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Tracking universal health coverage

2023 global monitoring report

Executive summary

World Health Organization

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Foreword

'Leaving no one behind' is a central promise of the 2030 Agenda for Sustainable Development, which recognizes health as a fundamental human right. The best way to fulfil this promise is through universal health coverage (UHC), which means that all people – no matter who they are or where they live – can receive quality health services, when and where they are needed, without incurring financial hardship.

This 2023 UHC Global Monitoring Report is being released on the eve of the High-Level Meeting on UHC at the 78th United Nations General Assembly, reflecting the vital role of national political commitment in the pursuit of UHC. Achieving UHC is no easy feat, but with concrete and coordinated actions, countries can create the conditions in which the right to health is ensured, upheld, and respected for everyone.

This report presents an alarming picture on the state of UHC around the world, even before the COVID-19 pandemic hit. The expansion of health service coverage has largely stalled since the launch of the Sustainable Development Goals in 2015, and financial protection for those who do receive health services has worsened. Based on the most up-to-date data, this report shows that as of 2021, about half the world's population – 4.5 billion people – was not covered by essential health services, and in 2019 about two billion people experienced financial hardship due to out-of-pocket spending on health, including 344 million people living in extreme poverty.

Reaching the goal of UHC by 2030 requires substantial public sector investment and accelerated action by governments and partners, building on solid evidence and reorienting health systems to a primary health care approach, to advance equity in both the delivery of essential health services and financial protection. Achieving UHC also requires modern, fit-for-purpose health information systems that provide timely and reliable data to inform policy design. Such shifts are essential as we continue to respond to and recover from the COVID-19 pandemic's impacts on health systems and the health workforce, and as the challenges posed by deepening macroeconomic, climate, demographic, and political trends threaten to reverse hard-won health gains around the world.

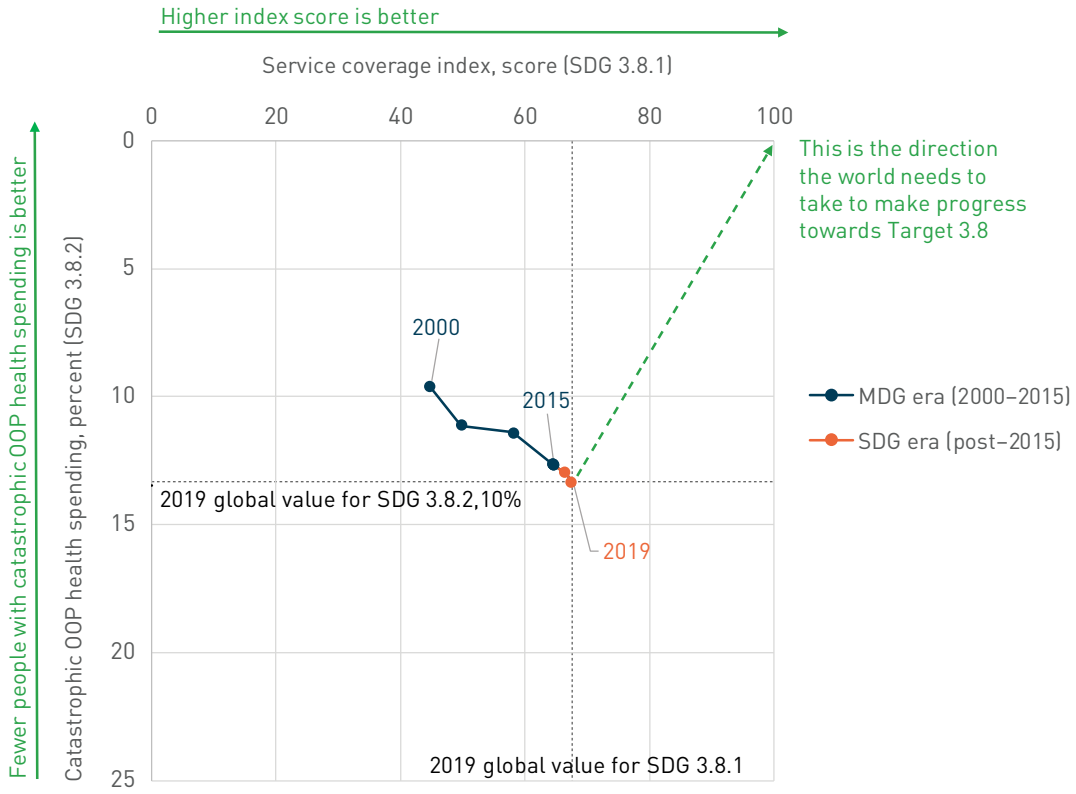
Dr Tedros Adhanom Ghebreyesus
Director-General, World Health Organization

