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Achieving Universal Health Coverage in low- and middle-income countries: a global policy agenda for longevity

Health and care
Inequalities
International
Prevention
Life expectancy
Disease and Conditions

Acknowledgements

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Executive summary

In 2015, the UN member states set an official target of achieving Universal Health Coverage (UHC) by 2030 to ensure everyone has access to quality essential health services without financial hardship.

But fast forward 10 years, and the world isn't on track to meet this goal. Low- and middle-income countries (LMICs) still lag behind high-income countries (HICs). This is despite a 46% increase in UHC coverage globally between 2000 and 2021, with the biggest gains coming from LMICs. This contributed to a reduction of over 25% in UHC inequalities between HICs and LMICs during this period. However, progress has stalled since 2015 – and in some areas it has even reversed. This includes the proportion of households spending over 10% of their income on healthcare. Huge inequalities still remain, and are only likely to increase as populations age.

LMICs are not only ageing fast, but they're doing so at a quicker rate than HICs.

> The number of older people will rise to 2.1 billion globally by 2050: more than double the current figure. And 80% of these older people will reside in LMICs.
>
> Investment in healthy ageing by LMICs could not only save 150 million lives but also generate $3.2 trillion in economic returns, which would equate to a return on investment of roughly 16:1.

Although many important steps can still be taken, realistically, it is impossible to make any meaningful progress on UHC without building adequate, resilient health systems that are prepared for, and respond to, the needs of ageing populations. This means that governments around the world must act quickly to ensure that existing public infrastructure and policies work for everyone, regardless of age.

What the data tells us about UHC in LMICs

The *ILC Healthy Ageing and Prevention Index* ranks 153 countries on six healthy ageing metrics: life span, health span, work span, income, and environmental performance. We've used figures from our Index, with figures from the World Health Organization's (WHO) UHC Service Coverage Index, to help us understand how well countries have adapted to greater longevity. This UHC index gives scores both for

overall UHC coverage and subcategories of coverage: reproductive, maternal, newborn and child health (RMNCH); infectious disease management; noncommunicable disease (NCD) management; and service capacity and access. We find that in 2021:

- People who live in countries that invest more in UHC live on average 16 more years in good health compared to those that don't.
  - Countries that invest more in **RMNCH management** perform better in our Index and have half the fertility rate than those that don't – a key determinant of better child and maternal health.
  - Countries that invest in **infectious disease management**, including immunisation programmes, rank higher on our Index and have fewer deaths from infectious diseases.
  - Countries that invest more in **NCD management** rank higher on our Index and report half as many NCD deaths per 100,000 people compared to those that don't.
  - Countries that spend more of their fiscal budgets on health have more comprehensive healthcare **service capacity and access**.

Older people's experiences with their healthcare systems

Global and national discussions and policy around UHC often overlook the health needs of older people. We worked with HelpAge International to conduct focus group discussions in Rwanda, Mongolia, and Zambia to better understand how older people view and access healthcare services in their countries. We found that they face significant barriers in accessing healthcare:

- **Physical barriers** such distance to healthcare facilities or cost of travel significantly hinder access to healthcare.
- **High healthcare costs** including secondary costs like accommodation, limited insurance and expensive medicines force people to choose between foregoing care or facing financial hardship.

- **Human resource and specialist service shortages**, lack of material resources, gaps in healthcare infrastructure along with unclear dissemination of healthcare system information, prevent delivery of timely, effective care.
- **Ageism**, difficulty exercising autonomy in their own healthcare decisions can restrict access to care for older people. Community health workers are vital in promoting healthcare access for older people, but are currently under-funded.

What happens next

We know that UN member states are unlikely to meet the 2030 UHC targets. Governments must begin preparations for the next phase of global commitments to providing UHC for all. Future targets must address the profound impact of demographic change and population ageing on healthcare access and outcomes, embedding these challenges and solutions into UHC strategies to ensure sustained progress. We strongly urge governments and international organisations to implement 3 key solutions:

1. What: Invest in national health schemes[a] a to strengthen and expand the provision of healthcare and prevent catastrophic out-of-pocket spending on health.

Why: Well-designed national health schemes are essential for achieving UHC and reducing inefficiency, inequity, and worsened health outcomes. Policies and programmes must ensure that individuals can access care without enduring financial hardship.

How: Governments can address this challenge by:

- Focusing on coverage for the most high-burden diseases over the next 20 years
- Implementing targeted subsidies and expanding financial protection to alleviate economic barriers for those most at risk of financial hardship
- Strengthening procurement and supply chain systems to ensure sustainable access to essential medicines

[a]Including but not limited to models that include different types of national health insurance, community-based health insurance and social health insurance.

2. What: Position primary healthcare as the cornerstone of UHC

Why: 90% of essential UHC interventions can be delivered through primary healthcare, while also reducing burdens on hospitals and clinics.

How: Governments must:

- Establish or expand community healthcare programmes focused on primary care, preventative care, and NCDs, ensuring that community health workers receive standardised pay
- Expand rural care through innovative solutions like telemedicine, drone delivery and community health hubs
- Allocate at least 6% of health budgets to prevention, phased in through gradual annual increases of 0.5%-1% depending on fiscal capacity
- Expand and improve the training of healthcare professionals to deliver person-centred, inclusive care that meets our diverse needs across the life course

3. What: Build a data-driven, life course approach to UHC

Why: Older people are often left out of data collection, even though it can support better targeted policies and health interventions. What isn't measured doesn't get done.

