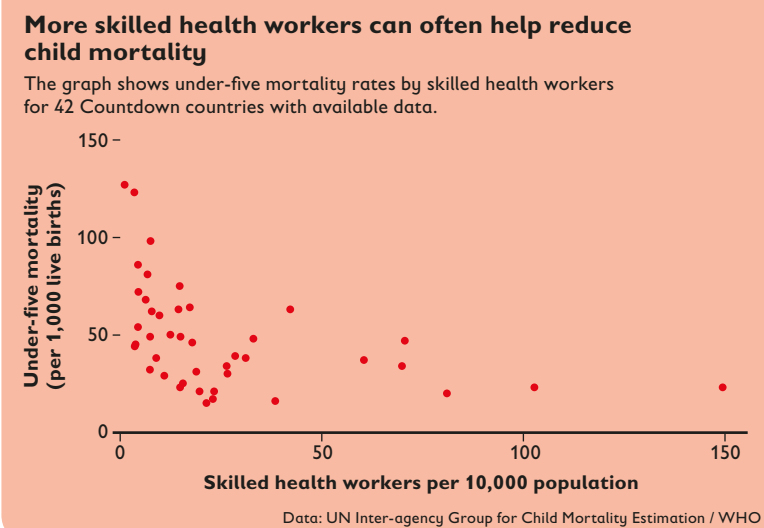


## PRIORITISING PRIMARY HEALTH CARE

Primary health care must be prioritised as the first step towards UHC, ensuring high-quality, accessible health and nutrition services for all communities, free at the point of use, with a focus on reaching the most deprived and marginalised communities.

A strong primary health care system can meet 90% of all health needs, according to the World Bank.<sup>1</sup> The World Health Organization recommends that 57% of government health expenditure should be on primary-level services.<sup>2</sup>

Adequate numbers of well-trained and remunerated health workers, especially deployed in areas of need, are required to progress towards achieving UHC.

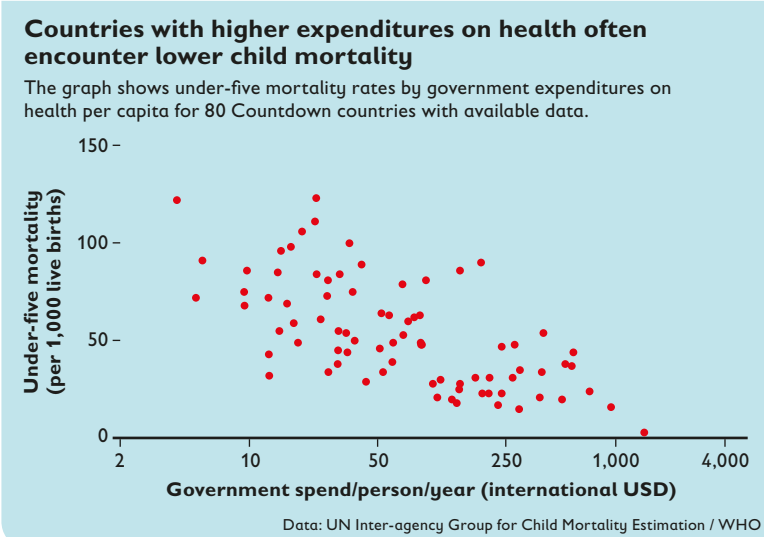


## PAYING FOR UNIVERSAL HEALTH COVERAGE

In too many countries, people are paying out-of-pocket for their healthcare. This is the least fair way to pay for health.

Our projections show that in 2030, 1.2 billion people will spend at least 10% of their household budget on healthcare and 282 million will spend 25% – which can cause financial catastrophe.

Governments need to increase public spending on healthcare to at least 5% of GDP. And they must raise revenue for health systems in an equitable way, through progressive taxation which is organised in a single pool and covers the whole population, and purchase services in a strategic way. They must remove out-of-pocket payments for health and nutrition services, such as user fees, at least for vulnerable populations and priority services.



