Good-quality, timely and disaggregated data to track progress towards UHC, and the policies that support it, require investment and political commitment to enhance country health information systems.**

COVID-19 has underscored the need to develop rapid data collection approaches, track barriers to access, disaggregate health data and complement traditional household surveys with nimble forms of monitoring using other modalities such as mobile phone and social media surveys to track both service coverage and financial hardship. It is also critical to monitor policies introduced to safeguard access to quality health services and their implementation, particularly those related to COVID-19.