Tracking universal health coverage

2025 global monitoring report

World Health Organization

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Foreword

Universal health coverage (UHC) is central to building more resilient, equitable, and prosperous societies. The promise of UHC is improved health outcomes, greater human capital accumulation, and protection from financial hardship due to the need to seek health care. But health care also creates jobs and drives inclusive development. Healthy people are better equipped to seize opportunities and fuel economic expansion. We can make real progress that improves health, transforms lives, and builds stronger economies.

But we need to invest much more in health and accelerate progress if we want to turn the vision of universal health coverage into reality—one where everyone, everywhere, can access the care they need without financial hardship.

The latest data confirm both the progress made and the scale of the challenge ahead. A decade after the world committed to achieving UHC by 2030 under the Sustainable Development Goals, this Global Monitoring Report offers the most comprehensive assessment of where we stand today—and what must change to accelerate progress.

Global progress has been made in expanding access to essential health services and reducing the financial hardship caused by health costs. Yet progress has been uneven and, amid a global polycrisis, has slowed in recent years. As of 2023, an estimated 4.6 billion people still lacked coverage for essential health services, and in 2022, 2.1 billion people experienced financial hardship due to out-of-pocket health spending.

Progress in controlling infectious diseases stands in contrast to slower gains in other areas of health. Financial hardship continues to fall disproportionately on the poorest and most vulnerable, with 1.6 billion people pushed into or deeper into poverty in 2022 because of out-of-pocket health spending. Socio-demographic factors—including where people live, household composition, sex, and age—further compound these inequities.

The way forward is clear. Adequate public funding must underpin health coverage—especially for the poor—through essential benefit packages with zero or minimal cost-sharing. Strengthening health services across the life course and engaging the private sector strategically can accelerate equitable progress. Reducing high spending on medicines—the largest driver of out-of-pocket costs—alongside promoting cost-effective care, efficient resource use, and stronger public health functions will be critical.

Achieving this demands sustained political commitment, smarter investments, and an unwavering focus on those most at risk.

With only five years left until 2030, this report highlights both the progress achieved and the urgency to act. What is needed now is leadership—to transform commitment into action and make health for all a lived reality.

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Abbreviations

DHS	demographic and health survey
DTP3	diphtheria, tetanus toxoid and pertussis vaccine (3 doses)
EHIS	European Health Interview Survey
EU-SILC	European Statistics of Income and Living Conditions survey
HIC	high-income country
IAEG	Inter-Agency and Expert Group
IHR	International Health Regulations
ITN	insecticide-treated net
LIC	low-income country
LMIC	lower-middle-income country
MIC	middle-income country
NCD	noncommunicable disease
OOP	out-of-pocket
PHC	primary health care
RMNCH	reproductive, maternal, newborn, and child health
SCI	service coverage index
SDG	Sustainable Development Goal
SPL	societal poverty line
UHC	universal health coverage
UMIC	upper-middle-income country
UNDESA	United Nations Department of Economic and Social Affairs
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Glossary of key terms

This glossary includes technical definitions, when available, and terminology used in the report. Rather than being presented in alphabetical order, terms are grouped conceptually under the two Sustainable Development Goals (SDG) indicators of universal health coverage (UHC).

Universal health coverage (UHC) means that all people receive the health services they need without facing financial hardship *(1)*.

Related to the service coverage dimension of UHC:

- **Health services**: Any good or service delivered in the health system within the full continuum from health promotion to prevention, treatment, rehabilitation and palliative care across the life course *(2)*.
- **Essential health services:** Health services that all countries, regardless of their demographic, epidemiological or economic profile, are expected to provide. For global service coverage monitoring, this includes essential services based on selected tracer interventions that span reproductive, maternal, newborn and child health (RMNCH), infectious diseases, noncommunicable diseases (NCDs), and service capacity and access, among the general and the most disadvantaged populations *(3,4)*.
- **Effective coverage**: The proportion of people in need of health services who receive services of sufficient quality to obtain potential health gains *(4,5)*.
- **SDG indicator 3.8.1 – Service coverage index (SCI)**: Corresponds to the population-weighted geometric means of selected essential services spanning four health domains: RMNCH, infectious diseases, NCDs, and service capacity and access. As an index score, the SCI cannot be directly interpreted as the percentage of the population covered by a set of essential services *(3)*.
- **Forgone care:** Forgoing services occurs when people recognize a health need but cannot access care, medicines or other products due to barriers at any point in the care pathway. It is distinct from unmet need, which can exist without awareness of the need. Surveys typically capture forgone care by asking about recent situations where needed treatment was not received and the reasons why *(6)*.
- **Unmet need for health care**: Unmet health care need ranges from unexpressed demand, where people do not seek care, to expressed demand that is inadequately met due to ineligibility or poor-quality treatment. Some individuals experience both *(6)*.

Related to the financial hardship dimension of UHC:

- **Out-of-pocket (OOP) health spending** is voluntary, paid at point of care without risk pooling. In effect, it is what people pay directly from their own income, savings or loans when using health services or buying health products, excluding anything covered by insurance, taxes or reimbursements. It includes costs such as medicines, doctor visits, hospital care and diagnostics. It does not include indirect costs such as transportation, nor the opportunity cost of seeking health care (e.g. lost income) or non-medical expenses such as gym memberships or nutritional supplements.
- **Financial hardship in health** occurs when OOP health spending reduces people's ability to meet basic needs or substantially reduces their ability to afford other goods and services. SDG indicator 3.8.2 is used for global tracking of financial hardship in health.
- **Financial hardship due to OOP health spending:** see financial hardship in health definition. Both terms are used interchangeably.
- **Financial protection in health** refers to the absence of financial barriers to accessing needed care and lack of financial hardship due to out-of-pocket health spending. Global monitoring using SDG indicator 3.8.2 (original or revised) does not capture financial barriers to access *(7)*.
- **Basic needs**: Reflect sufficient consumption to meet a minimum energy requirement based on food consumption patterns within each country plus a small allowance for non-food expenditures *(8)*. Poverty lines can represent the cost of meeting basic needs *(9)*.
- **Societal poverty line (SPL)** is a hybrid poverty line that combines an absolute level of need (the intercept) with a relative component that rises gradually in line with consumption or income levels (the gradient) *(8)*. The SPL allows for the poverty threshold to vary across countries, essentially allowing for the cost of meeting basic needs to increase with the economic development of societies. This results in a definition of poverty that is more closely aligned with each country's own assessment of basic needs. As a result, the SPL can be used as a single practical definition of basic needs across countries. It is more easily referred to for a cross-country comparison exercise, compared to using different absolute or relative poverty-line definitions depending on the countries' level of economic development. Other regional and national methods to define household discretionary budget (defined below) and methods to estimate basic needs exist and are relevant to contextualize findings. For SDG indicator 3.8.2, the SPL is defined in 2017 purchasing power parities and corresponds to whichever is greater: US$ 2.15 (the international absolute poverty line) or US$ 1.15 + 50% of median household consumption expenditure or income net of OOP health spending. The 2021 purchasing power parities will be applied in the 2027 UHC monitoring report *(10)*.
- **Discretionary budget**: Total consumption expenditure or income net of the cost of basic needs. People living in poverty have negative discretionary budgets, as their level of consumption expenditure or income is below what is required to meet basic needs. For global monitoring of financial hardship due to out-of-pocket health spending, the revised SDG indicator 3.8.2 relies on the SPL as a measure of the cost of basic needs.
- **Revised SDG 3.8.2 – Financial hardship indicator (discretionary budget approach):** Proportion of the population with positive out-of-pocket household expenditure on health exceeding 40% of household discretionary budget. The financial hardship indicator can be decomposed into the proportion of the population with impoverishing OOP health spending and the proportion with OOP health spending that is large but non-impoverishing (defined below).

- **Impoverishing OOP health spending** reduces people's ability to meet basic needs. Therefore, it classifies any spending by people who cannot afford basic needs as a source of financial hardship. In technical terms, impoverishing OOP health spending is OOP health spending that exceeds 100% of discretionary budget, or spending that leaves people with no discretionary budget once OOP is subtracted from their total budget. The population incurring impoverishing health spending can be divided into two mutually exclusive groups of those further impoverished by OOP health spending and those pushed into poverty (defined below).
- **Large OOP health spending** does not impact ability to meet basic needs but substantially reduces people's ability to consume other goods and services. Under the revised SDG 3.8.2 indicator, this refers to the share of the population whose OOP health spending exceeds 40% but remains below 100% of their discretionary budget.
- **Further impoverished by OOP health spending:** People who are further impoverished are people who would be poor regardless of whether they incur OOP health spending, yet such spending further reduces their ability to meet basic needs. Under the revised SDG 3.8.2 indicator, the proportion further impoverished corresponds to those who live below the societal poverty line and incur *any* OOP health spending, as a share of the total population. These are people with negative discretionary budgets, and therefore any positive OOP health spending is above 40% of the discretionary budget.
- **Pushed into poverty by OOP health spending**: Under the revised SDG 3.8.2 indicator, the proportion pushed into poverty corresponds to the share of the total population who do not live in societal poverty, based on their total consumption (or income), but whose consumption (or income) falls below the SPL when net of OOP health spending. In other words, these are people living in households that have positive discretionary budgets and spend all of their discretionary budget on OOP health spending.
- **Original SDG 3.8.2 – Catastrophic out-of-pocket health spending indicator (budget share approach)**: Proportion of the population with OOP health spending exceeding 10% and 25% of household total budget (consumption expenditure or income) *(11).*

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Executive Summary

Universal health coverage (UHC) means that all people can receive the quality health services they need without incurring financial hardship. In 2015, United Nations Member States recognized its importance and committed to reach UHC by 2030 in the context of the Sustainable Development Goals (SDGs).

Tracking progress towards UHC demands attention to both dimensions, since expanding coverage and reducing financial hardship simultaneously is a complex challenge. Policy-makers must often make difficult choices about which populations and services to prioritize, and how much cost-sharing (fees) to introduce.

The SDG global monitoring framework adopted two relevant indicators (SDG indicators 3.8.1 and 3.8.2) in 2015. In 2025, the United Nations Statistical Commission approved proposals for revisions of the SDG UHC indicators, made jointly by the World Health Organization and the World Bank, as part of a comprehensive review of all SDG indicators. The revised global UHC monitoring framework uses the following two indicators:

1. **SDG indicator 3.8.1 is the UHC service coverage index,** a composite index with a score from 0 to 100, composed of 14 tracer indicators in the four broad health domains of reproductive, maternal, newborn and child health (RMNCH); infectious diseases; noncommunicable diseases; and service capacity and access.

2. **SDG indicator 3.8.2 tracks the proportion of the population facing financial hardship in health,** reflecting out-of-pocket (OOP) health spending that reduces households' ability to meet basic needs (impoverishing OOP) or that substantially reduces ability to consume other goods and services (large OOP).[1]

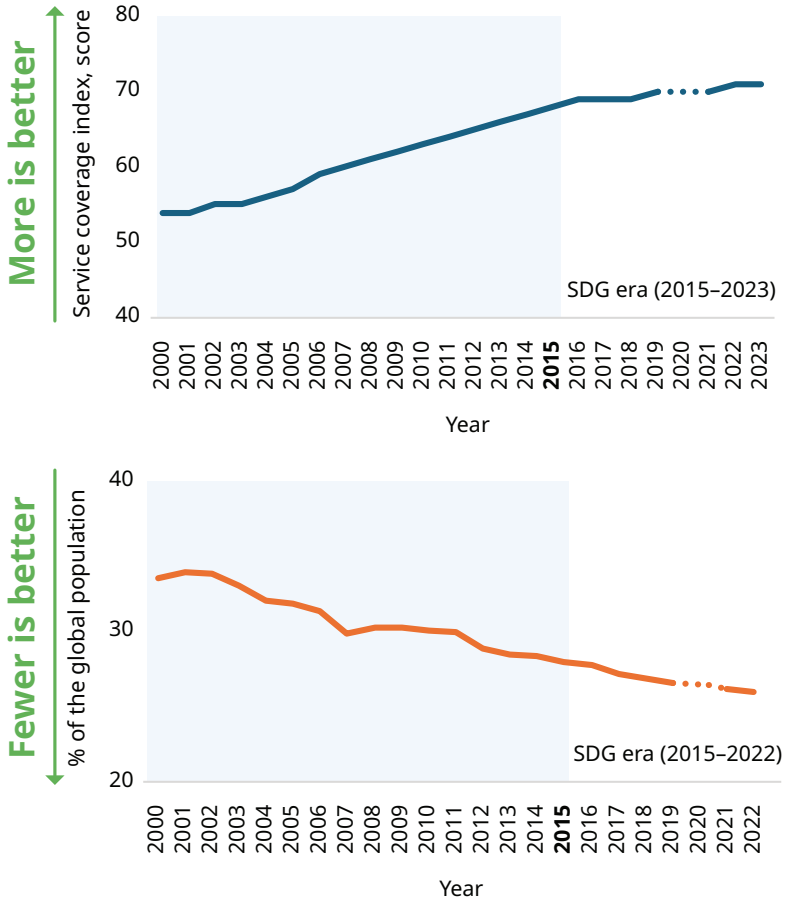
This *Global monitoring report 2025* marks the first round of UHC tracking to use these updated metrics, with reproduction of all country, regional and global results since 2000.

[1] The technical definition of the revised SDG indicator 3.8.2 is "the proportion of the population with positive out-of-pocket household expenditure on health exceeding 40% of household discretionary budget (budget net of the cost of basic needs)". The budget corresponds to the total consumption or income and the cost of basic needs is measured with the societal poverty line.

Slow global progress towards UHC

Since 2000, the world has advanced on both pillars of UHC, expanding health service coverage and reducing financial hardship. The global UHC service coverage index (SCI) rose from 54 index points in 2000 to 71 in 2023. The share of the global population incurring financial hardship due to OOP health spending fell from 34% in 2000 to 26% in 2022 (Fig. 1).[2]

Fig. 1. Global trends in UHC service coverage index (top) and financial hardship (bottom), 2000–2022/2023



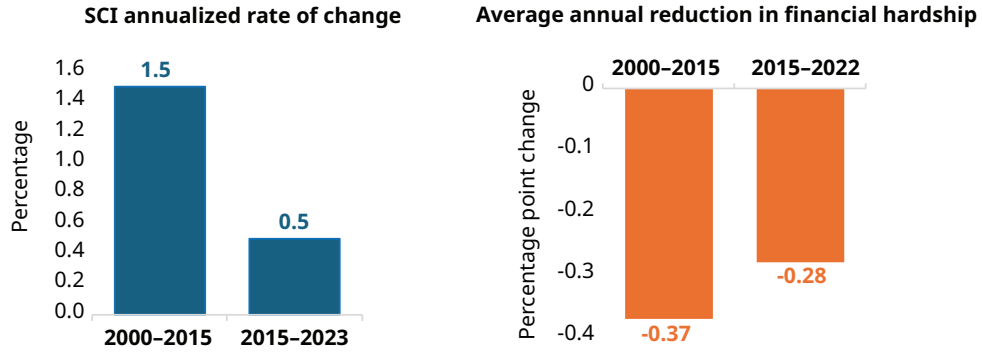
Note: The peak years of disruption caused by the COVID-19 pandemic are depicted in dotted lines because data from this period do not account for the pandemic's full impact.

Source: SDG indicator 3.8.1 and 3.8.2 (2025 definitions), Global service coverage and financial hardship databases assembled by WHO and the World Bank, 2025 update.

[2] Previous trends compared to the revision are discussed later in this summary as well as section 1.6.

During the SDGs era, global progress towards UHC has slowed, highlighting the need for renewed efforts to accelerate gains. Global progress in health service coverage dropped to one-third the annualized rate of the 2000–2015 period, while annual reductions in financial hardship were 23% slower than before 2015 (Fig. 2). Midway through the SDG era, 4.6 billion people worldwide still lacked access to essential health services in 2023, and 2.1 billion faced financial hardship in health in 2022.

Fig. 2. Global annual rates of progress, 2000–2015 and 2015–2022/2023

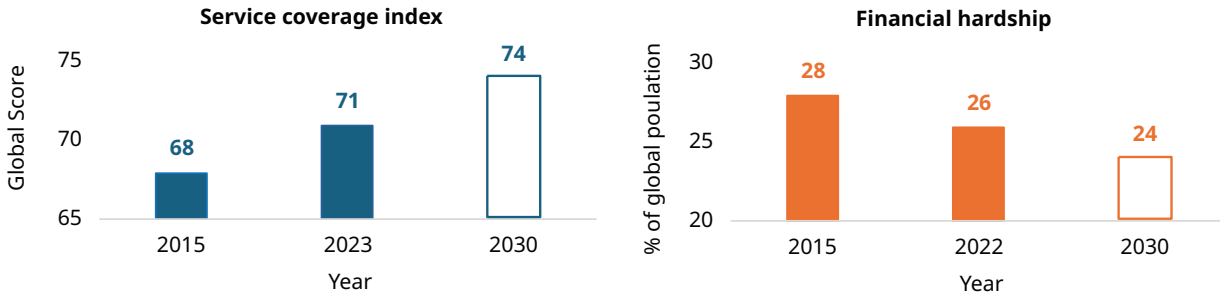


Notes: Authors computations. SCI, service coverage index.

Source: SDG indicator 3.8.1 and 3.8.2 (2025 definitions), Global service coverage and financial hardship databases assembled by WHO and the World Bank, 2025 update.

At the current pace of progress, the world is not on track to achieve UHC. The global UHC service coverage index will remain below 80, and close to 1 in 4 people globally will continue to face health-related financial hardship in 2030, the endpoint of the SDGs (Fig. 3).

Fig. 3. Global estimates and projected values of UHC pillars to 2030



Notes: Authors computations assuming SDG era pace of progress between 2015–2022 or 2015–2023 continues.

Source: SDG indicator 3.8.1 and 3.8.2 (2025 definitions), Global service coverage and financial hardship databases assembled by WHO and the World Bank, 2025 update.

The slowing momentum is also reflected in country-level data, with fewer countries making simultaneous progress on both UHC dimensions. While 53% of countries progressed in both UHC pillars between 2000 and 2022/2023, this share fell to 38% during the SDG period (2015–2022/2023).

Most country income groups and all regions registered gains in the SDG era. All country income groups except high-income countries made progress in service coverage and reduced financial hardship between 2015 and 2022/2023. Results in high-income countries have been largely static in the SDG period, but their levels were already relatively high. As a group, low-income countries posted the fastest gains, although they still have the largest gaps to close. All WHO regions saw progress in service coverage, while half (Africa, South-East Asia, and the Western Pacific) also reduced financial hardship.

Progress in service coverage has been uneven

Infectious disease indicators have powered the global rise in service coverage since 2000, while gains in noncommunicable diseases (NCDs) were slower. The infectious diseases sub-index accounted for 52% of change in the global service coverage index between 2000 and 2023. The deceleration of progress is due to stagnation in the RMNCH and service capacity and access sub-indices. NCDs sub-index scores rose globally and across WHO regions, but NCDs finished the period with the lowest score among the four coverage sub-indices.

Service coverage gaps between countries are narrowing. Progress has been fastest in countries that were initially lagging, and the number of countries with low or very low coverage (coverage index <40) decreased from 55 in 2000 to only 8 in 2023. Globally, the UHC service coverage index and its sub-indices saw decreasing between-country inequality, with index values converging towards higher levels.

Within-country inequalities in access to care and unmet need persist. Evidence from a subset of low- and middle -income countries suggest notable within-country inequalities in accessing health services. Within countries, women living in poverty, in rural areas and less educated ones report more difficulties in accessing care, and the gap between women in the richest versus lowest fifth of the population has narrowed little in the past decade (about 5 percentage points). Even within countries in the European region, which has among the highest UHC results, population sub-groups – such as the disabled or poorest – still report higher unmet needs.

Global poverty reduction drove progress on financial hardship in health

The downward trend in financial hardship results from a declining share of the population facing impoverishing OOP health spending since 2000.[3] The rate of impoverishing OOP health spending – meaning either being pushed into poverty or further impoverished due to OOP health care payments – reduced from 29% in 2000 to 20% in 2022, corresponding to 1.6 billion people facing impoverishing OOP health spending in that year. At any point in time, most people experiencing financial hardship in health are incurring impoverishing OOP health spending.

[3] The rates of impoverishing OOP health spending are different from the World Bank estimates of the number of people pushed into or lifted out of poverty. Impoverishing OOP health spending captures both those who are pushed into poverty as well as those that are further impoverished by OOP health spending. It is also not a calculation of the change in poverty rates from one year to another but rather an assessment of the extent to which OOP health spending is impoverishing within a given year.

Fewer people live in poverty, but a higher *proportion* of the poor is further impoverished by OOP health spending. Global poverty rates declined since 2000 from 43% to 25%,[4] reducing the total number of people at risk of being further impoverished by OOP health spending. Over the same period, the proportion of those living in poverty who spend OOP on health has increased from 64% to 76%. This suggests that the decline in impoverishing OOP health spending was driven by global poverty reduction rather than by health systems' ability to provide better financial protection to the poor.

Financial hardship in health also affects a smaller but growing proportion of the non-poor worldwide, who face disproportionately large OOP health spending. Such spending represents more than 40% of the household's discretionary budget (budget net of the cost of basic needs) and thus means a substantial reduction in living standards. The rate of the population with large but non-impoverishing OOP health spending increased from 5% in 2000, representing almost 290 million people, to 6% in 2022, representing almost 450 million people. This trend is concentrated in middle-income countries, where service coverage expansion is often achieved with reliance on OOP spending.

Experience of financial hardship in health also varies with demographic factors. Analysis of primary data from a large set of countries shows that rural populations experience a 13.7% higher median rate of financial hardship than do urban populations. People living in multigenerational households face higher rates of impoverishing OOP health spending relative to those in households with other demographic compositions, while adults over 60 face higher rates of large health spending.

Spending on medicines accounts for more than a half of people's OOP health spending in most countries. Across countries, the typical share of OOP health spending devoted to medicines is 56%. The share is even higher, around 60% – among the poorest fifth of the population.

Implications of indicator revision for global trends

The revised service coverage index shows a trend similar to that presented in the previous edition of the report with the original indicator. Relative to the original index, the revision updated the definitions of 3 out of the 14 tracers by replacing a proxy indicator with a newly available coverage measure and aligning two indicators with other SDG indicators. It also introduced a new weighting of the service coverage indicators to better reflect the population affected by each indicator. The revision did not alter the high-level global trend, which shows that most of the increase in the service coverage index occurred from 2000 to 2015, followed by a slowdown during the SDG era.

The trends in the original and the revised SDG indicator 3.8.2 are not directly comparable. The original indicator measured the incidence of catastrophic OOP health spending, defined as OOP health spending exceeding 10% and 25% of the household total budget, and presented a continuous deterioration in this partial measure of financial hardship. The revised indicator now measures both impoverishing and large OOP health spending.[5] Impoverishing OOP health spending classifies *any* spending by people who cannot meet basic needs as financial hardship. The reduction in the revised indicator is driven by a reduction in its impoverishing OOP component. The large OOP component of the revised indicator reflects a deterioration, which is aligned with that of the original SDG indicator 3.8.2.

[4] As measured by the societal poverty line.

[5] This is achieved by considering OOP health spending in relation to the discretionary household budget rather than the total budget.

Policy implications: protect progress, accelerate change

The trends described above highlight specific gaps and challenges for accelerating UHC progress, which translate into the following high-level policy directions relevant for many countries but requiring discussion and adaptation to each country's context:

- **Ensure essential health care is free at the point of access for the poor** to reduce the growing share of people living in poverty who spend on health.
- **Strengthen publicly funded compulsory prepaid coverage** to accelerate the reduction in financial hardship among the whole population and reduce the rate of large OOP.
- **Address high OOP health spending on medicines,** which absorbs on average 56% of OOP spending health spending in most countries.
- **Accelerate expansion of essential NCD services** as the NCDs sub-index has the lowest score while burden of NCDs is rising, a trend that does not only increase the health needs of the population but also puts financial strain on people who have to pay OOP for chronic care.
- **Strengthen primary health care**, encompassing prevention, early detection and treatment, to reduce barriers that hinder access to or disrupt the continuity of health services.
- **Adopt multisectoral UHC approaches,** as key determinants of health and drivers of UHC lie also beyond the health sector. Indeed, global poverty reduction has driven reductions in financial hardship and access to basic sanitation have driven gains in service coverage.

Strong political commitment is required. Evidence to date has shown that countries achieving better results on service coverage and financial hardship rely more heavily on public spending, which in turn is predominantly buoyed by growth but also reflects governments' ability to collect revenues and political will to prioritize health in budgets. As many countries face macro-economic uncertainly and constrained fiscal space, political commitment is more important than ever. Now is the time for bold action to protect progress and accelerate inclusive gains, delivering essential health services without financial hardship to all.

Introduction: A revised and improved monitoring framework for universal health coverage

The goal of universal health coverage (UHC) is for all people to receive the quality health services they need, when and where they need them, without incurring financial hardship. UHC covers the full continuum of essential health services, from health promotion to disease prevention, treatment, rehabilitation and palliative care across the life course.

The Sustainable Development Goals (SDGs) incorporate UHC as SDG target 3.8. Two SDG indicators measure progress on the core pillars of UHC *(1)*:

- Indicator 3.8.1 tracks the service coverage dimension of UHC via the UHC service coverage index (SCI) *(2).*
- Indicator 3.8.2 captures the financial protection dimension of UHC by measuring financial hardship due to out-of-pocket (OOP) payments for health services *(3)*.[6]

The World Health Organization (WHO) and the World Bank support country monitoring for SDG UHC indicators. WHO acts as SDG data custodian for indicator 3.8.1. WHO and the World Bank serve as co-custodians for indicator 3.8.2.

The window to 2030, the SDG target year, is closing. Without accelerated and sustained progress, hard-won UHC gains risk being lost, and the pursuit of full service coverage and no financial hardship will remain out of reach. This 2025 UHC Global monitoring report demonstrates why. Using revised and improved UHC indicators and fully reproduced time series for both, the report presents the latest available UHC data and concludes with a call to shared action.

This introductory chapter briefly presents the updated UHC indicators and discusses data issues. Online technical appendices provide additional background and technical features. Key terms with technical definitions, when available, and terminology used in the report are defined in the glossary.

