



# Primary Health Care on the Road to Universal Health Coverage

2019 MONITORING REPORT  
EXECUTIVE SUMMARY



World Health  
Organization

WHO/HIS/HGF/19.1

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Printed in Switzerland.

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## Foreword

**T**his 2019 Global Monitoring Report comes out on the eve of the High-Level Meeting on Universal Health Coverage at the United Nations General Assembly. This level of political commitment is more welcome than ever because it is essential on two fronts: first, to accelerate progress in areas where we have seen improvements; and second, to remove the barriers that are slowing down access to services in some countries and among certain populations.

On the upside, the report documents global progress in expanding access to essential health services. It shows that all regions and all income groups have made improvements, with lower income countries making the greatest gains. On the downside, poorer countries still lag behind, the overall pace of progress is slowing, and more people are paying for health care out of their own pockets.

For the first time, the report focuses on gender issues, shedding light on how gender norms and power influence access to health services. Having the right data, broken down in the right way, is giving us vital insights about who is being left behind and why, and highlighting where more investments are needed. We clearly have to go beyond country averages that mask failures that leave those

who are worst off behind. The path to success starts with a solid commitment to focus on the most disadvantaged.

As we celebrate the rising investments in health seen in the last few years, we must also emphasize the need to invest first and foremost in strong primary health care, particularly in low- and middle-income countries. That will make a real difference – saving millions of lives and increasing life expectancy.

This report issues a clear call to action for governments in all countries to invest an additional 1% of gross domestic product for primary health care. That is the surest way to move us closer to a world where every person benefits from the human right to health. It is in our hands, and the hands of our political leaders, to make the right choices – the right economic, financial and social choices for universal health coverage through primary health care.

Our goal of universal health coverage is ambitious. It is also achievable. I have always argued that UHC is first and foremost a political choice. That's why this year's High-Level Meeting is so important. Strong political commitment from world leaders is the essential ingredient for overcoming barriers and making progress on the road to a healthier, safer, fairer world.

**Tedros Adhanom Ghebreyesus**  
Director General  
World Health Organization

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## 2019 MONITORING REPORT

### EXECUTIVE SUMMARY

#### Assessing progress to set priorities

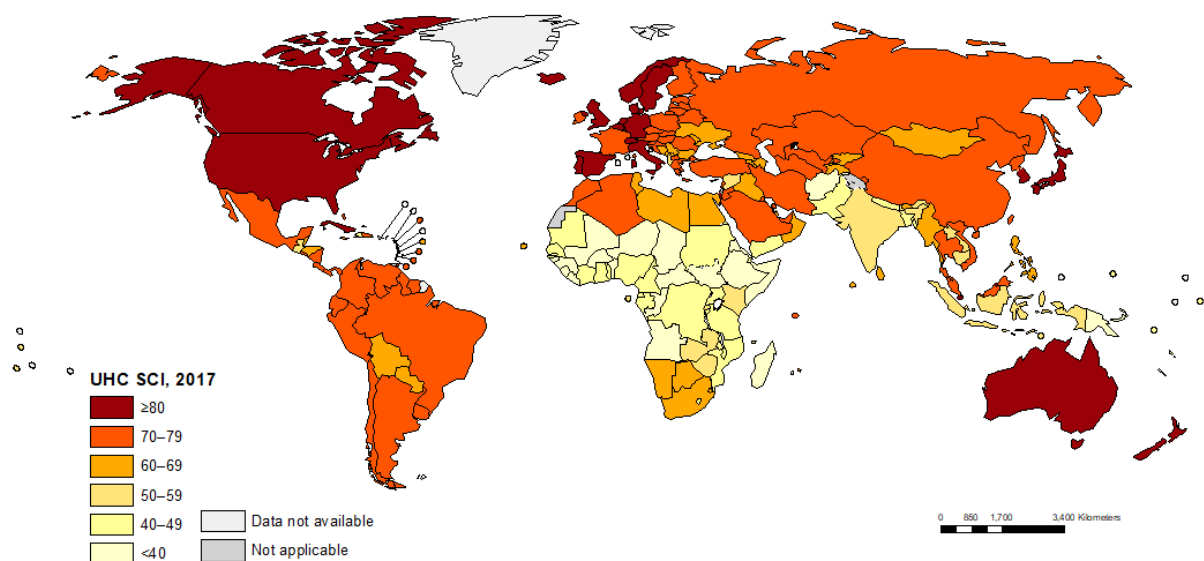
The 2030 Sustainable Development Goals emphasize having all people receive the quality health services they need without financial hardship. Critical to attaining universal health coverage (UHC) is a formal monitoring mechanism to assess progress. This report does just that. It highlights the global coverage of health services and financial protection. It

also addresses gender and equity related challenges. And it identifies primary health care as the route to universal health coverage.

