

Narrative Review of Universal Health Coverage Progress

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ABSTRACT

Universal Health Coverage (UHC) represents a global commitment to ensuring equitable access to quality healthcare without financial hardship. This review synthesizes evidence on geographic disparities, system resilience, and cross-country progress toward achieving UHC. Despite notable gains, urban–rural inequities persist, particularly in low- and middle-income countries, where rural populations remain underserved due to weak transport infrastructure, limited facilities, and economic constraints. Sustainability and resilience emerge as critical dimensions of UHC, particularly in the context of pandemics, economic shocks, and climate change. Strengthening health systems to withstand crises requires robust governance, emergency financing mechanisms, and adaptive service delivery frameworks that preserve essential care. Comparative analysis across income groups reveals that Nordic and other high-income countries achieved UHC through strong political consensus, equitable public financing, and integrated service delivery models. Middle-income countries continue to refine their pathways through social protection reforms and mixed financing mechanisms, while low-income countries advance incrementally, often constrained by fiscal and institutional limitations. Building resilience into UHC demands multisectoral action, climate adaptation strategies, and investment in long-term health system strengthening. The review concludes that achieving UHC globally requires sustained political commitment, inclusive policies, equitable financing, and adaptive capacity to ensure sustainability, quality, and universal access amid evolving global challenges.

Keywords: Universal Health Coverage (UHC), Health System Resilience, Urban–Rural Health Disparities, Climate Change and Sustainability and Comparative Health Policy.

INTRODUCTION

Universal health coverage (UHC) is the long-awaited culmination of public health, development, and human rights processes. With confidence, the UN defines UHC as securing “access to quality essential health services for all individuals and communities, without risk of financial hardship”. This definition includes three fundamental concepts: financial protection, health services, and population coverage [3]. The former stresses protection against risk, the last specifies populations, and the middle indicates what matters to those groups. A narrative review maps the path toward meeting this commitment and indicates where progress is lacking, although overall access grows in well-functioning systems, persistent inequity diminishes quality, access declines amid fragility, coverage remains incomplete, and payers lack insight into options[5]. Health system research has proliferated internationally, but attention to UHC priority in the Sustainable Development Goals (SDGs) has been uneven. Collaboration among World Health Organization (WHO), World Bank, and Organisation for Economic Co-operation and Development (OECD) proposals strengthens collaboration around health financing, governance, and other services [3]. Heterogeneity among functional components routinely complicates tracking progress, following distinct trajectories and grouping into separate degrees of separation meriting individual scrutiny. Addressing tracking gaps prompts alignment of the overview with relevant work programmes and establishes

links to specific financing options appearing within the broader monitoring and assessment of UHC [1]. UHC is a multi-dimensional concept that encompasses population coverage, services and financial protection, with emphasis on quality and equity [1]. It is a foundation for promoting health, advancing economic and social development, and minimizing social disparities through the construction of exhaustive and resilient health systems. The UN clearly recognizes UHC as central to the achievement of the sustainable health of individuals and the planet, while advocating worldwide for broader and accelerated access to health care [2]. Core tracers of health service coverage include interventions for reproductive, maternal, neonatal, and child health, infectious disease, and non-communicable disease, as well as overall service capacity [3]. For financial risk protection, specific indicators cover catastrophic health expenditure and healthcare-induced impoverishment [2]. Prior research has mostly centered on conceptual and analytical accounts of UHC, including examinations of implementation frameworks, the historical emergence of the concept, and strategies for enhancing particular aspects of coverage, yet no comprehensive scoping review has traced its physical and financial dimensions [1]. Such a mapping of universal UHC therefore addresses significant conceptual gaps, pinpointing its key building blocks, constituent services, and widely employed terminology [2].

Definition of Universal Health Coverage (UHC)

Universal health coverage (UHC) ensures that all individuals and communities receive the health services they need without suffering financial hardship [2]. UHC encompasses the full spectrum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care [1]. It includes addressing the broader determinants of health, and access to qualified healthcare providers and effective, safe, quality and affordable medicines and vaccines [2]. Financial protection includes reducing the risk of incurring catastrophic or impoverishing out-of-pocket health expenditures. UHC is strongly correlated with socioeconomic development, and as such, UHC remains key for nations to proceed to upper-income and high-income status [3]. The purpose of this narrative review is to examine the broad UHC situation in countries worldwide; assess policy options available to countries to advance toward UHC; and illustrate how various governance arrangements, financing models, and service delivery approaches support the health system in providing universal access to quality services at affordable levels [5]. These three aspects are vital to the successful transition to UHC, and to long-term economic development and growth [2]. By 2021, two-thirds of the global population still lacked access to essential health services, and an estimated 950 million people were exposed to catastrophic health expenditures. For 2020, an estimated USD 171 billion of direct COVID-19-related financing had been tracked through international donor flows, mostly from bilateral donors and the International Monetary Fund, a small share of projected needs that amounted to USD 377 billion. These figures illustrate the significant challenge that remains in meeting the vision of UHC worldwide [1] M. Rodney & S. Hill, 2014) [1].