## ACCOUNTABILITY FOR UNIVERSAL HEALTH COVERAGE

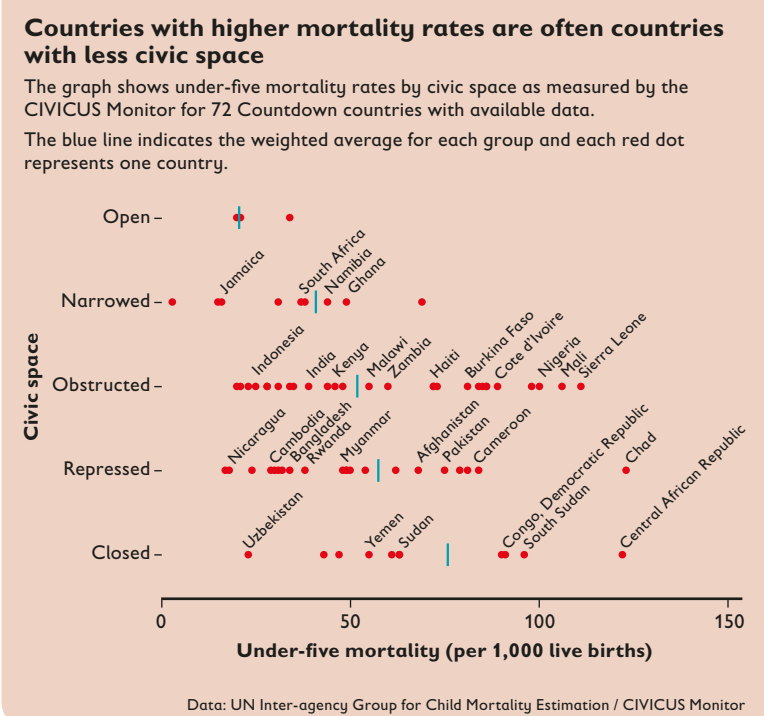
UHC legislation is critical in ensuring that all governments are obliged by law to deliver on their health commitments.

Legal guarantees recognising the right to health for all citizens are the foundation to ensuring UHC and should be supported by strong policy frameworks, costed plans, and mandatory space for civil society engagement.

Civic space is critical for civil society and communities to be able to advocate for improved fiscal space for health and increased domestic investment in primary health care.

Governments and donors should support and encourage community and civil society participation in planning, budgeting and monitoring to improve allocation of health resources and to increase efficiencies in the way health funds are spent.

We cannot measure what we don't know. Governments and donors should invest in national and sub-national research and budget analysis and share this information with civil society, to improve transparency and strengthen accountability.



The global community has committed to work together to achieve universal health coverage (UHC) by 2030, as part of the Sustainable Development Goals. Despite this, at least half the world's population still lack access to essential health services and increasing numbers of people are being pushed into poverty by having to spend too much of their household budgets on healthcare expenses.

Achieving a world in which all people can get the health services they need without financial hardship requires bold actions from governments. There is no single path to achieving UHC and countries must define their own essential health service packages and detailed pathways.

**The challenge now is to translate aspirations into achievements. The first-ever High-Level Meeting on Universal Health Coverage taking place in September 2019 provides a unique opportunity to galvanise political action needed to drive progress on UHC. We encourage governments and partners to make sure it is a truly transformational moment.**

## RECOMMENDATIONS

### We call on national governments to:

- Increase domestic health expenditure towards a 5% GDP target; raise revenue for health and nutrition systems in an equitable way through progressive taxation; purchase services in a strategic way; improve public financial management; and remove out-of-pocket payments for health and nutrition services, such as user fees.
- Prioritise primary health care as a critical first step towards UHC, ensuring access to health and nutrition services for the most deprived and marginalised communities to ensure no one is left behind.
- Remove barriers to accessing health and nutrition services, both financial and non-financial, including gender-related barriers.
- Support and empower communities and civil society to participate in planning and advocating for increased investment in primary health care.
- Take a comprehensive, multisectoral approach to health, ensuring UHC is integrated into national nutrition plans and financing, and nutrition in health plans and financing, demonstrating this also through commitments to the UN Decade of Action on Nutrition and the 2020 Nutrition for Growth Summit.