How: International organisations and governments must:

- Reform data collection and reporting to include populations of all ages
- Establish sustainable mechanisms for meaningful citizen engagement in shaping UHC policies and policies for national health schemes
- Leverage data to account for changing demographics and disease burdens, and set health targets for all ages within a global framework

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Introduction

Low- and middle-income countries (LMICs) are undergoing significant demographic change at a much faster rate than many high-income countries (HICs). It is estimated that the number of people aged 60 or over around the world will more than double by 2050, rising to 2.1 billion. 80% of these older people will reside in LMICs.[1] This will put a significant health burden on these countries. For instance, of the eight in every ten premature deaths that are attributed to noncommunicable disease (NCDs) globally every year, 77% occur in LMICs.[2]

Yet the health and economic benefits of investing in healthy ageing are huge: 150 million lives could be saved in LMICs by 2050. And in 2050 alone, LMICs would see an added economic benefit of $3.2 trillion, which would equate to an approximate return on investment of 16:1.[3]

Universal Health Coverage (UHC) is a way to ensure that everyone has access to quality essential health services without undue financial hardship. UHC has huge potential to greatly improve global health and reduce health inequity and poverty at all ages.

While we have seen clear, exponential progress in UHC around the world, the effects of such improvements are not necessarily being felt by every age group – especially by older people. Their voices are often left out of policy discussions on health, despite their often having the highest disease burden.

We want to change this narrative.

In this report, we:

- Use the ILC's Healthy Ageing and Prevention Index,[4] which ranks 153 countries on six healthy ageing metrics to understand how well they've adapted to longevity, to build evidence and raise awareness among global health policymakers of the importance of improving health in LMICs as the population of these countries age.
- Present findings from focus group interviews, conducted by HelpAge International, of 125 older people from Mongolia, Rwanda and Zambia. We carried these out to give older people's voices a global platform and better understand how they view and access healthcare services and systems in their communities.

- Examine discussions from two policy roundtables with regional experts from Africa and Asia, and a global policy forum at the 79th UN General Assembly to identify solutions for achieving UHC for all ages in LMICs.
- Showcase examples of good practice across six LMICs – Mongolia, Rwanda, Senegal, South Africa, Vietnam and Zambia – to demonstrate the value of UHC and identify interventions to scale out across other LMICs. These countries have seen large improvements in UHC, are politically stable, and in some cases have pioneered innovative UHC structures.

Older people face multiple barriers to good healthcare, including access barriers, economic barriers, and ageism. Healthcare systems are currently ill-equipped to deliver essential healthcare, further pushing older people between the cracks.

Tackling barriers to good health for all ages is crucial if we are to truly achieve UHC for all.[5] We are already off-track to meet the UN target of UHC by 2030 which includes financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. It will also be extremely difficult to make any meaningful progress without building resilient healthcare systems that are prepared for an ageing population.

For this reason, it's crucial that these conversations happen now, as improvements in UHC will require long-term investment and systematic changes.

LMICs face a disproportionate health and economic burden as they age

Policymakers often focus on getting HICs engaged with healthy ageing. But the numbers suggest a different priority: LMICs are ageing fast, and at a quicker rate than their high-income counterparts. HICs in Western Europe and North America have already passed through much of their potential demographic transition. In addition, LMICs are disproportionately affected by the growing global health burden, resulting in significant economic losses.

The trends aren't encouraging:

- Of the one billion people aged 60 or over in the world, 70% currently live in LMICs. By 2050, it's estimated that this number will more than double, (rising to 2.1 billion) making up 22% of the global population. 80% of these older people will reside in LMICs.[6]
- Four regions with a high number of LMICs are projected to triple their share of older people, while two will see them increase even more than that (see Table 1).[7]

Table 1: Number of people aged 65 or over, by global region (2019 & 2050)

GLOBAL REGION	Number in 2019 (millions)	Number in 2050 (millions)	% change between
Northern and Western Asia	29.4	95.8	226
Sub-Saharan Africa	31.9	101.4	218
Oceania, excluding Australia and New Zealand	0.5	1.5	190
Central and Southern Asia	119	328.1	176
Latin America and the Caribbean	56.4	144.6	156
Eastern and South-Eastern Asia	260.6	572.5	120
Australia and New Zealand	4.8	8.8	84
Europe and Northern America	200.4	296.2	48
GLOBAL	702.9	1548.9	120

Demographic change is a global trend: no country is exempt. This means that governments must act quickly to ensure that their existing public infrastructure and policies like UHC work for everyone.[8] This must include older people by default, ensuring healthcare systems meet the needs of their populations throughout the life course.

LMICs face a significant proportion of the global disease burden. Many face a "double burden" of infectious diseases and maternal/child illnesses on one hand, and a rapidly emerging NCD burden on the other. NCDs account for about 41 million deaths globally – and almost eight out of every 10 NCD deaths each year occur in LMICs.[9] The NCDs which put the biggest health burden on LMIC populations are largely age-related; they include cardiovascular disease, diabetes, respiratory disease, cancers and major depression. Indeed, the poorest and most marginalised people are most susceptible to NCDs because of higher rates of smoking, alcohol use and obesity, along with lower quality of healthcare. They are also least able to afford treatment costs.

In 2019, the World Health Organization (WHO) estimated that infectious and parasitic diseases caused 5.1 million deaths globally. Nearly 52% of these were due to eight major diseases (tuberculosis, HIV/AIDS, measles, hepatitis, malaria, dengue, yellow fever and rabies), many of which can be partly or entirely prevented by vaccines.