[6] Since 2025, indicator 3.8.2 monitors financial hardship due to out-of-pocket health spending using a discretionary budget approach. The original 3.8.2 indicator tracked catastrophic out-of-pocket health spending using a budget share approach. For definitions of terms, please see glossary of terms.

A clearer picture of UHC progress

A comprehensive review of all SDG indicators began in 2024 as part of the scheduled 2025 SDG review process *(4)*. Of the 68 proposals received during the open call, the United Nations Inter-Agency and Expert Group (IAEG) on SDG indicators retained 15 for global consultation, including revisions to UHC indicators 3.8.1 *(5)* and 3.8.2 *(6)*. WHO and the World Bank demonstrated the value added of the revision in several expert meetings.[7] As a result, in March 2025, the United Nations Statistical Commission approved the revised indicators for UHC's service coverage and financial hardship pillars in addition to changes to 10 other SDG indicators *(7)*.

The revision of the service coverage indicator reduces the use of proxies and increases alignment with other health SDGs. It also introduces a new weighting system for the tracer indicators that combine to make up the UHC SCI *(5)*. The revised financial hardship indicator addresses previous underestimation of the financial hardship experienced by the poor, a major concern for the objective of leaving no one behind in any country, at any income level *(6)*. Implications of the revisions for findings are discussed in the next chapter (see Table 1.3)

Tracking health service coverage: SDG indicator 3.8.1

To represent the coverage of essential health services across the population, WHO calculates the UHC SCI, a composite measure based on 14 tracer indicators[8] spanning four domains: reproductive, maternal, newborn and child health (RMNCH); infectious diseases; noncommunicable diseases (NCDs); and service capacity and access. The revision of indicator 3.8.1 incorporates modifications in three of the 14 SCI tracers (Table 0.1).

The initial construction of SDG 3.8.1 in 2017 highlighted the challenge posed by the lack of available data on effective service coverage *(8)*. In place of effective service coverage indicators, proxy indicators were provisionally adopted (e.g. mean fasting plasma glucose as a proxy for the coverage of diabetes treatment). From the outset, the intention was to revise or replace proxy measures as coverage indicators became available.

Revised SDG indicator 3.8.1 also incorporates a new weighting scheme for all tracer indicators used in calculating the SCI. Previously, each of the SCI's four sub-indices was a geometric mean of its constituent tracer indicators, with equal weights for each. Because of the equal weighting, the change measured in the global SCI from 2000 to 2021 was driven disproportionately (over 75%) by trends in the coverage of infectious disease-specific treatments, especially antiretroviral therapy for people living with the human immunodeficiency virus (HIV), which alone accounted for over 60% of total change in the UHC SCI over the period. The revised measurement scheme uses a weighted geometric mean that is less sensitive to these effects. The new approach considers the number of people affected by each tracer indicator and so captures service burden more accurately. The overall UHC SCI remains a geometric mean of the four sub-indices.

The revision of SDG indicator 3.8.1 offers an improvement, while highlighting areas where the construction of the index could be further improved. Key health areas such as mental health, injuries and emergencies continue to lack robust coverage indicators; many of the

[7] August 2024: Member State information session on monitoring universal health coverage (Sustainable Development Goals target 3.8): Revision of SDG UHC indicators 3.8.1 and 3.8.2; October 2024: Fifteenth meeting of the IAEG-SDGs, agenda item 5; Nov. 2024: IAEG-SDGs monthly meeting for financial hardship.

[8] See Annex 1 for a list of the 14 tracer indicators.

indicators measure contact coverage as opposed to effective coverage (see glossary). The continued use of proxy indicators in place of coverage indicators can result in bias towards a particular indicator (e.g. the tobacco use reduction indicator in the NCDs sub-index). The 14 tracer indicators continue to be indicative of service coverage, not a complete or exhaustive list of health services and interventions that are required for UHC. Moreover, the SCI does not measure the population covered by essential health services, and this is derived using a different method (see section 1.3). Sustained investment in country-owned health information systems including civil registration and vital statistics, routine facility data, and patient-level reporting, is essential to generate accurate, country-level assessment of effective coverage in the long run.

Table 0.1. Revisions to UHC service coverage index tracer indicators

Tracer area	Revised indicator	Original indicator	Rationale for the revision
Family planning	Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods.	Percentage of women of reproductive age (15–49 years) who are married or in-union who have their need for family planning satisfied with modern methods	Aligns with SDG 3.7.1 on contraceptive use *(9)*.
Health workforce	Health workers (medical doctors, nursing and midwifery personnel).	Health workers (physicians, psychiatrists, and surgeons).	Aligns with SDG 3.c.1 for health worker density *(10)* and increases data availability.
Diabetes management	Coverage of diabetes treatment (taking medication) among diabetic adults aged 30+ years (age-standardized estimate).	Age-standardized mean fasting plasma glucose for adults aged 18 years and older.	The revised indicator captures patient treatment, whereas the earlier indicator was a proxy measure.

Note: Revised language in green type. Replaced language in orange type. Where terms have been replaced with no implication for the indicator, no colour is used. SDG, Sustainable Development Goal; UHC, universal health coverage.
Source: Authors, based on *(2,5,11)*.

Tracking financial hardship in health: SDG indicator 3.8.2

The revised SDG indicator 3.8.2 monitors the financial hardship dimension of UHC in a more streamlined and comprehensive manner (Table 0.2). The original indicator sought to capture financial hardship due to OOP health spending with an exclusive focus on large OOP health spending, referred to as "catastrophic" OOP health spending. This was done by using a "budget share" approach. Two thresholds, 10% and 25% of total household income or consumption (budget), were applied to all people. This approach did not sufficiently acknowledge that even relatively small OOP health payments (<10% of

household total budget) further reduce the ability of people living in poverty to meet basic needs. Meanwhile, wealthier people may still enjoy high living standards after spending 10% or 25% of their total budget on health. Catastrophic out-of-pocket health spending based on this total budget share approach, as defined with the original SDG 3.8.2 indicator, tended to be concentrated among the better-off economically *(12)*.[9]

The revised indicator 3.8.2, referred to as the "financial hardship indicator," better captures the impact of OOP health spending on poorer populations by focusing on households' discretionary budget (total budget minus the societal poverty line (SPL), which represents the cost of basic needs (see glossary)). The new approach registers as financial hardship *any* level of OOP spending by those who live below the SPL and thus have no discretionary budget. It still captures financial hardship among the non-poor but in a stricter way. For wealthier people, toward the top of the income/consumption distribution, 40% of their discretionary budget typically amounts to well above 10% of the total budget. The revision of indicator 3.8.2 is based on methods developed by the World Bank *(13)* and the WHO Regional Office for Europe *(14)*, building on "capacity to pay" approaches *(15,16)*.

The revised indicator simplifies the UHC global monitoring framework, which previously supplemented the SDG indicator of catastrophic health spending with additional indicators of impoverishing OOP health spending using two different poverty lines to capture financial hardship across the whole population (i.e. poor and non-poor). The total population facing financial hardship was monitored by adding up those incurring impoverishing and catastrophic OOP health spending without double counting. The new financial hardship indicator can directly be decomposed into mutually exclusive categories of impoverishing and large (but not impoverishing) OOP health spending and, as such, does not require any additional indicator (Table 0.2).

The shift to the SPL in calculating SDG 3.8.2 is guided by the global nature of the SDG indicators. The SPL was developed by the World Bank *(17)* following the recommendation of the Atkinson Commission on Global Poverty to introduce a "societal" headcount. It is a measure of basic needs that adapts to each country's median living standard and was developed as the closest empirical fit to national poverty lines. The SPL includes both absolute and relative components, recognizing that the costs of basic needs and social inclusion increase as a country gets wealthier. The SPL increases as median consumption increases, making poverty measurement relevant across country income groups. The SPL is used for the global tracking of financial hardship. Other thresholds are applied to track financial hardship at the national and regional level and to develop evidence-based policy recommendations *(18–20)*.

[9] Other approaches to define catastrophic OOP health spending exist, and those based on capacity to pay approaches tend to produce measurements that are more concentrated among people living in poverty (see *UHC Global Monitoring Report 2023 (1)*, annex 8).

Table 0.2. Revisions to SDG indicator 3.8.2 and complementary indicators

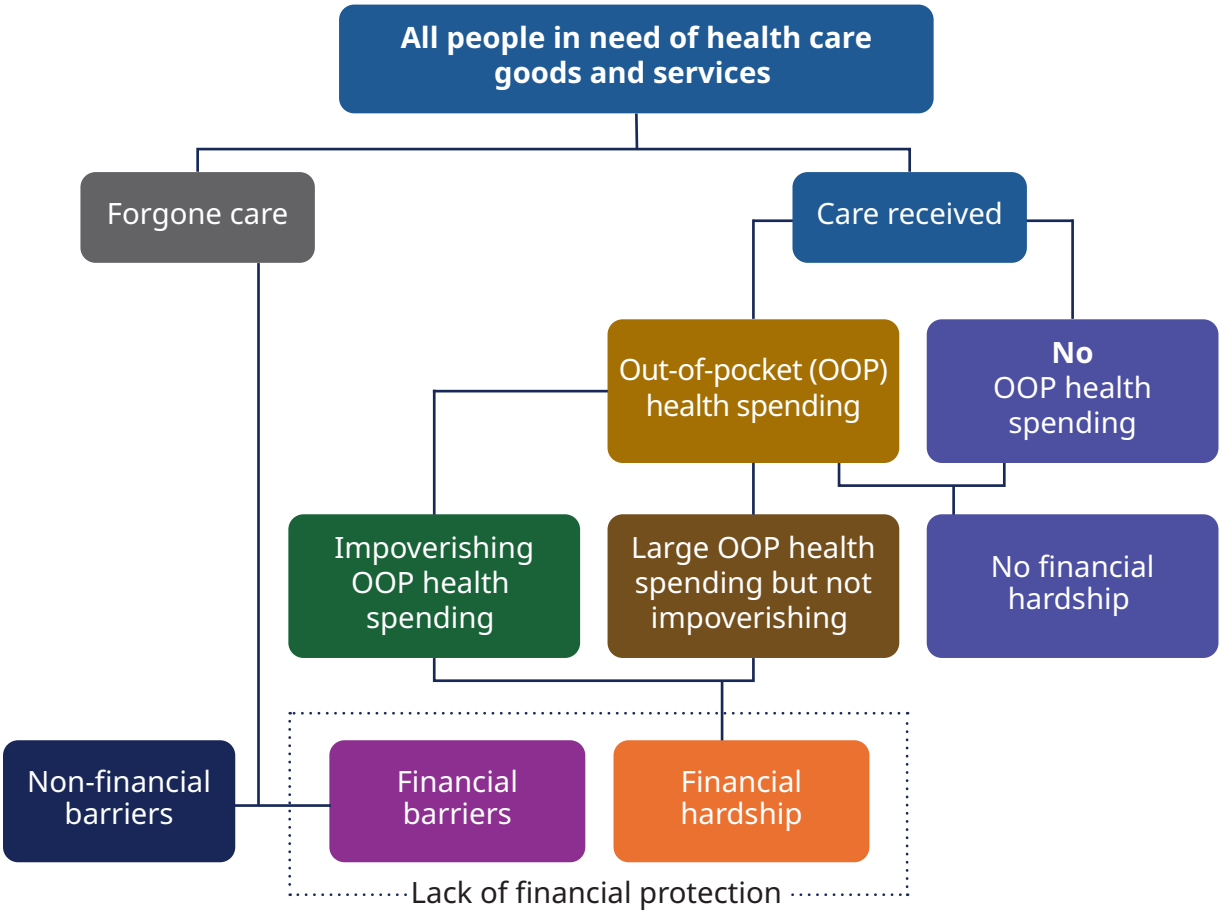
Revised indicator	Original indicator	Rationale for the revision
SDG 3.8.2		
Proportion of the population with positive out-of-pocket (OOP) household expenditure on health exceeding 40% of household discretionary budget*, referred to as financial hardship. The indicator can be decomposed into 2 mutually exclusive categories: [a]	Proportion of the population with large household expenditure on health exceeding 10% and 25% of the household's total consumption or income, referred to as catastrophic out-of-pocket health spending (budget share approach).	To recognize any impoverishing OOP as financial hardship, regardless of its size relative to the household budget. To have a more stringent definition of what constitutes financial hardship among the economically better-off.
SDG 3.8.2		
1. Proportion of population facing impoverishing OOP health spending (OOP that reduces households' ability to meet basic needs)[b] 2. Proportion of population facing large but not impoverishing OOP health spending.[c] *Discretionary budget is defined as the total household consumption expenditure or income (budget) minus the cost of basic needs, represented by the societal poverty line (SPL).[d]		The adoption of the SPL as a measure of basic needs enables incorporation of impoverishing OOP into the global tracking in a way that is relevant to countries of all income levels, given its alignment with national poverty thresholds. No changes in data requirements. Aligns with SDG 1 *(21)* (poverty eradication) and SDG 10 *(22)* (reduce inequalities).
Complementary indicators included in previous UHC global monitoring reports		
None.	A. Proportion of the population with impoverishing OOP health spending using two poverty lines: the international absolute poverty line and relative poverty lines set at 60% of each country's median per capita consumption or income. B. Proportion of the population facing financial hardship due to OOP health spending, including those that experienced catastrophic health expenditure (at the 10% level), impoverishing health expenditure, or both without double counting.	This is no longer needed because the revised indicator tracks financial hardship (B) through a unified approach, achieved by applying the discretionary budget method. This allows it to capture impoverishing OOP health spending (A), while also addressing large OOP health spending – the focus of the original SDG 3.8.2 indicator.

Note: Revised language in green type. Replaced or deleted language in orange type. [a] Not required within the SDG monitoring framework but reported by WHO and the World Bank to understand what drives overall financial hardship. [b] In technical terms, impoverishing OOP corresponds to positive OOP household expenditure on health exceeding 100% of the household discretionary budget. The proportion of the population facing impoverishing OOP health spending can be further decomposed into the proportion of the population pushed into poverty and the proportion further impoverished. The proportion pushed into poverty corresponds to the increase in poverty headcount ratio due to including or excluding OOP health spending from household total consumption or income *(23)*. The proportion further impoverished corresponds to those who are poor and are spending on health as a share of the total population *(24)*. [c] In technical terms, large but not impoverishing OOP health spending corresponds to positive OOP household expenditure on health exceeding 40% but below 100% of the household discretionary budget. [d] In 2017 purchasing power parities, the SPL corresponds to whichever is greater: US$ 2.15 (the international absolute poverty line) or US$ 1.15 + 50% of median household consumption expenditure or income net of OOP health spending.

Source: Authors, based on *(6,25)*.

SDG indicator 3.8.2 remains limited in scope, even after its revision. SDG 3.8.2 alone is not sufficient to monitor *financial protection* in health, as it focuses exclusively on the financial hardship dimension (see glossary) – capturing how OOP health spending affects households' living standards – and does not account for financial barriers that prevent people from accessing needed care (Fig. 0.1). Therefore, the population facing financial hardship is an underestimation of the population without financial protection.

Fig. 0.1. Financial hardship and financial barriers to accessing health care



Note: All concepts are defined in the glossary.

Source: Authors, based on *Tracking universal health coverage: 2023 global monitoring report (1)*.

In addition, the indicator does not distinguish how OOP health spending is financed – whether from income, informal support, or distress financing such as borrowing or selling assets, patterns that have different short- and long-term consequences. Most data sources generally lack this level of detail. As a result, neither the initial nor the revised definition can fully capture the impact and temporal dynamics of OOP health spending on living standards *(26,27)*. Further methodological limitations, including those related to survey design and reporting timelines, are noted in the revised metadata *(2,3)*.

Joint limitations of SDG 3.8.1 and 3.8.2 indicators

To obtain a comprehensive picture of progress towards UHC, the financial hardship indicator must be interpreted together with SDG 3.8.1 on service coverage, hence the focus in chapter 1 on progress in both dimensions.

The UHC SDG indicators 3.8.1 and 3.8.2 are obtained from different data sources and cannot be used to determine, within a given country, who benefits from service coverage without financial hardship. It is not possible to estimate the overlap between the number of people without access to essential health services, which is derived from SDG 3.8.1 (presented in chapter 1), and the number of people facing financial hardship (presented in chapters 1 and 3).[10] Finally, the different types of household surveys used for production of both indicators might not collect information on marginalized and/or vulnerable groups (e.g. those living in slum areas or displaced populations).

Data sources and background for interpretation

This sub-section discusses data issues related to the report and provides information to facilitate interpretation.

Progress on service coverage is monitored in 195 countries and territories[11] with annual estimates from 2000–2023. The values of the tracer indicators used to compile the SCI are derived from country reported data (such as administrative and facility data), existing WHO and United Nations agency modelled estimates, and published results from household surveys. On average, 50% of data points from 2015 to 2023 had country data for indicators re-reporting household surveys or administrative/facility data. To calculate the annual UHC SCI, missing values of a tracer indicator are imputed by extending existing data or using regional medians in the absence of country data. WHO collated tracer indicators to calculate the UHC SCI in early 2025, with support from the United Nations Children's Fund (UNICEF) and the United Nations Department of Economic and Social Affairs (UNDESA).

WHO and the World Bank jointly collated data for the financial hardship indicator. Trends in financial hardship due to OOP health spending have been tracked using data drawn from 1112 household surveys from 168 countries or territories. WHO and the World Bank processed the majority of survey data to obtain country–year estimates of financial hardship rates.[12] To produce population-weighted global and regional aggregates for the period 2000 to 2022, WHO and World Bank teams used the country data to interpolate or model rates for all missing country–year pairs.

Beginning in April 2025, WHO consulted with designated focal points from national governments and national statistical offices in 195 countries on SCI and financial hardship estimates. The consultation period lasted two to three months, depending on countries' level of engagement. Based on country feedback, data for at least one UHC indicator were revised in 58 countries. Results presented in this report reflect data available to WHO and the World Bank as of July 2025.

[10] The World Health Survey Plus has been designed to collect data at the household level on both areas, enabling joint measurement for global monitoring in the future.

[11] Statistics in this report refer to countries and territories. See Annex 3 for the full list.

[12] During the country consultation on SDG UHC indicators, WHO received primary estimates on the revised SDG 3.8.2 from 15 countries or territories out of the total 168 included in the analysis presented in this report.

For a more detailed technical discussion of data sources, data availability, and analytic methods in service coverage and financial hardship, see Annexes 1 and 2.

Interpreting results

A single SCI score from 0 to 100 cannot fully capture all the health services defined in UHC. The SCI uses a selection of indicators to represent overall coverage of essential health services. The higher the SCI score, the more comprehensive the service coverage. Importantly, as noted in the previous discussion on limitations, the SCI should not be interpreted in terms of population coverage (see also section 1.3).

It is often useful to group country SCI findings for interpretation in terms of broad levels: very high service coverage (SCI of 80 or above), high service coverage (SCI between 60 and 79), medium service coverage (SCI between 40 and 59), low service coverage (SCI between 20 and 39) and very low service coverage (SCI <20).

The rate of financial hardship due to OOP health spending is measured at the population level and can be interpreted as the share of the population facing financial hardship due to either impoverishing OOP health spending or OOP health spending that is large but not impoverishing, simply referred to as large OOP health spending in the remainder of this report. People living in households incurring large OOP health spending can cover their basic needs but have a substantially lower ability to pay for other goods and services. Impoverishing OOP health spending reduces people's ability to meet basic needs. The revised indicator's decomposability into these two elements is one of its new main technical advantages, in addition to better capturing the financial hardship faced by people in poorer economic conditions.

The population experiencing impoverishing OOP health spending can be further divided into two groups: (a) people further impoverished who are already living in poverty and spend on health out-of-pocket, further reducing their ability to afford basic needs; (b) people who are not poor in the absence of OOP health spending, but who cannot afford basic needs after spending on health out-of-pocket, are referred to as those pushed into poverty (see glossary and Table 0.2).

Monitoring during COVID-19 pandemic

The global and regional estimates for 2020 and 2021 presented throughout this report do not fully capture the impact of the peak years of disruption caused by the COVID-19 pandemic, when the world experienced multiple health and economic shocks *(28–34)*. All figures in this report display a shaded grey area for these two years.

For service coverage indicators using reported administrative data and household surveys, no attempt was made to further adjust for the effect of the pandemic. Some indicators show the impact of COVID-19, with noticeable drops in coverage globally during the pandemic's peak years. However, the global SCI appears relatively smooth over this period. This is due to its construction as a weighted geometric mean across 14 tracer indicators, some of which are proxy indicators that do not directly measure service delivery or are less sensitive to short-term shocks (see Annex 1 for detailed indicator sources).

For financial hardship, trends in 2020/2021 appear smooth because the values are interpolated (based on preceding and subsequent years) or modelled to a larger extent due to the interruption of many household surveys. No attempt was made to model the effect of the pandemic, due to insufficient primary country data.[13]

[13] Available data based on surveys conducted in 2020 or 2021, from 26 of the 168 countries, are treated consistently in the same way as data from other years, without attempting to isolate the pandemic's specific effects.

Report roadmap

The core sections of this report are organized as follows. Chapter 1 presents the latest data on global progress towards UHC. It describes global trends and levels in the revised SDG 3.8 indicators for service coverage and financial hardship for the period from 2000 to 2022/2023. The chapter also analyses UHC results by country-income groups and WHO regions. Chapter 2 offers a deep dive on service coverage, including the contributions of different tracers to SCI changes over time and an analysis of salient inequalities between and within countries. The chapter touches on forgone care and unmet need for health services. Chapter 3 offers an in-depth treatment of key topics in financial hardship in health. It analyses relationships between poverty and financial hardship in health, then looks at heterogeneities in financial hardship associated with factors such as individuals' age groups, household age composition, sex of the household head, and rural-urban residence. Chapter 3 also discusses the share of medicines in total OOP health spending. A short concluding chapter discusses the implications of the report's findings.

Chapter 1:
Progress towards UHC

Key messages and supporting data

- **Since 2000, the world has made progress on both pillars of UHC, increasing service coverage and reducing financial hardship.**
  - The global UHC service coverage index rose from 54 index points in 2000 to 71 in 2023, largely driven by improvements in infectious disease control.
  - The share of the global population facing financial hardship due to out-of-pocket health spending fell from 34% in 2000 to 26% in 2022, driven by declines in the rate of impoverishing out-of-pocket health spending.
  - Large but non-impoverishing OOP health spending increased from 5% to 6% in the same period.

- **The rate of progress towards UHC has been slower in the SDG era relative to preceding years. Without faster gains, the world will fall short of its 2030 UHC goals.**
  - Since 2015, progress on both UHC pillars has slowed compared to the rate since 2000. At the current pace, the global service coverage index will only reach 74 points in 2030, and close to 1 in 4 people globally will still face financial hardship at the SDG endpoint.
  - In 2023, 4.6 billion people worldwide still lacked access to essential health services.
  - In 2022, 2.1 billion people faced financial hardship due to out-of-pocket health spending.

- **Most countries, country income groups and WHO regions have achieved UHC gains**.
  - Since 2000, 53% of countries with at least two data points have achieved progress in both UHC dimensions, but since 2015, only 38% have done so.
  - Among country income groups, low-income countries saw the biggest improvements since 2015 but still face the largest gaps to on both UHC pillars.
  - All WHO regions have increased service coverage since 2015. The African, South-East Asia, and the Western Pacific regions also reduced the share of the population facing financial hardship.

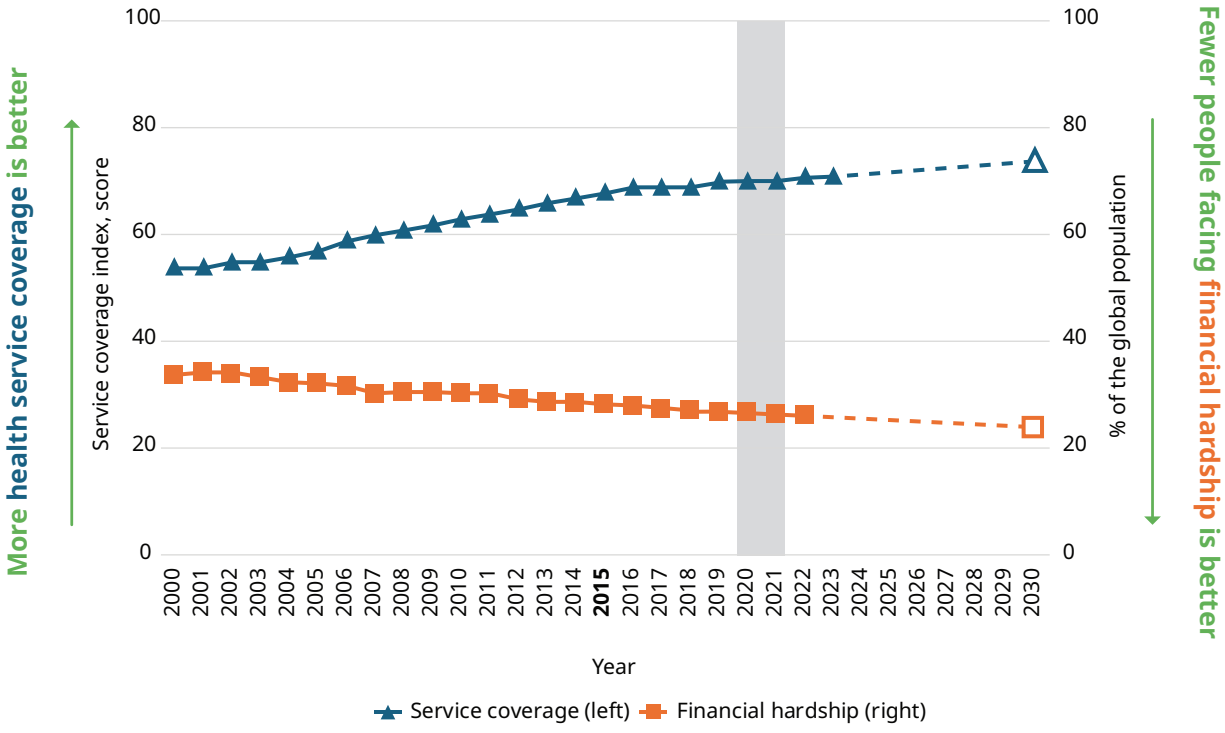
This chapter presents the latest available global and regional data on UHC. The chapter's first core section summarizes global trends in the UHC indicators over their respective measurement periods: 2000 to 2023 for service coverage and 2000 to 2022 for financial hardship. Section 1.2 breaks down the global results by key indicator components. Section 1.3 examines the gaps that still stood between the world and its UHC goals in 2022/2023, at the midpoint of the SDG era. The chapter's last two sections present service coverage and financial hardship results by country income groups and WHO regions.[14] The implications of the revision of indicators for assessing progress towards UHC are discussed in Box 1.1.