Ajay Banga
President, World Bank Group

Executive summary

The world is off track to make significant progress towards universal health coverage (UHC) (Sustainable Development Goals (SDGs) target 3.8) by 2030 as improvements to health services coverage have stagnated since 2015, and the proportion of the population that faced catastrophic levels of out-of-pocket (OOP) health spending[1] has increased (see Fig. ES.1).

Fig. ES.1. Estimates of UHC service coverage index (SDG 3.8.1) and catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), 2000–2019



Note: The global UHC service coverage index refers to the global population-weighted score of an index of selected essential services; higher scores indicate more service coverage. Catastrophic OOP health spending refers to the global population-weighted incidence rate of catastrophic health spending, defined as the proportion of the population with household out-of-pocket health expenditure exceeding 10% of the household budget (consumption or income); the lower the incidence, the better.

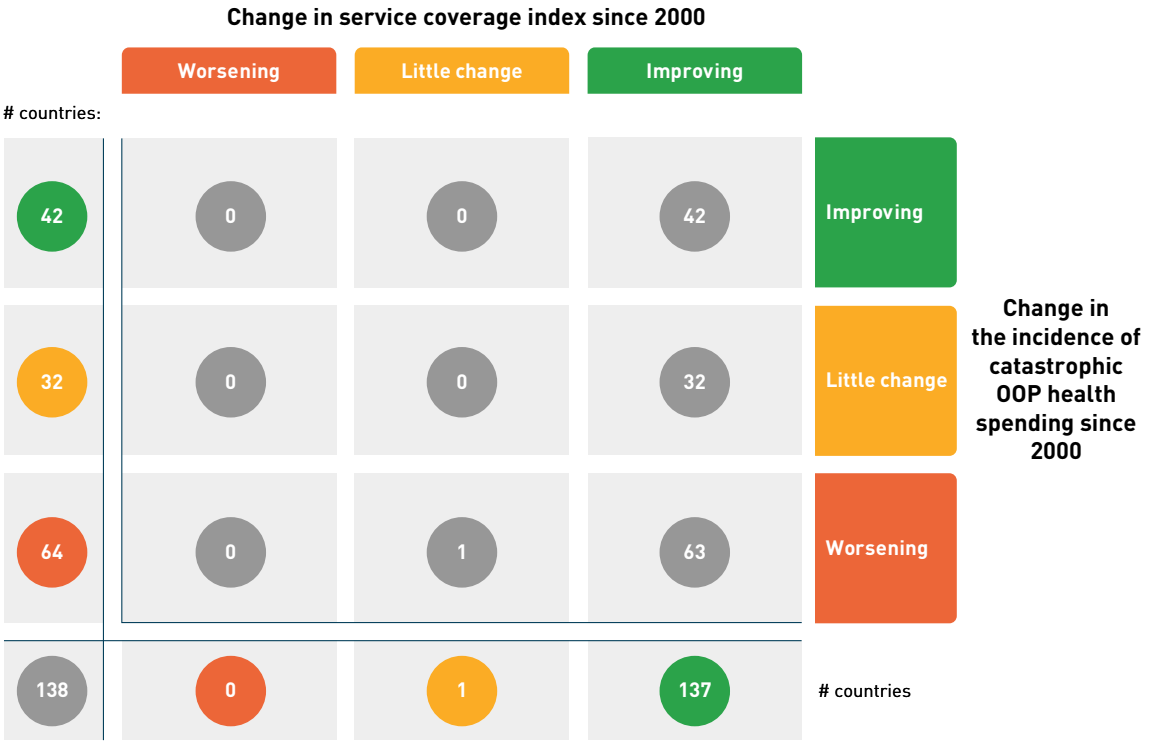
Sources: SDG indicator 3.8.1, WHO global service coverage database, May 2023 *(1); SDG indicator 3.8.2,* Global database on financial protection assembled by WHO and the World Bank *(2,3).*

[1] Defined as OOP health spending exceeding 10% of their household budget (SDG indicator 3.8.2 at the 10% threshold).