Much progress has been made in prevention and treatment of all conditions, particularly for infectious disease. But many infectious diseases are still among the leading causes of death and disability in low-income countries,[10] with the mortality rate approximately 10 times higher in LMICs than in HICs.[11]

The economic cost of ill health is significant. The World Bank estimates that in 2019 alone, the economic value of premature mortality was $29.4 trillion – this represents approximately 23% of annual global income. The largest economic losses are felt in sub-Saharan Africa (34% of annual income), followed by India (23%), and Eurasia, the Mediterranean, Latin America and the Caribbean (22%).[12]

Conversely, investment in healthy longevity, including preventative health, could save 150 million lives in LMICs and extend millions more lives, resulting in significant economic benefits by 2050.[13] In fact, LMICs could see an added economic benefit of $3.2 trillion by investing in healthy ageing, which would equate to a return on investment of roughly 16:1.[14] The Lancet Commission on *Investing in Health*

additionally reported that around a quarter of LMICs' economic growth between 2000 and 2011 resulted from investing in population health. The estimated return on investment in health from improved economic growth was 9:1.[15]

Box 1: What is Universal Health Coverage?

UHC means that everyone has access to the full range of quality healthcare services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

UHC is one of the targets under the UN Sustainable Development Goal (SDG) 3: Good Health and Wellbeing. It's designated to target SDG 3.8. Progress is jointly tracked by WHO and the World Bank using two indicators, SDG 3.8.1 and SDG 3.8.2:[16]

1. Coverage of essential health services (SDG 3.8.1)

- Reproductive, maternal, newborn and child health (RMNCH)
- Infectious diseases
- NCDs
- Service capacity and access

These metrics are measured with a score out of 100, on a unitless scale. Very high service coverage has an index of >80; high service coverage is 60-79; medium service coverage is 40-59; low service coverage is 20-39; and very low service coverage is <20.

2. Catastrophic health spending (SDG 3.8.2)

This refers to people incurring a large out-of-pocket (OOP) expense on health, relative to their total consumption or income. Catastrophic OOP health spending makes it harder for households to afford other essential goods and services like food, shelter, clothing or education. If a household's OOP health spending exceeds 10% or 25% of its income or consumption (both are used to measure different levels of catastrophic OOP health spending) this is considered catastrophic health spending. Both measures are used for global reporting and tracking UHC. Other metrics, such as "impoverishing health spending", complement this and are reported on to provide a comprehensive picture of UHC.

Which countries are LMICs?

Every year on 1 July, the World Bank revises its classification of the world's economies based on per capita gross national income (GNI) for the previous year.[17] Economies are assigned into one of four income groups: low, lower-middle, upper-middle or high income. LMICs, therefore, refer to those countries that fall into all but the high-income category. The classifications for 2024-2025 below are based on results from 2023.[18]

Classifications for 2024/25	GNI (per capita in $)
Low-income	< $1,145
Lower-middle-income	$1,146 – $4,515
Upper-middle-income	$4,516 – $14,005
High-income	> $ 14,005

Case study 1: Vietnam – a good approach to financial protection

Vietnam ranks 65th on our *Healthy Ageing and Prevention Index*, and ranks 58th for both health span and life span.[19]

Vietnam has historically struggled with infectious diseases like tuberculosis and malaria. Before 2000, its fragmented healthcare system made access to care difficult, especially for rural populations. Poor nutrition and sanitation only compounded these challenges. In 2000, nearly 20% of deaths were attributed to infectious disease, or maternal and nutritional conditions, while NCDs caused over 70% of deaths.[20]

	2000	2021
Overall service coverage	36.99	68.08
RMNCH management	58.74	80.04
Infectious disease management	12.38	66.9
NCD management	40.3	57.6
Service capacity and access	63.84	69.66

In 2002, Vietnam established the Healthcare Fund for the Poor, which covered about 15% of the population and enabled free healthcare access[21] and expanded clinics in rural areas.[22] In 2008, this fund was integrated into the Social Health Insurance Law, which requires both individuals and employers to contribute to a centralised fund. This law ensures access to maternal and child care, immunisation, primary healthcare and essential medicines from public hospitals and clinics. At-risk groups, including the poor, children under six and adults over 65 may all access healthcare for free without contributing to the fund.[23] By 2020, 91% of the population was enrolled in the fund and the Vietnamese government aims to have 95% enrolled by 2030.[24]

Alongside insurance reforms, programmes to increase human and material healthcare resources have resulted in easier access to treatment and reduced overcrowding in urban hospitals. Since 2021, 3,000 new medical techniques were provided at rural health centres, benefitting 40,000 additional patients.[25] Nutrition strategies and programmes for maternal nutrition, vitamin provision and education on nutrition means that between 2008 and 2018, malnourishment decreased from 18% to 11%.[26]

Achieving Universal Health Coverage

In 2012, the UN General Assembly (UNGA) endorsed a resolution on Global Health and Foreign Policy which urged countries to fast-track progress toward UHC. During the 2015 UN General Assembly,[27] member states officially set a target to achieve UHC in all countries by 2030: this included financial risk protection, access to quality essential healthcare services, and access to safe, effective, high-quality and affordable essential medicines and vaccines for all.