1.1 The world progressed on both UHC pillars, but progress has slowed in the SDG era

The world made progress in both the service coverage and financial hardship dimensions of UHC in the period from 2000 to 2022/2023. The global UHC SCI rose from 54 index points in 2000 to 71 index points in 2023. The percentage of the global population facing financial hardship due to OOP health spending fell from 34% in 2000 to 26% in 2022 (Fig. 1.1).

Fig. 1.1. UHC progress is too slow: at the current pace, service coverage will remain under 80, and nearly 1 in 4 people will face financial hardship in 2030

Global trends in UHC SCI and financial hardship, 2000–2022/2023 and projected to 2030



Note: Rates of change observed between 2015 and 2022/2023 were used for the projected 2030 values. The peak years of disruption caused by the COVID-19 pandemic are marked in grey because data from this period do not account for the pandemic's full impact (see Introduction).

Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(35)*; SDG indicator 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

[14] In accordance with resolution WHA78.25 (*2025*), Indonesia was reassigned to the WHO Western Pacific region as of May 27, 2025. Therefore, unless otherwise noted, the regional estimates for the WHO South-East Asia region do not include Indonesia.

The bulk of global progress in both indicators occurred during the period 2000 to 2015, before the launch of the SDGs. The annualized rate of change in the SCI was 1.5% between 2000 and 2015 and 0.5% between 2015 and 2023. The average annual reduction in the proportion of the world's population facing financial hardship was about 0.37 percentage points before 2015 and about 0.28 percentage points thereafter (corresponding to a 23% reduction in rate, without rounding).

If the slower pace of change observed between 2015 and 2022/2023 continues, by 2030, the close of the SDG era, the global service coverage score would reach about 74, and 24% of the world's population would still face financial hardship due to OOP health spending (Fig.1.1).[15] UHC would remain far out of reach, highlighting the urgency for faster and more ambitious action.[16]

1.2 Progress on indicator components was uneven

Among SCI sub-indices (Fig. 1.2.a), the infectious diseases sub-index showed the largest gains over the period 2000 to 2023 and led change in the SCI (see section 2.1). In magnitude of gains, NCDs, service capacity and access, and RMNCH followed. In 2000, RMNCH had the highest score (68) among the four sub-indices but ended the period with the next-to-lowest rank.

The recent global slowdown in SCI progress can be attributed to stagnation in service capacity and access and RMNCH. Despite steady improvements, NCDs remain among the lower sub-index scores globally. Addressing the gaps in NCD service coverage is vital, as global NCD burdens continue to grow, accounting for 75% of non-pandemic-related deaths in 2021 (compared to about 60% in 2000) *(37)*.

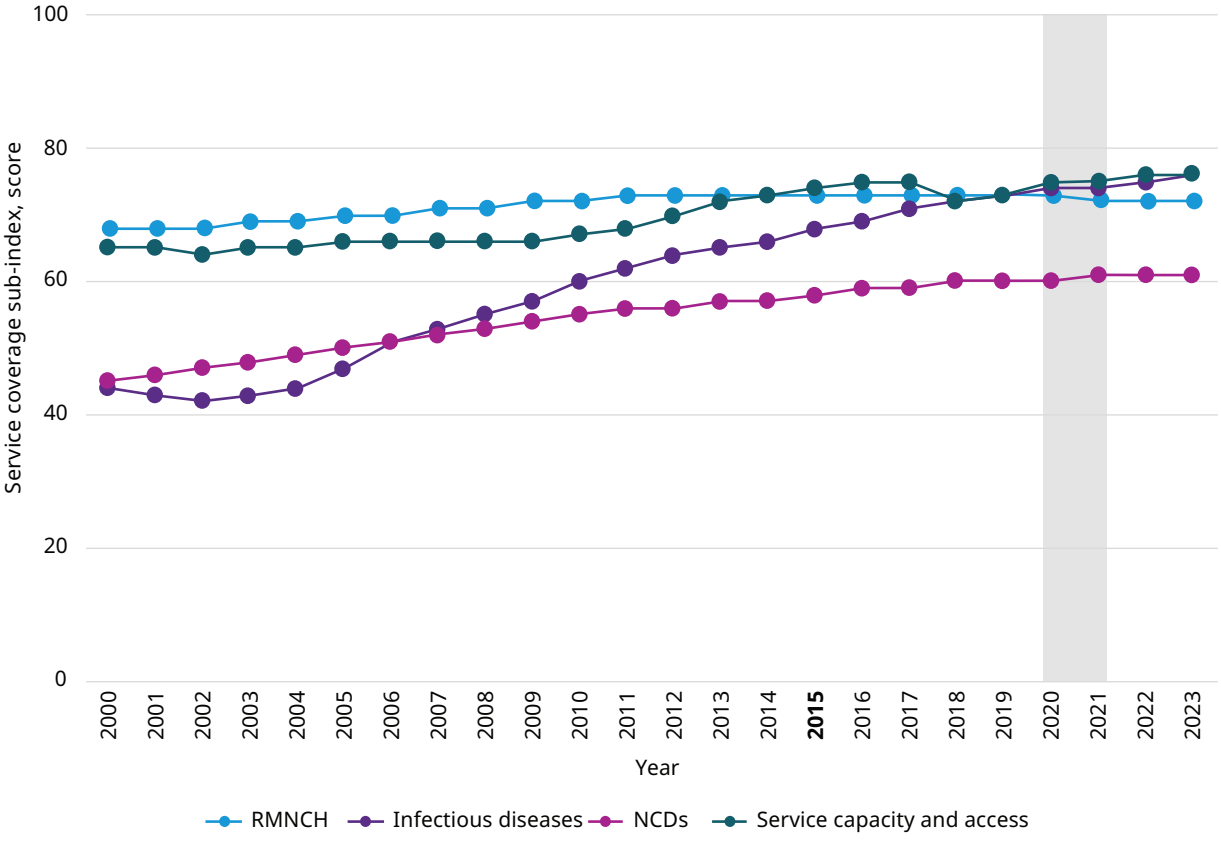
The overall trend of reduction in financial hardship due to out-of-pocket health spending has been mainly driven by a decline in the rate of impoverishing OOP health spending from 28.9% of the global population in 2000 to 20.4% in 2022 (Fig 1.2.b). In contrast, the same period saw a moderate increase in the proportion of the global population with large OOP health spending, from 4.6% to 5.6% (Fig. 1.2.b).

[15] The projection to 2030 reflects a simple extrapolation based on indicators' rates of change since 2015.

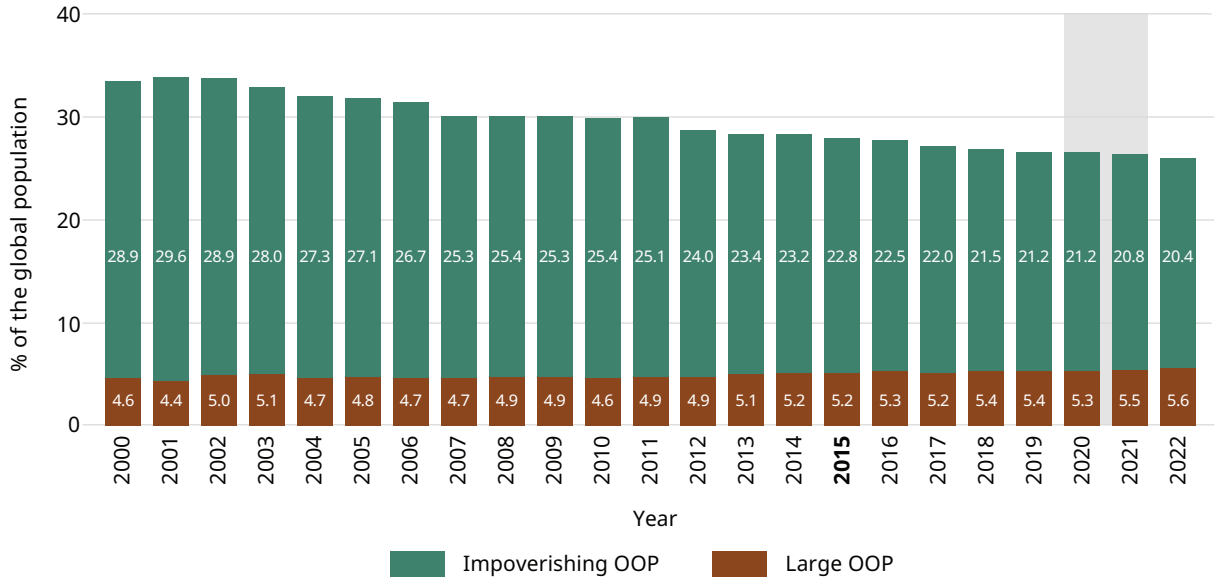
[16] SDG 3.8 is without an explicit numeric target in its definition: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

Fig. 1.2. Since 2000, infectious disease control and lower impoverishing OOP have driven UHC gains – but progress in both slowed after 2015

a. Global trends in UHC SCI by sub-index, 2000–2023



b. Global trends in financial hardship components, 2000–2022



Note: The peak years of disruption caused by the COVID-19 pandemic are marked in grey because data from this period do not account for the pandemic's full impact (see Introduction).

Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(35)*; SDG 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

1.3 Despite global progress, large UHC shortfalls persist

4.6 billion people did not have access to essential health services in 2023.

As an index score, the SCI cannot be directly interpreted as the percentage of the population covered by a set of essential services. The SCI is a composite score for a health system, evaluating access to essential services, derived by aggregating normalized scores for tracer indicators. It summarizes system performance across the population but does not track the same individuals or groups across tracers.

The percentage of the population with access to a set of essential health services provides a different perspective on progress toward UHC. A conversion method has been developed to translate country-level UHC SCI scores into the corresponding percentages of people receiving essential health services, using 12 tracer indicators which are aligned with SCI health domains. This conversion differs from the SCI and is not affected by the revision to the latter. It adjusts the proportion of individuals who are covered by the set of defined essential services simultaneously. Since many people receive some services but not the full set, the actual proportion of the population with full coverage can be lower than the average coverage the SCI score suggests (see Annex 1).

Applying the index conversion suggests that the proportion of the global population not covered by essential health services decreased by 20% between 2000 and 2023. However, in 2023, some 4.6 billion people worldwide lacked access to essential health services. This represented about 57% of the world's population (Fig. 1.3).

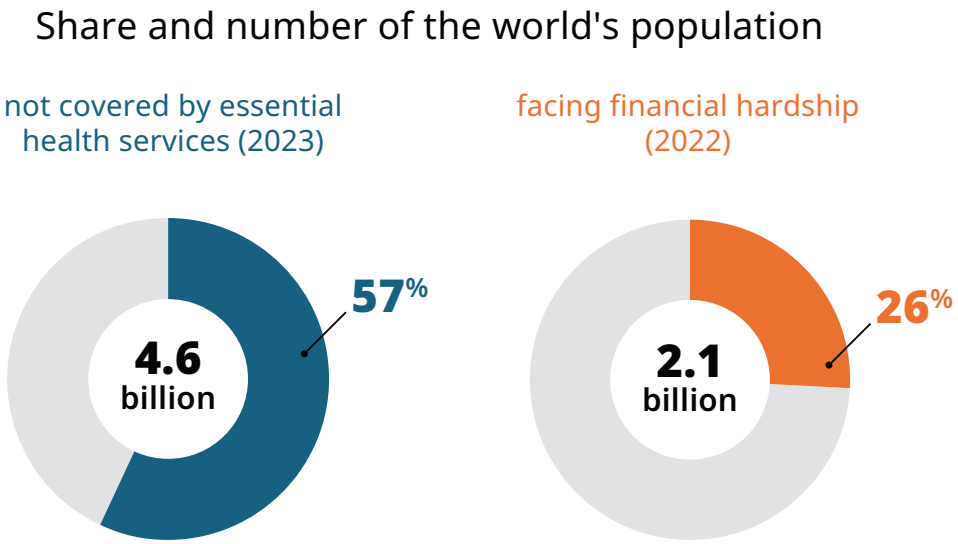
More than 2 billion people faced financial hardship due to OOP health spending in 2022.

Despite the reduction in the *rate* of financial hardship, due to population growth, there was a net increase in the *number* of people experiencing financial hardship (+16.3 million in 22 years, or 739 thousand more people facing financial hardship per year).[17] In 2022, about 2.1 billion people worldwide belonged to households that suffered financial hardship due to OOP health expenditures (Fig. 1.3). Of these 2.1 billion people, 1.6 billion incurred impoverishing OOP health spending, and about 450 million faced large OOP health spending.

Different data sources are used for estimating service coverage and financial hardship. Therefore, it is not feasible to assess how much overlap there is between those who face financial hardship and those who lack access to essential health services. Those incurring financial hardship due to OOP health spending receive some care but might still lack access to some essential services.

[17] The number of people worldwide facing impoverishing OOP health spending fell by 145 million from 2000 to 2022, while 161 million more people lived in households experiencing large OOP health spending.

Fig. 1.3. Midway through the SDG era, over half of the world was not yet fully covered by essential health services, and more than a quarter of all people faced financial hardship



Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(35)*; SDG 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

More than half of countries advanced on both UHC pillars from 2000 to 2022/2023, but joint progress faltered after 2015.

Of the 138 countries with available time series data for both UHC indicators,[18] 97% have made progress on service coverage since 2000, and 54% have made progress in reducing financial hardship (Fig. 1.4, left panel). 73 of the 138 countries have at least two available data points on each indicator since 2015. Within this subset of countries and shorter time period (since the start of the SDG era), the rates of progress declined to 71% for service coverage and 52% for financial hardship (Fig. 1.4, right panel).

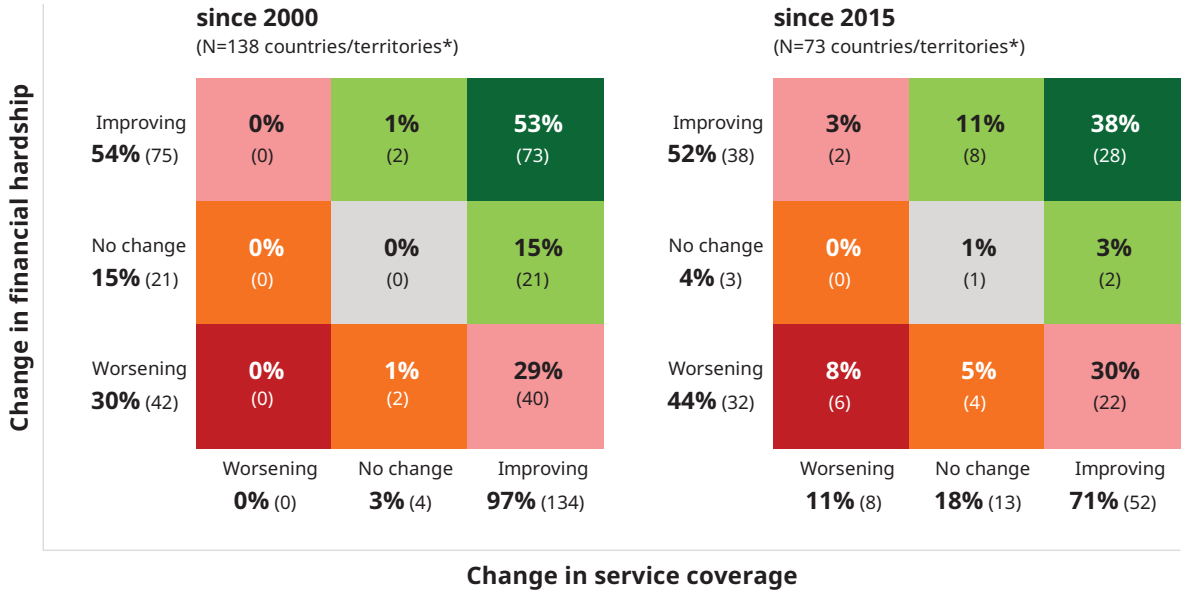
53% of the countries have achieved simultaneous improvements in both service coverage and financial hardship since 2000. After 2015, concurrent improvement fell to 38%, as there was an increase in the share of countries where service coverage remained unchanged but financial hardship improved (11%), or where both dimensions deteriorated (8%) (Fig. 1.4, right panel). After 2015, there was a marginal rise in the share of countries that improved on service coverage while financial hardship worsened (30% versus 29% for the full period) (Fig. 1.4).

[18] From 2000 to 2023, data for service coverage are available for 195 countries. For financial hardship, time series exist for 139 countries, while 17% of countries have no data.

Overall, since 2000, service coverage gains and financial hardship reductions have been widespread. However, in recent years, concurrent deterioration has emerged in some countries, and gains in one dimension do not consistently translate into progress in the other. For instance, expanded service coverage can also result in higher rates of financial hardship if the expansion is achieved with reliance on OOP health spending.

Fig. 1.4. Since 2000, more than half of countries have improved service coverage and reduced financial hardship – but since 2015, fewer than 4 in 10 have done so

Categories of change in UHC SCI and financial hardship for countries since 2000 and since 2015



Note: *The analysis includes countries or territories with at least two reported data points for SDG 3.8.2: 138 since 2000, accounting for 92% of the world's population in 2022; and 73 between 2015 and 2022/2023, accounting for 53% of the world's population in 2022. Annualized rates of change are based on the available periods for each indicator. For SDG 3.8.2, the primary time series of estimates is country-specific for each period, with the median minimum and maximum year ranging from 2002 to 2018 across the sample of 138 countries, versus 2015 and 2021 in the sub-sample of 73 countries. For SDG 3.8.1, all years 2000 to 2023 were available for all countries. Thresholds to define change are based on average annualized rate of change, as follows: worsening financial hardship (>0.1 percentage point); no change in financial hardship (-0.1 p.p. to 0.1 p.p.); improving financial hardship (<-0.1 p.p.); worsening service coverage (<-0.1%); no change in service coverage (-0.1% to 0.1%); improving service coverage (>0.1%).

Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(35)*; SDG 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

1.4 Results across country income groups converged slowly, but important disparities remain

Table 1.1 summarizes changes in service coverage and financial hardship indicators from 2015 to 2022/2023 for the four groups of the World Bank country income classification: low-income countries (LICs), lower-middle-income countries (LMICs), upper-middle-income countries (UMICs), and high-income countries (HICs) *(38)*.[19]

Table 1.1. After 2015, 3 out of 4 country-income groups made gains in service coverage and reduced financial hardship, with the fastest progress in low-income countries

	Changes in service coverage and sub-indices Annualized rate of change in %, 2015 to 2023 (Levels 2015 to 2023)					**Changes in financial hardship and its components** Annual percentage point change, 2015 to 2022 (Levels 2015 to 2022)		
Income group	**UHC SCI (SDG 3.8.1)**	**RMNCH**	**Infectious diseases**	**NCDs**	**Service capacity and access**	**Financial hardship (revised SDG 3.8.2)**	**Impoverishing OOP health spending**	**Large OOP health spending**
Low-income	**+1.0**	**+0.1**	**+2.9**	**+0.8**	**+0.2**	**-0.5**	**-0.4**	**-0.1**
	(43 to 47)	(51 to 51)	(33 to 42)	(63 to 67)	(33 to 34)	(38.5% to 34.7%)	(35.7% to 33%)	(2.8% to 1.8%)
Lower-middle-income	**+0.7**	**-0.3**	**+1.8**	**+1.3**	**+0.1**	**-0.4**	**-0.6**	**+0.1**
	(59 to 63)	(68 to 66)	(58 to 67)	(51 to 57)	(62 to 63)	(34.4% to 31.5%)	(28.1% to 24.2%)	(6.3% to 7.3%)
Upper-middle-income	**+0.5**	**< |0.1|**	**+1.3**	**< |0.1|**	**+0.4**	**-0.2**	**-0.3**	**<|0.1|**
	(78 to 81)	(83 to 83)	(84 to 94)	(60 to 61)	(86 to 89)	(26.5% to 24.9%)	(20.8% to 19%)	(5.7% to 5.9%)
High-income	**< |0.1|**	**< |0.1|**	**-0.1**	**+0.6**	**-0.2**	**<|0.1|**	**<|0.1|**	**<|0.1|**
	(85 to 85)	(84 to 84)	(99 to 98)	(64 to 67)	(97 to 96)	(9.5% to 9.8%)	(6.9% to 6.8%)	(2.6% to 2.9%)

Note: The table reports numbers (or levels) for 2015 and 2022/2023 in parentheses, and shows type of change between these two years with the following colour coding: Green means progress, grey no change, purple worsening. Unrounded numbers are used to calculate the thresholds: average annualized rate of change in % for service coverage and percentage point change for financial hardship. Cut-off values are set at 0.1 to identify a change (i.e. "no change" includes values within the range -0.1 to +0.1). Country income groups based on World Bank classification. Numbers in parentheses are levels for 2015 and 2023 (service coverage) or 2015 and 2022 (financial hardship).

Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(35)*; SDG 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

The levels in UHC indicators are consistently better with higher income-group classification. HICs consistently post the highest service coverage scores and the lowest rates of financial hardship, while the opposite is true for LICs. For example, in 2015, the service coverage score of LICs was about half the score in HICs (43 vs. 85), while LICs' rate of financial hardship was four times higher (38.5% vs. 9.5%). It is important to note, however, the substantial variation in outcomes among countries in the same income category.

The pattern of increasing service coverage scores with higher income levels recurs across service coverage sub-indices, except for the NCD sub-index. On NCDs, LICs scored higher than the middle-income groups and similarly to HICs in 2023 (67 index points). The LICs maintained the lowest rate of tobacco use among country-income groups *(39)*. This, coupled with a broad population age spectrum measured in reductions of tobacco use

[19] Country income group classification is year specific. The number of countries in an income group can vary.

(hence a larger population weight in the NCD sub-index computation) results in greater contribution from the indicator in driving the level and changes in the sub-index. This enabled LICs to post one of the higher NCD sub-index scores. Of note, no income-group NCD score surpassed 70.

Another exception to the pattern in which results follow income-group rankings concerns large but non-impoverishing OOP health spending. Such spending is relatively low in LICs and in HICs, but higher among the middle-income groups. Overall, as countries advance up the income ladder, service coverage typically expands and financial hardship declines, partly reflecting reductions in impoverishing health spending alongside broader poverty reduction. However, during the transition from low- to middle-income status, the share of OOP payments in total health spending often rises, as does the incidence of large OOP expenditures. At higher income levels, mechanisms for pooling health resources and protecting households against health-related financial risk generally strengthen, resulting in a declining share of OOP spending in overall health financing and a reduced financial hardship. Taken together, these patterns in service coverage and financial hardship across income groups align with the notion of a "health financing transition" *(40)*.

While the levels of UHC indicators are better with higher income-group classification, the opposite is true for the trends. HICs saw no change in overall SCI, financial hardship, or any financial hardship components. LICs were the only group to make progress in all UHC components, improving in the SCI and all four sub-indices concurrent with a reduction in overall financial hardship, impoverishing OOP, and large OOP health spending. LICs saw the largest reduction in population rates of financial hardship and large OOP health spending between 2015 and 2022 and the second-largest drop in impoverishing OOP health spending. LMICs posted the largest reduction in impoverishing OOP health spending but were the only income group in which large OOP health spending and the RMNCH sub-index score worsened between 2015 and 2023. LMICs saw the largest increase among income groups in the NCD coverage score (Table 1.1).

1.5 All regions raised service coverage, and half reduced financial hardship

Table 1.2 summarizes changes in service coverage and financial hardship indicators from 2015 to 2022/2023 by WHO regions.[20] All WHO regions saw progress in the UHC SCI between 2015 and 2023, and half posted a reduction in the proportion of the population incurring financial hardship between 2015 and 2022.

The African and Western Pacific Regions saw improvements in all UHC SCI components while rates of financial hardship reduced as well. These two regions led progress in service capacity and access. The African Region (alongside the Region of the Americas) led consistently with the highest NCD scores while maintaining average gains over the period. Reductions in tobacco use largely drive the NCD sub-index, and tobacco use in the African Region is estimated at less than half of the global average *(39)*. When rescaled to non-tobacco use this led in a score 1.2 times higher than the global average. However, the African Region continued to face the highest levels of financial hardship and lowest SCI score in 2022/2023.

[20] Values with and without Indonesia included in the WHO Western Pacific and South East Asia Regions are available online. Corresponding statistics for World Bank regions are reported online.