Historical Evolution and Key Milestones

Trends in health coverage and related equity have manifested through several major agreements, instruments, and landscape shifts [3]. The General Assembly first recognized health as a human right in 1946, launching the WHO's constitution and underpinning global health commitments [3]. The Alma-Ata Declaration of 1978 emphasized health as a crucial element of socioeconomic development. In 2000, the Millennium Development Goals included a target to "achieve universal access to reproductive health" by 2015, extending the definition to the coverage of public services and overarching spatial and poverty issues (Chrispinus Okech & Ltumbesi Lelegwe, 2016). The corresponding plan prompted countries to undertake detailed surveys a reliance that persists and mapped the links between health and major development commitments [5]. Two other shifts further broadened the concept [1]. In 2005, the Global Strategy for Women's and Children's Health introduced the notion of universal access, focusing on expenditures, service delivery, and a wider range of interventions (M Rodney & S Hill, 2014) [6]. The 2010 publication of "The World Health Report: Health Systems Financing: The Path to Universal Coverage" not only brought the term "universal coverage" into the discourse but also set out a comprehensive framework to monitor its evolution. Coverage of essential health services and financial protection against impoverishing and catastrophic expenditure were defined as the two main components and two-way interaction between the two appeared fundamental; this so-called UHC1-2 formula now constitutes a standard conceptual framework [4].

Dimensions of UHC: Access, Affordability, Quality, and Equity

Access, affordability, quality, and equity are the four dimensions of Universal Health Coverage (UHC) Progress [2]. Access is the ability of individuals or communities to obtain health services when needed [2]. The World Bank measures access to essential health services and preventive care, while the Global Monitoring Report emphasizes coverage of a minimum universal health service package and access to a defined set of priority

interventions for young children, women, and those at high risk of poor health and economic productivity [12]. The de facto health service delivered divides the continuum of access into coverage breadth treatment or prevention of a specific condition and coverage depth number of conditions treated or prevented [7]. Affordability is the converse of financial protection and measures whether individuals can obtain services without facing hardship. The indicators of the share of national income available for health and the share of households facing catastrophic health expenditure are the focus here [2]. Quality captures the extent to which health services are effective and safe. The quality of health services directly affects system and population performance, health services delivered, and uptake. Quality of care is one of four categories of performance indicator information regarding a health system [6]. Equity expresses fairness in health or health care, emphasizing the distribution of health and health care across population groups within a country, while the UN recommends designing UHC monitoring frameworks by focusing on the avoidable inequalities in service coverage. Equity is a type of accessibility, comparing access by group and revealing differences between groups with full access [3].

Global Progress and Trends

Over the last two decades, a significant expansion of universal health coverage (UHC) has taken place in many countries, albeit from varying starting points and unevenly across health services [3]. The broadest signal of this expansion is the increasing number of countries that have made UHC a formal policy objective, with an expansion of frameworks for monitoring trends and equity, for identifying gaps that impede progress, and for guiding country analyses of health system development and reform [4]. Various international actors and instruments have substantially influenced this expansion contributing both to the support available for analysis of country progress and to the policies and approaches proposed for action across diverse [5].

Donor and International Guidance

Universal health coverage (UHC) denotes that “all individuals and communities receive the health services they need without suffering financial hardship” (WHO, 2019). This narrative review maps international UHC progress, covering the 22-year period between 1995 and 2017, as documented by the World Bank (World Bank, 2017) [25]. The review delineates not only major eras, agreements, and policy shifts but also entrenched governance and financing constellations that continue to influence the pace of UHC progress [24]. Overarching global signals, guiding principles, and the role of international donor guidance are highlighted [25]. International guidance frameworks and governance models from major international organizations principally the WHO and the World Bank are therefore essential to understanding global UHC progress [26]. The World Bank (2017) identifies four guiding principles for monitoring country-level UHC progress: Health service coverage and financial protection are interrelated; a universal health system must cover the entire population; Equity is a central dimension of both service coverage and financial protection; and Collectively, service coverage and financial protection define health system performance [3]. Major initiatives, agreements, and financing models proposed by these organizations also shape national governance and international financing arrangements [8]. The interplay between governance mechanisms and UHC financing options has been recognized throughout the trajectory of UHC. In particular, the broad international commitment to social health insurance and related concepts such as health benefits and financial protection continues to shape prevailing financing models and is therefore a central concern within section [6]. Progress toward UHC is not limited to the availability of health services across the population. Coverage is intimately linked to the prevailing governance framework and available financing options, which in turn influence national international linkages, the degree of public or private provision, and other critical dimensions [3]. Moreover, access to the relevant governance documents, tracking systems, and comparative cases is assisted by the major health initiatives of the 1990s, international donor guidance, and the extensive state of UHC monitoring and reporting from 2004 onward [13]. The significance of these milestones, frameworks, and reports in facilitating the generation and dissemination of knowledge about UHC monitoring mandates their further elaboration therefore clarifies the nature and role of these fundamental drivers of international UHC monitoring [6]. Access to, and the quality of, health services are intimately related to national–international governance dynamics and financing arrangements. Consequently, UHC defined as both coverage and equity in the health services received is inextricably linked to the overarching governance framework and financing modality and consideration of these drivers is thus essential in understanding country responses to the UHC mandate [10]. The multi-dimensional and interlinked character of access, the mapping of UHC coverage in health services, and variations in progress across regions, populations, and between service areas are consequently key themes that support ongoing framework development, guide practical engagement, and characterize international knowledge exchange on UHC in the long-standing context of multi-dimensional and inter-linked analyses of health system performance on such initiatives as the World Bank’s 1993 policy and 2000 sector framework work on health