This target was built into the 2030 Sustainable Development Goals (SDGs) as central to achieving good health and wellbeing for all (SDG 3). Most crucially, member states officially recognised UHC's essential role in contributing to societal inclusion, equality, ending poverty, improving education, economic growth and development, and peaceful societies.[28]

In September 2019, member states at the UN High-Level Meeting on UHC endorsed the most ambitious and comprehensive political declaration on health ever. The declaration reaffirmed the right of every human being, without distinction of any kind, to enjoyment of the highest attainable standard of physical and mental health, and recommitted to achieve UHC by 2030. In the same year, WHO's 13th General Programme of Work proposed the Triple Billion targets, which sought to ensure that one billion more people benefit from UHC, one billion more are better protected from health emergencies, and one billion more enjoy better health and wellbeing by 2025. Only the last target is likely to be met by the 2025 deadline (along with SDG target 3a on tobacco use). The target for UHC is the furthest behind of the Triple Billions, with only 43% of the goal achieved so far.

In 2023, the High-Level Meeting on UHC gave stakeholders another opportunity to develop a path to making health a reality for all by 2030. To this end, member states adopted the 2023 political declaration titled *Universal health coverage: expanding our ambition for health and wellbeing in a post-COVID world*.[29] The declaration emphasised the growing health needs of older people in the context of the current Decade of Healthy Ageing.[30] It also put significant emphasis on the critical intersectoral issue of climate change on health outcomes, especially for people living in LMICs.[31]

In 2024, the UNGA High-Level Meeting on antimicrobial resistance (AMR) saw world leaders adopt a political declaration aimed at accelerating action to combat AMR. It referenced UHC's crucial role in tackling AMR by helping to prevent the misuse and overuse of antimicrobials – especially in resource-poor LMICs – by ensuring equitable access to high-quality, safe, effective, affordable and essential health services, medicines, vaccines, diagnostics and health technologies.[32] In addition, at last year's UN Summit of the Future, world leaders adopted the most wide-ranging international agreement in many years: *The Pact for the Future*. This is intended to set the stage for more effective global governance and cooperation, allowing us to tackle today's and tomorrow's challenges. The Pact, while broad in remit, recognises UHC's important role in tackling poverty and inequality.[33]

We must invest in older people's health

UHC has the potential to significantly improve global health and reduce poverty - but only if it works for everyone, including older people. UHC must be available, accessible and of good quality. This includes ensuring the full continuum of healthcare provision, from prevention to long-term care.

One crucial way to achieve UHC is by investing in primary healthcare. This is the most effective approach for delivering comprehensive, accessible, integrated and person-centred services that can support quality of life at all ages. In fact, in a properly organised and funded system staffed by well-trained personnel, 90% of essential services can be delivered through primary healthcare. Currently, LMICs invest on average only $15-$60 per capita on primary healthcare. It's projected that LMICs would need to spend $87 per capita to achieve 80% population coverage.[34] But if they implement primary healthcare properly, it could prevent up to 60 million premature deaths and increase life expectancy by 3.7 years.[35]

The majority of health and care systems are still ill-prepared for longevity. Many older people don't have access to the health and care services they need.[36] The WHO has already stated that we're not on track to make significant progress towards UHC by 2030. Improvements to healthcare services have stagnated since 2015, and the proportion of the global population facing catastrophic levels of out-of-pocket health spending has increased steadily since 2000.[37]

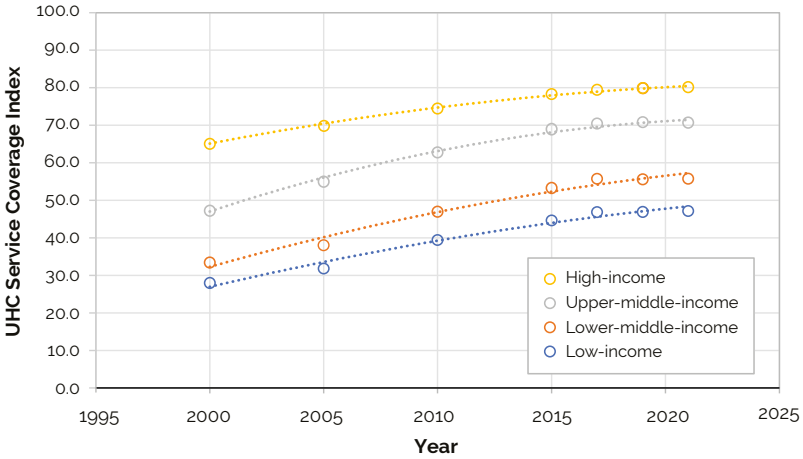
If UHC fails to reach older people and fails to address their health needs, the expectations set at the beginning of the SDGs, or restated subsequently, won't be achieved. Population ageing is likely to further stall progress towards UHC, so it's vital to promote healthy ageing if we are to achieve the other targets covered under SDG 3: Good Health and Wellbeing.

Our findings: trends in UHC across LMICs

UHC coverage increased significantly between 2000 and 2021, with the biggest improvements in LMICs

Between 2000 and 2021, global UHC coverage, as measured by the WHO Global Health Observatory's *UHC Service Coverage Index*, has increased by 46%. The index score has risen from 43.5 to 63.5, with the biggest improvements occurring in LMICs.

Figure 1: UHC coverage over time, by country income level



Source: Data on UHC Service Coverage Index from WHO Global Health Observatory

Within LMICs, upper-middle-income countries improved the most, by 23 points (from 47.5 to 70.5), followed by lower-middle-income countries, which saw a 22.7 point increase (from 33.3 to 56). The smallest increase was in low-income countries, which saw a 19.7 point increase (from 27.7 to 47.4). During this same period, HICs experienced an increase of 14.6 points (from 65.4 to 80).