Table 1.2. From 2015 to 2022/2023, half of the WHO regions progressed or held steady in all components of the SDG UHC indicators

	Changes in service coverage and sub-indices Annualized rate of change in %, 2015 to 2023 (Levels 2015 to 2023)					Changes in financial hardship and its components Annual percentage point change, 2015 to 2022 (Levels 2015 to 2022)		
WHO region	**UHC SCI (SDG 3.8.1)**	**RMNCH**	**Infectious diseases**	**NCDs**	**Service capacity and access**	**Financial hardship (revised SDG 3.8.2)**	**Impoverishing OOP health spending**	**Large OOP health spending**
African Region	**+1.1**	**+1.0**	**+1.6**	**+0.5**	**+1.1**	**-0.4**	**-0.4**	**<|0.1|**
	(47 to 51)	(50 to 54)	(37 to 42)	(66 to 69)	(39 to 43)	(37.7% to 35%)	(34.7% to 31.8%)	(3% to 3.2%)
Region of the Americas	**+0.1**	**<|0.1|**	**+0.4**	**+0.7**	**-0.6**	**<|0.1|**	**<|0.1|**	**<|0.1|**
	(82 to 83)	(80 to 81)	(91 to 93)	(69 to 73)	(89 to 85)	(15.1% to 15.6%)	(12.2% to 12.3%)	(2.9% to 3.2%)
South-East Asia Region	**+1.4**	**-0.5**	**+3.8**	**+1.6**	**+0.5**	**-0.5**	**-0.7**	**+0.1**
	(61 to 68)	(72 to 70)	(59 to 80)	(46 to 53)	(70 to 73)	(34.7% to 30.9%)	(27.1% to 22.3%)	(7.7% to 8.6%)
Eastern Mediterranean Region	**+0.4**	**<|0.1|**	**+1.4**	**+0.1**	**+0.2**	**<|0.1|**	**<|0.1|**	**-0.1**
	(61 to 63)	(63 to 63)	(70 to 78)	(61 to 61)	(52 to 53)	(28.7% to 28.1%)	(22.2% to 22.7%)	(6.4% to 5.4%)
European Region	**+0.3**	**+0.2**	**+0.2**	**+0.7**	**-0.1**	**<|0.1|**	**<|0.1|**	**<|0.1|**
	(80 to 82)	(80 to 82)	(96 to 97)	(57 to 61)	(94 to 93)	(12.6% to 13%)	(9.7% to 9.7%)	(3% to 3.3%)
Western Pacific Region	**+0.7**	**+0.1**	**+1.6**	**+0.3**	**+1.1**	**-0.5**	**-0.6**	**<|0.1|**
	(76 to 81)	(85 to 86)	(84 to 95)	(57 to 58)	(83 to 91)	(30.7% to 27%)	(24.7% to 20.3%)	(6% to 6.7%)

Note: The table reports numbers (or levels) for 2015 and 2022/2023 in parentheses and shows type of change between these two years with the following colour coding: Green means progress, grey no change, purple worsening. Unrounded numbers are used to calculate the thresholds: average annualized rate of change in % for service coverage and percentage point change for financial hardship, with cut-off values at 0.1 to identify a change (i.e. no change includes all values within the range -0.1 to +0.1). Numbers in parentheses are levels for 2015 and 2023 (service coverage) or 2015 and 2022 (financial hardship). In accordance with resolution WHA78.25 (*2025*), Indonesia was reassigned to the WHO Western Pacific Region as of 27 May 2025. Estimation methods to produce regional values are explained in annexes.

Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(35)*; SDG 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

Two regions (Region of the Americas and European Region) lost ground in service capacity and access while still maintaining very high levels (≥80). The Region of the Americas did not improve in RMNCH but maintained their very high levels, while their other UHC SCI dimensions improved. These regions made no progress in financial hardship or any of its components, but they had among the lowest baseline values at the start of the period, attesting to prior advances.

The Eastern Mediterranean Region showed modest improvements in most components but still registered the third-highest rate of financial hardship in 2022 and the second-lowest SCI score in 2023. The South-East Asia Region made the greatest progress across regions in the overall UHC SCI and two of its sub-indices, as well as in reducing financial hardship and impoverishing OOP health spending. However, it was also the only region with deteriorating RMNCH coverage and the only one with an increase in the proportion of the population incurring large OOP health spending.

There was substantial variation across regions at baseline. Despite positive overall evolution, large variations persist as of 2022/2023, with many regions needing to accelerate progress.

1.6 The revision of indicators influences findings in both UHC dimensions

Box 1.1 compares the findings reported above using the revised UHC indicators, based on the 2025 database, with results calculated using the original indicators applied to the 2023 database that was used to produce the 2023 UHC global monitoring report. The 2025 database includes more data points than the 2023 version. The pure effect of the change in indicator definition is described in the materials prepared to request the indicator revision *(41)*.

Box 1.1. Implications of indicator revisions for global UHC monitoring

Relative to the last edition of this report, from 2023, the 2025 UHC Global monitoring report presents newer data on an expanded time frame with revised SDG indicators.

Revisions to SDG indicators 3.8.1 (service coverage) and 3.8.2 (financial hardship), approved in 2025, affect both levels and trends. The SCI retains the same name but is calculated differently, with revised tracer indicators and a different approach for weighting them, resulting in higher levels but a slower improving trend. For financial hardship, bigger methodological changes were introduced.

The original SDG 3.8.2 indicator focused only on large OOP health spending relative to total household budget. To provide a more complete picture, previous editions of this report presented complementary trends in impoverishing OOP health spending, using the international poverty line and relative poverty lines. The revised indicator captures both impoverishing and large (but non-impoverishing) OOP health spending by considering OOP health spending relative to the household *discretionary* budget. Impoverishing OOP is now measured using the societal poverty line. These changes mean that the revised indicator 3.8.2 should not be directly compared with the original indicator, as the two indicators represent different definitions of what constitutes financial hardship. The introduction to this report presents more information on the indicator revision.

The table below compares the main global trends presented in this report, using the revised indicators, with those presented in the previous 2023 Global monitoring report *(1)*, which used the original indicators.

Table 1.3. Comparison of trends presented in Global monitoring reports, 2023 and 2025

Indicator or component	2023 UHC Global monitoring report	2025 UHC Global monitoring report
SDG 3.8.1-Service coverage	Found progress overall between 2000 and 2021 in the UHC SCI, with a slowdown since 2015.	Finds progress overall between 2000 and 2023 in the UHC SCI, with a slowdown since 2015; the values are higher overall, and trends are attenuated.
Sub-indices	Found the largest improvements were observed across the infectious disease indicators, while other areas saw gradual increases prior to 2015, followed by minimal or no improvements.	Finds that infectious diseases indicators still had the largest improvements, followed by modest improvement in NCDs. RMNCH and service capacity and access saw declines or stagnation in recent years. The use of population at risk as weights increases the prominence of tobacco use reduction in the NCD sub-index, reducing variation between LIC and HICs.
SDG 3.8.2	Showed a continued ***increase*** in the rate of catastrophic OOP health spending between 2000 and 2019, using the total budget share approach to identify large spending (SDG 3.8.2 original definition)**.**	Shows a continued ***decline*** in the rate of financial hardship between 2000 and 2022, capturing both large and impoverishing OOP health spending**.**
Large OOP	Showed an increase in large OOP relative to household total budget (SDG 3.8.2, original definition).	Shows an increase in large OOP, as measured relative to household *discretionary* budget (SDG 3.8.2 subcomponent in 2025 definition).
Impoverishing OOP	Showed a reduction when using the international poverty line but an increase when using a relative poverty line (complementary indicators to SDG 3.8.2).	Shows a reduction using the societal poverty line (SDG 3.8.2 subcomponent in 2025 definition) – the only poverty line used.

Indicator or component	2023 UHC Global monitoring report	2025 UHC Global monitoring report
Number of people without access to essential health services **Number of people incurring financial hardship**	Found that in 2021, about 4.5 billion people were not fully covered by essential health services and in 2019, 2 billion faced catastrophic OOP, impoverishing OOP (relative poverty line) or both, without double counting. Found diverging trajectories on number of people facing catastrophic and impoverishing OOP without double counting, depending on the poverty line.	Finds that approximately 4.6 billion people were not fully covered by essential health services in 2023, and about 2.1 billion faced financial hardship in 2022. Finds diverging trajectory in number of people facing large and impoverishing OOP health spending – the two components of the 2025 SDG 3.8.2 definition. Due to population growth, finds that the total number of people incurring financial hardship increased by 16.3 million between 2000 and 2022.
Country-level progress towards UHC	Found that 42/138 countries or territories with at least two data points over time improved service coverage and reduced catastrophic OOP health spending since 2000.	Finds that since 2000, 73/138 countries or territories with time series improved service coverage and reduced financial hardship.

Note: Comparisons should be interpreted with caution and are not indicative of trends between two points in time from the different reports, as data have been updated and methods changed.
Source: Authors, based on this report and *Tracking universal health coverage: 2023 Global monitoring report (1).*

This chapter has summarized the latest global and regional UHC trends, highlighting progress and remaining gaps. The data show some encouraging developments. Between 2000 and 2022/2023, the world advanced on both pillars of UHC, service coverage and protection from financial hardship. All regions made progress over the period, and the poorest countries scored the largest gains. Despite these positive trends, the world and most regions remain far from their UHC goals, with the pace of progress slowing since 2015. Midway through the SDG era, billions of people still did not receive the health services they needed and/or saw OOP health spending reduce their ability to meet basic needs. The following two chapters offer deep dives on service coverage and financial hardship, to provide more granular information on both UHC dimensions.

Chapter 2:
Deep dive on service coverage

Key messages and supporting data

- **Infectious disease control drove global service coverage gains, while other sub-indices improved much more slowly**.
  - Gains in the infectious disease sub-index accounted for 52% of the rise in the global UHC service coverage index (SCI) from 2000 to 2023.
  - 3 out of the 14 SCI tracer indicators – basic sanitation, insecticide-treated nets, and tobacco use – together accounted for 78% of the change in the global SCI.
  - The noncommunicable diseases (NCDs) sub-index contributed 27% to global SCI gains but finished the period with the lowest coverage score among the four SCI sub-indices.
- **Key inequalities in service coverage between countries have narrowed**.
  - Globally, since 2000, the SCI and its sub-indices have seen decreasing between-country inequality, with SCI values converging.
  - The number of countries with low or very low coverage fell, from 55 in 2000 to only 8 in 2023.
- **Available data suggest that within-country inequalities in access to health care have persisted or narrowed only slightly**.
  - Data for 38 low- and middle-income countries show inequalities related to economic status, education level and urban-rural place of residence in barriers to accessing health care among women ages 15–49. These inequalities have remained unchanged or only decreased slightly over the past decade.
  - In 30 European countries in 2019, there were inequalities related to economic status, disability status and place of residence in unmet need for health care due to financial barriers, long waiting lists and transport difficulties. Across 25 European countries in 2024, inequality in unmet need related to economic status was higher for dental care than medical care.

This chapter explores topics in the service coverage dimension of UHC. Section 2.1 looks at how specific sub-indices and tracer indicators contributed to change over time in the UHC service coverage index (SCI). Section 2.2 documents global and regional reductions in between-country inequalities on the SCI from 2000 to 2023. Finally, section 2.3 addresses forgone care and unmet need for health services, including inequalities in unmet need, drawing primarily on data from European countries. The aim of this analysis is to gain insights on ways to target services for more inclusive progress towards UHC.

2.1 Infectious disease indicators drove progress on the UHC service coverage index

Decomposition methods have been developed to understand how summary measures vary due to component factors.[21] In the context of the UHC SCI, these methods were used to determine the extent to which individual indicators contribute to overall changes in the SCI over time. The contribution is the combined effect of the change in the indicator and the population relevant to each indicator.

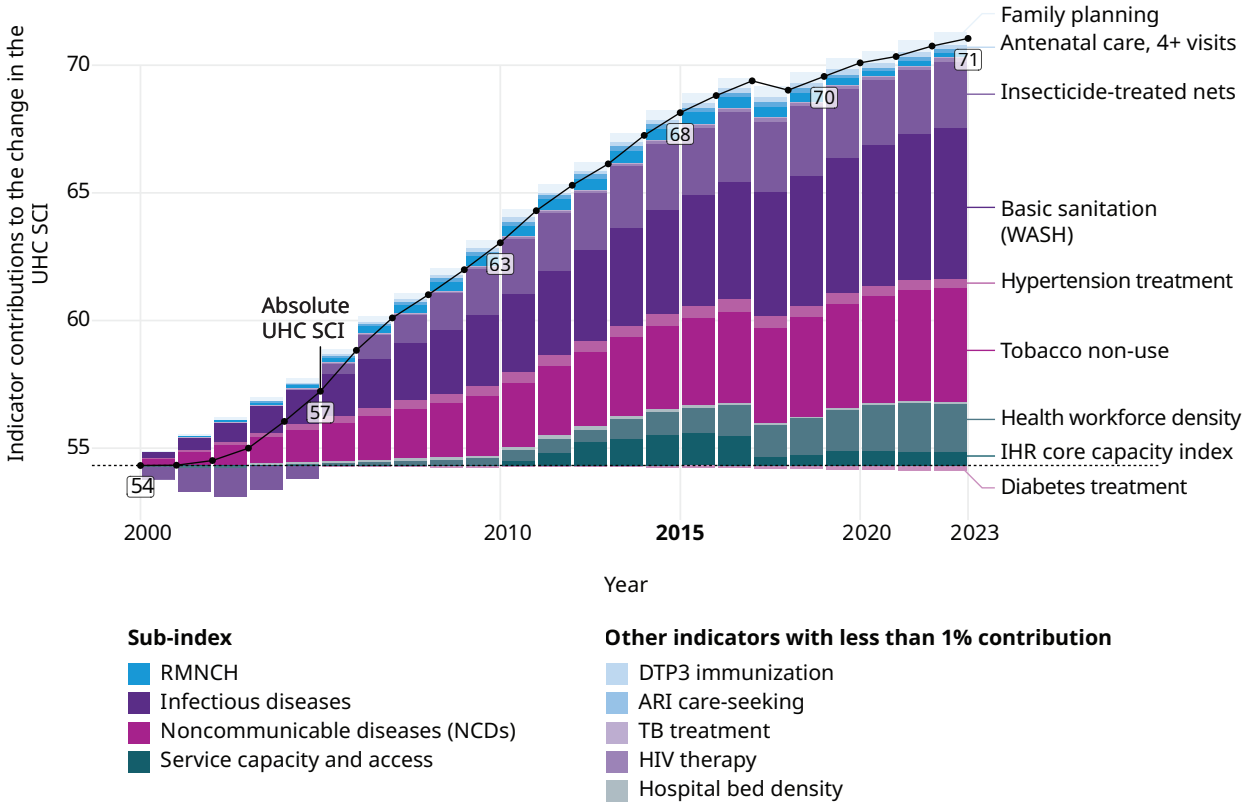
Globally, the infectious diseases sub-index accounted for 52% of the change in the SCI between 2000 and 2023 (Fig. 2.1). This sub-index began the period with the lowest score (44) to end with one of the highest (76). The remaining three sub-indices – NCDs, service capacity and access, and RMNCH – contributed 27%, 15% and 6% to overall SCI change, respectively. Although the NCD sub-index made a sizable contribution to overall SCI gains, it continues to report one of the lower scores for the time series and was the only sub-index to finish below 70 in 2023.

Two tracers largely drove the change seen globally in the infectious diseases sub-index: coverage of insecticide treated nets (ITN) in malaria-endemic areas and basic sanitation. In the NCD sub-index, the main contributor to global SCI change was reduction in tobacco use. Together, these three tracer indicators accounted for 78% of the change in the global SCI. For the period 2015–2023 only, the health workforce contribution grew and replaced ITNs as one of the top three tracers.

[21] See Annex 1 for details.

Fig. 2.1. Three tracer indicators accounted for more than three-quarters of change in the global SCI, 2000 to 2023

Cumulative indicator contributions to change in the UHC SCI



Note: Black line shows the trend of the global UHC SCI. Coloured bars represent the cumulative contributions of the corresponding tracer indicators to SCI change over time. IHR, International Health Regulations; DTP3, three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine; ARI, acute respiratory infection.

Source: WHO global service coverage database *(35)*.

The highest-contributing indicator in each WHO region accounted for at least 40% of regional SCI change between 2000 and 2023. The highest-contributing indicators at regional level were basic sanitation, coverage of ITNs and reductions in tobacco use; their contributions were positive towards the change in all applicable regions.[22] In addition, health workforce and the International Health Regulations (IHR) core capacity index contributed positively in all WHO regions (Fig. 2.2). Similarly for country income groupings, basic sanitation was the largest contributing indicator (range 42% to 75%) in each group except HICs over the period 2015 to 2023. For HICs the dominant driver was reductions in tobacco use.

[22] Use of ITNs is not included for regions that are not endemic for malaria.

Fig. 2.2. Progress in basic sanitation led SCI gains in half of WHO regions, 2000 to 2023

Cumulative indicator contributions (%) to change in the UHC SCI

	Tracer indicator	African Region	Region of the Americas	South-East Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region
RMNCH	Family planning	6	8	3	16	5	0
	Antenatal care, 4+ visits	1	1	1	1	3	1
	DTP3 immunization	2	-1	1	0	2	0
	ARI care-seeking	4	3	-2	5	-2	7
Infectious diseases	TB treatment	0	0	0	0	0	0
	HIV therapy	3	0	0	0	0	0
	Insecticide-treated nets	46	-	-	-	17	-
	Basic sanitation (WASH)	14	20	49	10	40	46
NCDs	Hypertension treatment	0	5	2	14	-1	2
	Diabetes treatment	-2	0	-1	3	-5	-1
	Tobacco non-use	12	50	32	43	24	14
Service capacity and access	Hospital bed density	2	1	0	0	-1	4
	Health workforce density	6	6	11	4	8	25
	IHR core capacity index	7	7	3	3	10	2

≥9 4–8 1–3 ≤0 Not applicable

Indicator contribution (percentage)

Note:.Use of ITNs is not applicable for regions that are not endemic for malaria. IHR, International Health Regulations; DTP3, three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine; ARI, acute respiratory infection.

Source: WHO global service coverage database *(35)*.

2.2 Between-country inequalities in service coverage narrowed, but more slowly after 2015

Gini coefficients measure the degree of variation in a group and are used to assess inequality. Gini coefficients vary between 0, indicating no variation or perfect equality, and a maximum of 1, with increasing values corresponding to greater variation or inequality.

Globally, the UHC SCI Gini coefficient fell from 0.21 in 2000 to 0.13 in 2023, signalling decreasing inequality. Globally and by WHO regions, between-country inequalities in the UHC SCI and its sub-indices decreased over the same period, except for the service capacity and access sub-index in the Eastern Mediterranean Region. Globally, the NCD sub-index showed the lowest Gini coefficient in 2023 (0.09), and the infectious diseases sub-index experienced the highest annualized rate of change in its Gini coefficient over the period 2000–2023.

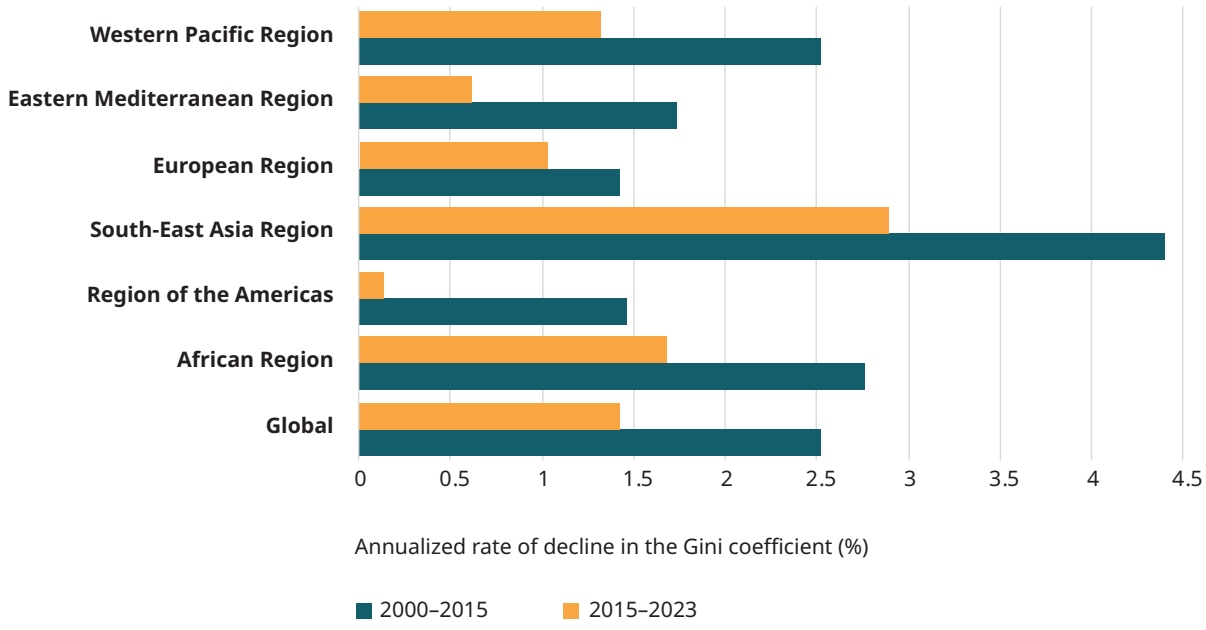
The South-East Asia Region saw a substantial overall reduction in its UHC SCI Gini coefficient (0.26 to 0.11) from 2000 to 2023. The region's annualized rate of change was 3.9%, almost double the global rate. Globally and for all WHO regions, progress in reducing inequalities has slowed in the SDG era (based on annualized rate of change) (Fig. 2.3).

When analysing by country income groups, the Gini coefficient in 2023 ranged from 0.04 in HICs to 0.13 in LICs. Between 2015 and 2023, reductions in the Gini coefficient were seen in the middle-income country groupings only, with the greatest progress in LMICs (annualized rate of reduction of 1.2%). LMICs were the only grouping to see reductions in all sub-indices. Both LICs and HICs saw increasing Gini coefficients over the same period.

Country SCI estimates have converged since 2000, meaning that countries starting with lower scores have made greater relative progress, gradually narrowing the gap with higher-scoring countries. In 2000, 55 countries had low or very low levels of service coverage (SCI <40) compared to 8 countries in 2023, an impressive shift upwards. Of those with medium service coverage (SCI 40–59), 25 of 28 countries were able to advance to high coverage (SCI 60–79). Among the 103 countries with high coverage (SCI 60–79) in 2000, progressing to very high coverage proved challenging. Only 50 countries (49%) managed to reach at least 80 index points by 2023. Convergence was slowest in the service capacity and access sub-index, and initial progress has decelerated over time for all areas. This may signal that some countries have already achieved easier gains, and that continued progress will require targeting more complex barriers, such as health systems capacity and workforce shortages.

Fig. 2.3. Between-country inequalities in service coverage narrowed globally and across WHO regions, but gains have slowed after 2015

Annualized rates of decline in the UHC SCI Gini coefficient, 2000–2015 and 2015–2023



Source: WHO global service coverage database *(35)*.

2.3 Inequalities in forgone care and unmet need hamper UHC progress

To continue making progress on service coverage, health leaders want to know how, where and to whom additional services should be targeted. Key evidence to inform these choices includes findings on forgone care and unmet need. Forgone care occurs when someone realizes that she/he needs health services but is unable to access that care (including services, medications or other health products) due to a range of barriers. Forgone care can emerge prior to establishing initial contact with health services or at any point along the patient pathway and continuum of care *(42)*. Unmet need is a broader concept that encompasses forgone care and also health services or care that people may not realize are needed *(42)*. Researchers have most commonly measured these variables using self-reported household or health surveys. Other possible sources include administrative health records and patient satisfaction surveys.

Assessing unmet need provides insight into the extent to which individuals have health needs over their life course, yet do not receive services because of limited availability, quality or affordability. Understanding the reasons individuals do not receive services or forgo care highlights the barriers people face when engaging with the health system.

While data in this area are limited, comparable data are available from Demographic and Health Surveys (DHS) for women in some low- and middle-income countries globally and from the European Statistics of Income and Living Conditions (EU-SILC) survey and the European Health Interview Survey (EHIS) for the populations in some countries in the European region. The analyses in the following sub-sections are based on these data.

Inequalities in perceived barriers to health care access among women in select low- and middle-income countries

Disaggregated data were sourced from DHS in 38 low- and middle-income countries *(43,44)*.[23] The analysis assessed within-country inequalities related to economic status, education and place of residence in the proportion of women aged 15–49 years who reported having problems in accessing health care for themselves. Problems with health care access could include: knowing where to go for treatment; getting permission to go for treatment; getting money for treatment; distance to health facility; having to take transport; not wanting to go alone; and/or concern there may not be a female provider. Women were asked to consider situations when they were sick due to any reason.

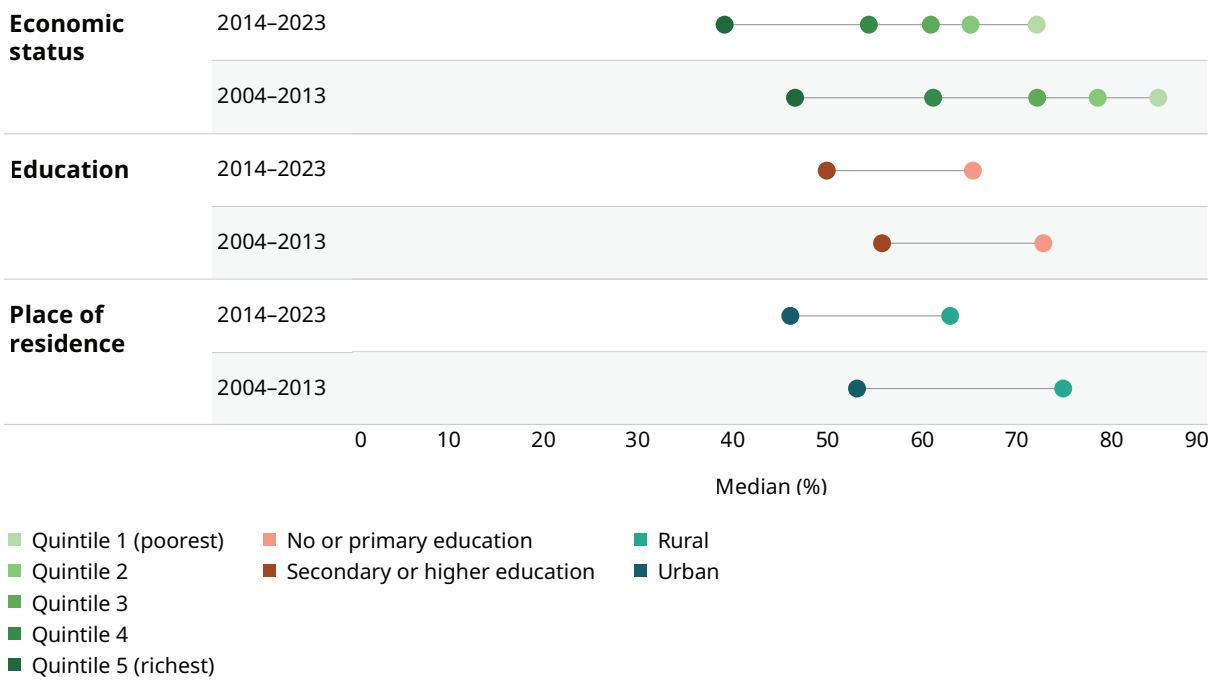
For each country, the analysis included data from two time points: (1) the latest available data from a survey conducted in 2014–2023 to assess the latest situation of inequality; and (2) an older survey conducted about 10 years prior, in 2004–2013, to assess changes in inequality over time.