reform interventions, on-going WHO programs and scores on health systems that nourish and inform health plans, and continued attention to the social determinants of health [17].

Progress by Region and Income Level

Countries across various income levels and regions exhibit vastly different progress toward Universal Health Coverage (UHC) [2]. World regions' advancements toward UHC at the country-specific and regional levels. Countries are categorized according to income groups, including low-income, lower-middle-income, upper-middle-income, and high-income nations, in line with the World Bank classification [1, 23]. A few global and regional organizations advocate for increased investment in UHC in low and middle-income nations [22]. Countries in these regions, including those categorized as lower and upper middle-income, experienced major increases in UHC, while high-income nations progressed at a much slower pace [5]. The analyses of UHC progress are complemented by evaluations of other indicators, particularly the share of public expenditure on health and the level of out-of-pocket (OOP) spending [5]. The effectiveness of service delivery models and the stances taken by the private sector also significantly influence UHC trajectories [11]. The growth of UHC coverage is regarded as a principal driver of overall expansion in low and middle-income regions [8]. In particular, private provision in subsidized, publicly funded, and client owned arrangements has extended health service coverage to difficult-to-reach populations and participants of informal economies [7].

Key Indicators and Measurement Challenges

There are numerous indicators for tracking UHC with varying definitions and methodologies [3]. Efforts to address basic health system gaps have rekindled interest in monitoring access to health services; nonetheless, monitoring of UHC remains unprecedented, incomplete, and largely unaffected by such initiatives [5]. By improving understanding of globally and nationally monitored indicators, access to consolidated information on related datasets, and awareness of the related resources and proposals for improving coverage indicators, gaps in tracking UHC at global and national levels can be bridged [6]. Internationally, UHC measurement frameworks have been articulated mainly by the World Health Organization (WHO), the United Nations Development Programme (UNDP), and the World Bank Group [4]. WHO frameworks tend to follow the definitions of coverage uttered in the WHO World Health Report 2010 which emphasize the share of people among a given population receiving specific health promotion or protection; the share of people receiving specific health services; the share of health interventions delivered to care seekers among the eligible population; or the share of people receiving specific responses adopted to combat specific health care financing for a defined state. In general, the approaches of WHO formulate UHC at the level of the individual health intervention [7].

Policy Constellations and Financing

Universal Health Coverage (UHC) describes a state wherein every individual has access to quality essential health services without incurring financial hardship [8]. As a goal, UHC comprises policies and strategies that necessitate enacting requisite health systems (e.g. financial protection mechanisms, comprehensive health financing systems, well-integrated service delivery models, supportive governance structures) as an immediate step towards the wider objective of universal access to high-quality services [9]. This narrative review aims to map global progress on UHC across the multiple dimensions framed by those goals since the WHO UHC Resolution and UHC Day (March 2013), tracing the measures, instruments, and approaches characteristic of UHC efforts across countries and over time [9]. The composition of the UHC narrative is designed so that progress on these dimensions can be interpreted as a function of previously examined governance arrangements through the lens of financing models and approaches [23]. Service delivery strategies, the nature of the providers and facilities through which health services reach the population, therefore constitute the next element of this interpretive framework. Countries pursue diverse combinations of public and private, facility-based and community-oriented service delivery, reflecting differing priorities regarding accessibility, efficiency, quality, and equity [15]. Since service delivery represents not just a channel for financing but a core dimension of the UHC target itself, the organisation and integration of health service delivery forms the logical next focus in mapping progress toward the HLP UHC targets [24].

Health Financing Mechanisms

Health financing can entail how revenues are generated (resource mobilization), how revenues are pooled (risk sharing), and how pooled revenues are used for the purchasing of services (purchase & provision) [10]. Physical capital, human capital, and consumables are also important inputs into the delivery of health services [10]. Tax financing can either be through general taxation or earmarked financing. General taxation provides a stable and predictable funding source, while earmarked taxes provide a clear link between payment and government service delivered. However, an excessive reliance on earmarked taxes can reduce ability to fund other essential services