However, across all income groups, the biggest increases occurred between 2000 and 2010, with post-2010 improvements progressing more slowly.

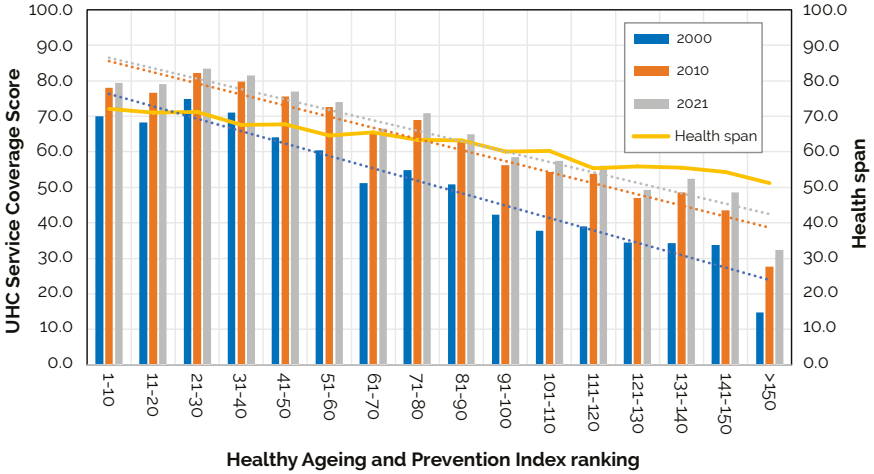
Countries ranked 101-110 and 131-140 in our Index (you can view our Index ranking here) have seen the biggest improvements in UHC (a 60% increase between 2000 and 2021 on average). These are mostly African countries, but the list also includes Bangladesh, India and

Myanmar. Encouragingly, the results show a reduction of over 25% in UHC inequality between HICs and LMICs over the last two decades.

The country that saw the biggest improvement between 2000 and 2021 was Thailand, an upper-middle-income country. It improved its UHC score by 38.8 points, jumping from 43.2 to 82. Thailand is also the second-highest ranked LMIC on our Index, with a rank of 37 globally.[38] The country's success with UHC is recognised internationally; it was one of the first LMICs to adopt UHC in 2002.[39] Since then, out-of-pocket health expenditure has reduced from 27.2% in 2002 to 12.4% in 2019, with publicly funded healthcare covering 98% of its population.[40]

Countries that invest in UHC perform better on our Index and live well for longer

Figure 2: ILC Index ranking and health span score by UHC index score



Source: Data on UHC Service Coverage Index from WHO Global Health Observatory

ILC's *Healthy Ageing and Prevention Index*[41] ranks 153 countries on six healthy ageing metrics: life span, health span, work span, income, and environmental performance to understand how well they've adapted to longevity. Our analysis (Figure 2) not only finds that countries which invest in UHC perform better on our Index, but that there's a strong correlation between UHC scores and health span, meaning countries that invest in UHC also have healthier populations. Countries in the top 30 of our Index (which are all HICs) have an average UHC score of 81.6

and an average health span of 71 while those in the bottom 30 (which are all LMICs) have an average UHC score of 50.1 and their health span is only 55. In other words, people who live in countries that invest more in UHC live on average 16 more years in good health compared to those that don't.

LMICs still lag behind HICs, with varied progress

Despite improvements and a narrowing of inequalities between HICs and LMICs, in 2021, there was still a 22 point difference in overall UHC coverage according to the WHO *UHC Service Coverage Index*.

On average, the inequality in UHC coverage is relatively small between upper-middle-income countries and HICs, at 9.5 points. But the difference between low-income countries and upper-middle-income countries is much higher, at 23.1 points. This suggests wide variability between LMICs with different income levels, making it valuable to consider different income groups separately.

There's also variation for different types of metric. The *UHC Service Coverage Index* includes four sub-indices that cover:

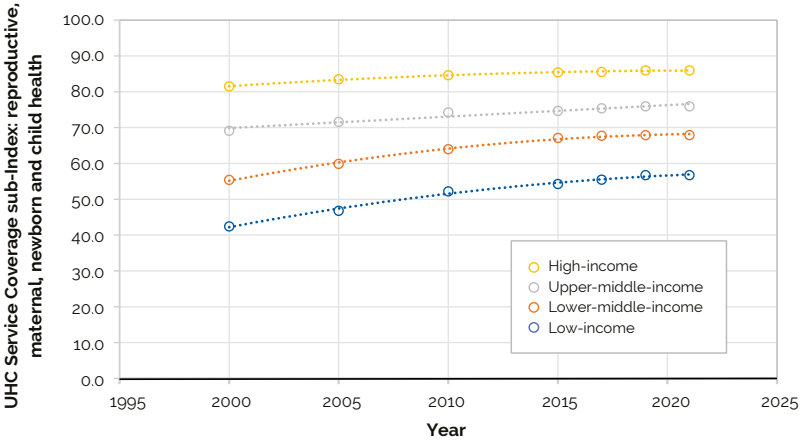
- Reproductive, maternal, newborn and child health (RMNCH) management
- Infectious disease management
- NCD management
- Service capacity and access

The progress seen by different LMICs varies across those metrics, as detailed in the following sections.

Reproductive, maternal, newborn and child health management

Globally, scores in **RMNCH management** increased by 15% between 2000 and 2021 (from 62.1 to 71.6). However, LMICs improved by 20% (from 55.6 to 66.8), a greater relative improvement than HICs, where scores went up by only 6% (from 81.5 to 86). Inequalities between the two groups have decreased slightly, especially between 2000 and 2017. However, there were no further improvements from 2019 to 2021.