Across the 38 low- and middle-income countries, a median of 58.6% of women experienced problems in accessing health care in 2014–2023, compared to 67.8% in 2004–2013. Low-income and middle-income country groups demonstrated a similar reduction in the proportion of women experiencing problems in accessing health care (about 10 percentage points), though overall levels remained higher among low-income countries (63.4%) than middle-income countries (56.1%) in 2014–2023.

[23] The data used are publicly available via the DHS Program application programming interface *(44)*.

Across the 38 countries, the study found inequalities related to economic status, education and place of residence in the proportion of women experiencing problems in accessing health care. Inequalities in women's perceived barriers to care remained unchanged or narrowed slightly over the study period. For instance, the gap between median estimates among women in the richest and poorest 20% of the population across 38 countries was 38.4 percentage points in 2004–2013 and 33 percentage points in 2014–2023 (Fig. 2.4).

Fig. 2.4. Change in inequalities in the proportion of women experiencing problems in accessing health care across 38 low- and middle-income countries, 2004–2013 and 2014–2023



Source: Authors' analysis based on DHS.

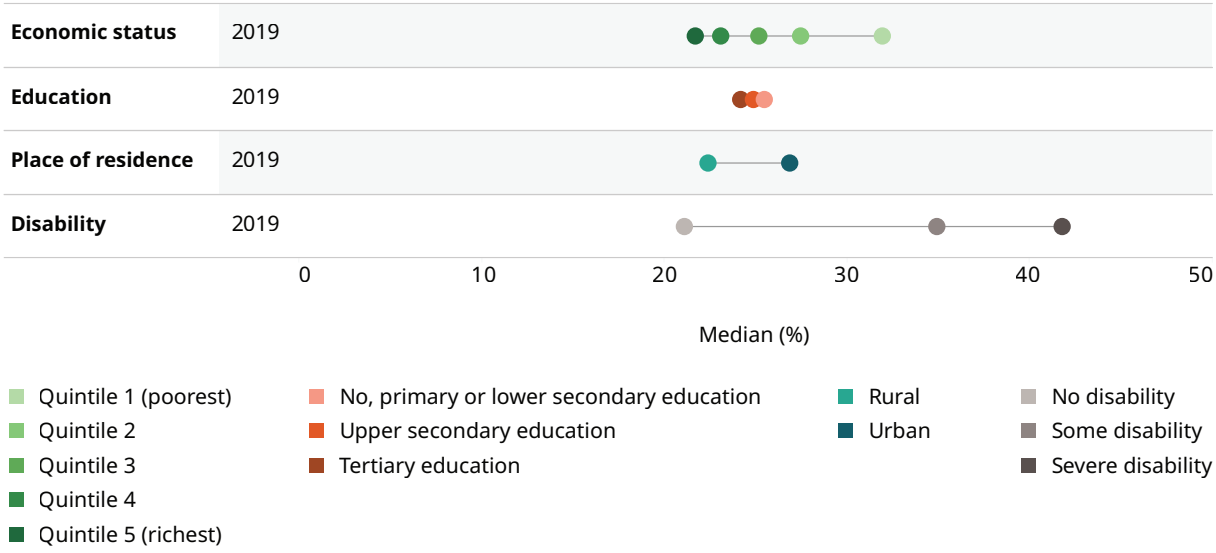
Inequalities in unmet need: findings from European countries

Disaggregated data were sourced from the EU-SILC and EHIS (publicly available via Eurostat) *(13,14,18–20,45)*. Using EHIS data, analysis assessed within-country inequalities related to economic status, education, place of residence and disability status in the proportion of people who needed health care in the past 12 months but did not have it due to financial barriers, long waiting lists, or distance and transportation problems. Using EU-SILC data, analysis assessed within-county inequalities related to economic status (defined using the risk-of-poverty threshold, which is set at 60% of the national median equalized disposable income after social transfers) in the proportion of people who needed medical or dental care in the past 12 months but did not have it due to financial barriers, long waiting lists, or distance and transportation problems.

Analysis of inequalities included 30 countries (27 high-income and 3 upper-middle-income) that had conducted an EHIS in 2019, and 25 countries (23 high-income and 2 upper-middle-income) that had conducted EU-SILC surveys in 2021–2024.

Across 30 European countries in 2019, there were inequalities related to economic status, disability status and place of residence in unmet need for health care due to financial barriers, long waiting lists, or distance and transportation problems (Fig. 2.5). There was a difference of 10.3 percentage points in median values between the poorest and richest quintiles of the population (32.2% versus 21.9%); a difference of 20.8 percentage points in median values between people with severe disability and no disability (42.1% versus 21.3%); and a difference of 4.5 percentage points in median values between urban and rural dwellers (27.1% versus 22.6%). However, there was little inequality related to education overall.

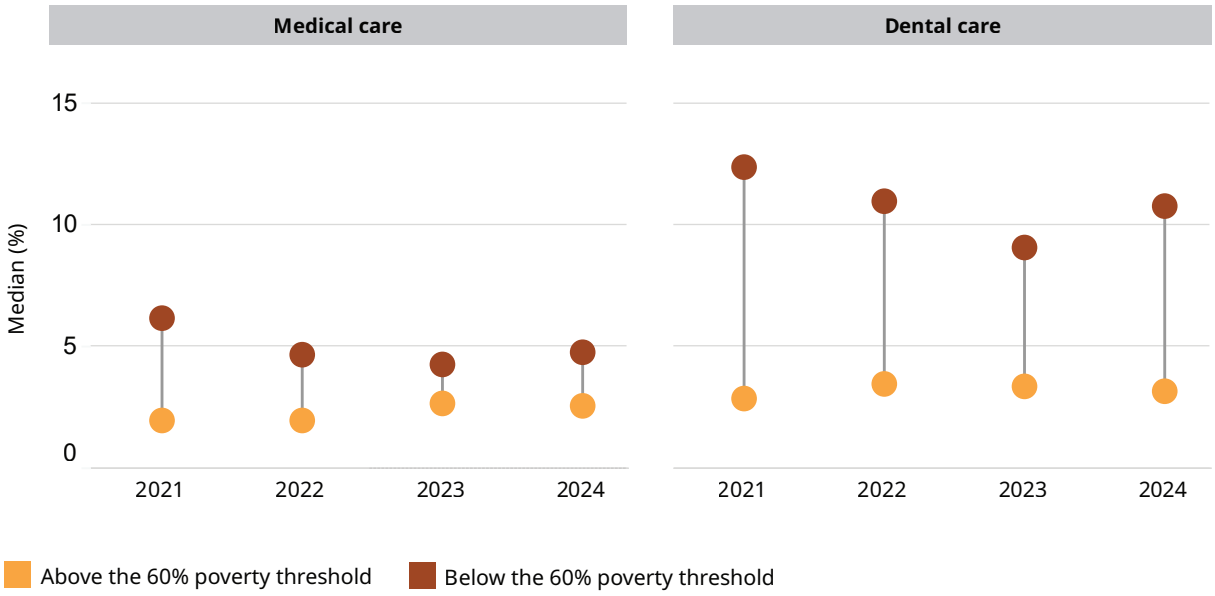
Fig. 2.5. Inequality in the proportion of people who needed health care in the past 12 months but did not have it, 30 European countries, 2019



Source: Authors' analysis based on data from EHIS/Eurostat.

Across 25 European countries in 2024, the median proportion of people who reported needing health care in the past 12 months but not having it due to financial reasons, long waiting lists, or transportation problems was 2.6% for medical care and 4.5% for dental care. These proportions have not changed substantially over time; in 2021 they were 2.7% and 4.2%, respectively. Across these 25 countries, there was inequality related to economic status (Fig. 2.6). The analysis found that, in 2024, the median value of unmet need for medical care was 1.8 times higher among people who were below the risk-of-poverty threshold compared to those above it (4.8% versus 2.6%), while the median value of unmet need for dental care was 3.4 times higher for those below the threshold (10.8% versus 3.2%). There was a reduction in these inequalities between 2021 and 2023, but a slight increase in 2024. Levels of unmet need are higher overall for dental care than medical care, and economic-related inequality is also substantially higher for dental care. This reflects the coverage of dental care being typically lower than medical care in European health systems, disadvantaging the poorer sub-groups of the population *(18,19)*.

Fig. 2.6. Inequality in the proportion of people who needed medical or dental care in the past 12 months but did not have it, 25 European countries, 2021–2024



Source: Authors' analysis based on data from EU-SILC/Eurostat.

An analysis of 17 countries in the Region of the Americas yielded similar findings of persistent inequalities in access to health care across socioeconomic and demographic groups. Unmet health care needs in these 17 countries due to financial, geographic or organizational barriers were higher among poorer populations compared to the wealthiest groups, with differences between the richest and poorest 20% of the population ranging from 2 to 15 percentage points. These inequalities, seen even in high-income contexts, underscore the global nature of health inequalities and support the call for countries to institutionalize health inequality monitoring and adopt equity-oriented policies that target the structural determinants of health *(46)*.

Data constraints limit monitoring for equity

Data limitations remain a major barrier to monitoring service coverage with an equity lens. Estimates of SCI tracer indicators are not systematically available for target sub-populations, making it harder to track patterns of exclusion affecting vulnerable groups. The use of proxies means that for some of the tracer indicators, measuring for sub-populations is not applicable (an example is the hospital bed density tracer indicator).

Surveys are key to monitoring service coverage, with over half of the tracer indicators using surveys as an underlying data source. Surveys such as DHS provide monitoring of a wide range of indicators, including maternal and child health and family planning, which are essential for tracking UHC progress as well as estimating complementary measures such as unmet need. However, to ensure effective UHC tracking, countries may need to diversify data sources, integrate proven digital technologies, and build stronger, more resilient health information systems to support decision-making and service delivery.

This chapter has explored topics in the service coverage dimension of UHC. The next chapter focuses on the second, complementary dimension of UHC: protection from financial hardship. It explores the magnitude and drivers of financial hardship due to OOP health spending, examining financial hardship's relationships with poverty and other socio-demographic factors, along with the types of health goods and services that people purchase out-of-pocket.

Chapter 3:
Deep dive on financial hardship

Key messages and supporting data

- **Most impoverishing out-of-pocket health spending affects people who are already poor.**
  - Impoverishing OOP health spending mainly includes people already living in poverty who are further impoverished due to OOP health spending. In 2022, OOP health spending further impoverished 19% of the world's population.
- **Global poverty reduction drove progress in reducing impoverishing out-of-pocket health spending and the total rate of financial hardship.**
  - The downward trend in the share of the world's population experiencing impoverishing OOP health spending is mainly explained by reduction in the global poverty rate.
  - From 2000 to 2022, the number of people living in poverty reduced, but the share of the poor paying OOP for health increased.
- **The proportion of the population experiencing financial hardship varies with people's age, where they live (rural or urban areas), and who they live with**.
  - Rural populations experience a 14% higher median rate of financial hardship than urban populations, with large variation across countries.
  - People living in multigenerational households face higher rates of financial hardship due to OOP health spending relative to those living in households with different age structures. Those living with adults over 60 face higher rates of large OOP health spending.
- **Spending on medicines accounts for more than half of OOP health spending in most countries.**

This chapter examines the financial hardship dimension of UHC. Section 3.1 presents global evidence on the relationship between socio-economic status and financial hardship. Sections 3.2 and 3.3 draw on multi-country sub-samples (covering 50–80% of the global population in 2022)[24] to assess socio-demographic inequalities and the role of spending on medicines as the main driver of OOP health spending and financial hardship.

3.1 Poverty reduction drove progress in reducing impoverishing OOP health spending, but gains were uneven

This sub-section explores several facets of the relationship between poverty, consumption/income quintiles, and financial hardship in health. It starts by unpacking the concept of impoverishing OOP health spending, then estimates the share of total OOP health spending borne by people who experience impoverishing OOP. The results of these analyses are important for crafting fiscally realistic policies to reduce financial hardship in health. Finally, the sub-section presents data on differential rates of financial hardship across country consumption quintiles.

Impoverishing OOP health spending is heavily concentrated among people who are already living in poverty

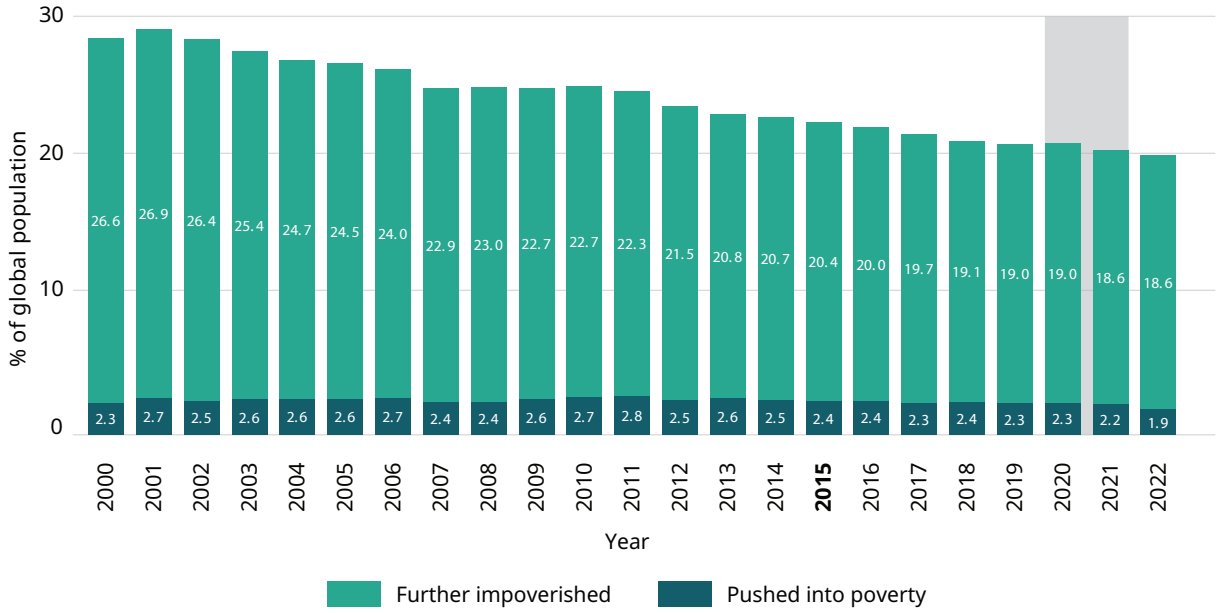
The financial hardship indicator can be decomposed into mutually exclusive rates of impoverishing and large OOP spending (see glossary). Chapter 1 established that financial hardship is mostly made up of impoverishing OOP health spending and that the declining trend in the global rate of financial hardship is driven by a reduction in impoverishing OOP health spending, which outweighed the increase in the share of the population facing large OOP health spending.

The rate of impoverishing OOP health spending itself can be further decomposed. At any point in time, most of the rate of impoverishing OOP health spending comes from people living below the societal poverty line who incur OOP health spending. In the remainder of the chapter, we refer to this group as "further impoverished." In other words, these people would be classified as poor whether or not they have had OOP health spending. A second, smaller component of the rate of impoverishing health spending stems from people who are not in societal poverty based on total consumption but whose consumption falls below the poverty line once OOP spending is deducted. For brevity, we refer to this group as "pushed into poverty" (Fig. 3.1).

[24] For more details, see the notes to figures and tables in this chapter, along with Annex 2 on data availability.

Fig. 3.1. The rate of impoverishing OOP health spending is mainly driven by people further impoverished due to OOP health spending

Proportion of the global population pushed into poverty and further impoverished by OOP health spending, 2000–2022



Note: Background data prepared for the 2025 update to the global database on financial protection.

Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

The decline in impoverishing OOP health spending has been driven by a reduction in the global share of people further impoverished, which fell from 26.6% to 18.6% between 2000 and 2022.[25] The share of those pushed into poverty has changed little over time – ranging between 1.9% and 2.8% from 2000 to 2022.

While global poverty reduction has lowered rates of impoverishing OOP health spending, a larger proportion of the poor are being further impoverished because of health payments.

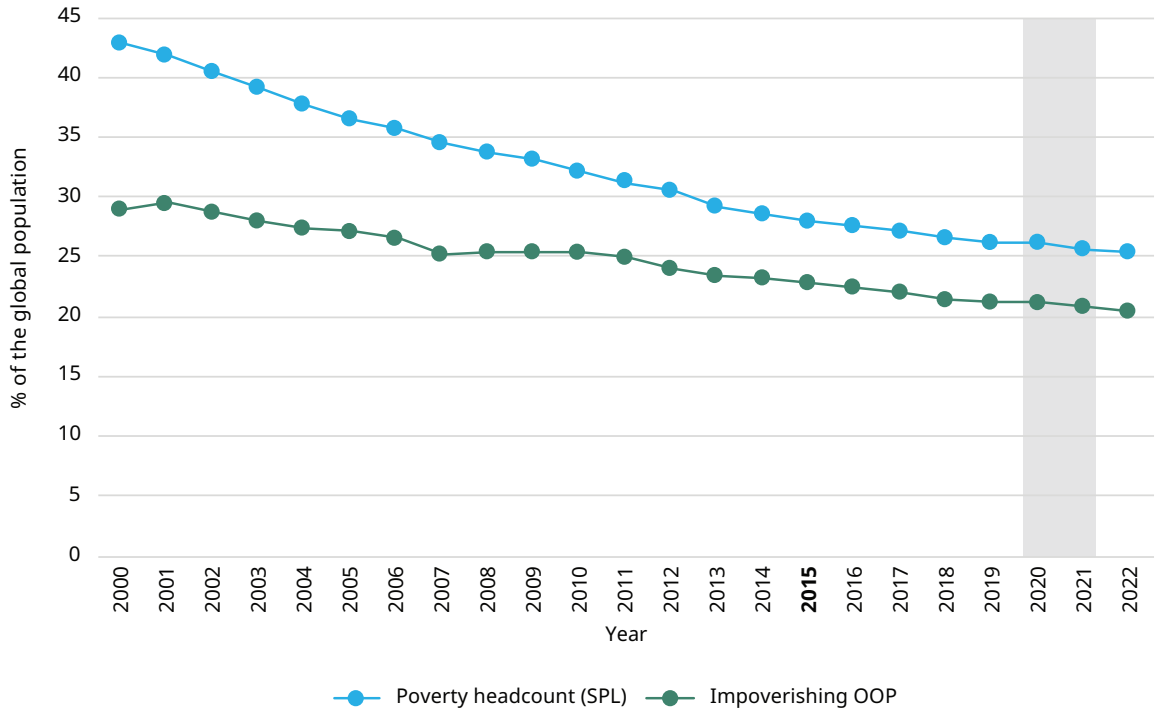
The reduction in impoverishing OOP from 2000 to 2022 was concurrent with a reduction in the global poverty rate (Fig. 3.2a). However, the rate of reduction in impoverishing OOP health spending has been slower than the rate of poverty reduction. As a result, the concentration of those pushed into poverty and further impoverished due to OOP health spending among the global population living in poverty increased over the period (Fig. 3.2b).

This suggests, first, that the overall downward trend in impoverishing OOP health spending was driven by reductions in poverty rates – rather than by how health systems provide financial protection in health to the poor. Second, it highlights that OOP health spending had an increasing relative role in deepening poverty among those already poor between 2000 and 2022. A larger share of the poor spent out-of-pocket on health, which may reflect higher use of health care by the poor. It is nevertheless worrying from the financial protection perspective, as any OOP spending by the poor further reduces their ability to afford basic needs.

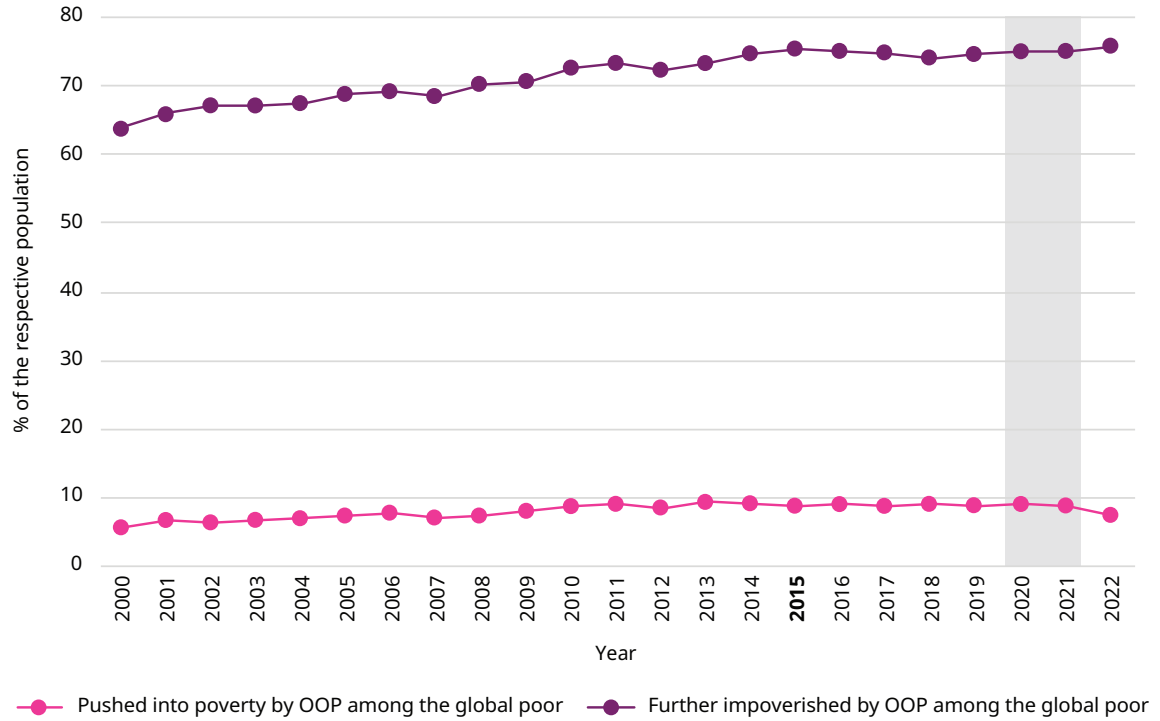
[25] For reference, 25.1% of the world's population lived in societal poverty in 2022 *(47)*.

Fig. 3.2. Global poverty and impoverishing OOP health spending rates declined, but the relative contribution of OOP health spending to poverty increased

a. Trends in global poverty rate at the societal poverty line and global impoverishing OOP health spending rate, 2000–2022



b. Trends in the percentage of the global poor pushed into poverty and further impoverished by OOP health spending, 2000–2022



Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

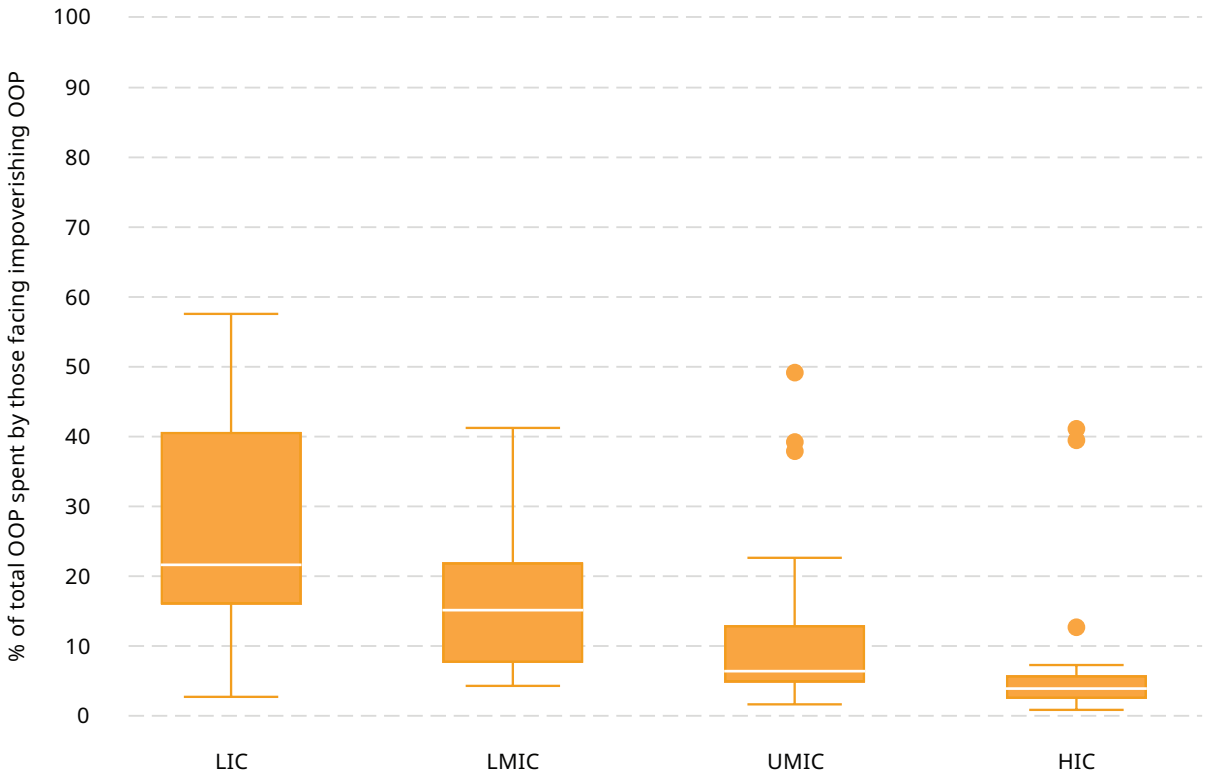
The median share of total OOP health spending borne by those incurring impoverishing OOP health spending accounts for 4% to 22% of total OOP health spending in the different income groups, but with large variation across countries.

The latest evidence from 137 countries across all income groups and regions shows that the median share of OOP health spending borne by those facing impoverishing OOP health spending (the further impoverished and those pushed into poverty) ranges from about 4% in HICs to 22% in LICs (Fig. 3.3). The data reveal a clear income gradient, with LICs displaying the widest variation across countries.

From a health-financing policy perspective, this evidence is critical. On the one hand, it indicates that spending by the poor and those further impoverished is not negligible, raising serious equity concerns. On the other hand, it shows that while the burden is significant for this group, it is not so large that fully subsidizing the poor and limiting OOP payments for the near poor would be unattainable. Prioritizing these measures through pooled public resources appears feasible. These estimates do not capture the full cost of prioritization, as there are larger service coverage gaps for the poor. Nevertheless, they provide insights for designing financing strategies that are both equitable, because they protect the most vulnerable, and fiscally realistic, thereby advancing progress towards UHC.