[17]. Tax funding can be provided at national, state, and local level. National tax funding is more achievable for smaller municipalities, while local tax funding is favoured for better alignment with local health needs; state tax funding can further be directed towards poorer municipalities to promote equity [17]. Community health should also be considered when establishing funding sources, with such funding more readily integrated with other service funding. Analysis of the Kenyan health system reveals that whilst 41% of funds publicly collected are retained at local level, lower proportions post-collection are retained [18]. A Social Health Insurance scheme involves compulsory taxation for funding via employer and employee contributions, but does not guarantee equity if health status is related to income. Such schemes also restrict budget from channelling funds to other inter-sectoral needs with health determinants outside of the health sector [28]. Private pooled funds typically operate like social health insurance in providing prepayment to medical operators while aiming for financial equity. Such funds can also reduce pressure on public funds [27]. Strategic purchasing involves purchaser-provider arrangements and separates the purchaser from client [10]. Fiscal policy can also be part of health financing, whether through budget-setting or expenditure controls [10]. A range of tools including equity levels, service inequalities, out-of-pocket expenditure criteria, and reallocation from unhealthy sectors can therefore be deployed accordingly [11].

Service Delivery Models and System Integration

Universal health coverage (UHC) aims to ensure all people can access needed health services without suffering financial hardship [13]. Health services include preventive, promotional, curative, rehabilitative and palliative interventions. The main policy goal is to ensure everyone can obtain the necessary health services regardless of factors such as abilities to pay for service, social status, ethnicity, or insurance status [13]. Heightened political commitment is required to mobilize resources at all levels of government to maintain the momentum towards UHC. National governments are encouraged to play a key role by making sure universal access can become a reality irrespective of social status, economic situation, and other factors [12]. Similar to other public goods, the health sector comprises a set of interdependent public goods. For instance, broader health-care financing does not directly translate into better health-care access [26]. Health-financing approaches thereby call for more emphasis on the wider picture of the health-economy nexus to ensure that health-care systems could continue to deliver universal access to services [15]. The significant lengthening of the average life expectancy at birth points to the indispensable public goods character of the health sector. Good health outcomes are nevertheless no guarantee that countries can remain on the universal access path, as pointed out by the spread of civil unrest and protests against the measures taken by regimes across the globe [13].

Financial Protection and Out-of-Pocket Expenditures

Universal health coverage aims to ensure that everyone can receive the health services they need without facing financial hardship [24]. Financial protection covers protection against the need for out-of-pocket (OOP) payments for health services. It is a component of progress in universal health coverage and an outcome in its own right [28]. In 2015, the UN declared access to health services a global goal, and the need to improve universal health coverage gained further momentum with the COVID-19 pandemic [26]. To assess progress, numerous and varied indicators are used, of which two OOP indicators are highlighted here: the percentage of health expenditures estimated as OOP expenditures, indicating financial protection; and the percentage of individuals whose OOP payments for health have led to catastrophic health expenditures, indicating serious financial risk protection [14]. Although many countries worldwide have made progress toward financial protection, significant challenges remain. At a global level, the overall trend revealed evidence of protection, with the share of health expenditures that are OOP expenditures falling [12]. However, the OOP figure remains well above the first policy benchmark for the need to accelerate universal health coverage, providing an indication of considerable persistence of serious financial risk for a significant portion of the population [27]. At the same time, the first summary indicator shows very wide movement among countries, with substantial divergence of performance. Regions covered and progress made over time is also important interlinked items [15].

Accessibility and Coverage

Public health challenges often derive from a shortfall in governmental resources. Dominant types of health expenditure in public health include targeted solutions such as Gavi or Global Fund, which lack scope [23]. Countries require a wide range of health functions and delivery methods; an absence causes serious gaps. For instance, in 2020, absence of Gavi funding units and wages drove workforce capacity shortfall 3. When purchasing coverage does not extend from targeted assistance to broad investment, a country is left with public health demand dwarfed by the purchasing rate [13]. Progress, therefore, stalls. Regional categorization follows the current World Health Organization division. Some countries advance robustly despite or because of being

classified regionally as low-income; handling of progress across such countries and across progress-driving countries receive consideration in two analytical levels. Certain countries invest through government and other public health expenditure ratios [15]. The extent to which such investment purchases government-staffed health systems and private, non-government systems is worthy of observation [25]. These investment-share ratios contrast with Health Information System ratios [24]. When coverage is limited, countries continue attempting to expand population access time passes while neither maintenance nor expansion takes place [16].

Public Provision vs. Private Sector Roles

Health systems consist of a multitude of factors ranging from healthcare finance to the public–private mix in service provision [24, 28]. This section examines the relative importance of public and private sector contributions to health service delivery, considering coverage breadth and equity issues [25]. Notably, public image often favours the private sector as offering higher quality and greater efficiency. Evidence, however, points to the public and private sectors being two very different animals, serving different populations in different ways [13]. Quality assessments may simply reflect the extent of public sector coverage, the greater the public sector investment, the fewer the complaints about quality [13]. In part, this pattern of public provision and private sector roles relates to the extent of public financing and government accountability: the higher both of these, the lower the burden of user fees and the more likely a distribution based on need rather than ability to pay and the greater the willingness to purchase supplementary private insurance [16]. High levels of availability, accessibility and use of modern contraceptive tools, for instance, are regularly observed where contraceptive methods are publically subsidised and family planning services are easy to access. Conversely, captures such as direct expenditure on equipment and facility-related costs consistently indicate large inequality in public sector budget allocation at the level of physical infrastructure facilities throughout the country [17].