Very few countries have managed to improve service coverage and reduce catastrophic OOP health spending. Improvements in service coverage were seen in nearly all countries since 2000, while catastrophic spending worsened or saw little change in most countries (see Fig. ES.2). Since 2000, only 42 of the 138 countries with available data for the same years for both UHC indicators achieved an expansion of service coverage, while reducing their respective share of the population incurring catastrophic OOP health spending. Moreover, the majority of countries (108/194) experienced worsening or no significant change in service coverage since the launch of the SDGs in 2015.[2]

Compared to countries with higher income levels, low-income countries (LICs) and lower-middle-income countries (LMICs) saw the most significant improvements in the UHC service coverage index (UHC SCI) since 2000 and experienced the largest increases in catastrophic OOP health spending. While there was substantial regional variation in SDGs 3.8.1 and 3.8.2 levels when the SDGs era began in 2015, all regions have since shown the same pattern of stagnating service coverage and worsening financial hardship. The causes of this lack of progress vary by region and country, and addressing them requires context-specific policies.

Fig. ES.2. Categories of change in SDG indicators 3.8.1 and 3.8.2 for 138 countries since 2000



Notes: Analysis only includes the 138 countries with at least two reported data points for SDG 3.8.2 since 2000; annualized rate of change based on the available periods for each indicator, for SDG 3.8.2, the median minimum year was 2004, and the median maximum year was 2017; for SDG 3.8.1, all years 2000–2021 were available for all countries.

Thresholds are based on average annualized rate of change to define change: worsening financial hardship (>0.1), no change (-0.1–0.1); improving financial hardship (<-0.1), worsening service coverage (<-0.1), no change (-0.1–0.1); improving service coverage (>0.1).

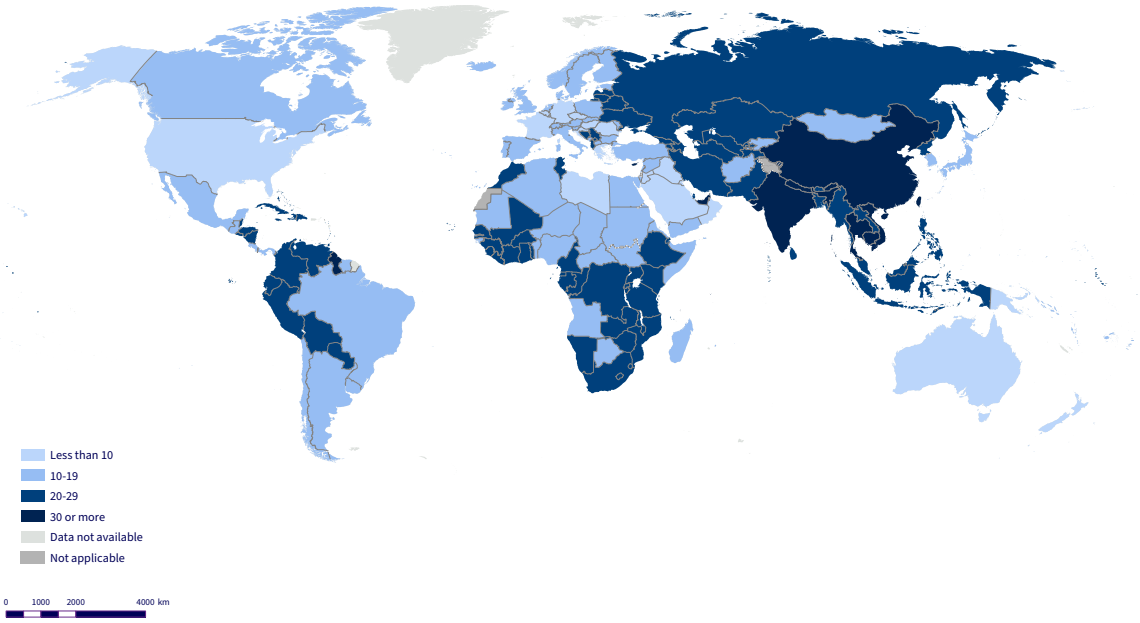
Sources: SDG indicator 3.8.1, WHO global service coverage database, May 2023 *(1); SDG indicator 3.8.2,* Global database on financial protection assembled by WHO and the World Bank *(2,3).*

[2] Calculated for all 194 countries from 2019 through 2021 using the criteria noted in Fig. ES.2.