Fig. 3.3. The share of total OOP health spending contributed by those facing impoverishing OOP health spending is generally low, but it is highest in low-income countries

Share of total OOP contributed by those with impoverishing OOP health spending



Note: Data from 137 countries. For each country, the most recent year with available survey is used. The median year is 2016.

Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

Financial hardship affects all consumption/income quintiles but hits the lowest hardest.

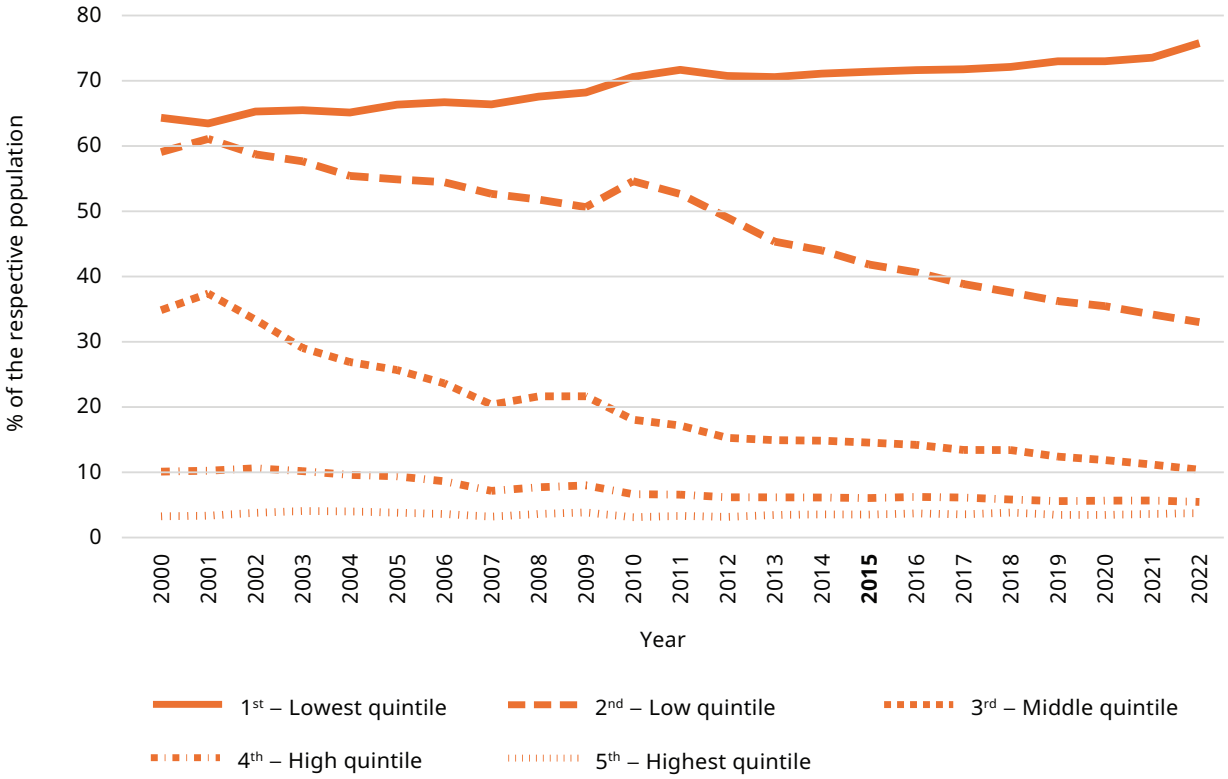
The preceding analysis focused on the relationship between poverty and financial hardship. Another way to assess the relationship between financial hardship and socioeconomic status is to look at trends across different consumption/income quintiles. Dividing the population into five equal groups (quintiles) based on the consumption or income per capita distribution in each country allows us to identify those in the lowest 20% – who are in relatively worse economic conditions even if they are not all officially below the poverty line – and those in the highest 20%, who are better off even if not all among the very richest. In countries with poverty rates above 20%, as measured with the societal poverty line, people living in poverty are not just concentrated in the lowest consumption quintile. The higher the poverty rate, the greater the number of quintiles classified as living in societal poverty.

Throughout the period 2000 to 2022, those living in the lowest consumption quintile consistently had the highest financial hardship rate. Moreover, their rate increased over the period, from 64% to 76% (Fig. 3.4). This trend is consistent with the upward trend in financial hardship among the poor (Fig. 3.2b).

Rates decreased or remained largely unchanged for other quintiles (Fig. 3.4). The overall global decline in impoverishing OOP health spending (Fig. 3.1) was driven by large improvements for those living in the second-lowest and the third (middle) consumption quintiles, from 59% to 33% and from 35% to 10%, respectively. The rate for those living in the fourth consumption quintile reduced more moderately (from 10% to 5%), while in the highest consumption quintile, financial hardship remained at around 3.3% to 3.7%. These trends reflect the overall decrease in impoverishing OOP health spending as a smaller share of the population lived in poverty, as well as the moderate increase in large OOP health spending. At the same time, they demonstrate that financial hardship can be a concern for people anywhere along the consumption/income distribution.

Fig. 3.4. Globally, financial hardship rose in the lowest consumption quintile and fell or changed little in the other quintiles, 2000–2022

Trends in the global proportion of the population facing financial hardship, by consumption/income quintile, 2000–2022



Note: Quintiles are country specific, and the global rate of financial hardship is computed as the population-weighted average rate across quintiles (see annexes for methods). Calculations are based on the methods used to obtain the global aggregated rates presented in Fig. 1.1.

Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

3.2 Socio-demographic factors amplify disparities

Beyond poverty and economic status, other factors are associated with differential vulnerability to financial hardship from OOP health spending. This sub-section considers several of these factors. The data analysed in this and the following sub-section are not drawn from the global financial hardship database but are primary data from different groups of countries.[26]

All financial hardship rates discussed in the following pages are reported at the sub-population level, not the household level. These rates always correspond to the proportion of the sub-population group facing financial hardship, impoverishing OOP health spending or large OOP health spending, even if heterogeneity is explored along household characteristics. For example, the financial hardship rate reported under multigenerational households corresponds to the proportion of the population living in multigenerational households facing financial hardship.

[26] Details on the respective sets of countries analysed appear in the figure notes in sections 3.2 and 3.3.

Age groups and household age structure

Age is associated with financial hardship in health, as both people's needs and ability to pay change over the life course (Fig 3.5). A first analysis compares rates of financial hardship in health across the following age categories: child (ages 0–9 years), adolescent (ages 10–19 years), adult (ages 20–59 years), and older adults (60 years and above). Children have the highest median rate of living in a household incurring financial hardship due to OOP spending (28.9%), followed by adolescents (26.9%) and older adults (25.1%), while adults ages 20–59 have the lowest rate (20.9%).

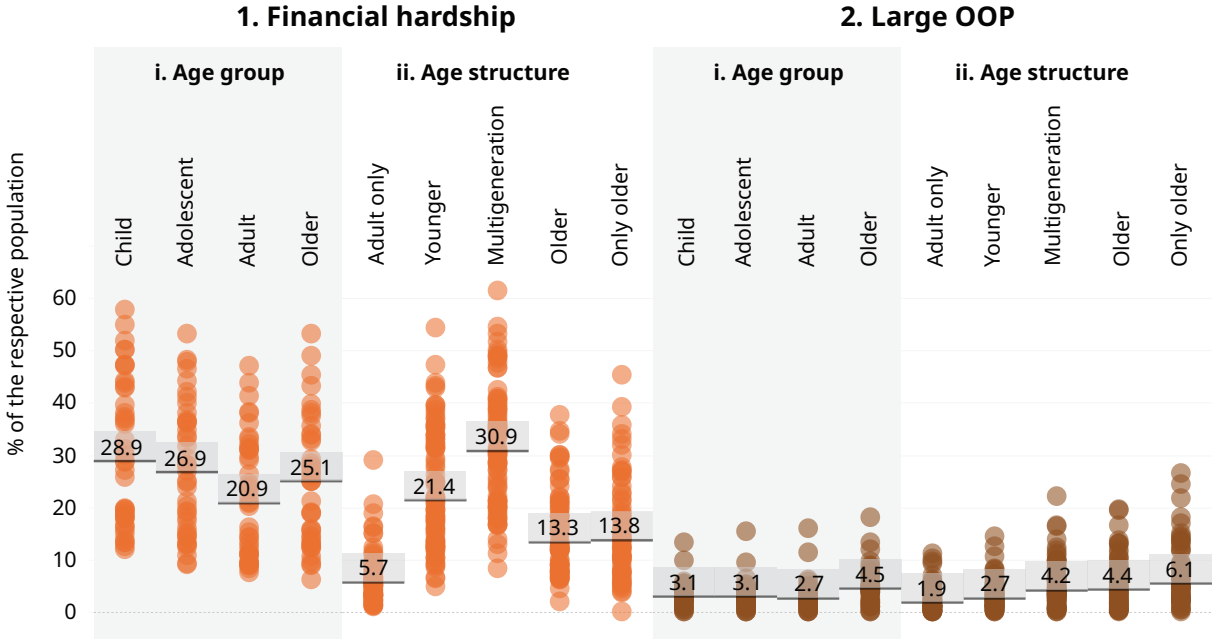
Household age composition further amplifies these differences *(48–50)* (Fig 3.5a). It is important to keep in mind that individuals rarely live alone, especially not children, and that budgets and OOP health spending are measured at the household level, although rates of financial hardship and its components are calculated at the (sub-group) population level in this report. The median financial hardship rate is highest, at 30.9%, for people living in multigenerational households (those that include children/adolescents, adults and older adults) and is lowest, at 5.7%, for those in adults-only households. For large OOP spending (Fig. 3.5b), older adults are most affected: the median rate is 4.5% overall, rising to 6.1% for those living in older-adult-only households and falling to 4.4% when older adults live with adults aged 20–59.

These results should be interpreted with caution, as people and households with different age structures may also differ in their socioeconomic status in ways that vary across countries. In some contexts, for example, reaching older age could be correlated with wealth. That might reduce the likelihood that older adults live in households experiencing impoverishing OOP health spending. In other contexts, there could be a relationship between fertility rate and socio-economic status. The higher rate of impoverishing OOP for children could be explained by children's higher likelihood of living in poor households rather than patterns of OOP health spending for children.

Fig. 3.5. People in multigenerational households face the highest median financial hardship rate, while those living in households of only older adults face higher rates of large OOP spending

a. Proportion of the population facing financial hardship, by age group and the age structure of respondents' households

b. Proportion of the population facing large but not impoverishing OOP health spending, by age group and the age structure of respondents' households



Note: Sample of 83 countries with survey data from 2015 onwards. Together, countries represented 52% of the world's population in 2022. For each country, only the most recent year with available data was used. The median year was 2019. Country–year observations were included only if data on both financial hardship and large OOP were available. The rates indicated in bold in the figure are medians across the country surveys analysed.

Household age structures are defined as follows: Multigenerational – a household that includes at least one child/adolescent, one adult, and one older adult (0–19, 20–59, ≥60). This type also includes "skipped generation" households comprising only older person(s) and child(ren)/adolescent(s); Younger – all household members are <60 years, with at least one adult and at least one child or adolescent (0–19 and 20–59); Older – household includes only adults and older person(s) (20–59 and ≥60); Adult only – all household members are aged 20–59 years; Only older – all household members are older persons (≥60).

Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

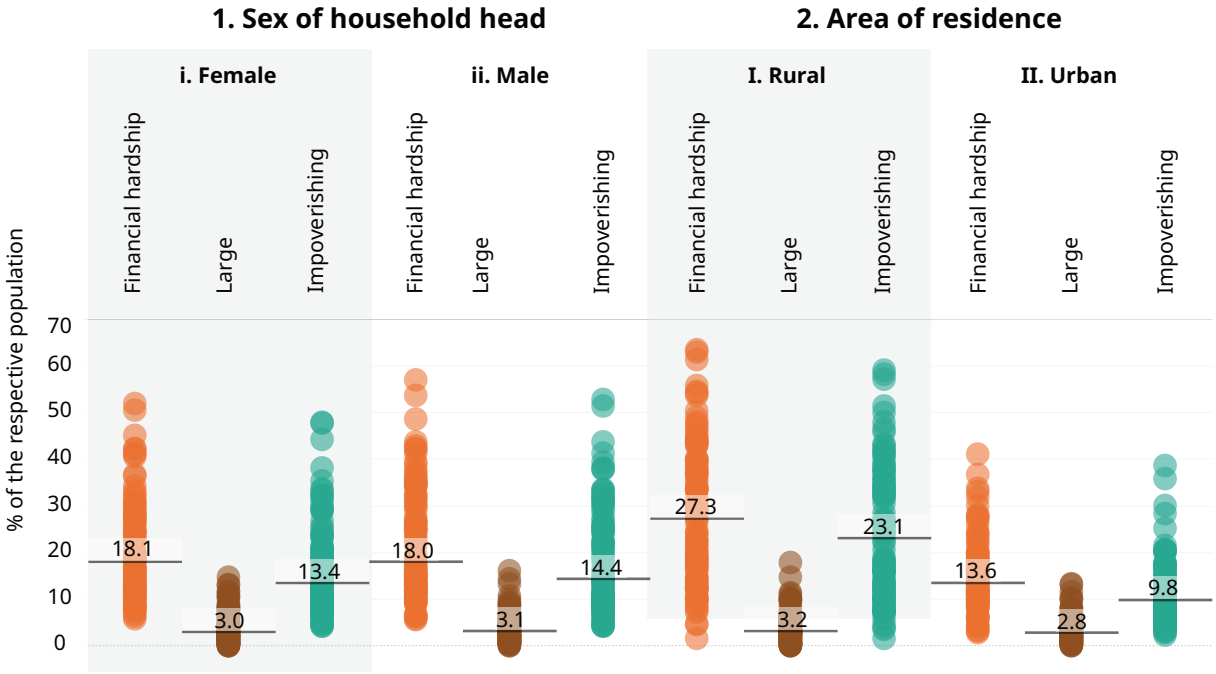
Sex of household head and rural-urban residence

Beyond age and household composition, both the sex of the household head and people's place of residence are associated with financial hardship. Across 97 countries, the median share of the population facing financial hardship is slightly lower in female-headed households than in male-headed households – 18.1% vs. 18.0% – driven by lower impoverishing OOP in female-headed households (13.4% vs. 14.4%), while large OOP rates are similar (Fig. 3.6a).[27]

Fig. 3.6. Financial hardship is slightly lower in female-headed households, but markedly higher in rural populations

a. Variability in financial hardship in female-headed households across countries is large

b. Impoverishing OOP health spending drives rural/urban inequalities in financial hardship



Notes: Panel (a): Data from 97 countries comprising 58.5% of the global population in 2022. Panel (b): Data from 98 countries comprising 77.9% of the global population in 2022. For each country, only the most recent year with available data was used. The median year was 2019. Country-year observations were included only if data on financial hardship, impoverishing and large OOP were available. The rates indicated in bold in the figure are medians across the surveys analysed.

Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

[27] Interpretation should be cautious: surveys record the sex of the reference person (not gender identity), HHF are heterogeneous (e.g. widows, single mothers, partnered women recognized as head), and structural barriers affecting women's economic opportunities vary across contexts *(51)*.

There is a bigger difference when comparing rural vs. urban residence: Across 98 countries, rural populations have a 27.3% median financial-hardship rate versus 13.6% in urban populations – a 13.7 percentage-point gap – driven mainly by higher impoverishing OOP in rural areas (Fig. 3.6b). Variation is also wider in rural settings. Rates fall below 12% in a quarter of countries but exceed 34.9% in the highest-burden contexts. By contrast, median rates of large but non-impoverishing OOP are more similar between rural and urban populations.

Taken together, these patterns indicate that OOP health spending compounds structural inequities and that country context matters. The rural–urban disparities underscore the structural disadvantages many rural communities face and the need for targeted financial-protection measures, in line with the 2030 SDG Agenda to eradicate rural poverty. Substantial cross-country variation cautions against treating differences in isolation. Simultaneously considering inequalities along different dimensions helps identify populations at greatest risk and informs targeted, equity-oriented financial-protection policies.

3.3 In most countries, spending on medicines is the largest component of OOP health spending

The evidence in this chapter makes clear that poorer populations, together with people in rural areas, children, adolescents and older adults, are the most affected by financial hardship due to OOP health spending. In this section the share of OOP spending on medicines is analysed among spenders (not just those facing financial hardship).

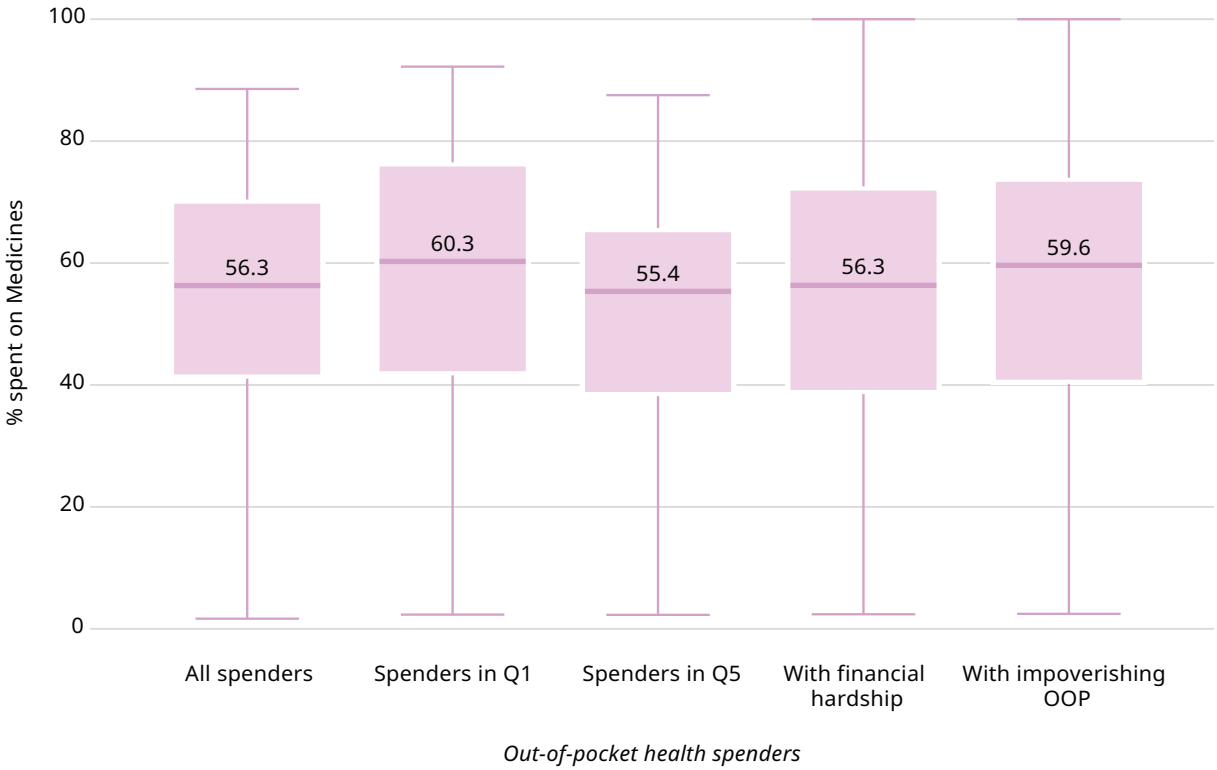
Previous global reports on universal health coverage, drawing on region-specific analysis from around 70 countries, have consistently shown that medicines – often alongside outpatient care – represent the largest share of OOP health spending for those paying for health at point of care *(24,52)*. In Latin America and the Caribbean *(53,54)*, South-East Asia *(55)*, Africa *(56)*, and the Western Pacific *(57)*, medicines account for the majority of OOP spending and absorb a particularly high share among poorer households. In Europe and central Asia, medicines are also the leading driver of financial hardship *(18,19)*, followed by dental care, medical products and inpatient care. Across regions, the burden of OOP spending on medicines is consistently greater for the poorest quintiles. The focus on medicines, however, does not imply that other spending categories do not have an important role in explaining financial hardship. High spending on inpatient care that is associated with acute health shocks can lead to large OOP health spending if health coverage schemes do not sufficiently protect against such shocks.

Given this body of evidence on the predominance of spending on medicines, the following analysis collates and expands the data from previous reports to compare the share of OOP spending on medicines among all people with OOP spending (the "spenders"); between spenders in the lowest and highest quintiles; and among those facing financial hardship or impoverishing OOP health spending (Fig. 3.7). The analysis is based on household surveys conducted between 2015 and 2023 in 83 countries, representing all income groups (the latest available survey for each country is used).[28] Together, these countries represented about 48.25% of world's population in 2022.

[28] The year-specific income classification of the 83 countries is as follows: 17 LICs, 26 LMICs, 18 UMICs, 21 HICs, 1 country/territory unclassified.

Fig. 3.7. Medicines account for over 55% of OOP health spending in most countries with available data

Medicines as a percentage of household total OOP health spending, average among OOP health spenders and by type of financial hardship, evidence from 82–83 countries



Note: "All spenders" corresponds to the population in each country spending OOP on health. "Spenders in Q1" and "Spenders in Q5" correspond to the population in the lowest and highest consumption quintiles spending on health OOP. "With financial hardship" and "with impoverishing OOP" correspond to the population in each country facing financial hardship or impoverishing OOP health spending, respectively, among spenders. Total number of countries/territories is 83 except for spenders in the first quintile, which is based on 82 countries/territories.

Source: Global database on financial protection assembled by WHO and the World Bank, 2025 update *(36)*.

Spending on medicines accounted for at least 40% of all OOP health spending among those with any OOP health spending in 75% of the countries. The median rate of OOP spent on medicines among those facing financial hardship, 56.3%, is similar to the rate of OOP spent by the broader set of households with positive OOP. Among those facing impoverishing OOP health spending, the median rate is higher by three percentage points. The share might be lower for spenders who are facing neither financial hardship nor impoverishing OOP health spending.

Spending on medicines represents a higher share of total OOP among the first consumption/income quintile, with a median of 60.3%, relative to the highest quintile, with a median of 55.4%.

These results highlight that most countries will struggle to reduce rates of financial hardship without addressing the drivers of OOP spending on medicines. The potential drivers, however, are multiple (Box 3.1). The household surveys used for this analysis typically provide limited information on the nature of spending on medicines. Additional data sources would be required to inform the design of national policies to address this issue.

This chapter has analysed issues related to financial hardship in health, in particular the complex associations between poverty and financial hardship. Global poverty reduction has powered lower rates of financial hardship, even as OOP health payments spell further impoverishment for a larger share of the poor. The chapter presented evidence on differences in financial hardship rates associated with socio-demographic factors, such as household age composition and rural vs. urban residence. It highlighted the contribution of OOP payments for medicines to total OOP spending and financial hardship. The report's conclusions now draw the threads of this and the preceding chapters together and discuss their implications for global action to deliver UHC.

Box 3.1. A health system approach to address financial protection

The policy dialogue on financial protection in health often focuses on health financing levers, especially prepaid coverage mechanisms. Indeed, the most direct determinants of financial protection outcomes relate to how much individuals must spend OOP for a given health service or product – mainly driven by prices and fees. The design of publicly financed coverage programmes provides policy-makers with different avenues to affect financial protection outcomes, such as defining who is entitled, designing benefit packages and purchasing arrangements, and use of co-payments, among others *(18,19)*. In addition to the recognized importance of these policies, there are many additional factors that can influence whether people incur financial hardship from OOP spending or forgo care altogether.

Even when individuals are covered by prepaid schemes such as social health insurance or free health care policies, they may still face OOP payments if they seek care not eligible for coverage. This could occur if the services they need fall outside what is included in the benefit package, but quality, availability and accessibility of care also play an important role. For example, individuals turn to private pharmacies when medicines are out of stock in public facilities, or if waiting times are long and hours of operation are limited. In other cases, individuals bypass primary care facilities to seek care at a higher level or with private providers whom they perceive as more competent, resulting in higher costs. Thus, financial protection depends not only on how much people need to pay OOP for a given form of care (service or product), and whether they choose to seek care at all, but also on the type of care they receive. This in turn depends on the different care options available to them, which option they choose, and on their interaction with providers who can suggest different medical interventions or further refer them.

The care needed and related coverage policies that determine financial protection outcomes are also shaped by the underlying health needs of the population. Many countries are working to reorient their health systems towards the primary health care approach that highlights the role of health promotion, disease prevention, and strong public health functions in shaping health needs and outcomes of a population. While these interventions may not directly improve financial protection outcomes in the short term, they can have significant long-term impacts and form the basis for care needs and related coverage policies. Linking prevention and promotion to financial protection outcomes can also strengthen the case for greater investment in these areas *(58)*.

Box 3.1. A health system approach to address financial protection (cont.)

Together, these examples point to the need for a broader health system approach to improving financial protection and advancing UHC. This means identifying not only the direct drivers of high OOP spending but also the wider entry points for policy dialogue, and action around improving financial protection with service coverage.

Drivers of financial hardship exist even beyond the health system. Critically, financial hardship is determined by both the level of OOP payments and households' ability to pay. As this report shows, reductions in impoverishing health spending have been driven more by poverty reduction than by reduction in OOP health spending by the poor. This underscores the importance of cross-sectoral action. For instance, high spending among households with older adults could be addressed not only by expanding health coverage but also by strengthening pensions and broader social protection systems. Ultimately, sustainable progress on UHC requires coordinated policies that address its multidimensional drivers through engagement across health, social protection, and other sectors.

While specific policies to improve financial protection are context specific, there are several important entry points that have wide relevance, particularly around OOP spending on medicines. For instance, spending on medicines could be reduced by changes to prepaid coverage schemes, in terms of benefit package and cost-sharing rules, but also by policies to reduce self-medication and reforms to promote use of cheaper generic and biosimilar drugs. Affordability of medicines could also be addressed though changes in procurement and importation, as well as local production *(59)*. Proper diagnosis of the multi-dimensional drivers of financial protection can serve as the basis for effective and concrete policies that expand coverage and address the health-system and broader factors that drive financial hardship and forgone care. In this way, policies can work concurrently to improve both financial protection and service coverage.