Figure 3: RMNCH management over time, by country income level



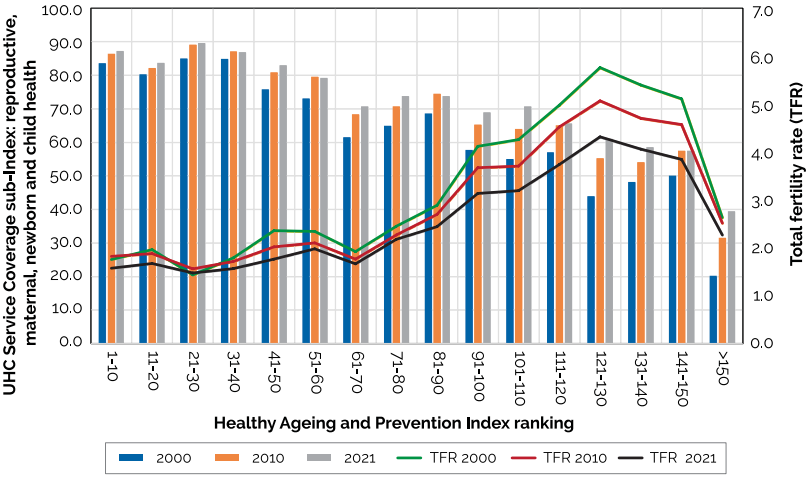
Source: Data on UHC Service Coverage sub-Index on RMNCH from WHO Global Health Observatory

Within different LMIC groups, there was a 26.7 point difference between low-income and upper-middle-income groups in 2000, which had been reduced to 19.2 points by 2021 (see Figure 3).

Rwanda (a low-income country) has seen the biggest improvement in RMNCH, improving by 46.5 points (from 20.7 points in 2000 to 67.2 points in 2021). It is also the African nation that's seen the most improvement in its overall UHC score. 90% of the population is enrolled in its health insurance scheme and healthcare access has steadily increased in rural areas. In particular, emergency obstetric care programmes have improved health outcomes significantly (see Case study 3). In addition, Rwanda is in the top 50% LMICs of our Index for health span, ranking 99th globally (you can view our Index ranking for health span here). [42]

Countries which invest in **RMNCH management** perform better in our Index and have lower total fertility rates (TFR). Countries ranked in the top 30 of the Index have an average RMNCH score of 87.8 and a TFR of 1.7 whereas those in the bottom 30 have an average score of 60.2 and TFR of 4.

Figure 4: ILC Index ranking and TFR by UHC sub-index score



Source: Data on total fertility rates from World Bank

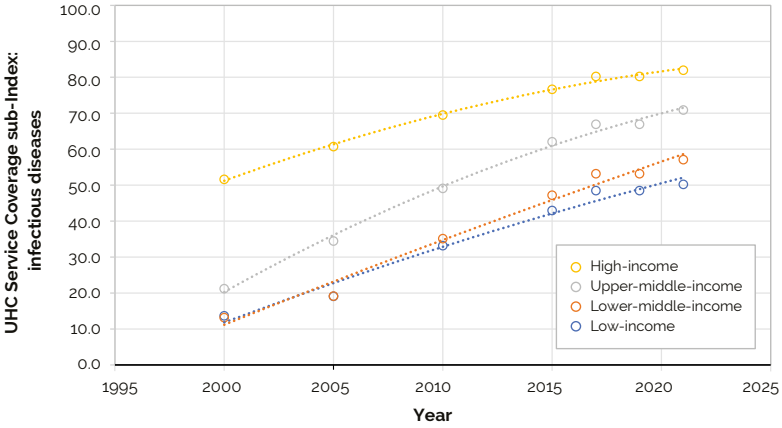
The **RMNCH management** metric examines four categories: whether women of reproductive age (15-49 years) have their need for family planning satisfied with modern methods;[b] the percentage of women aged 15-49 with a live birth who received antenatal care four or more times in a given time period; immunisation coverage for diphtheria tetanus toxoid and pertussis (DTP3) among one-year-olds; and the percentage of care-seeking children that have symptoms of acute respiratory infection.[43]

Improved child survival is one of the strongest predictors of declining fertility. In some countries such as Italy, Japan, and South Korea, there's now a clear demographic and economic argument to increase TFR, but generally countries with higher fertility rates have relatively poor child survival. Higher TFR in low-resource settings are related to lower results for child and maternal health. The risk of mortality in infancy and early childhood is greater for higher-order births, i.e. the more pregnancies a woman undergoes. As this number goes up, it puts the mother at risk of mortality too.[44] This correlation is evident in Figure 4.

[b]Modern methods of contraception include female and male sterilization, intra-uterine devices (IUD), implants, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), the lactational amenorrhea method (LAM), emergency contraception and other modern methods. Traditional methods of contraception include rhythm (e.g., fertility awareness-based methods, periodic abstinence), withdrawal and other traditional methods. (definition obtained from UN World family planning report).

Infectious disease management

Figure 5: Increase in infectious disease management coverage over time, by income



Source: Data on UHC Service Coverage sub-Index on infectious disease management from WHO Global Health Observatory

Between 2000 and 2021, scores for **infectious disease management** have increased across all countries, from 24.9 to 65.1 – an average increase of 161%. Scores have been increasing at a slightly slower pace since 2015, as seen in Figure 5.