Important gains in service coverage since 2000 have stalled in recent years, threatening further progress toward UHC. While substantial gains in service coverage were observed globally over the past two decades (see Fig. ES.3a), progress has stalled in recent years (see Fig. ES.3b). The global UHC SCI score increased from 45 to 68 out of 100 between 2000 and 2021, with a stagnating pace of improvement in recent years. The change in the country-level index scores from the 2000 baseline to 2021 ranged from less than one up to 39 index points, with a plurality of countries (n=85) seeing improvements of 20–29 points from the 2000 SCI baseline index score (see Fig. ES.3a). However, since 2015, the beginning of the SDG era, there was a global increase of only three index points with very few countries continuing to see a similar level of service coverage expansion as in the previous years (see Fig. ES.3b). Moreover, there was no change in the global SCI score between 2019 and 2021, a period during which the COVID-19 pandemic impacted health systems and economies worldwide.

Fig. ES.3. Gains in service coverage globally, 2000–2021

(a) Change in overall SCI points, 2000–2021



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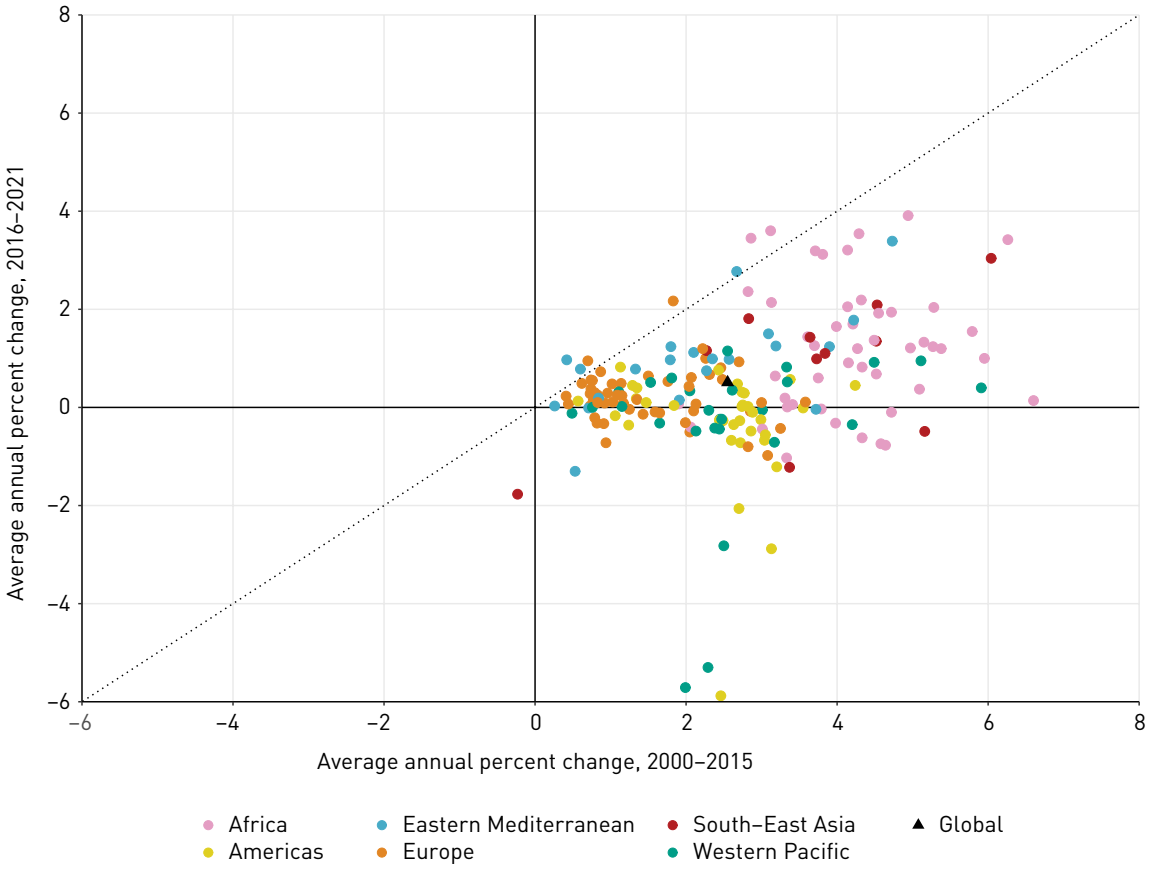
Source: WHO global service coverage database, May 2023 *(1).*

(b) Percent average annual change in SCI by country, 2000–2015 versus 2016–2021



Note: Colours designate WHO regions.