#### Service coverage improving – but not fast enough

The UHC service coverage index, measuring progress on SDG indicator 3.8.1, increased from a global average of 45 (of 100) in 2000 to

**FIGURE 1** Outside of higher-income countries, country-level UHC SCI values in 2017 varied – often substantially – within WHO regions



**Note:** This map has been produced by WHO. The boundaries, colours or other designations or denominations used in this map and the publication do not imply, on the part 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 acceptance of such boundaries or frontiers.

Source: WHO.

66 in 2017. All regions and all income groups recorded gains. Progress has been greatest in lower income countries, mainly driven by interventions for infectious diseases and, to less extent, for reproductive, maternal, newborn and child health services. But the poorest countries and those affected by conflict generally lag far behind. In absolute numbers, middle income countries account for the largest population lacking coverage of essential health services in 2017.

### The pace of progress needs to accelerate

Globally and for many countries, the pace of progress has slowed since 2010. Progress requires considerable strengthening of health systems to provide UHC, particularly in lower income settings. Such improvements should also address slower gains related to noncommunicable disease services. In 2017, nearly half the world’s population (33% to 49%) were covered by essential health services. The number of people covered during the SDG era (2015–2030) is projected to increase by 1.1 to 2.0 billion, but this trend is offset by population growth. So, the percentage of people covered could rise more slowly. If current trends continue to 2030, it is projected that 39% to 63% of the global population will be covered

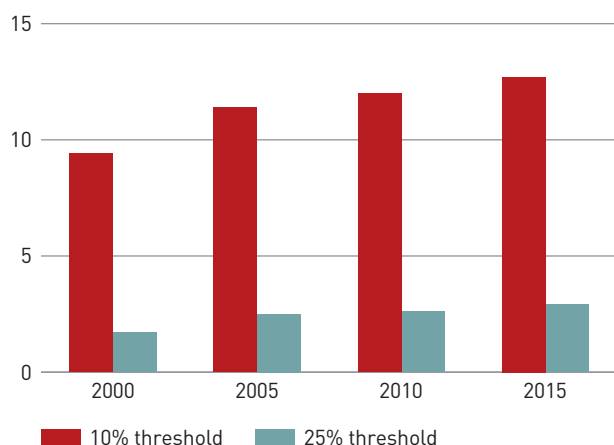
by essential health services. Therefore, progress must markedly accelerate – and coverage needs to double – to reach the SDG target of UHC for all by 2030.

### Financial protection – going in the wrong direction

The gains in service coverage have come at a major cost to individuals and their families. Catastrophic health expenditure (SDG indicator 3.8.2), defined by the out-of-pocket spending in relation to household consumption or income, increased continuously between 2000 and 2015. The proportion of the population with out-of-pocket spending exceeding 10% of their household budget rose from 9.4% to 12.7%, and the proportion with out-of-pocket spending exceeding 25% rose from 1.7% to 2.9%. So about 930 million people spent more than 10% of their household income on health care in 2015, and about 210 million people spent more than 25%. Based on a relative poverty line, defined as 60% of median daily per capita consumption or income, that spending pushed the percentage of the population impoverished from 1.8% in 2000 to 2.5% in 2015. Overall, financial protection is deteriorating not improving – although countries with more public investments in health tend to fare better.

**FIGURE 2** 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

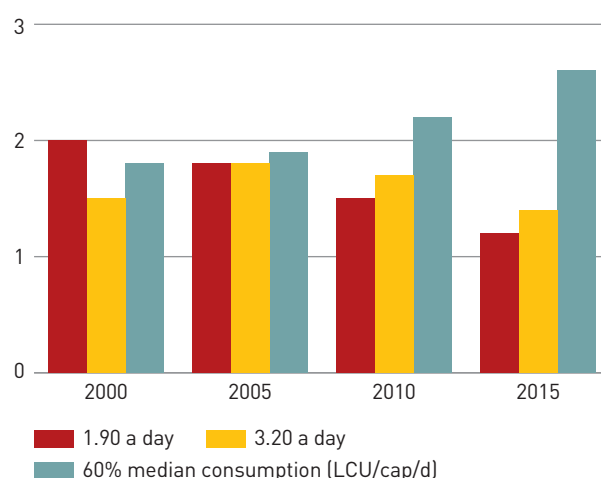
Percentage of the population (SDG indicator 3.8.2) with out-of-pocket health spending exceeding 10% or 25% of the household budget



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.

**FIGURE 3** Globally, the population impoverished by out-of-pocket health spending is decreasing at the \$1.90 and \$3.20 a day absolute poverty lines but increasing at the relative poverty line of 60% of median daily per capita consumption or income

Percentage of the population



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.