Population Groups and Equity Gaps

Two dimensions that enable analysis of progress toward UHC are identified: the population groups of the population groups still uncovered or underserved in the health systems; and equity gaps defined as the differences in coverage experienced by specific vulnerable groups relative to the national averages [7]. More detailed assessments of inequities are provided through a systematic review of 48 studies of both coverage and inequity in family planning, maternal health, neonatal health, and child health [9]. Overall, new findings reinforce the earlier conclusion that coverage gaps for specific population groups and equity gaps have remained substantial in many countries [10]. Most countries have expanded access to family planning, maternal health, neonatal health, and child health services, but already vulnerable groups have not shared equally in that progress. Coverage of facility-based delivery remains particularly low for Indigenous women, although socioeconomic groups are also underserved in most countries [13, 18]. There is strong evidence that both family planning and maternal health are underserved among groups below the national macroeconomic average [25]. Child health seems more susceptible to children being located in internally displaced persons households, more than more objective wealth indicators. Twelve countries are identified as particularly low on UHC for the whole population [5]. Countries where the most disadvantaged population groups comprise the majority exhibit the largest equity gaps, sowing doubts about policy approaches based on incremental universalization and privilege out of choice [17]. Further features of countries with large equity gaps include underequipped health facilities, inadequate packaging of maternal and child health products, limited service availability and poor affordability of transport systems [12]. Some transitions can widen gaps while dead ends can contain them [19]. For example, Bolivia, Senegal, and South Sudan achieved temporary large declines in maternal health inequity aligned to widespread strategic sectorial investments. In contrast, El Salvador and Mongolia achieved large increases in the family planning equity gap after sectorial investments that privileged service supply rather than equity per se [13].

Quality of Care and Health System Performance

Key components of health system performance encompass clinical effectiveness and patient safety [3]. Clinical effectiveness relates to achieving the desired health outcomes for patients according to evidence-based, clinical guidelines delivered through appropriate settings [13]. An effective health system enables timely patient care, optimizes the number of health interventions that address the prevalent disease burden, and utilizes sophisticated and new technologies at a level consistent with evidence-based global norms [28]. Patient safety refers to avoiding inadvertent or preventable harm to patients associated with health care services [26]. Moreover, health system performance is tracked through intermediate measures of performance, such as for workforce, facility readiness, and governance [5].

Clinical Effectiveness and Patient Safety

Universal health coverage (UHC) seeks to ensure the provision of quality healthcare services to the entire population so as to measurably enhance health outcomes while simultaneously contributing to the sustainability of health systems [15]. The quality of healthcare is itself a multidimensional concept encompassing clinical effectiveness, patient safety, and patient-centeredness [2]. Clinical effectiveness denotes the extent to which healthcare activities achieve desirable health outcomes as specified in international clinical practice guidelines [3]. Such guidelines, which are typically developed by international medical associations, offer authoritative recommendations according to the best scientific evidence available and reflect international consensus regarding the expected treatment pathway [28]. Patient safety addresses the risk of adverse events and avoidable harm arising from the provision of care [18]. Such events often reflect deficiencies in broad aspects of health system performance, ranging from technical issues, such as inadequate training, supervision, and infrastructure, to the functioning of supply chains vital for sustaining the treatment continuum [17]. Notably, monitoring systems are costly to establish and frequently lack coverage across countries and regions. Consequently, prioritisation of the measurement of clinical effectiveness is common, and the relevant data are typically easier to obtain and cover a wider geographical spectrum [16]. Nevertheless, enhancing both dimensions is crucial to achieve the desired rise in overall health performance [5].

Facility Readiness and Workforce Capacity

Universal Health Coverage (UHC) is defined as ensuring that all people obtain the health services they need without facing financial hardship when paying for them [24]. Therefore, UHC has three related dimensions: the population coverage of the services, the extent of services covered, and the proportion of out-of-pocket expenses in total health expenditure [12]. The purpose of this narrative review is to map progress towards UHC globally and by region and income group [23]. The review covers major eras, agreements, and policy shifts in UHC since the establishment of the World Health Organization in 1948; international commitment to Universal Health Coverage at the 2012 United Nations General Assembly High-Level Meeting; the 2014 World Health Assembly resolution on the 2030 Agenda for Sustainable Development; the establishment of UHC2030; and endorsement of ten global health targets for UHC, coordinated by WHO with bilateral and multilateral partners at the World Health Assembly in 2018 [16]. These milestones illustrate the evolving convergence of UHC concerns and the role of international guidance in shaping the financing and governance policy constellations that facilitate progress [25].