But scores in LMICs have increased the most, by an average of 270% between 2000 and 2021. Until 2010, scores in low-income countries were similar to those in lower-middle-income countries, but since then, lower-middle-income countries have made faster progress.

Despite significant improvements in this metric, there are inequalities between LMICs. For instance, in 2021, low-income countries still scored 20.7 points less than upper-middle-income countries. But in 2000 there was only a 7.5 point difference between these groups, suggesting that inequalities between LMICs have widened on this measure.

China (an upper-middle-income country) has seen the biggest increase in its **infectious diseases management** score between 2000 and 2021. Its score rose from 12.3 to 85.2 (an increase of 593%). China is the 5th highest ranked LMIC in our Index (ranking 49th globally). It's also the 2nd highest ranked LMIC for both life span (36th) and health span (33rd).[45] You can view our Index here.

Case study 2: South Africa – a good response to infectious disease

South Africa ranks 120th on our *Healthy Ageing and Prevention Index*.[46]

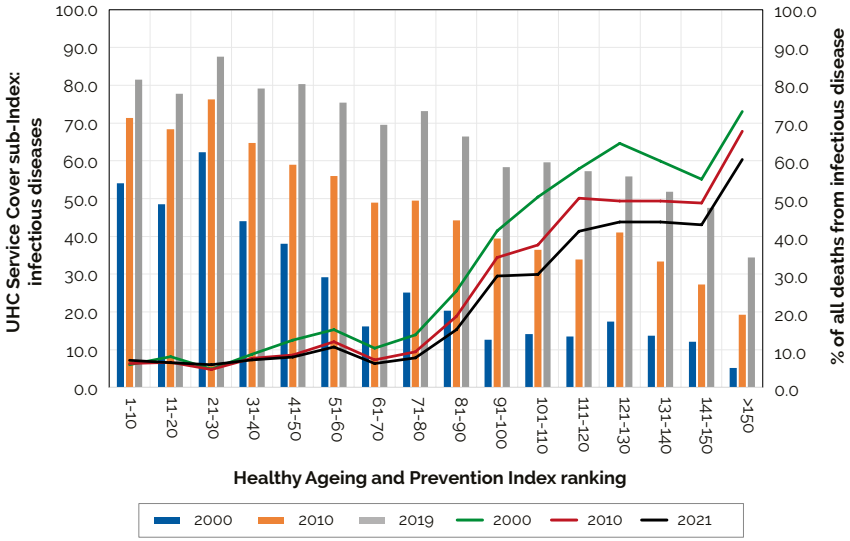
Racial segregation through apartheid rule in South Africa left Black, Asian and Coloured populations without adequate services, resulting in significantly worse health outcomes than those of White citizens.[47] After the advent of democracy in 1994, the most urgent health challenges were maternal and child health and infectious diseases. By 2000, 25% of all deaths were linked to AIDS and anti-retroviral drugs (ARV) were not publicly available.[48]

	2000	2021
Overall service coverage	43.07	70.95
RMNCH management	67.66	76.38
Infectious disease management	13.56	68.77
NCD management	48.25	60.66
Service capacity and access	77.7	79.53

The 1996 Constitution ratified free primary healthcare for all, while the National Health Act of 2004 introduced means-tested fees for secondary and tertiary care based on income, and free health services for maternal, reproductive and child health, as well as chronic diseases like HIV/AIDS. A decentralised healthcare system allowed provincial responsibility for healthcare provision, which was further expanded with the introduction of ward-based primary healthcare provision, typically led by nurses and community health workers. Community-based care helps with vaccination, nutrition, maternal care, and screening for and treating infectious diseases.[49]

These initiatives have significantly improved health outcomes. ARV provision has gone from just 48,000 in 2004[50] to nearly six million in 2024.[51] Life expectancy from birth increased by seven years from 56 in 2010 to 65 in 2019, largely as a result of HIV treatment and management. The incidence of tuberculosis has consistently decreased, especially among HIV-positive individuals, and South Africa met the WHO target of decreasing cases by 20% between 2015 and 2020.[52] In 2024, a new National Health Insurance allows individuals to access services from both private and public healthcare providers while limiting out-of-pocket costs.

Figure 6: ILC Index ranking and % deaths from infectious disease by UHC sub-index score



Source: Data on % of all deaths from infectious disease from World Bank

Countries that invest in immunisation programmes and other infectious disease prevention interventions rank higher on our Index. The top 30 countries on our Index have an average **infectious disease management** score of 84.4, compared to the bottom 30, which have an average score of 53.3. However, countries ranked between 91 and 120 and those ranked 130-140 have all seen more than a three-fold increase in scores for this metric. This includes four of the six countries featured in our report: Rwanda, Senegal, South Africa, and Zambia. Investing in **infectious disease management** is also related to significant differences in life span and health span scores in our Index. And economic benefits are significant too: every $1 spent on adult immunisation generates a socioeconomic return of $19 that goes beyond healthcare spend, including productivity gains from individuals and their caregivers.[53]

Nepal (a lower-middle-income country) has seen a steady decrease in infectious disease rates. Between 2000 and 2019, it also saw the biggest decrease in deaths from infectious disease of over a third: from 57.9% to 24.8%. The country ranks 92nd for life span and 90th for health span globally in our Index, putting it in the top 50% of LMICs.[54] Between

Wave 1 (2019) and Wave 2 (2022) of our Index, it saw the biggest improvement in life span, an appreciable increase of 0.9 years (from 69.6 to 70.5 years). You can view change over time on our Index here.