### We call on donors and development partners to:

- Ensure that their aid and funding are on-budget; transformative, invest in nationally-driven plans and priorities; support countries to increase domestic fiscal space for health and nutrition; and strengthen equitable health and nutrition financing systems.
- Ensure their support drives progress on the 'leave no one behind' agenda, focusing on access to health and nutrition services for the most deprived and marginalised communities.
- Ensure that civil society organisations and community voices shape health agendas at the global and national levels.

## Notes

<sup>1</sup> Doherty G and Govender R, *The cost effectiveness of primary care services in developing countries: A review of international literature*, Working Paper No. 37, Disease Control Priorities Project, World Bank, WHO and Fogarty International Centre of the US National Institutes of Health, 2004

<sup>2</sup> Stenberg K, Hanssen O, Tan-Torres Edejer T et al. 'Financing transformative health systems towards achievement of the Sustainable Development Goals: A model for projected resource needs in 67 low- and middle-income countries', *The Lancet*, 5.9, 2017, 875–887. Henceforth: 'SDG Price Tag'

<sup>3</sup> Countdown to 2030 tracks progress in the 81 countries that account for more than 90% of under-five child deaths and 95% of maternal deaths in the world. <http://countdown2030.org/>

For further information contact Tara Brace-John, Health Advocacy Advisor, [t.brace-john@savethechildren.org.uk](mailto:t.brace-john@savethechildren.org.uk)

Cover photo: Allan Gichigi/Save the Children

Published by  
Save the Children  
1 St John's Lane  
London EC1M 4AR  
UK  
+44 (0)20 7012 6400

First published 2019  
© The Save the Children Fund 2019  
The Save the Children Fund is a charity  
registered in England and Wales  
(213890) and Scotland (SC039570).  
Registered Company No. 178159

[savethechildren.org.uk](http://savethechildren.org.uk)

# UNIVERSAL HEALTH COVERAGE AND ACCOUNTABILITY INDEX





# UNIVERSAL HEALTH COVERAGE AND ACCOUNTABILITY INDEX

This Index presents progress on 12 key indicators for driving progress and accountability on UHC. It covers 81 Countdown to 2030 countries that together account for more than 90% of under-five child deaths and 95% of maternal deaths in the world.<sup>3</sup> It shows that without concerted effort from governments, donors, civil society and the international community, we will not achieve UHC by 2030.

## PRIORITISING PRIMARY HEALTH CARE

### Under-five mortality

**Global target: 25 per 1,000 live births by 2030**

According to WHO, 5.4 million children under five died in 2017 but globally, the under-five mortality rate has decreased by 58% since 1990. 117 countries have met the SDG reduction target.

Data source: WHO Global Health Observatory <http://apps.who.int/gho/data/node.home>

### Under-five mortality, relative inequality

Save the Children's projections suggest that 49 out of 78 Countdown countries with available data are likely to miss the SDG target. Of the 58 Countdown countries where GRID, Save the Children's Child Inequality Tracker, has projections for levels of inequality, 51 will miss the SDG target for at least one disadvantaged group.

Data source: WHO Global Health Observatory <http://apps.who.int/gho/data/node.home>

### UHC service coverage index

**Global target: 100%**

The UHC service coverage index is a composite of essential health services. Of the 56 out of 81 Countdown countries with available data on GRID, 34 have less than 50% coverage of essential health services.