Source: WHO global service coverage database, May 2023 *(1).*

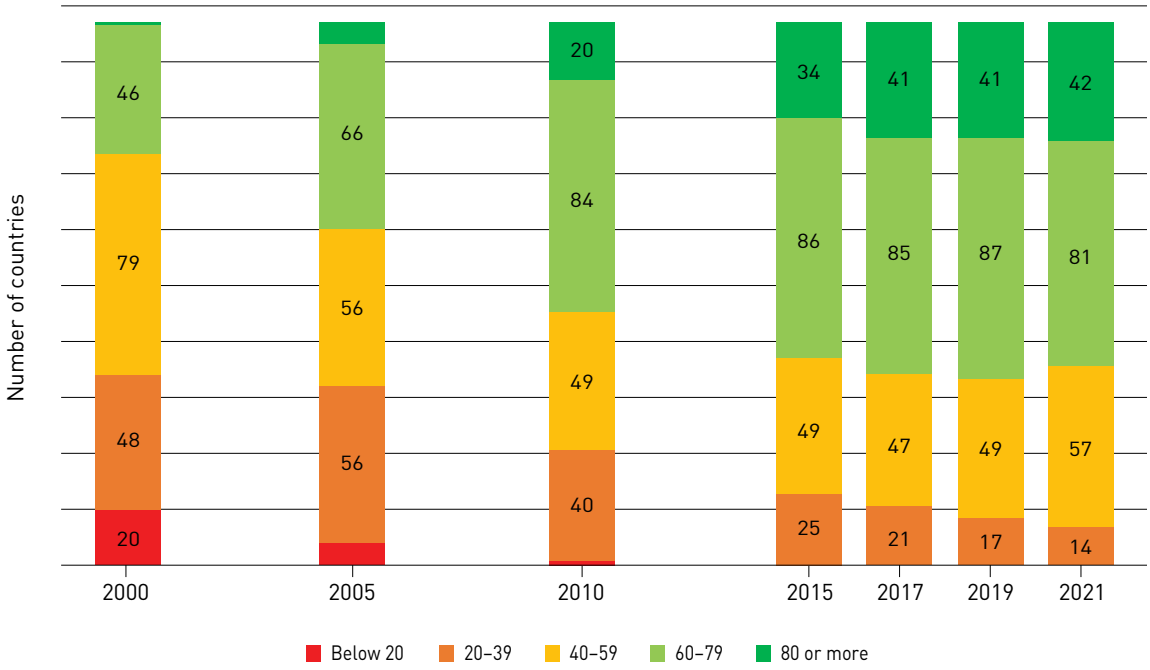
The most significant improvements since 2000 were observed in the infectious disease component of service coverage, improving by an average of 7% per year. In contrast, the SCI scores for the other components – noncommunicable diseases (NCDs), reproductive, maternal, newborn, and child health (RMNCH), and health service access and capacity – saw only gradual increases (1% or less) prior to 2015, followed by continued minimal or no improvements in recent years.

Inequalities in service coverage persist within and between countries. Different population groups, such as those living in more rural settings and the poorest households, experience less coverage of essential health services than national averages.

The proportion of the population not covered by essential health services decreased by about 15% between 2000 and 2021, with minimal progress made after 2015. This indicates that in 2021, about four and a half billion people (ranging from approximately 14–87% of the population at the country level) were not fully covered by essential health services.

Across countries, substantial variation in SCI scores persisted in 2021, ranging from 28 to 91, with a strong positive association between SCI and countries' income levels. More countries have higher levels of service coverage in 2021 than in 2000, but progress has stagnated. In 2000, 68 countries had low or very low levels of service coverage (SCI <40) compared to 14 countries in 2021 (see Fig. ES.4). Conversely, in 2000, only one country had very high service coverage levels (SCI 80+), which improved substantially to 42 countries by 2021. In line with these improvements, since 2000, all country-level SCI scores have converged or become more equal, as countries with lower scores in the earlier years made more relative progress on expanding service coverage than countries with higher scores at the beginning of the period. However, there was an abrupt reversal in this trend towards more global equality in service coverage after 2015 in all regions except the WHO African and South-East Asia Regions, both of which continued to see convergence of country-level scores.