Governance, Accountability, and Monitoring

Governance, accountability, and monitoring are core components of universally accepted principles that reflect and support the end-goals and content of internationally agreed development agendas such as the Sustainable Development Goals (SDGs) [26]. Health service delivery is a multidimensional process closely related to governance, health system performance, transparency, accountability, and health sector integrity. Universal Health Coverage (UHC) and sustained national health services must be monitored, and sustained national health policy directions must be maintained, to ensure progress on the global agenda is attained [3]. A comprehensive assessment of governance and policies, both in general and in the health sector, in relation to UHC, enables a preliminary evaluation of linkages between UHC and health system performance that can guide the choice of UHC indicators and analytical approaches [17]. Considerations of governance and health system performance therefore assist in the selection of methodologies adopted. National health policies and strategies form a conducive health policy framework that promotes policy coherence between the health sector and other sectors in development, thereby reinforcing partnerships [26].

Policy Coherence and Multi-Sectorial Action

Across the UHC movement, key actors, frameworks, and guidance instruments shape directions, milestones, and progress assessments [3]. Countries pursue objectives defined in different guidance instruments [2]. The WHO monitors UHC systematically since 2010 and countries report on UHC indicators every two years [3]. National UHC targets and associated plans inform the global agenda, and WHO tracks their implementation [19]. Official guidance and monitoring help to align country decisions with internationally accepted approaches [12]. Clear frameworks on public financing for health, service delivery models, and operational arrangements assist in understanding countries' UHC strategies [23]. Tracking the UHC agenda facilitates the delineation of financing, service delivery, and governance options as countries move from the pre-coverage toward UHC, a key transition affecting the interpretation of the governance, financing, and accountability sections [24].

Transparency, data, and monitoring frameworks

Measuring trends and monitoring progress towards UHC and equity requires transparent data and the establishment of sound monitoring frameworks [26]. Such frameworks have been developed within and outside

the context of UHC by various international organisations, including the WHO and the World Bank [26]. They are instrumental for tracking coverage at both national and global levels, ensuring that policies and investments deliver the intended benefits and support equitable access to essential services [3]. Monitoring frameworks, assessments, and reports provide guidance and structure for documenting progress on UHC nationally and internationally [28]. Countries have been assessed for their UHC advancements sometimes coupled with analysis of the health sector more widely through several systematic reviews and technical studies, which identify barriers and enablers to their endeavour for UHC [6]. Global indicator frameworks facilitating the monitoring of UHC and other international priorities have also been developed, including the 2030 Agenda and the SDGs. Further information on these monitoring frameworks and national assessment activities is provided in the analysis of measurement challenges [25]. Country and global progress towards UHC is generally assessed using six core indicators on service coverage based on national health accounts, enabling comment on trends in financial protection and the distribution of values across different population groups [23]. A country is considered to have made significant progress toward UHC if five core indicators pertaining to service coverage and financial protection have been systematically reported across three or more comparable rounds of national health accounts data. Comprehensive reporting across additional supplementary indicators further strengthens the assessment of country progress [17].

Special Populations and Equity Considerations

Universal health coverage (UHC) seeks to ensure equality in access to high-quality care [3]. Consequently, UHC must consider vulnerable groups, marginalized communities, and urban-rural disparities; the need for disaggregation motivates a social protection and risk approach [3]. Vulnerable groups such as the chronically ill, elderly, persons with disabilities, migrants, refugees, indigenous peoples, and those engaged in informal employment, often lack UHC coverage. Marginalized populations, including migrant workers, drug users, sex workers, the detained, and those whose sexuality contravenes social norms, face additional barriers to attaining health rights [8]. The non-poor excluded from coverage tend to be elderly, chronically ill, or disabled, while out-of-pocket payers face substantial impoverishing expenditure [5]. UHC must likewise target people in the informal sector to remove barriers to receiving adequate health services. Geographic inequities arise in the coverage and provision of health services, notably between urban and rural settings [7]. Rural populations frequently endure longer distances to health facilities, limited transport options, lower facility density, and supply chain challenges. Conversely, urban inhabitants often encounter overcrowded facilities. Such imbalances remain unaccounted for in many UHC assessments that overlook urban-rural differentiation or consider the two as separate sectors [9].

Vulnerable Groups and Marginalized Communities

Social groups in vulnerable positions like older persons, those with chronic diseases, people living with disabilities, internally displaced persons (IDPs), and members of ethnic minorities are often more exposed to health system exclusion than the general population and face greater risks of having their fundamental right to health realized [18]. They experience heightened barriers when accessing health-related services and goods despite efforts to address the social determinants of health [20]. Vulnerability derives from the overarching patterns of social exclusion that deny individuals and groups essential liberties. Social exclusion fosters vulnerability and restricts the freedoms and well-being of affected populations [17]. Meanwhile, individuals and groups can be socially excluded for a variety of reasons, including disabilities, displacement status, marital status, skin color or ethnicity, child age, sex, or disfigurement [15]. Social protection thus emerges as a core instrument for UHC expansion; its implementation is more effective when embedded within other public policies that address the social determinants of health [21].