Data source: WHO Global Health Observatory <http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGV>

### Skilled health workers

**Global target: 44.5 per 10,000 people**

Central to achieving UHC is a strong health force. Governments must ensure that adequate numbers of skilled health workers are trained, employed, deployed, supervised, remunerated and retained in areas of need.

Data source: WHO Global Health Observatory <http://apps.who.int/gho/portal/uhc-hss-cabinet-wrapper-v2.jsp?id=1030103>

## ACCOUNTABILITY FOR UNIVERSAL HEALTH COVERAGE

### UHC mandate

Specific UHC legislation is critical in ensuring that all governments are obliged to deliver health commitments. Legal guarantees recognising the right to health for all citizens are the foundation to ensuring UHC.

Data source: WHO Global Health Observatory <http://apps.who.int/gho/portal/uhc-hss-cabinet-wrapper-v2.jsp?id=1030103>

### Space for civic engagement

Civil society engagement and oversight are key to improving health governance, but countries vary to the extent that they allow civil society to engage with government in policy dialogue and in accountability processes.

- CIVICUS, the global civil society alliance, assigns each country a rating, as follows:
  - Open: The state enables and safeguards the enjoyment of civic space for all people.
  - Narrowed: While the state allows individuals and civil society organisations to exercise their rights to freedom of association, peaceful assembly and expression, violations of these rights also take place.
  - Obstructed: Civic space is heavily contested by power holders, who impose a combination of legal and practical constraints on the full enjoyment of fundamental rights.
  - Repressed: Civic space is significantly constrained. Active individuals and civil society members who criticise power holders risk surveillance, harassment, intimidation, imprisonment, injury and death.
  - Closed: There is complete closure – in law and in practice – of civic space.

Data source: CIVICUS Monitor 2018 <https://monitor.civicus.org/Ratings/>

## PAYING FOR UNIVERSAL HEALTH COVERAGE

### Per capita government spend on health

**Global target: \$86 minimum per capita**

Public financing of health services is the most equitable and sustainable way to progress towards UHC. Governments need to increase their per capita spend to ensure that people are not forced to pay out-of-pocket for their healthcare.

Data source: Global health expenditure database <http://apps.who.int/nha/database/SelectIndicators/en>

### Domestic general government health expenditure

**Global target: 5%**

The Civil Society Engagement Mechanism (CSEM) of UHC2030 and others have identified 5% of GDP as the minimum governments should spend on health.

Data source: Global health expenditure database <http://apps.who.int/nha/database/SelectIndicators/en>

### Out-of-pocket expenditure

**Global target: Less than 10% of household income**

WHO says that if households have to spend more than 10% of their income on health they are pushed into impoverishment; and that if out-of-pocket payments are more than 20% of household income, the consequences can be catastrophic.

Data source: Global health expenditure database <http://apps.who.int/nha/database/SelectIndicators/en>

### Government expenditure on primary health care as a % of government expenditure on health

**Global target: 57% of health budgets**

According to WHO, 57% of the health budget must be spent on primary health care; this is a good indicator of whether health care is being targeted at the most essential needs of the whole population.

Data source: Global health expenditure database <http://apps.who.int/nha/database/SelectIndicators/en>

### Budget transparency

To be able to properly monitor UHC, CSOs need to be able to access budget information, engage in budgeting, track expenditure, and monitor budget processes. Civil society engagement in budgeting processes results in needs-based budgeting and more efficient use of resources.

The Open Budget Index assigns countries a transparency score based on the amount and timeliness of budget information that governments make publicly available in eight key budget documents in accordance with international good practice standards. 100 is the most transparent.

Data source: Open Budget Index 2017 <https://www.internationalbudget.org/open-budget-survey/open-budget-index-rankings/>

### Perceived levels of public sector corruption

Health resources get wasted and misused when corruption is unchecked. Every dollar being diverted for other purposes will have an impact on the quality of health services. Perceptions that a country is corrupt also affect expansion of fiscal space and make domestic resource mobilisation a much bigger challenge.