### Weak health systems combine with socioeconomic factors to impede coverage

Factors in and beyond the health system influence patterns of service use and often intersect. Inadequate basic infrastructure, human resource gaps, poor quality services, and low trust in health practitioners and medical authorities remain barriers to achieving UHC. In addition, socioeconomic factors exert a major influence over access to health services and ultimately health outcomes. Poor people have lower coverage even for basic services such as immunization, sanitation and antenatal care. For these basic services, rural areas generally have lower coverage than urban areas, but in some regions, such as the Western Pacific, the poorest quintile of the population now has lower coverage in urban areas than in rural areas.

### Gender drives health service access and health-seeking behaviour

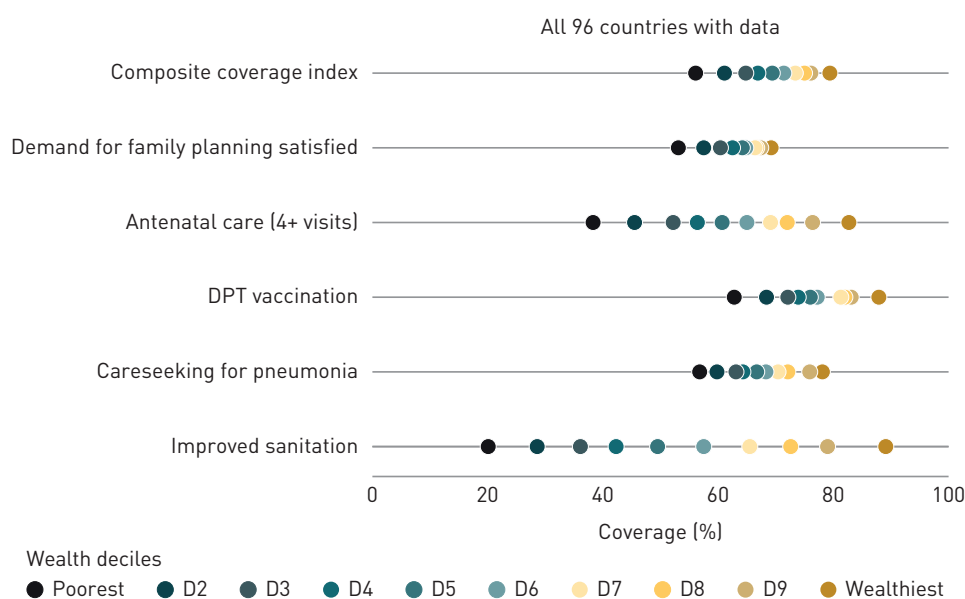
Access to sexual, reproductive and child health care services is improving, but many women and children are still not being reached, especially in the African Region. Coverage is also lower among women living in poverty and in rural areas. Noncommunicable

diseases are increasing for both men and women, accounting for over 70% of all deaths. Gender norms and power relations influence women's access to health services and timely diagnosis, while harmful notions of masculinity and aggressive marketing of tobacco and alcohol increase men's risk taking and reduce their willingness to use health services.

### Close the data gaps to identify health investment priorities

The weakness of global and especially country health information systems leaves data gaps for most countries – on service coverage, on financial protection and on gender and equity markers. Indeed, the average coverage indicators mask substantial within-country variation across different socioeconomic groups. Stronger country data systems are thus needed to determine not only the percentage of people using a service but also the need and quality of those services. More data are needed on both service coverage and financial protection for the peri-urban poor, for migrants and refugees and for other marginalized populations. And methods have to be devised to assess real-time improvements in health system performance.

**FIGURE 4** Use of reproductive, maternal and child health services is worse in poorer households than in richer households



**Note:** Includes 96 countries with a Demographic and Health Survey or Multiple Indicator Cluster Survey, latest survey for each country, 2010–2017. Estimates are averages of country values weighted by population.

**Source:** Demographic and Health Surveys and Multiple Indicator Cluster Surveys.

### Policy priorities for four country groups

While detailed contextual and political economy analysis is required by country before making policy prescriptions, our analyses of service coverage and financial protection reveal four broad categories of countries, with distinct implications for policy.

- For high and upper middle-income countries, with high service coverage and low financial hardship, the major challenge is to continue to make efficiency and equity gains.
- For lower middle-income countries, with high service coverage but high levels of financial hardship, ensuring inclusive, universal mechanisms to protect against high out-of-pocket spending will be the key challenge.
- Countries with low service coverage and high financial hardship need comprehensive reform of both their service delivery and health financing arrangements, giving priority to addressing inequities.
- Countries with low service coverage and low financial hardship, mainly highly vulnerable and conflict-affected states, need to build the foundations of their health

systems, including human resources, supply chains and infrastructure.