Conclusions

This edition of the UHC Global monitoring report has presented the most recent data on progress toward UHC in the context of the SDGs. The report reflects the first round of UHC tracking to incorporate revised SDG indicators for health service coverage (SDG 3.8.1) and financial hardship (SDG 3.8.2), introduced in 2025. Using the revised indicators, and reproduction of the full time series, the report has presented global and regional trends in service coverage from 2000 to 2023, based on time series data for 195 countries or territories, and global and regional trends in financial hardship from 2000 to 2022, based on primary country time series for 168 countries.

Relative to the tracking period covered in the last edition published in 2023 *(1)*, this report adds data on the years 2022–2023 for service coverage and on the years 2020–2022 for financial hardship. During these years, the world experienced the COVID-19 pandemic and entered a phase of recovery that was uneven and multifaceted – marked by efforts to restore disrupted health services, rebuild fiscal and economic capacity, and address the social and human capital losses created by the crisis *(28–30,60)*. This period was shaped by health, economic and geopolitical shocks *(61,62)* with different short- and long-term implications *(34,63)*. While it is important to keep this context in mind, the analysis in the report does not attempt to measure the impacts of COVID-19 and other shocks, and the evidence in this report does not fully capture the impact of the pandemic's peak years on UHC outcomes.

Slow progress towards UHC

The report has documented meaningful global progress in advancing UHC, with service coverage expanding and financial hardship due to OOP health spending declining. However, during the SDG era that started in 2015, progress has slowed, particularly in service coverage. UHC remains out of reach. In 2023, the global SCI stood at 71 out of 100, and 4.6 billion people lacked access to essential health services, while in 2022, 26% of the world's population – 2.1 billion people – still faced financial hardship in health, with 20.5% and 5.6% incurring impoverishing and large OOP health spending, respectively. Unless progress accelerates, the global SCI will remain under 80, and close to 1 in 4 people globally will continue to face financial hardship in 2030, the end of the SDG era.

It is important to understand how the new trends presented in this report are impacted by the revision of the SDG indicators tracking UHC. With respect to SDG indicator 3.8.1, the service coverage index, the revision did not change the overall trend. The new results are similar to those presented in the 2023 edition of the report *(1)*, using the original indicator, showing the bulk of the increase in the SCI from 2000 to 2015, with a slowdown in the SDG era. For SDG indicator 3.8.2, on the other hand, the original and revised indicators show different trends. The 2023 UHC Global monitoring report tracked the incidence of catastrophic health spending and showed a continuous *increase,* in contrast to the *downward* trend now seen in the revised indicator tracking financial hardship. The change in trend is because the earlier catastrophic health spending indicator only captured large spending (defined as OOP health spending exceeding 10% and 25% of household total budget), while the revised indicator captures both impoverishing and large spending (identified as OOP health spending exceeding 40% of household discretionary budget),

providing a fuller picture of financial hardship. When only focusing on large but non-impoverishing OOP health spending, as captured by the revised indicator, the increasing trend is consistent with the rising trend in catastrophic OOP health spending observed in previous reports (see Box 1.1).

Since 2000, 53% of the countries have both improved service coverage and reduced financial hardship. However, fewer than 4 in 10 countries have made joint progress on both UHC pillars since 2015, with the largest number of countries achieving progress on only one of the two. This highlights the challenge and importance of sustaining progress in both dimensions simultaneously, as higher service coverage could lead to higher OOP spending on health when there is cost-sharing or use of care that is not eligible for prepaid coverage. Conversely, lower incidence of financial hardship per se is not sufficient to guarantee progress, as it can be driven by a rise in the share of people forgoing health care, due for example to greater financial barriers to access. A global survey conducted in 141 economies in 2024 showed that medical costs are the second most prevalent cause of financial worry, including for 26% of adults in low- and middle-income countries, highlighting the importance of health payments as a source of financial stress *(64)*.

Uneven progress towards UHC

Although progress has been made, persistent gaps and inequalities remain and demand stronger action to ensure no one is left behind. The global increase in the SCI has largely been driven by advances in infectious disease control. Service coverage for NCDs experienced consistent gains, while improvements in service capacity and access and RMNCH have been modest, with recent deteriorations. The recent slowdown of progress in the UHC SCI is mirrored in certain key health outcomes across RMNCH *(65)*, infectious diseases *(66)* and NCDs *(37)*, underscoring the importance for renewed efforts to strengthen comprehensive service delivery. Inequalities between countries in UHC SCI scores have narrowed since 2000, but service coverage in low- and lower-middle-income countries remains substantially lower than in the higher income groups.

The reduction in the rate of financial hardship has been driven by fewer people facing impoverishing OOP health spending since 2000. This trend in turn is explained by a reduction in global poverty (using the societal poverty line) and not by the ability of health systems to provide better financial protection for the poor. While the overall *number* of poor reduced, a growing share of the poor is spending OOP on health. The latter trend might reflect, at least to some extent, higher health care utilization among the poor *(67,68)*. It nevertheless shows that financial protection for the economically worse-off remains far from assured, underscoring the need for policy-makers to prioritize policies that specifically protect and support these vulnerable groups. Another less encouraging trend is the increasing rate of large OOP spending among the non-poor. This pattern is concentrated in middle-income countries, where use of health services and goods is growing, but reliance on OOP payments is high.

National-level results mask additional inequalities within countries. Among the poorest fifth of the population in each country, which includes most people living in poverty, 76% experience financial hardship versus 3.7% among the top consumption quintile. Rural populations face significantly higher financial hardship than urban populations, largely due to higher rates of impoverishing OOP health spending. Data on women from a set of low- and middle-income countries found inequalities related to economic status, education level, and urban/rural place of residence in reported barriers to accessing health care. For instance, a higher proportion of women living in rural areas reported barriers to accessing

health care compared to those living in urban settings. These inequalities have remained unchanged or only decreased slightly over the past decade. In 17 countries in the Region of the Americas, unmet health care needs due to financial, geographic or organizational barriers were higher among poorer populations *(46)*. Even in European countries, which have the highest UHC SCI scores, rates of unmet need for health care due to financial reasons, waiting list or distance or transportation vary by economic status and disability status, with higher economic-related inequalities in unmet need for dental care compared to medical care *(18,19)*.

Many health systems face stark challenges in the years ahead

Beyond the gaps described above, health systems also face major challenges that will shape progress towards UHC in the years ahead. Among the many existing and emerging challenges are macro-economic uncertainty and constrained fiscal space, increasing burdens of NCDs and mental health conditions, and population ageing.

It will be challenging to maintain UHC progress, let alone accelerate it, in the coming years. Governments' ability to invest in health largely depends on their macro-fiscal conditions, with external aid providing an important supplement in poorer countries. Increasing global economic uncertainty poses mounting fiscal risks, limiting countries' capacity to sustain public investment and social spending. This puts further pressure on governments already struggling to finance and deliver on UHC owing to weak economic growth, high public debt burdens, and stagnant revenue collection efforts. Further, sharp cuts to external aid will drastically alter the health financing landscape, especially in LICs *(69)*. It will require strong political commitment to prioritize health in this context.

A critical challenge that health systems at all income levels are facing is the rising burden of NCDs, including mental health conditions. In 2021, NCDs were responsible for over 43 million deaths globally *(37)*, and the progress in reducing premature mortality from NCDs has slowed in recent years (SDG indicator 3.4.1). More people are living with chronic conditions that require sustained care, often complicated by co-morbidities. This places additional service-delivery burdens on health systems and greater financial pressure on people who must pay out of pocket for chronic care *(70,71)*. Of the four SCI sub-indices, NCD coverage has the lowest global score and ranks lowest among the four sub-indices in four out of six WHO regions, despite the gains achieved. Health systems need to be reshaped to prevent and address NCDs and mental health conditions *(72)* with emphasis on integrated service delivery and continuity of care. Yet achieving the goals of person-centered integrated care for chronic diseases has proven difficult historically, even in many well-resourced systems *(73–75).*

Population ageing, while reflecting historic development gains, will increasingly test health-system service delivery and financing capacities worldwide *(76–78)*. This challenge will be most acute in middle-income countries that are ageing faster than they are getting wealthier. As shown in chapter 3, households with older adults have higher rates of large OOP health spending, reflecting older adults' typically greater needs for health care and often lower ability to generate income. In such contexts, current pensions and other social protection systems are unlikely to be sufficient to financially protect households with increasing health expenses for older members *(79)*.

Action is needed to accelerate UHC gains

While a global monitoring report cannot provide prescriptive solutions, the findings indicate potential directions for policy action that health leaders and stakeholders may consider to accelerate sustainable progress towards UHC. Chapter 1 showed that around half of countries at all income levels and across all regions have achieved progress in both UHC dimensions since 2000 and more than one-third have done so since 2015. Other countries can learn from these experiences and accelerate progress by building on what already works *(20,46,56,57)*. UHC monitoring at the regional and country level, with analyses more attuned to specific contexts, is crucial to identify gaps and drivers to inform national policies on the path to UHC. An example is UHC Watch, an online platform tracking affordable access to health care in Europe and central Asia *(80)*. Data-driven, evidence-based policy-making requires commitment to strengthen data systems and data analysis capacities.

Strengthening primary health care (PHC) is a pivotal strategy as it addresses the broader determinants of health and promotes equity *(81)*. Country experiences suggest that policies that expand PHC infrastructure can reduce access barriers and improve health outcomes, particularly for disadvantaged populations *(82)*. Reshaping health systems to be more integrated and people-centred can address the unmet need discussed in chapter 2 *(83,84)*.

Building on these foundations, it is essential to ensure that PHC systems are equipped to consistently deliver a comprehensive range of NCD services. Countries may leverage the recommended NCD service packages – such as standardized hypertension and diabetes care linked to clinical targets; early detection and timely referral for major NCDs; dependable access to essential diagnostics and medicines; and prevention strategies for tobacco control – while systematically extending coverage to groups that are currently underserved. Anchoring delivery in first-contact care co-designed with communities can help address practical barriers and promote continuity *(74)*. Prioritization of evidence-based prevention and promotion interventions can slow rising NCD burdens and reduce OOP in the longer term.

Governments should ensure free access to essential care by the poor. This report shows that the share of the poor paying OOP for health services is rising, but that the median contribution of the poor to total OOP spending is relatively low. This suggests that many countries, including LICs, can take action to address rising OOP spending among the poor, even under tight budget constraints *(19)*. Reliance on OOP health spending, rather than public financing, means that the poor must divert resources from their budgets, already insufficient for meeting basic needs, when they cope with a health shock.

More broadly, governments should enhance mandatory and prepaid coverage for health care by pooling funds – including revenues from taxes, levies and mandatory health insurance contributions – to enhance financial protection in health for the whole population and to reduce fragmentation *(85)*. While there is a need to prioritize the poor, the report also shows an increase in the rate of large but non-impoverishing OOP, particularly in middle-income countries. Coverage should be strengthened in terms of the populations and care covered and of lower cost-sharing. The efficacy of such policies would be compromised if rules are not enforced and if the population is not aware of their entitlements and benefits.

While health coverage policies are most directly linked to financial barriers and levels of OOP, achieving better results in reducing financial hardship requires adopting a broader health system approach that considers the multidimensional factors contributing to poor financial protection. People nominally entitled to coverage may end up paying OOP to seek care outside it, due to access barriers, quality shortfalls or other health system

constraints. This means that prepayment mechanisms by themselves will not eliminate financial hardship if service delivery platforms are not ready to provide the care eligible for coverage under such mechanisms. The choice of policy interventions should be guided by careful diagnosis of the drivers of lack of financial protection, to inform policy-making and implementation *(86)*.

Reducing financial hardship due to OOP health spending will require measures to better address out-of-pocket spending on medicines, which accounts for most of OOP health spending in most settings. This is another area where a range of policy solutions need to be considered based on careful analysis of the drivers of OOP health spending. Policies can cover a wide span, from modification of coverage schemes to pro-generic reforms or regulations related to intellectual property rights and trade, among others *(87)*.

Policy-makers should also look beyond the health sector to advance UHC, as factors outside the sector can spur substantial improvements. Chapter 2 underscored the contribution of basic sanitation to global progress against infectious diseases. Chapter 3 showed that the decline in impoverishing OOP health spending has been driven by reductions in the global societal poverty rate, not by changes in OOP health spending patterns among the poor. Poverty reduction and social protection policies are critical, since whether a given level of OOP spending causes financial hardship depends on people's ability to pay. These are mutually reinforcing issues, however, as reducing OOP health spending in low-income households will also contribute to poverty reduction.

Now is the time for bold action to protect UHC progress and accelerate inclusive gains, delivering essential health services with financial protection to all. Faster progress, especially given the mounting challenges economies and health systems face, cannot be made without strong political commitment, prioritization of the UHC agenda in government budgets, and multi-sectoral mobilization to advance it.

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Annex 1. Methods to calculate the UHC service coverage index, SDG 3.8.1, additional analyses and data availability

1. Calculation of UHC SCI (SDG 3.8.1)

Input data

Fourteen indicators are used to calculate SDG 3.8.1. The indicators are drawn from four key areas related to health service coverage: reproductive, maternal, newborn, and child health (RMNCH), infectious diseases, noncommunicable diseases (NCDs), and service capacity and access. Details about the indicators are shown in Table A1.1.[29]

Table A1.1. Data sources used in the calculation of the UHC SCI (SDG 3.8.1)

Tracer indicator	Data source	Denominator	Denominator data source
Reproductive, maternal, newborn, and child health (RMNCH)			
Demand for family planning satisfied with modern methods in women of reproductive age (15–49 years) (%)	Estimates and projections of family planning indicators 2024. United Nations Population Division (https://population.un.org/dataportal/)	Number of women aged 15–49 with a need for family planning	Estimates and Projections of Family Planning Indicators 2024. United Nations Population Division (https://population.un.org/dataportal)
Antenatal care coverage, +4 visits (%)	Global Health Observatory. Antenatal care coverage – at least four visits (%) (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/antenatal-care-coverage-at-least-four-visits)	Number of women aged 15–49 with a live birth in the same period	United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024 (https://population.un.org/wpp/)

[29] Indicator definitions are available within Annex 1 of source *(2)* in the main report.

Tracer indicator	Data source	Denominator	Denominator data source
DTP3 immunization coverage in children aged 1 (%)	WHO/UNICEF Estimates of National Immunization Coverage, 2024 revision (https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage)	Children 1 year of age	United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024 (https://population.un.org/wpp/)
Care seeking for children <5 with acute respiratory infection (%)	UNICEF global database (November 2024 update, https://data.unicef.org/)	Number of children younger than 5 years with symptoms of acute respiratory infection in the two weeks preceding the survey[a]	
Infectious diseases			
TB treatment coverage (%)	WHO Global Tuberculosis Programme (2024 revision) (https://www.who.int/teams/global-tuberculosis-programme/data)	Estimated number of incident TB cases	WHO Global Tuberculosis Programme (2024 revision) (https://www.who.int/teams/global-tuberculosis-programme/data)
HIV ART coverage (%)	UNAIDS/WHO Global Health Observatory data repository, 2024 revision (https://www.who.int/data/gho/data/themes/hiv-aids)	Number of adults and children living with HIV during the same period	UNAIDS/WHO Global Health Observatory data repository, 2024 revision (https://www.who.int/data/gho/data/themes/hiv-aids)
Insecticide treated net (ITN) use	World malaria report 2024 (https://iris.who.int/handle/10665/379751)	Population living in malaria endemic areas	World malaria report 2024 (https://iris.who.int/handle/10665/379751)
Population using at least basic sanitation services (%)	WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP), 2025 revision (https://washdata.org/)	Total population	United Nations, Department of Economic and Social Affairs, Population Division (*2024*). World Population Prospects 2024 (https://population.un.org/wpp/)

Tracer indicator	Data source	Denominator	Denominator data source
Noncommunicable diseases			
Coverage of hypertension treatment in adults aged 30–79 (%)	WHO/NCD-RisC estimates (2021 revision), published in the WHO Global Health Observatory (https://www.who.int/data/gho/data/themes/topics/noncommunicable-diseases-risk-factors)	Number of adults aged 30–79 years with hypertension (defined as having systolic blood pressure ≥ 140 mmHg, diastolic blood pressure ≥ 90 mmHg, or taking medication for hypertension)	WHO/NCD-RisC estimates (2021 revision), published in the WHO Global Health Observatory (https://www.who.int/data/gho/data/themes/topics/noncommunicable-diseases-risk-factors)
Coverage of treatment for diabetes among adults aged 30 years and over with diabetes (%)	WHO/NCD-RisC estimates (2024 revision), published in the WHO Global Health Observatory (https://www.who.int/data/gho/data/themes/topics/noncommunicable-diseases-risk-factors)	Total number of adults aged ≥ 30 years with diabetes, defined as fasting plasma glucose (FPG) ≥7.0 mmol/L, glycated haemoglobin (HbA1c) ≥6.5%, or taking medication for diabetes	WHO/NCD-RisC estimates (2024 revision), published in the WHO Global Health Observatory (https://www.who.int/data/gho/data/themes/topics/noncommunicable-diseases-risk-factors)
Current tobacco use in adults aged 15+ (%)	WHO global report on trends in prevalence of tobacco use 2000–2024 and projections 2025–2030 (https://www.who.int/publications/i/item/9789240116276)	Adults aged 15 or older	United Nations, Department of Economic and Social Affairs, Population Division (*2024*). World Population Prospects 2024 (https://population.un.org/wpp/)
Service capacity and access			
Hospital beds per 10 000 population	Global Health Observatory. hospital beds (per 10 000 population) (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hospital-beds-%28per-10-000-population%29)	Total population	United Nations, Department of Economic and Social Affairs, Population Division (*2024*). World Population Prospects 2024 (https://population.un.org/wpp/)

Tracer indicator	Data source	Denominator	Denominator data source
Health workforce: density of medical doctors, nursing and midwifery personnel per 1000 population	WHO National Health Workforce Accounts Database (https://apps.who.int/nhwaportal/)	Total population	United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024 (https://population.un.org/wpp/)
International Health Regulations core capacity index	Electronic State Parties Self-Assessment Annual Reporting Tool (e-SPAR), 2024 revision (https://extranet.who.int/e-spar)	Total number of attributes [b]	

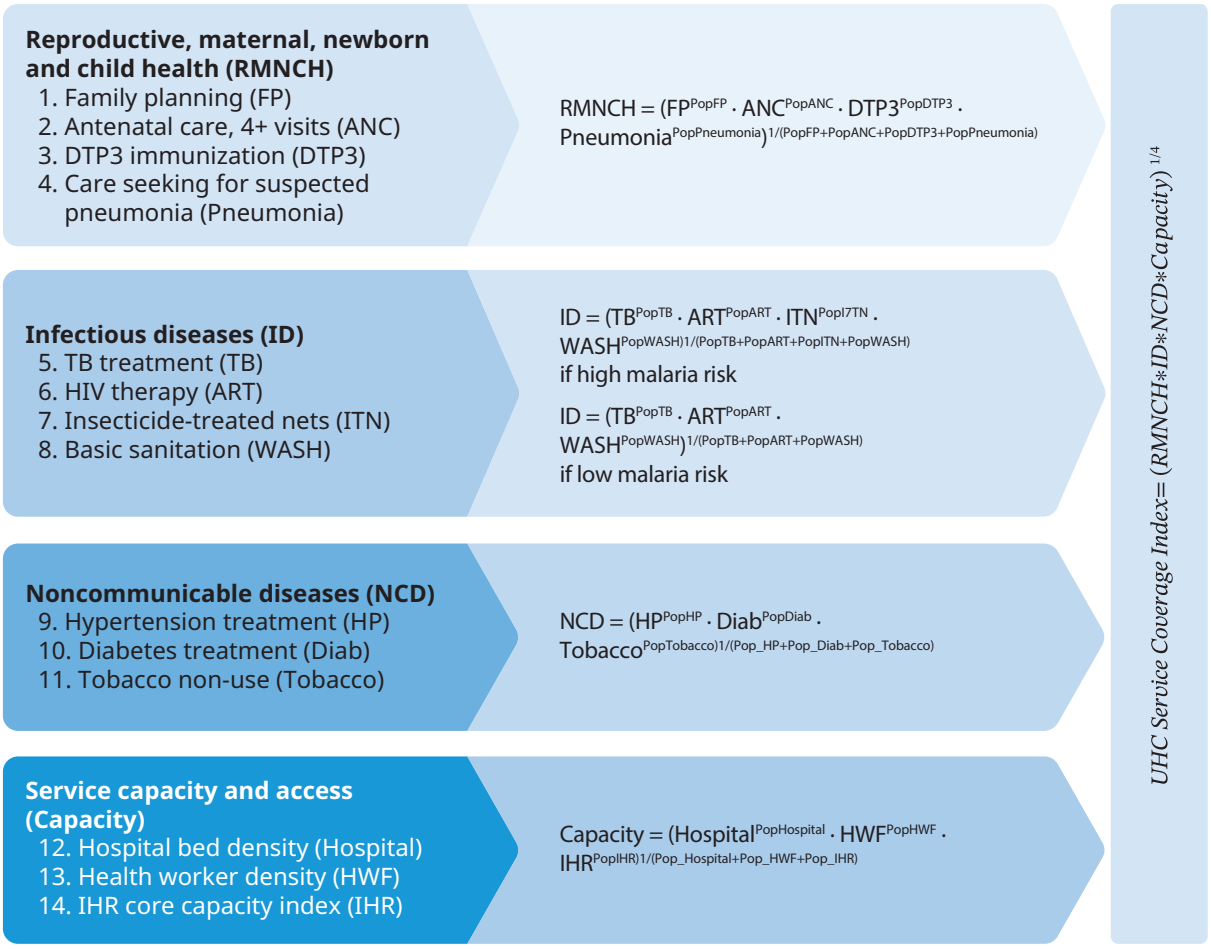
Notes: Data sources were accessed on 30 May 2025. Some indicators may include data validated as part of the country consultation process, which were not publicly available. [a] Children under 5 years of age is used in the index calculation. [b] Total population is used in the index calculation.

Computation of the index

To compute annual UHC SCI, data is necessary for each country or territory, for each calendar year and for each indicator, hence imputation of missing values is often necessary. In addition, to build an index, all tracer indicators need to be placed on the same scale, with 0 being the lowest value and 100 being the optimal value. For a few indicators, conversion and/or rescaling are required to obtain appropriate values on this scale.[30] Once all tracer indicator values are on a scale of 0 to 100, weighted geometric means (where the weight is the denominator population presented in Table A1.1) are computed within each of the four health domains, and then a geometric mean is calculated from those four values (see Fig. A1.1)

[30] See section 4c of source *(2)* in the main report.

Fig. A1.1. Schematic of UHC SCI (SDG 3.8.1) components and calculation



Using the country-level tracer indicators and corresponding denominators, an aggregate at the tracer level and summed denominator population is computed and used to calculate the UHC SCI as outlined in Figure A1.1 for regional and global aggregates.

As presented in chapters 1 and 2, for service coverage, the annualized rate of change of the UHC SCI is defined as: $\ln(\text{UHC SCI}_{t2}/\text{UHC SCI}_{t1}) / (t2–t1)$, where $t1$ and $t2$ refer to different years with $t1 < t2$. This is also used for projecting global progress to 2030.

2. Population not covered by essential health services

The UHC SCI is first calculated as the weighted geometric mean of 14 tracer indicators on an annual basis for each country,[31] as described at the beginning of this annex. As an index score, the SCI *is not* the percentage of the population covered by a set of essential services within a country. However, building on previous conceptual approaches to estimating the population covered by essential health services,[32] the index score was assumed to be an indication of the average coverage of the indicators within a country. This average coverage was then converted to the percentage of people with full coverage (defined as

[31] Country refers to country or territory.

[32] This analysis combined two previously published methods, which had been presented in: Tracking universal health coverage: 2017 global monitoring report *(5)* and the WHO Thirteenth General Programme of Work: methods for impact measurement, version 2.1 *(6)*.

receiving most needed services) in each country, region and globally. The conversion uses a regression model based on co-coverage data from household surveys in low- and lower-middle-income countries to capture the relationship between average coverage across a set of essential services and the likelihood that individuals receive most or all needed services. By applying this equation to national average coverage values, the proportion of the population with full coverage is estimated. Finally, for each location, 100% minus the percentage of population with full coverage (i.e. the percentage of population without full coverage) was multiplied by the total population to obtain the number of people not covered by essential services in each country. The estimated global population not covered by essential services was divided by the global population for each year to determine the percentage of the population not covered by essential services.

3. Decomposition of service coverage index

Decomposition methods have been developed to understand how summary measures vary due to component factors *(1–3)*. In the context of the UHC SCI, these methods were used to determine the extent to which individual indicators contribute to overall changes in the SCI over time.

The calculation of the SCI at time t can be represented by the function F which takes as input the 14 tracer indicators $i_t^1, \ldots i_t^{14}$, and the tracer indicators' corresponding populations $p_t^1, \ldots p_t^{14}$.

$$SCI_t = F\left(i_t^1, \ldots i_t^{14}, p_t^1, \ldots p_t^{14}\right)$$

The pseudo-continuous decomposition method by Horiuchi, et al *(3)* as implemented in the DemoDecomp R package *(4)* is used to attribute changes in the overall SCI between two time points to changes in each of the 14 tracer indicators $\delta_{i1,\ldots}\delta_{i14}$, and to changes in each indicator's population $\delta_{p1,\ldots}\delta_{p14}$. A property of this algorithm is that the decomposed contributions sum to the overall change in time t_1 and time t_2

$$SCI_{t1} - SCI_{t2} = \delta_{i1,} + \cdots + \delta_{i14} + \delta_{p1} + \delta_{p14}$$

To simplify interpretation, the total contribution attributed to each indicator via changes in the indicator estimate and the corresponding indicator population is presented.

$$\delta^1 = \delta_{i1} + \delta_{p1}$$

$$SCI_{t1} - SCI_{t2} = \delta^1 + \cdots + \delta^{14}$$

The decomposition was run separately for each country and aggregate location. The change between each successive year was decomposed before summing to the total change between 2000 and 2023 for each location.