Transparency International publishes its Corruption Perceptions Index annually. Countries are ranked by their perceived levels of public sector corruption, on a scale from 100 (very clean) to 0 (highly corrupt), as determined by expert assessments and opinion surveys.

Data source: Corruption Perceptions Index 2018 <https://www.transparency.org/cpi/2018>

Countdown 2030 (81 countries)	Under-five mortality (per 1,000 live births), 2017	Under-five mortality, relative inequality, 2017	UHC service coverage index, 2015	Skilled health workers per 10,000 people	Per capita government spend on health (US\$)	Domestic general government health expenditure as a % of GDP, 2015	Out-of-pocket expenditure as a % of current health expenditure, 2015	Government expenditure on primary health care as a % of government expenditure on health, 2016	UHC mandate	Civic engagement	Budget transparency	Corruption Perception Index, 2018
Afghanistan	68	2.0	34	6 (2016)	10	1	78	44	No	Repressed	49	16
Algeria	24	1.9			728	5	28		Yes	Repressed	3	35
Angola	81	2.6	36		93	1	33		No	Repressed	25	19
Azerbaijan	23		64	103 (2014)	241	1	79		Yes		34	25
Bangladesh	32	1.7	46	7 (2015)	13		72		No	Repressed	41	26
Benin	98	2.0	41	8 (2016)	17	1	40		No	Obstructed	39	40
Bhutan	31			19 (2016)	207	3	20		Yes	Obstructed		68
Bolivia	35		60		303	4	26		Yes	Obstructed	10	29
Botswana	38		60	31 (2012)	534	3	5		Yes	Narrowed	8	61
Burkina Faso	81		39	7 (2012)	27	2	36	86	No	Obstructed	24	41
Burundi	61	2.3	43		25	3	19	75	No	Closed	7	17
Cambodia	29	4.1	55	11 (2014)	44	1	59		No	Repressed	20	20
Cameroon	84	3.0	44		24	1	70		No	Repressed	7	25
Central African Republic	122				4	1	40		No	Closed		26
Chad	123	1.2	29	4 (2013)	23	1	56		No	Repressed	2	19
Comoros	69	1.3			16	1	75		No	Narrowed	8	27
Congo	48				88	1	44		No	Repressed		19
Congo, Democratic Republic	91	1.5	40		6	1	37		No	Closed		20
Cote d'Ivoire	89	1.7	44		41	1	36	46	No	Obstructed	24	35
Djibouti	62		47	8 (2014)	80	2	20	72	No	Repressed		31
Dominica	34				398	4	28		No	Open		57
Equatorial Guinea	90				186	1	72		No	Closed		16
Eritrea	43				13	1	52		No	Closed		24
Ethiopia	59	1.3	39		18	1	38	80	No	Closed		34
Gabon	48	1.5	52	33 (2016)	283	2	26	44	No	Closed		31
Gambia, The	64	2.0		17 (2015)	53	3	20		Yes			37
Ghana	49	1.4	45		87	2	36	69	No	Narrowed	50	41
Guatemala	28	2.9	57		142	2	56	58	No	Obstructed	61	27
Guinea	86	2.9	35	4 (2016)	10	1	54	74	No	Obstructed		28
Guinea-Bissau	84	1.0			31	2	37		No	Obstructed		16
Guyana	31	1.2			173	2	41		No	Narrowed		37
Haiti	72	1.6			13	1	36	79	No	Obstructed		20
Honduras	18		64		137	3	49		No	Repressed	54	29