### Primary health care – the engine for UHC

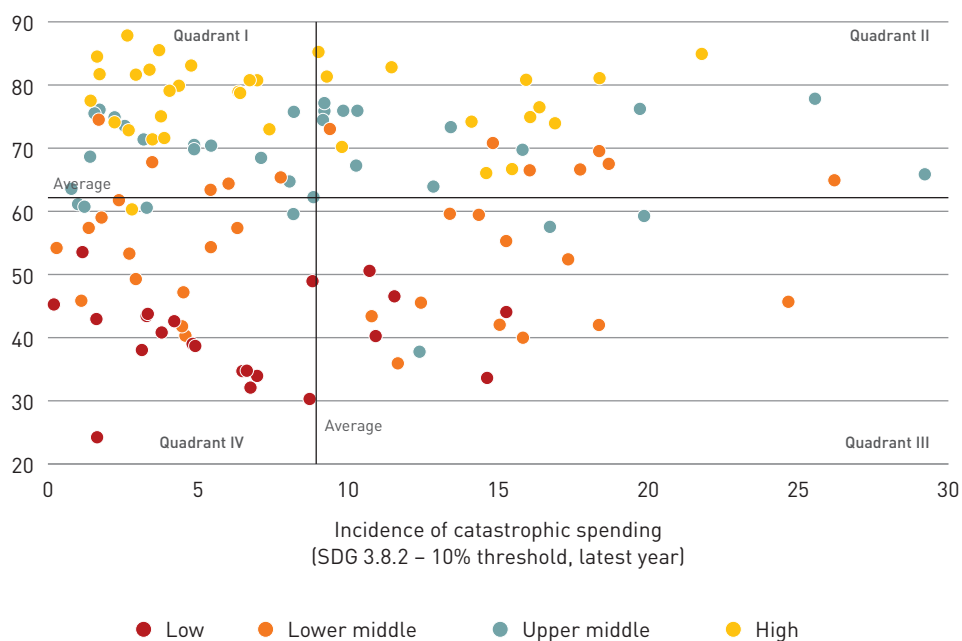
Primary health care provides the programmatic engine for UHC in most contexts, if not all. It reflects the right priorities and is a critical milestone along the road to achieving UHC targets. Emphasizing community empowerment and social accountability, it is multisectoral with links to education, nutrition and water and sanitation. It provides a platform for integrating previously separate services for communicable diseases with those for women and children’s health and noncommunicable diseases, for addressing both the demographic and epidemiological challenges facing most countries, and for innovations such as digital health. And it remains the most cost-effective way to address comprehensive health needs close to people’s homes and communities.

### Funding from domestic resources and better targeted aid

To achieve the targets for primary health care requires an additional investment of

**FIGURE 5** Countries are at different stages in service coverage and financial protection

Service coverage index (SDG 3.8.1, 2015)



**Note:** SDG 3.8.1 values and income group classification for 2015. SDG 3.8.2 estimates for the most recent year available. Income-group classification of 2015.  
**Source:** SDG 3.8.2 Global database on financial protection assembled by WHO and the World Bank: <http://apps.who.int/gho/portal/uhc-financial-protection-v3.jsp> SDG 3.8.1 September 2019 Global database on UHC service coverage assembled by WHO: <http://apps.who.int/gho/portal/uhc-service-coverage-v3.jsp>



around US\$ 200 billion a year, and to achieve UHC requires another US\$ 170 billion a year for a more comprehensive package. These amounts may appear significant, but they would represent only about a 5% increase beyond the US\$ 7.5 trillion already spent on health globally each year. Scaling up primary health care interventions across low and middle-income countries could save 60 million lives and increase average life expectancy by 3.7 years by 2030; investing in broader health systems would save close to 100 million lives.

Most countries could reach the targets by raising domestic resources to increase public spending on health, by reallocating spending towards primary health care, or by doing both. The key is to improve domestic tax and revenue performance in line with the Addis Ababa Action Agenda, to increase government revenues. All countries should immediately allocate or re-allocate at least an additional 1% of GDP to primary health care. But for the poorest countries, including many affected by conflict, this may be neither feasible nor sufficient. To be avoided are approaches to

health financing that may bring in additional resources but that further fragment systems and become obstacles to UHC rather than enablers. Instead, humanitarian and development assistance for health, as well as long-term technical assistance, must increasingly be focused on low income countries, developing, evaluating and expanding new and innovative models of service delivery and system strengthening.

### **UHC is, after all, a political choice**

The UHC goals are ambitious but achievable. Progress must be urgently accelerated, and primary health care provides the means to do so. In addition, major global health actors are increasingly aligned, under initiatives such as the Global Action Plan to Reach SDG 3, to support countries in a more systematic and coherent way. To ensure that every person benefits from the human right to health, political leaders have to make the right choices, the rational economic, financial and social choices for UHC.







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