Fig. ES.4. Number of countries by UHC SCI group, 2000–2021



Source: WHO global service coverage database, May 2023 *(1).*

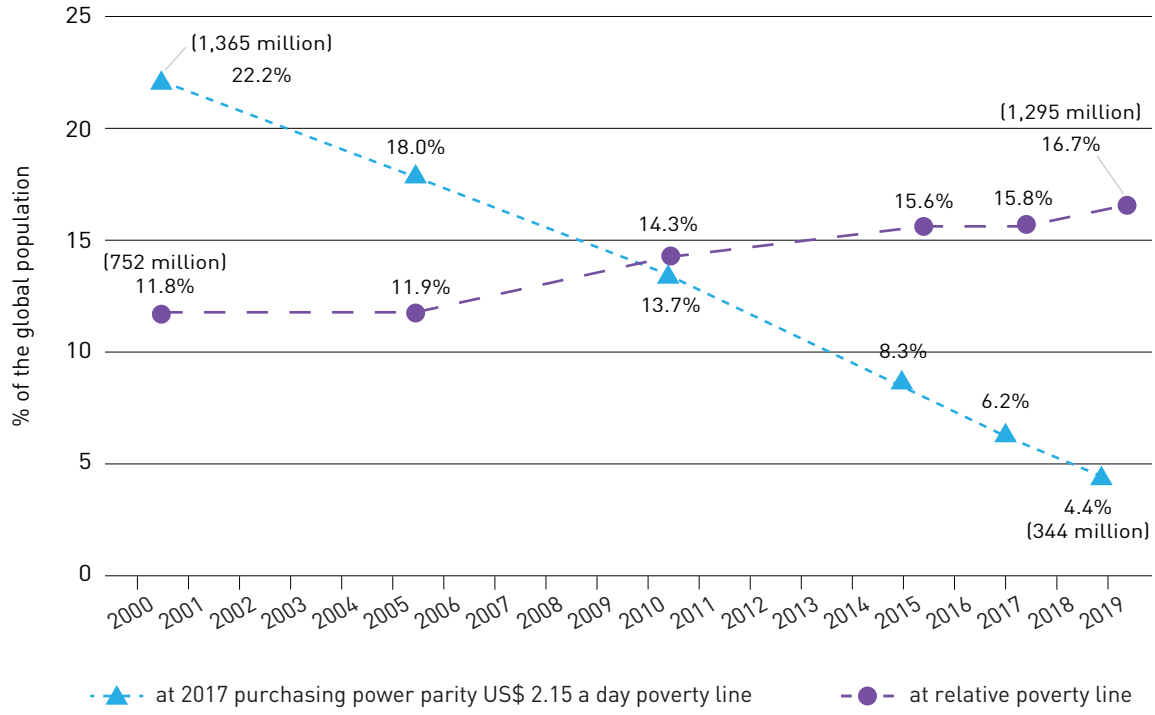
The population incurring catastrophic OOP health spending continuously increased globally since 2000 and surpassed 1 billion by 2019. Catastrophic OOP health spending reduces households' ability to consume other essential goods and services such as food, shelter, clothing, or education. The global percentage of people living in households spending more than 10% of the household budget on OOP health expenses has continuously increased from 9.6% in 2000 to 12.6% in 2015 and reached 13.5% in 2019 (see Fig. ES.1). Overall, the estimated number of people incurring such relatively large OOP health spending increased by 76% during the same period from 588 million people in 2000 to 1.04 billion in 2019. Within countries, catastrophic OOP health spending is more prevalent among people living in households with older members (age 60 years or over). However, there is no strong relationship between countries' income levels and catastrophic OOP health spending rates.

The proportion of the global population with impoverishing OOP health spending decreased by 80% at the extreme poverty line between 2000 and 2019, but during the same period the rate with impoverishing OOP health spending at the relative poverty line increased by 42%. For people living in poverty or in near poverty, any amount of OOP health spending can be a source of financial hardship, even if it represents less than 10% of their household budget, as they have a lower capacity to pay for health care. The global population share with impoverishing OOP health spending at the extreme poverty line of US$ 2.15 a day in 2017 purchasing power parity reduced from 22.2% in 2000 to 15.6% in 2015 and 4.4% in 2019. However, the progress made in reducing impoverishing health spending for those living in extreme poverty or close to extreme poverty was partially offset by an increase in impoverishing health spending experienced by those living in relative poverty or near to relative poverty,[3] which rose from 11.8% in 2000 to 15.8% in 2015 and 16.7% in 2019 (see Fig. ES.5).

