EXECUTIVE SUMMARY

MISSING (FROM) THE UHC-TARGETS: LEAVING BEHIND THE MOST VULNERABLE

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EXECUTIVE SUMMARY

Through providing free medical care to people in conflict settings, natural disasters, pandemics, and among people excluded from the health system, MSF teams see first-hand the challenges in accessing healthcare around the world. Our report draws on this practical experience, identifying specific barriers to accessing healthcare for the most vulnerable. We recognize the UNHLM on Universal Health Coverage (UHC) as a key flashpoint on commitments, but we are concerned that the **current UHC agenda and most UHC country plans fall short of the 'Leave no one behind' principle.**

> **Universal Health Care means that all people receive the health services they need, of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship.** *(Source: WHO)*

MSF has previously raised concerns about the way UHC targets are developed, with a lack of attention to important barriers to accessing care. In this report we have collected illustrations of problems in getting access to care for the most vulnerable and people in the most critical health situations, such as those in emergencies and crises; migrants and refugees; and people forced to forego essential care because of financial barriers. Through these examples, augmented by the academic and grey literature on financing for UHC, we highlight the **real-life and acute gaps between the declared aspirations of UHC and the lived experiences of millions of people.** Without action on critical challenges for those without timely and affordable health care, the UHC agenda and country plans will miss their goal and diminish UHC's credibility.

Funding for health is in crisis. With governments slashing the previous increases in spending for healthcare during the COVID-19 pandemic, and the collapse of external financing for health through global aid budgets, many low-and-middle-income countries face challenges in providing health care. As a result, there is little 'new money' to expand access to healthcare, and in many countries public resources for health have even been reduced. This has led to increases in out-of-pocket (OOP) spending and to catastrophic health expenditures at the individual patient level.

UHC BUT NOT FOR THOSE UNABLE TO PAY

This report documents the direct consequences of these trends. In Mali, Burundi, Sierra Leone, South Sudan, and Afghanistan, **unaffordability of OOP expenses makes people forego or delay care**, and erstwhile **free healthcare initiatives are at risk** of disappearing. Essential medicines are too often unavailable in public services, forcing people to seek drugs from private outlets at higher costs borne out of pocket, or to go without those medicines entirely.

A worrying occurrence is the detention of patients who cannot afford hospital bills, as directly noted by MSF for instance in Burundi and Zimbabwe. Increasingly costs are being shifted onto patients through user fees in public health services. In South Sudan, where healthcare is almost entirely dependent on donors, the cuts in aid have resulted in facilities imposing user fees, leading to in a 50% reduction in consultations at facilities for immunization, sexual and reproductive health, and antenatal care.

Women's health has been a major casualty of the contracting finances. In Sierra Leone, nearly half of all rural women deliver outside of health facilities due to the distance to the health facility and cost of care. In Mali, financial access was a key deterrent to healthcare. In Afghanistan, the return of the Taliban has seen major restrictions on access to opportunities for women. With donor-funded initiatives either withdrawn or curtailed, the financial challenges for women seeking healthcare have grown. In Zimbabwe, funding challenges have resulted in the imposition of exorbitant consultation fees for primary care to new mothers; some facilities are reporting a near 50% reduction in the number of consultations and facility deliveries. In Haiti, maternal mortality remains high and access to urgent care is often unaffordable, as a patient can be charged up to US$190 in the public sector for a C-section.

Funding for infectious diseases is extremely challenged. Malaria remains a major infectious disease killer in Sub-Saharan Africa. Yet in Burundi, Guinea, Sierra Leone, and South Sudan MSF almost routinely fills gaps in availability of medicines and pays for patients who cannot afford the costs of treatment. Across countries, among patients with drug-sensitive tuberculosis (TB) in 2022, between 30 and 50% of households experienced catastrophic health expenses – and double this proportion among households with an individual with Drug Resistant TB or co-infection with HIV. In the Democratic Republic of Congo, South Sudan, Guinea, and Mozambique, despite availability of donor-funded services, there are significant OOP expenses for medicines or lab tests outside the package of HIV & TB care provided free of charge. Too often this results in patients presenting late to care, many with advanced HIV disease because of forgone timely care.

Patients with **non-communicable diseases** (NCDs) require ongoing treatment, but are paying OOP for transport costs to facilities for follow-up checkups, lab tests or medicines in public services when not available free of charge. While in Kenya primary care is free, most primary health care facilities do not include NCDs and outpatient care at hospital level is costly. CBOs report problems in availability of free NCD-drugs, and they assessed that for instance in Embu County about half of patients could not access their treatment; for many even the subsidized community revolving pharmacies were unaffordable. In Lebanon, the economic crisis has significantly impacted on the availability of care and limited options to access affordable services. With rising costs and frequent shortfalls of medicines in the public sector, many NCD -patients cannot afford healthcare.

MSF teams have also noted specific financial and other barriers for **extremely vulnerable populations**, such as people who use drugs in Kenya, or sex workers and men who have sex with men in Mozambique, or victims of sexual and gender-based violence in Guinea. They face out of pocket costs for basic medical exams and cannot access medical care.

MSF/Alexandre Marcou/Haiti

UHC BUT NOT FOR PEOPLE IN CRISIS SITUATIONS

During crisis situations linked to epidemics, conflict and natural disasters, pre-existing vulnerability and health service gaps often worsen and health care barriers for vulnerable groups are disproportionally worsened. Measures to protect people in such crises are lacking in many places; timely measures to ensure access to essential care, for existing and new health needs, are missing in particular from UHC country plans.