4. Data availability

The availability of timely primary data impacts the extent to which the SCI can provide an accurate measurement of service coverage within a country. Primary data include data gathered through routine reporting systems or household surveys. Primary data are either used directly for indicator values or as inputs for models to estimate the indicators. Regular data collection ensures that the estimates reflect the most recent situation. It is recommended that administrative data be reported on an annual basis and that household surveys be conducted at least every five years to ensure that up-to-date measurements are included in the SCI.

Primary data availability varied across countries (23% to 100%) for the latest five-year period (2019 to 2023). 29 countries had primary data for less than 50% of indicators. The WHO African and South-East Asia regions had the highest coverage (69/70%), and the remaining four had similar, slightly lower coverage (61% to 65%).

Table A1.2. Availability of primary data by WHO region and globally, 2019–2023

WHO region	Percentage of UHC SCI tracer indicators for which primary data were available (2019–2023)
African Region	69%
Region of the Americas	65%
South-East Asia Region	70%
Eastern Mediterranean Region	62%
European Region	62%
Western Pacific Region	61%
Global	64%

Source: Authors analysis based on data sources listed in Table A1.1.

Annex 2. Data availability and global/ regional aggregation methods for financial hardship

1. Country-level data availability

The available dataset used to produce this report and to calculate the global and regional estimates of financial hardship has expanded since the 2023 report. It relies on 1112 primary estimates for 168 countries or territories on financial hardship (compared to 987 primary estimates in 2023 on catastrophic payments (budget share approach)) and 1071 primary estimates for 166 countries or territories on impoverishment (compared to 856 primary estimates in 2023) (see Tables A2.1 and A2.2 below). Primary estimates are based on household surveys collected by countries' national statistical offices, including information on household OOP health expenditures and household total consumption expenditures or income. They are used to produce annual regional and global estimates for 22 years since 2000, versus seven reference years in the 2023 report (see methods section for further details). Altogether, the countries with validated primary estimates represent about 95% of the world's population in 2022 and more than 91% of the regional populations in 2022 (Table A2.1).

Half of the data points were collected after 2011, with the median most recent year ranging between 2016 and 2019 (Table A2.1). Globally, on average, there were 6.6 estimates (survey-years) per country available (see Table A2.2). The WHO Western Pacific Region has the highest number of countries with just one estimate (survey–year), followed by the WHO Region of the Americas. On average, globally, the frequency of estimates was every 4.5 years, with the highest frequency in the WHO European Region (every 2.6 years) and the lowest frequency in the WHO African Region (every 6.5 years).

Table A2.1. Availability of survey-based estimates for financial hardship (SDG 3.8.2)

	Number of observations	Number of countries	Median year	Median most recent year	2022 Population coverage (%)
Global	1112	168	2011	2018	95.2
African Region	173	43	2011	2018	95.3
Region of the Americas	149	27	2012	2018	91.8
Eastern Mediterranean Region	68	16	2010	2017	92.6
European Region	550	49	2010	2019	92.1
South-East Asia Region					
With Indonesia	71	10	2011	2020	98.7
Without Indonesia	48	9	2010	2019	98.5
Western Pacific Region					
With Indonesia	117	23	2014	2019	97.8
Without Indonesia	94	22	2014	2018	97.4
Non-Member States	7	1	2009	2016	5.2

Note: Data availability for global monitoring, which may not necessarily align with the availability of data at national or regional levels.

Source: Based on an analysis of the microdata from the Global database on financial protection assembled by WHO and the World Bank (2025 update) *(7)*.

Table A2.2. Average number and frequency of survey-based estimates for financial hardship (SDG 3.8.2)

	Financial hardship (SDG 3.8.2 indicator)		
	Average number of estimates per country	% countries with just one estimate	Average frequency of estimates, in years
Global	6.6	17.2	4.5
African Region	4.0	4.7	6.5
Region of the Americas	5.5	25.9	5.2
Eastern Mediterranean Region	4.3	12.5	4.3
European Region	11.2	12.2	2.6
South-East Asia Region			
With Indonesia	7.1	0.0	3.9
Without Indonesia	5.3	0.0	4.3
Western Pacific Region			
With Indonesia	5.1	52.2	4.0
Without Indonesia	4.3	54.5	4.3
Non-Member States	7.0	0.0	2.2

Source: Based on an analysis of the microdata from the Global database on financial protection assembled by WHO and the World Bank (2025 update) *(7).*

2. Data availability by socio-demographic characteristics

Three disaggregation characteristics were considered to compare financial hardship across different types of households: residence, household head's sex, and the household's age structure.

Household age structure is described in chapter 3. A Sample of 83 countries with survey data from 2015 onwards was used in chapter 3. Together, countries represented 52% of the world's population in 2022. For each country, only the most recent year with available data was used. The median year was 2019. Country–year observations were included only if data on both financial hardship and large OOP were available.

For the sex of the household head, data were available from 97 countries, with the most recent estimate available for the 2015–2024 period. The median most recent year is 2019, representing 58.5% of the world population in 2022.

Information on household residence (urban or rural) was recorded in each survey. For surveys using the standardized methodology adopted by the UN Statistical Commission, which classifies local administrative units into three types – cities, towns and suburbs, and rural areas – cities, towns and suburbs were reclassified as "urban." Households were further classified as female- or male-headed according to the sex of the individual identified as head in the roster.

For analyses by household residence, data were available from 98 countries, with the most recent estimate available for the 2015–2024 period. The median most recent year is 2020, representing 77.9% of the world population in 2022.

3. Global and regional aggregation for the financial hardship indicator

Country-specific survey estimates are used to produce estimated global and regional annual rates of financial hardship, which are population weighted, for the years 2000–2022, while previous global monitoring reports reported estimates for selected reference years. The approach for generating the estimates, however, is identical to that used in the previous global monitoring report from 2023.

To produce the aggregated estimates, rates are required for each country and territory for all reference years (2000–2022). Since household surveys with information on total consumption or income and OOP health expenditure are not available for every country and every year, rates in each reference year need to be projected for each country and territory with missing primary data points. The projection depends on the data availability for each country and uses the following steps:

1. **Case 1:** If a primary data point (estimate generated from a survey conducted in the country in the reference year) is available for the reference year, the survey estimate of the financial protection indicator is directly used.

2. **Case 2:** If a data point is not available for the reference year, but two data points exist before and after the reference year within a window of +/– 5 years around the reference year, the country's rate for the reference year is projected by a linear interpolation between the two years with available data.
3. **Case 3:** If the conditions above are not met, but there are at least two data points for the country at any time since 2000, the reference year rate is predicted based on an estimated fixed effects regression model. In the regression model, a logarithm of the financial protection indicator is regressed on a logarithm of gross domestic product (GDP) per capita, the logarithm of the aggregate share of OOP health spending over final household consumption (OOP/C), a logarithm of the poverty headcount ratio at the societal poverty line, year, and country fixed effects. The time trend (year coefficient) is interacted with the World Bank's income group classification for the corresponding year. In addition to the availability of at least two data points, the implementation of this approach also requires available data on all the model's dependent variables.
4. **Case 4:** If all the conditions listed above are unmet, the financial protection indicator is projected as the median among countries in the same World Bank income group for which reference year values are produced in one of the three approaches listed above (cases 1–3). If a World Bank income group classification is not available for the country or territory, a regional reference group is used based on the United Nations Statistical Division M49 classification.

Table A2.3 below provides a country-level breakdown across the categories just described and the population coverage of these groups of countries for all reference years.

For the reference year 2018, for example, actual data points on financial hardship are used for 50 countries representing 47% of the world's population (Case 1), and for an additional 30 countries, there are data points within the 2013–2023 window (Case 2). Although the reference group median (Case 4) is used to project rates in 102 countries and territories, they represent only 9% of the global population. For Case 3, using the fixed effects model, the table reports separately countries for which there exists at least one survey point within a window of +/– 5 years around the reference year.

For all years, estimates for more than 80% of the global population are based on data points within the +/– 5 years window (Case 1, Case 2, or Case 3 with at least one point within the window).

Table A2.3. Categories of data points used to construct global estimates of financial hardship

		(*1*) Reference year point (Case 1)	(*2*) At least two points within +/– 5 years band (Case 2)	(*3*) Prediction based on fixed effects model, with at least one point within +/– 5 years band (Case 3)	(*3*) Prediction based on fixed effects model, without any point within +/- 5 years band (Case 3)	(*4*) Projection as median of reference group (Case 4)
2000	N	30	20	52	25	109
	%	37%	26%	22%	6%	10%
2001	N	25	30	52	19	110
	%	34%	13%	39%	5%	10%
2002	N	37	26	47	17	109
	%	39%	30%	14%	8%	10%
2003	N	35	32	48	14	107
	%	33%	38%	15%	5%	9%
2004	N	38	31	49	11	107
	%	40%	33%	14%	4%	9%
2005	N	46	35	44	7	104
	%	20%	55%	14%	2%	9%
2006	N	43	44	36	7	106
	%	38%	39%	12%	2%	9%
2007	N	43	49	35	6	103
	%	56%	22%	12%	2%	9%
2008	N	40	51	35	6	104
	%	20%	43%	26%	2%	9%
2009	N	50	45	34	6	101
	%	40%	21%	29%	2%	8%
2010	N	54	46	30	4	102
	%	33%	30%	28%	1%	7%

		(*1*) Reference year point (Case 1)	(*2*) At least two points within +/– 5 years band (Case 2)	(*3*) Prediction based on fixed effects model, with at least one point within +/– 5 years band (Case 3)	(*3*) Prediction based on fixed effects model, without any point within +/- 5 years band (Case 3)	(*4*) Projection as median of reference group (Case 4)
2011	N	48	49	32	4	103
	%	43%	19%	29%	1%	9%
2012	N	51	46	35	4	100
	%	27%	20%	43%	1%	9%
2013	N	43	59	27	6	101
	%	24%	24%	41%	2%	9%
2014	N	48	50	33	5	100
	%	24%	21%	46%	1%	8%
2015	N	57	39	36	6	98
	%	28%	14%	48%	1%	9%
2016	N	55	33	40	9	99
	%	26%	15%	49%	2%	9%
2017	N	40	40	45	11	100
	%	22%	20%	48%	2%	8%
2018	N	51	29	42	12	102
	%	48%	8%	31%	3%	9%
2019	N	39	34	45	17	101
	%	19%	16%	52%	4%	9%
2020	N	24	32	54	23	103
	%	18%	12%	54%	8%	9%
2021	N	42	9	50	31	104
	%	21%	7%	54%	9%	9%
2022	N	30	3	59	38	106
	%	38%	2%	40%	11%	10%

Notes: N, number of countries; %, percentage of world population. Data availability for global monitoring may not necessarily align with the availability of data at national or regional levels.

Source: Based on an analysis of the microdata from the Global database on financial protection assembled by WHO and the World Bank (2025 update) *(7)*.

4. Other data sources

In chapter 1 and chapter 3, some of the graphs and/or discussion are based on data that were not produced for this report but were obtained from external sources. Poverty rates and societal poverty lines are taken from the World Bank's Poverty and Inequality Platform (PIP) *(8)* and World Development Indicators (WDI) *(9)*, both from their respective June 2024 updates, and the International Monetary Fund's (IMF) World Economic Outlook (WEO) October 2024 update *(10)*. Purchasing power parities and values of average daily per capita income or consumption are taken from PIP and WDI. WHO's country classifications are based on the WHO reference database (July 2025 update) *(11)*, World Population Prospects October 2024 update *(12)*, and World Urbanisation Prospects *(13)*. Values for current health expenditure and domestic general government health expenditure are taken from WHO's Global Health Expenditure (GHO) Database, December 2024 update *(14)*.

Annex 3. Sustainable Development Goal (SDG) indicators of universal health coverage (UHC) by location, most recent year available

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Afghanistan**	42	34.6	2020	PPP2017$1.15+50%med_net
Albania	71	14.8	2017	PPP2017$1.15+50%med_net
Algeria	70	NA	NA	NA
Andorra**	75	5.6	2023	PPP2017$1.15+50%med_net
Angola	44	39.5	2018	PPP2017$1.15+50%med_net
Antigua and Barbuda	81	NA	NA	NA
Argentina	80	35.9	2017	PPP2017$2.15
Armenia	69	23.5	2020	PPP2017$1.15+50%med_net
Australia	89	NA	NA	NA
Austria	84	8.6	1999	PPP2017$1.15+50%med_net
Azerbaijan	67	9.1	2005	PPP2017$1.15+50%med_net
Bahamas	80	NA	NA	NA
Bahrain	78	NA	NA	NA
Bangladesh*	54	41.7	2022	PPP2017$1.15+50%med_net
Barbados	82	15.9	2016	PPP2017$1.15+50%med_net
Belarus	80	12.2	2020	PPP2017$1.15+50%med_net
Belgium	86	12.3	2009	PPP2017$1.15+50%med_net
Belize	70	17.1	2018	PPP2017$1.15+50%med_net
Benin	38	35.6	2021	PPP2017$1.15+50%med_net
Bhutan**	69	9.0	2022	PPP2017$1.15+50%med_net
Bolivia (Plurinational State of)	67	13.4	2021	PPP2017$1.15+50%med_net
Bosnia and Herzegovina	64	8.6	2022	PPP2017$1.15+50%med_net

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Botswana	60	11.8	2015	PPP2017$1.15+50%med_net
Brazil	84	24.0	2017	PPP2017$1.15+50%med_net
Brunei Darussalam	84	NA	NA	NA
Bulgaria	73	18.7	2023	PPP2017$1.15+50%med_net
Burkina Faso	47	38.6	2021	PPP2017$1.15+50%med_net
Burundi	48	56.6	2013	PPP2017$2.15
Cabo Verde	71	23.3	2015	PPP2017$1.15+50%med_net
Cambodia**	62	22.1	2023	PPP2017$1.15+50%med_net
Cameroon	48	38.8	2022	PPP2017$1.15+50%med_net
Canada	92	NA	NA	NA
Central African Republic	39	53.0	2021	PPP2017$2.15
Chad	26	33.6	2018	PPP2017$1.15+50%med_net
Chile	84	17.4	2021	PPP2017$1.15+50%med_net
China	85	33.6	2018	PPP2017$1.15+50%med_net
Colombia	82	12.5	2021	PPP2017$1.15+50%med_net
Comoros	52	32.4	2014	PPP2017$1.15+50%med_net
Congo	45	36.1	2011	PPP2017$1.15+50%med_net
Cook Islands	75	5.4	2015	PPP2017$1.15+50%med_net
Costa Rica	84	13.4	2018	PPP2017$1.15+50%med_net
Croatia	76	8.4	2010	PPP2017$1.15+50%med_net
Cuba	86	NA	NA	NA
Cyprus**	76	11.7	2023	PPP2017$1.15+50%med_net
Czechia	83	10.0	2023	PPP2017$1.15+50%med_net
Côte d'Ivoire	46	28.9	2021	PPP2017$1.15+50%med_net
Democratic People's Republic of Korea	77	NA	NA	NA
Democratic Republic of the Congo	41	60.0	2012	PPP2017$2.15

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Denmark	85	7.4	2010	PPP2017$1.15+50%med_net
Djibouti	47	6.5	2017	PPP2017$1.15+50%med_net
Dominica	75	NA	NA	NA
Dominican Republic**	73	15.5	2018	PPP2017$1.15+50%med_net
Ecuador	78	22.6	2013	PPP2017$1.15+50%med_net
Egypt	71	36.9	2019	PPP2017$1.15+50%med_net
El Salvador	79	10.5	2019	PPP2017$1.15+50%med_net
Equatorial Guinea	49	NA	NA	NA
Eritrea	40	NA	NA	NA
Estonia	79	8.9	2011	PPP2017$1.15+50%med_net
Eswatini	72	25.5	2016	PPP2017$1.15+50%med_net
Ethiopia	33	24.2	2021	PPP2017$1.15+50%med_net
Fiji	69	NA	NA	NA
Finland	86	10.1	2016	PPP2017$1.15+50%med_net
France	82	NA	NA	NA
Gabon	48	20.6	2017	PPP2017$1.15+50%med_net
Gambia	53	25.6	2015	PPP2017$1.15+50%med_net
Georgia**	71	27.9	2024	PPP2017$1.15+50%med_net
Germany	87	4.8	2010	PPP2017$1.15+50%med_net
Ghana	56	21.1	2016	PPP2017$1.15+50%med_net
Greece	77	18.8	2023	PPP2017$1.15+50%med_net
Grenada**	78	3.4	2008	PPP2017$1.15+50%med_net
Guatemala	58	20.6	2023	PPP2017$1.15+50%med_net
Guinea	43	37.0	2018	PPP2017$1.15+50%med_net
Guinea-Bissau	43	38.2	2021	PPP2017$1.15+50%med_net
Guyana	73	NA	NA	NA
Haiti	44	24.5	2013	PPP2017$1.15+50%med_net
Honduras	64	26.0	2004	PPP2017$1.15+50%med_net
Hungary	80	17.1	2007	PPP2017$1.15+50%med_net

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Iceland	90	10.4	1995	PPP2017$1.15+50%med_net
India	69	30.9	2022	PPP2017$1.15+50%med_net
Indonesia	67	26.6	2023	PPP2017$1.15+50%med_net
Iran (Islamic Republic of)	81	15.6	2022	PPP2017$1.15+50%med_net
Iraq	64	33.2	2017	PPP2017$1.15+50%med_net
Ireland	82	7.8	2009	PPP2017$1.15+50%med_net
Israel	85	16.6	2021	PPP2017$1.15+50%med_net
Italy	82	9.7	2010	PPP2017$1.15+50%med_net
Jamaica	74	21.5	2021	PPP2017$1.15+50%med_net
Japan*	86	10.9	2024	PPP2017$1.15+50%med_net
Jordan	74	14.7	2010	PPP2017$1.15+50%med_net
Kazakhstan	83	9.8	2018	PPP2017$1.15+50%med_net
Kenya	57	26.4	2015	PPP2017$1.15+50%med_net
Kiribati**	51	2.1	2019	PPP2017$1.15+50%med_net
Kuwait	84	NA	NA	NA
Kyrgyzstan	74	9.6	2022	PPP2017$1.15+50%med_net
Lao People's Democratic Republic	64	13.2	2018	PPP2017$1.15+50%med_net
Latvia	77	18.6	2019	PPP2017$1.15+50%med_net
Lebanon	67	33.3	1999	PPP2017$1.15+50%med_net
Lesotho	55	29.2	2017	PPP2017$1.15+50%med_net
Liberia	49	43.3	2016	PPP2017$1.15+50%med_net
Libya	71	NA	NA	NA
Lithuania	78	10.6	2021	PPP2017$1.15+50%med_net
Luxembourg	83	14.1	2023	PPP2017$1.15+50%med_net
Madagascar	33	8.4	2021	PPP2017$1.15+50%med_net
Malawi	52	43.0	2019	PPP2017$2.15
Malaysia*	80	17.8	2022	PPP2017$1.15+50%med_net
Maldives	71	14.2	2019	PPP2017$1.15+50%med_net

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Mali	41	40.1	2022	PPP2017$1.15+50%med_net
Malta	82	17.1	2015	PPP2017$1.15+50%med_net
Marshall Islands**	66	13.0	2019	PPP2017$1.15+50%med_net
Mauritania	40	NA	NA	NA
Mauritius	75	12.6	2023	PPP2017$1.15+50%med_net
Mexico	79	15.9	2022	PPP2017$1.15+50%med_net
Micronesia (Federated States of)**	65	4.8	2013	PPP2017$1.15+50%med_net
Monaco	85	NA	NA	NA
Mongolia	70	29.0	2023	PPP2017$1.15+50%med_net
Montenegro	70	12.1	2015	PPP2017$1.15+50%med_net
Morocco	65	27.1	2013	PPP2017$1.15+50%med_net
Mozambique	50	29.9	2019	PPP2017$2.15
Myanmar	52	26.7	2017	PPP2017$1.15+50%med_net
Namibia	66	27.0	2015	PPP2017$1.15+50%med_net
Nauru**	62	1.0	2012	PPP2017$1.15+50%med_net
Nepal**	58	24.9	2022	PPP2017$1.15+50%med_net
Netherlands (Kingdom of the)	85	3.2	2015	PPP2017$1.15+50%med_net
New Zealand	89	NA	NA	NA
Nicaragua	70	34.7	2014	PPP2017$1.15+50%med_net
Niger	39	38.6	2021	PPP2017$1.15+50%med_net
Nigeria	47	47.4	2022	PPP2017$1.15+50%med_net
Niue**	67	0.0	2015	PPP2017$1.15+50%med_net
North Macedonia**	69	10.0	2024	PPP2017$1.15+50%med_net
Norway	89	9.0	1998	PPP2017$1.15+50%med_net
occupied Palestinian territory, including east Jerusalem**	65	22.3	2023	PPP2017$1.15+50%med_net

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Oman	73	8.5	1999	PPP2017$1.15+50%med_net
Pakistan	56	33.9	2018	PPP2017$1.15+50%med_net
Palau	75	NA	NA	NA
Panama**	82	18.0	2017	PPP2017$1.15+50%med_net
Papua New Guinea	32	NA	NA	NA
Paraguay*	79	21.1	2023	PPP2017$1.15+50%med_net
Peru	68	28.5	2022	PPP2017$1.15+50%med_net
Philippines*	69	31.0	2023	PPP2017$1.15+50%med_net
Poland	82	14.1	2019	PPP2017$1.15+50%med_net
Portugal	83	14.6	2022	PPP2017$1.15+50%med_net
Qatar	84	NA	NA	NA
Republic of Korea*	88	9.7	2021	PPP2017$1.15+50%med_net
Republic of Moldova**	71	9.8	2023	PPP2017$1.15+50%med_net
Romania	77	15.6	2016	PPP2017$1.15+50%med_net
Russian Federation	81	15.4	2014	PPP2017$1.15+50%med_net
Rwanda	59	33.4	2016	PPP2017$1.15+50%med_net
Saint Kitts and Nevis**	80	10.6	2007	PPP2017$1.15+50%med_net
Saint Lucia	75	14.3	2016	PPP2017$1.15+50%med_net
Saint Vincent and the Grenadines	80	NA	NA	NA
Samoa**	62	11.7	2018	PPP2017$1.15+50%med_net
San Marino	74	NA	NA	NA
Sao Tome and Principe	60	18.1	2017	PPP2017$1.15+50%med_net
Saudi Arabia	83	NA	NA	NA
Senegal	48	30.9	2021	PPP2017$1.15+50%med_net
Serbia**	73	11.0	2022	PPP2017$1.15+50%med_net
Seychelles	80	11.4	2013	PPP2017$1.15+50%med_net

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
Sierra Leone	48	47.9	2018	PPP2017$1.15+50%med_net
Singapore	88	NA	NA	NA
Slovakia	78	10.0	2022	PPP2017$1.15+50%med_net
Slovenia	84	6.0	2022	PPP2017$1.15+50%med_net
Solomon Islands**	47	7.0	2012	PPP2017$1.15+50%med_net
Somalia	30	35.9	2017	PPP2017$2.15
South Africa	74	21.1	2014	PPP2017$1.15+50%med_net
South Sudan	41	34.3	2016	PPP2017$2.15
Spain	84	12.7	2023	PPP2017$1.15+50%med_net
Sri Lanka*	72	11.3	2019	PPP2017$1.15+50%med_net
Sudan	48	39.9	2014	PPP2017$1.15+50%med_net
Suriname	74	10.7	2022	PPP2017$1.15+50%med_net
Sweden	85	8.6	1996	PPP2017$1.15+50%med_net
Switzerland**	87	10.3	2017	PPP2017$1.15+50%med_net
Syrian Arab Republic	70	16.0	2007	PPP2017$1.15+50%med_net
Tajikistan**	72	30.8	2019	PPP2017$1.15+50%med_net
Thailand*	82	11.9	2017	PPP2017$1.15+50%med_net
Timor-Leste	48	11.6	2014	PPP2017$1.15+50%med_net
Togo	42	31.3	2021	PPP2017$1.15+50%med_net
Tokelau*	NA	1.3	2015	PPP2017$1.15+50%med_net
Tonga**	71	6.7	2021	PPP2017$1.15+50%med_net
Trinidad and Tobago	75	4.5	2014	PPP2017$1.15+50%med_net
Tunisia	76	31.2	2021	PPP2017$1.15+50%med_net
Turkmenistan	81	NA	NA	NA
Tuvalu**	65	0.5	2015	PPP2017$1.15+50%med_net
Türkiye	77	12.7	2016	PPP2017$1.15+50%med_net
Uganda	54	36.1	2019	PPP2017$1.15+50%med_net
Ukraine	80	14.6	2019	PPP2017$1.15+50%med_net

Country, area, or territory	SDG UHC indicator 3.8.1	SDG UHC indicator 3.8.2		
	Service coverage index (2023)	Financial hardship (% of the population)	Latest year	SPL[a] value in 2017 PPP
United Arab Emirates	84	NA	NA	NA
United Kingdom of Great Britain and Northern Ireland	88	7.5	2021	PPP2017$1.15+50%med_net
United Republic of Tanzania	49	37.5	2020	PPP2017$1.15+50%med_net
United States of America	88	6.8	2023	PPP2017$1.15+50%med_net
Uruguay*	85	13.4	2016	PPP2017$1.15+50%med_net
Uzbekistan	79	22.7	2003	PPP2017$2.15
Vanuatu	52	13.3	2019	PPP2017$1.15+50%med_net
Venezuela (Bolivarian Republic of)	75	NA	NA	NA
Viet Nam	71	23.6	2020	PPP2017$1.15+50%med_net
Wallis and Futuna*	NA	0.1	2005	PPP2017$1.15+50%med_net
Yemen	43	30.1	2014	PPP2017$1.15+50%med_net
Zambia	62	14.1	2015	PPP2017$2.15
Zimbabwe	59	13.4	2017	PPP2017$1.15+50%med_net
Kosovo[b]	NA	13.9	2016	PPP2017$1.15+50%med_net

Notes: For SDG UHC indicator 3.8.2 only: *Produced by the country, territory or area. **Produced in collaboration with the country, territory or area. [a] SPL=max (2.15, 1.15+50% med net). [b] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). SPL, societal poverty line; PPP, purchasing power parity.

Source: SDG indicator 3.8.1 (2025 definition), WHO global service coverage database *(15)*; SDG indicator 3.8.2 (2025 definition), global database on financial protection assembled by WHO and the World Bank, 2025 update *(7)*.

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(All references were accessed on 28 October 2025).