Urban-Rural Disparities and Geographic Access

Disparities in access to healthcare constitute a fundamental barrier to achieving UHC [27]. Access to health services is determined not only by the presence of facilities but also by factors such as transport infrastructure, geographical distance, socioeconomic determinants of demand, and outpatient service availability [26]. UHC monitoring in several countries indicates that proximity to healthcare facilities has less impact on utilization where transport networks are strong, health needs are low, and facilities offer integrated, affordable outpatient services [22, 23]. Urban-rural disparities in geographic access rise in significance as the policy focus shifts from coverage breadth to service integration and quality [19]. In many countries, rural populations constitute the largest and most vulnerable group lacking full coverage. Urbanization extends the urban-rural dichotomy in certain contexts [13].

Sustainability, Resilience, and Crisis Contexts

Universal health coverage (UHC) is essential during various crises, including pandemics, shocks, and climate-related events. UHC strengthens system resilience by ensuring equity, access, quality, and financial protection [3]. Countries must adopt appropriate policy measures to achieve sustainability and resilience [6]. Monitoring frameworks for UHC survival are well established at global, regional, and national levels, facilitating assessment of trends and impacts on equity [7]. Attention should focus on strengthening system resilience and addressing policy measures to enhance performance. Attention to UHC remains critical during pandemics and other shocks. Health systems must sustain delivery and prioritise essential, preventive, and curative services [16]. System resilience, determined by capacity to respond to shocks while maintaining essential service delivery, depends on emergency financing mechanisms, surge capacity, and ability to continue prioritised services. A financing continuum highlights the importance of long-term planning beyond crisis- and post-crisis periods. Climate change poses profound, long-term threats, making UHC commitment imperative [14]. Growth and development increase exposure to climate-related events [25]. Nations must build capacity, promote equity, and mitigate environmental impacts through health-oriented climate strategies. Strengthening systems likely requires up-front investment beyond difficult-to-reverse recovery [14].

UHC in the Context of Pandemics and Shocks

Financing and service delivery capacity to maintain provision, scaling up outreach and alternative modalities, and protecting core services [27]. Structural, functional, and organizational dimensions of resilience emphasize diverse capacities, redundancy and flexibility across the system, preemptive adaptability, wide accessibility, and continuing response to long-term trends [28]. Governance ensures integrated approaches, coordination across institutional domains, engagement of all stakeholders, inclusion of vulnerable groups, and effective communication of information and guidance [3].

Climate Change and Health System Resilience

Climate change adaptation and mitigation offer a vital opportunity to strengthen long-term health system resilience, including water and sanitation services [24]. Health system resilience refers to the capacity of health systems to absorb stresses, adapt to changing conditions, and recover from shocks. Strengthening resilience includes preparatory measures, building flexibility into existing structures and practices, and investing in long-term adaptation and system strengthening for the future [25]. Financing mechanisms that favor a collaborative health workforce; strategy-specific, multisectoral action; and the inclusion of health in the climate change agenda can further contribute to health system resilience [23]. All systems experience crises, shocks, and exogenous stressors; health systems are no exception. Analysis of how the Health Systems Strengthening and Universal Health Coverage agendas responded in the aftermath of the 2008 global financial crisis points to a number of potentially useful policy options [21]. These include: emergency health financing plans to assure the survival of system-building initiatives; maximization of existing system response capacity for continued delivery of essential health services; and the establishment of provisions and devices to protect the continued functioning of health systems [20].

Case Studies and Comparative Insights

Countries at various income levels have pursued universal health coverage (UHC) from diverse starting points. Nordic and high-income countries have strongly emphasized universal entitlement, high-quality nationwide health services, and a health systems approach that integrates governance, financing, and service delivery [8]. In middle-income countries, UHC has often evolved within a framework of broader social protection and equity concerns; UHC-related strategies typically involve multiple financing mechanisms, public and private provision, and complex policy interactions [3]. Low-income countries are increasingly advancing UHC in the face of challenging political, governance, and institutional contexts. Progress is commonly associated with the introduction of broad-sector reforms aimed at enhancing financial risk protection and closure of large health financing gaps. High-income and Nordic countries share extensive experience in universal coverage and robust health. Despite UHC-related legislation, some income countries still exhibit high inequality in health access and outcomes. A clear design framework facilitates multi-aspect evaluation of UHC-level indicators across financing mechanisms and health service systems [21]. Universal coverage encompasses four critical aspects security, accessibility, quality, and uniform equality whole-system indicators thereby link easily with four-sector statistics [25]. Priority indicators illustrate targeted economy role, financial mechanism, stake patterned coverage, continuous integration of whole-sector, and surplus supply disparity [26].