[3] The relative poverty line is country specific and is defined as 60% of the median per capita consumption or income.

Fig. ES.5. Trends in the incidence of impoverishing OOP health spending at the extreme and relative poverty lines, 2000–2019

Global proportion of the population impoverished and further impoverished



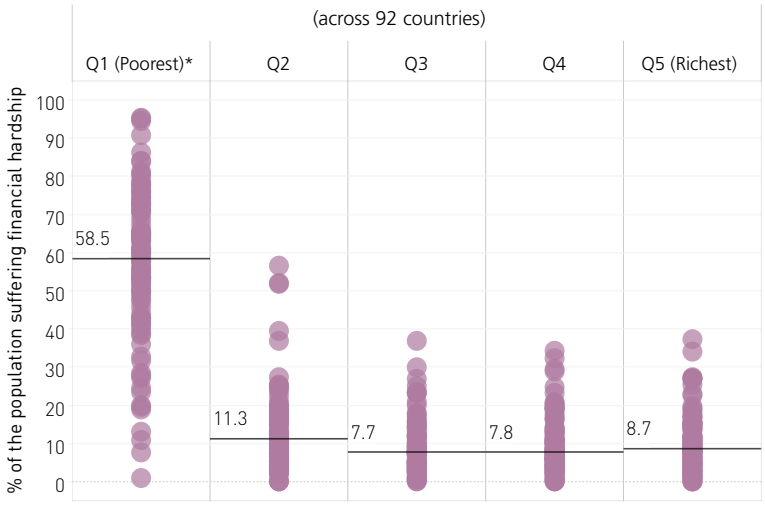
Source: Global database on financial protection assembled by WHO and the World Bank, 2023 update *(2,3)*.

In 2019, 1.3 billion people incurred impoverishing health spending at the relative poverty lines and 344 million people faced impoverishing OOP health spending at the extreme poverty line, i.e. almost half of the global population living in extreme poverty in 2019 (see Fig. ES.5).

Between countries, impoverishing OOP health spending at the extreme poverty line is primarily concentrated in LICs and LMICs that have higher poverty rates. There is no strong relationship between impoverishing OOP health spending at the relative poverty line and a country's income level. However, LMICs experienced the largest increases in the proportion of the population incurring impoverishing OOP health spending at the relative poverty line. Within countries impoverishing health spending is more prevalent among people living in rural areas, multi-generational households, with a male-headed household or younger household head (below 60 years of age).

Overall, financial hardship is concentrated among the less well-off households mostly due to the higher rates of impoverishing health spending rather than catastrophic health spending. In 2019, the total population experiencing catastrophic spending, or impoverishing health spending at the relative poverty line, or both (i.e. any form of financial hardship) was estimated to be 2 billion people. The latest available data shows that within countries the less well-off households were most likely to experience financial hardship (see Fig. ES.6).

Fig. ES.6. Proportion of the population with OOP health spending exceeding 10% of the household budget or impoverishing health spending (at the relative poverty line) or both, by per capita consumption quintile



*: Significantly higher than other quintiles at 95% level.

___: The horizontal line corresponds to the median of values across countries.

Note: The definitions of catastrophic and impoverishing health spending used for the global tracking of financial hardship are not mutually exclusive – people can experience neither, either, or both simultaneously. This figure shows the concentration of those incurring either or both at the same time without double counting by per capita consumption quintile based on the latest available survey-based estimates for 92 countries at all income levels during the period 2015–2019.

Sources: Background data produced by WHO and the World Bank for the 2023 update of the WHO and World Bank global financial protection database 2023 *(2,3)*.

Besides the absence of catastrophic and impoverishing OOP spending (financial hardship), *financial protection* requires that people do not forgo needed health care due to financial barriers. While forgone care is not tracked as systematically as the catastrophic and impoverishing health spending indicators, analysis of data from over 29 LICs and LMICs before the COVID-19 pandemic revealed that financial barriers were reported by 19% of the individuals self-reporting forgoing needed care.

COVID-19 has likely had an impact on progress toward UHC. The available evidence points toward a worsening of service coverage and financial protection during the pandemic. The SCI stagnated globally between 2019 and 2021, while sub-regional and country-level decreases were observed in some dimensions of the SCI, alongside significant acute disruptions in delivering health services not captured by the annual SCI at the global level. The disruptions occurred through a mix of demand and supply factors and the diversion of significant health system resources to COVID-19-related services. The combined macroeconomic, fiscal, and health impacts of the pandemic, and emerging evidence on rising poverty, led to the weakening of financial protection globally, with higher rates of forgone care due to financial barriers and more people incurring financial hardship due to catastrophic and impoverishing OOP spending.