Two billion people, or a quarter of the world's population now lives in **conflict-affected areas**. The protection of frontline health workers is difficult to ensure, further eroding the safety and security of healthcare to those who are wounded and sick. Amidst insecurity, with functional health facilities few and far apart, and without international support to provide essential care for free, people face unaffordable costs to access care, often foregoing care. Continuity of treatment is a specific challenge in times of crisis, in particular for people on treatment for HIV, TB and NCD. Timely access to care is a challenge for people affected by violence and displacement. The existing health services mostly are deficient, but also can be less effective in reaching certain people, as shown in northern districts of Mali and in Mozambique (Cabo Delgado province).

COVID-19 is a well-documented example of a major shock to health systems worldwide (including in advanced countries). It offered key lessons for proposed UHC plans, but these appear not to have been sufficiently heeded. MSF teams have witnessed access barriers during the pandemic, with unaffordable costs to diagnostics, treatment and hospital care in public and private facilities, but also the exclusion from vaccination programs of migrants and other vulnerable groups.

During any **epidemic outbreak**, financial barriers block timely health care seeking for health problems directly linked to the emergency but also affect negatively access to health care in general, leading to delayed reporting through health facility-based surveillance. Due to reduced vaccination coverage, currently many countries face vaccine preventable outbreaks, such as for measles, diphtheria etc.; timely, effective patient treatment and immunization campaigns are needed.


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UHC BUT NOT FOR ALL MIGRANTS AND REFUGEES

One in eight people today is a migrant or is forcibly displaced. Migrants, including refugees, often have poorer health outcomes and face multiple barriers in accessing health care. Health systems need to be adapted to provide preventive, primary, and mental healthcare in a way that legal, administrative, linguistic and discriminatory barriers are mitigated. The health needs of migrants and their precarity in accessing health care because of social and political determinants of health, should be addressed effectively, regardless of legal status.

Yet MSF's experiences in countries such as **Belgium, Italy, Poland, Greece, Lebanon, and South Africa** show that migrants face significant barriers to accessing even essential and urgent services, in some cases even when the policy environment explicitly provides for this. Effective access to affordable healthcare for migrants is frustrated by a range of administrative barriers, as well as often complex procedures. There are particularly acute examples of pregnant mothers and children under five being excluded from health services, often through the use of exorbitant fees. Following the economic crisis in Lebanon cost of care has risen and with UNHCR funding cuts, refugees face increased barriers to care, as they are now required to pay 50% of the cost of treatment OOP.

Country plans to implement UHC must include measures to eradicate the various barriers to access healthcare at all levels, as well as propose proper migrant-sensitive service delivery, ensuring care free of charge and with cultural and language-appropriate support. Active and effective community participation and engagement in navigating services and facilitating access may prove crucial.

HEALTH INSURANCE SCHEMES FAILING VULNERABLE PEOPLE

In many UHC country plans, health insurance is the proposed vehicle to achieve UHC. However, as more than 60% of the world's employed population are in the informal economy, social health insurance mechanisms which require employer contributions are elusive. Current insurance coverage rates are less than 10% in many low-income countries. This is not a likely mechanism to achieve healthcare for all in the immediate future. Furthermore, the schemes into which people are enrolled, as shown in Kenya and Burundi, have limited coverage of services that people need and do not protect sufficiently against out-of-pocket expenses. Enrollment of migrants and refugees into such schemes is administratively difficult.

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WE CONCLUDE OUR REPORT WITH SIX KEY RECOMMENDATIONS:

1. **Heighten the focus** on urgent action towards tangible improvements of people's access to essential care, in particular and foremost for the most vulnerable, such as those in emergencies and crises, migrants and refugees and people forced to forego essential care because of financial barriers.
2. **Priority support** to initiatives providing subsidized health services under exemptions of patient payments for broad population groups, specific vulnerable populations and to provide key health services with substantial public health impact free of charge, such as for women and children's health, HIV, TB, malaria, NCD, and during epidemic outbreaks and other crises.
3. **Update UHC country plans** with a specific chapter that includes the principles and practical modalities for effective and timely service delivery for health needs of people affected by crisis & emergency situations.
4. UHC country plans should ensure **systematic, proactive, and effective inclusion** of migrants, refugees and displaced populations, including asylum-seekers, undocumented people and other marginalized groups.
5. **In view of the economic issues** faced by many Low & Middle Income Countries, only domestic resource mobilization will fall short of the financing needs for health; the availability of additional international funding will determine the possibility of improving access to essential health services within a reasonable timeframe. Priority should go to ensuring that such services go to the most vulnerable first.
6. **Engage and involve** patients, communities, and civil society in the processes to develop and evaluate UHC country plans.

While MSF's experiences show the barriers that some of the poorest, most vulnerable and most discriminated people face in accessing healthcare, we are concerned that the current UHC-agenda and most UHC country plans fall short of the 'Leave no one behind' principle. There is not enough attention for people foregoing care, migrants and refugees, and people in critical crisis situations. As long as these vulnerable people are missing from the UHC-targets, the UHC agenda and country plans will fail.

Real change and tangible results in access to care – including and foremost for the most vulnerable people- are urgent to achieve.

For further information on the report, please contact | **Info-analysis@msf.org** | **www.msf.org**