Nordic and High-Income Country Experiences

Nordic and other high-income countries illustrate how universal health coverage (UHC) can be achieved and sustained [13]. Many adopted UHC early compared to other nations [25]. Although the political, economic, and epidemiological contexts differ widely, these countries share features that enable UHC: broad political consensus on the importance of equitable health care; commitment across the political spectrum to a model based on public financing through general taxation; and responsive service delivery models tailored to specific population needs and preferences [12]. The Nordic UHC experience underscores the importance of free, comprehensive provision informed by population need and delivered by a well-trained public workforce for health system performance beyond population coverage alone [15]. The Nordic countries progressed to achieve UHC around the 1950s, relying on input-based monitoring through legislation and regulations built on broad-coverage agreements between health authorities and the care delivery system [23]. Policy adjustments enacted since then include establishing guidelines such as patient access rights, quality assurance, and service evaluations to complement management autonomy [23]. Progress was supported by high levels of service integration and broad public input within a largely public-supply model [21]. In other high-income countries, UHC was introduced across a broad range of covered services, enhancing system sustainability and mitigating potential inequality. Furthermore, many implemented continuous data collection from population coverage and dependence on service supply for flexible, evidence-based system development [26, 27, 28].

Middle-Income Country Pathways

Ensuring population-wide access to quality health services while protecting against financial hardship is a core tenet of universal health coverage (UHC) [24]. Two immediate challenges facing middle-income countries seeking overarching, inclusive systems are the breadth of coverage (who is reached) and the depth of benefits (the extent of reliance on out-of-pocket spending versus pooled sources), with the framing of policies reflecting these concerns showing marked and previously illustrated regional differences [27]. A refined selection of UHC aspects for engagement is visualized in an illustrative “UHC prism” model below; attention is drawn to schemes in recent journey tracking and ongoing health coverage-related shapes in the discussion on levels attained [23]. Among the ten countries maintaining relatively broad UHC (over several decades, with service sovereignty mainly held at subnational scales), the commonalities identified are also summarized as follows. Service coverage is set to reflect stipulations associated with pooled share levels instead of sought extent per se [13]. Equitable progression into new policy realms and alternative coverage instruments, without diminishing earned elasticity within classical domains, is considered critical for protecting the commitment to universalisation; intentionally operating on the boundary is an established, value-based approach [26].

Low-Income Country Progress and Challenges

Progress toward universal health coverage (UHC) in low-income countries has typically occurred through gradual step-wise advancements frequently interrupted by reversals, setbacks, and regressions [26]. Although de jure coverage the legal entitlements recognized in law, constitutions, or formal social insurance programs, has increased markedly in recent decades as a consequence of a variety of reforms, actual de facto financial protection remains lower, with out-of-pocket expenditures still substantial [24]. Similarly, no country worldwide has achieved complete de facto coverage, even those that have enacted comprehensive reforms on paper; such countries typically experience progressively slower progress as they approach higher coverage levels, rendering the final stages more challenging [25-30]. Cross-country comparisons since 2000 reveal meaningful coverage improvements, albeit substantially below UHC aspirations. Preliminary investigations of Reina et al. (2021) corroborate this finding by highlighting markedly slower UHC advancement in low-income nations relative to the faster progress reported for middle-income countries. The international UHC movement has intensified along with the emergence of the Sustainable Development Goals (SDGs) [5]. Beginning in 2015, various international agencies, sovereign governments, and donor institutions articulated strong, multifaceted support for UHC as a global priority [27]. Concurrently, a growing body of knowledge has provided diverse perspectives on the effective design and implementation of UHC initiatives across countries at different stages of economic and social development [27]. While pertinent to all countries, low-income nations face distinct challenges and opportunities. De jure coverage has progressed considerably since the 1990s; nonetheless, low-income countries remain at risk of plateauing shortly after reaching the threshold of written entitlements because many still lack proportionate, coherent structural financing mechanisms [31-35].

CONCLUSION

Universal Health Coverage remains central to the global health agenda as both a developmental goal and a human right. The evidence reviewed underscores that while most nations have made measurable progress, significant disparities persist across regions and income levels. Rural populations continue to face substantial barriers in accessing healthcare due to infrastructural, financial, and systemic inequalities. Urban–rural divides, if unaddressed, risk undermining the inclusiveness and sustainability of UHC. The COVID-19 pandemic and other crises have revealed both the fragility and adaptive potential of health systems. Building resilience through robust governance diversified financing mechanisms, emergency preparedness, and equitable service delivery is essential for maintaining continuity of care during shocks. Climate change introduces additional pressures, threatening health security and demanding integration of health into national adaptation and mitigation strategies. Sustainable UHC must therefore embed climate resilience, ensuring that health systems can anticipate, absorb, and recover from environmental and economic disruptions. Comparative insights illustrate that high-income and Nordic countries succeeded in embedding equity through universal public financing and integrated governance. Middle-income nations are progressing through hybrid systems that blend social insurance and targeted subsidies, while low-income countries face persistent fiscal and institutional barriers that slow progress despite strong policy commitments. To achieve UHC globally, countries must go beyond expanding service coverage to ensure financial protection, equity, and quality of care. This requires coordinated multisectoral approaches, transparent monitoring frameworks, and sustained political will. Ultimately, the realization of UHC depends on creating resilient, inclusive, and sustainable health systems capable of delivering essential services to all regardless of geography, income, or circumstance.

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