The available evidence presents a potentially dire prospect for further progress toward UHC without urgent political action.

- Significant advances in the service coverage dimension of UHC by 2030 require accelerating the expansion of all essential health services, especially those with minimal progress, such as coverage for NCDs. Worryingly, the world has moved in the wrong direction, with a marked slowdown in the expansion of service coverage since 2015 and worsening or no significant improvements in service coverage in most countries since 2019.
- The most substantial improvements to service coverage have been concentrated in the infectious disease dimension of UHC. While there have been many successes, especially related to treatment coverage for HIV, tuberculosis (TB) and malaria prevention, complacency is not an option. Any reductions in coverage levels could lead to rapid increases in disease burden, potentially exacerbated by multiple crises, such as the expansion of infectious disease vector habitats due to global climate change.

- Continued progress in improving service coverage depends on concerted country efforts to improve services for NCDs and those related to RMNCH. Importantly, to support the expansion of all essential services, countries must have the workforce and infrastructure capacity to facilitate access and effective coverage. In addition, efficient and effective responses to public health risks and emergencies of national and international concern need to be supported through strong country-level commitments to the International Health Regulations (2005).
- Removing financial barriers to care would improve both service coverage and financial protection by reducing forgone care.
- Financial protection is undermined by a heavy reliance on OOP health spending to fund health systems, especially in LICs and LMICs. Pre-paid pooled compulsory contributions to fund health systems must be more significant.
- OOP health spending also undermines efforts to eradicate poverty globally, which can be avoided if OOP health payments are minimized for people living close to poverty and if those living in poverty are exempted from such payments.
- Proactive policy efforts are needed to decrease financial hardship from OOP payments. Specifically, public health funding needs to increase further and be used more efficiently and equitably, coverage for medicines extended, and OOP spending on health limited with low, fixed and capped co-payments for those from whom user charges are still collected and removed completely for the poor and most vulnerable.
- The WHO UHC Billion target *(4)*[4] – a composite measure of both service coverage and the proportion of the population incurring catastrophic OOP health spending – was established to catalyse and track progress during the WHO Thirteenth General Programme of Work (GPW13). In 2023, 477 million more people are expected to be covered by essential health services without facing catastrophic OOP health spending compared to 2018. However, efforts need to be re-doubled to achieve an additional billion people benefiting from UHC.
- A primary health care (PHC) approach can improve health systems and accelerate progress toward UHC. The PHC measurement framework *(5)* and indicators include UHC service coverage and financial protection metrics discussed in this report as outcome indicators. As countries strive to re-orient their health systems towards a PHC approach, the uneven progress in components of the SCI signals potential areas for action in expanding primary care services and the orientation towards the PHC approach *(5)*.
- Likewise, evidence from regional studies presented in this report shows that OOP spending on outpatient medicines – central to the provision of primary care – is a major driver of financial hardship. This underscores the need to improve policies by ensuring that primary care services include treatments, in addition to an adequate range of diagnostics and that user charges for these are minimized or completely removed for people with low incomes or chronic conditions.

As evidenced by the initial impact of the health and economic shock of COVID-19, improvements in UHC will continue to face challenges in the years to come in the absence of clear and deliberate policy choices to protect and prioritize public spending on health. This choice will be difficult, as COVID-19 set off a deep and widespread global economic crisis and despite the recent rebound in economic growth, escalating geopolitical tensions, macroeconomic shocks, and climate crises will continue to place pressures on public financing and household budgets alike. Reaching the goal of UHC by 2030 requires proactive, targeted, and accelerated efforts building on strong data and evidence. It will require strengthening partnerships with multilateral agencies, civil society, and the private sector. Leadership is needed now more than ever; UHC is ultimately a political choice.

[4] Triple Billion progress dashboard of WHO *(4)*.

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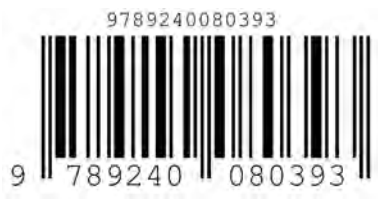
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