India	39	3.0	56	29 (2016)	61	1	65		No	Obstructed	48	41
Indonesia	25	3.1	49	16 (2012)	141	1	48		No	Obstructed	64	38
Iraq	30			27 (2014)	112	1	76		No	Repressed	3	18
Jamaica	15		60	21 (2016)	300	3	24		No	Narrowed		44
Kenya	46	1.2	57	18 (2014)	52	2	33	67	No	Obstructed	46	27
Korea	3		80		1442	4	37		No	Narrowed		57
Kyrgyz Republic	20	3.3	66	81 (2014)	129	4	48		No	Obstructed	55	29
Lao PDR	63	3.2	48	15 (2014)	58	1	45		No	Closed		29
Lesotho	86	1.1	45		143	5	17		No	Obstructed		41
Liberia	75	1.3	34		9	1	20	77	No	Obstructed		32
Madagascar	44		30	4 (2012)	35	2	22		No	Obstructed	36	42
Malawi	55	1.4	44		31	3	11		No	Obstructed	34	25
Mali	106	2.2	32		20	1	46	70	No	Obstructed	26	32
Mauritania	79	1.7	33		69	2	48	66	No	Obstructed	39	27
Morocco	23		65	15 (2014)	188	2	53		No	Repressed		27
Mozambique	72	0.7	42	5 (2013)	5		7		No	Obstructed	45	43
Myanmar	49	3.8		15 (2012)	61	1	74		No	Obstructed	41	23
Namibia	44	2.1			594	6	8	54	No	Repressed	7	29
Nepal	34	2.6	46	26 (2014)	27	1	60		No	Narrowed	50	53
Nicaragua	17		70	23 (2014)	229	4	36		No	Obstructed	52	31
Niger	85	1.3	33		14	2	52		No	Repressed	43	25
Nigeria	100	2.7	39		36	1	72		No	Obstructed		34
Pakistan	75	1.8	40	15 (2015)	37	1	66		No	Obstructed	17	27
Panama	16		75	38 (2013)	950	4	31		No	Repressed	44	33
Papua New Guinea	53				70	3	6		Yes	Narrowed		37
Paraguay	21	6.4	69	23 (2012)	388	4	36		No	Obstructed	50	28
Philippines	28	3.8	58		101	1	54		No	Obstructed	43	29
Rwanda	38	2.1	53	9 (2015)	31	2	26		No	Obstructed	67	36
Senegal	45	2.5	41	4 (2016)	31	1	44		No	Repressed	22	56
Sierra Leone	111	0.9	36		23	2	38		No	Obstructed	51	45
Solomon Islands	21			20 (2013)	23	2	38		No	Obstructed	38	30
Somalia	127			1 (2014)	107	5	3		No	Open		44
South Africa	37	1.6	67	60 (2016)	582	4	8		No		8	10
South Sudan	96				15	1	61		No	Narrowed	89	43
Sudan	63	1.9		42 (2014)	86	2	63		No	Closed	5	13
Suriname	20				513	3	10	50	No	Closed	2	16
Swaziland	54	2.0	58		407	5	11		No	Open		43
Tajikistan	34	2.4	65	70 (2014)	54	2	63		No	Repressed		38
Tanzania	54	1.1	39	4 (2014)	34	2	26	44	No	Repressed	30	25
Timor-Leste	48	2.2	47		88	2	10		No	Repressed	10	36
Togo	73	2.7	42		27	2	51	72	No	Obstructed	40	35
Turkmenistan	47	3.1		71 (2014)	240	1	71		No	Obstructed		30
Uganda	49	1.6	44	7 (2015)	19	1	41	65	No	Closed	60	20
Uzbekistan	23			149 (2014)	205	3	43		No	Repressed		26
Venezuela	31				276	2	46		No	Closed		23
Yemen	55	1.8	39		15	1	81		No	Repressed		18
Zambia	60	1.7	56	10 (2016)	74	2	28	62	No	Obstructed	8	35
Zimbabwe	50	2.0		12 (2014)	38	2	26		No	Repressed	23	22

## PRIORITISING PRIMARY HEALTH CARE

## PAYING FOR UNIVERSAL HEALTH COVERAGE

## ACCOUNTABILITY FOR UNIVERSAL HEALTH COVERAGE