Figure 6 clearly shows that further down our Index, investment in immunisation is significantly lower, while deaths from infectious disease are correspondingly higher – and these countries are mostly LMICs. The average percentage of deaths attributed to infectious disease is only 7% for countries in the top 30, compared to 44% for the bottom 30.

There's a clear economic case for these countries to invest in immunisation at all ages: every $1 invested in childhood vaccine by LMICs could generate up to $44 in socioeconomic return.[55] To date, vaccination programmes in LMICs have prevented 37 million premature deaths in the last 20 years alone – that's 36 million children aged less than five.[56]

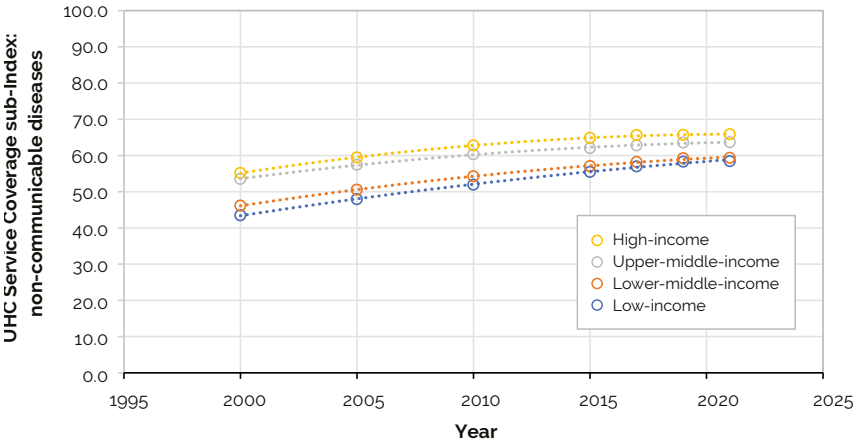
It's worth noting that the UHC **infectious disease management** metric looks at other preventative intervention outcomes such as the percentage of the population in malaria-endemic areas who slept under an insecticide-treated net the previous night, and the percentage of the population using at least basic sanitation services. Nevertheless, the clear value in improving immunisation coverage must not be overlooked.

NCD management

While LMICs have seen a greater relative improvement in **NCD management** scores than HICs (albeit from a low bar), it's been much slower than for **infectious disease management**.

Globally, there's been a 25% increase in **NCD management** scores (from 49.6 to 61.9) between 2000 and 2021. LMICs improved by 27% (from 47.7 to 60.5), while HICs saw a 19% increase (from 55.2 to 65.9), as seen below in Figure 7.

Figure 7: NCD management over time, by country income level

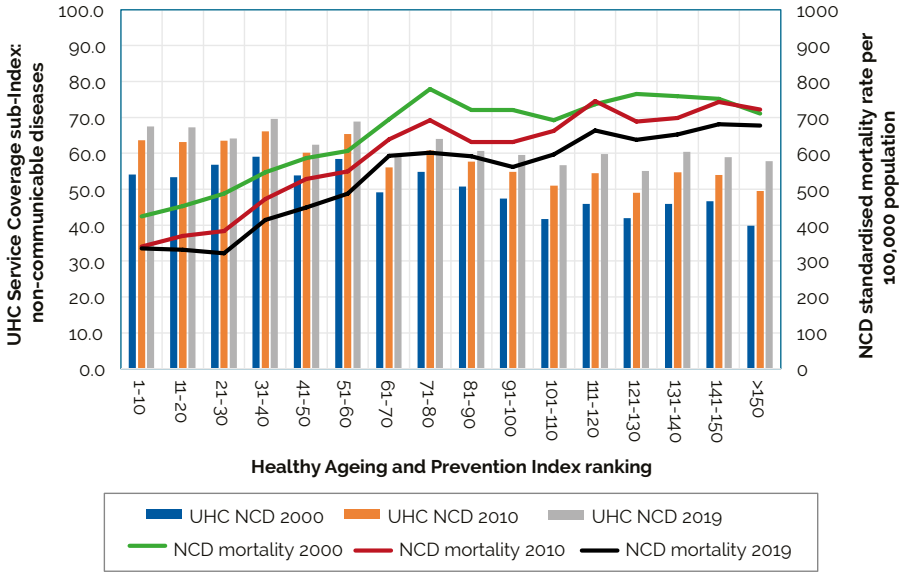


Source: Data on UHC Service Coverage sub-Index on NCD management from [WHO Global Health Observatory]

Again, there's variability between LMICs but since 2000, low-income countries have been catching up with upper-middle-income ones. In 2021, there was a 7.5 point difference, compared with a 10 point difference twenty years before. Myanmar (a lower-middle-income country) has seen the biggest increase in its **NCD management** score: 28.6 points between 2000 and 2021 (from 21.7 to 50.3 points). It also ranks in the top 50% of LMICs for health span in our Index (ranking 95th globally).

As with **infectious disease management**, we see that countries which invest in **NCD management** perform better in our Index and have fewer deaths arising from NCDs.

Figure 8: ILC Index ranking and deaths from NCDs by UHC sub-index score



Source: Data on NCD standardised mortality rate from WHO Global Health Observatory

Countries that invest more in **NCD management** rank higher on our Index and report half as many NCD deaths per 100,000 compared to those that don't. The top 30 countries in our Index have an average **NCD management** score of 66.3 and an average standardised mortality rate of 329.2 per 100,000 population. Those in the bottom 30 have an average score of 58.2 and average mortality rate of 657.2, as seen above in Figure 8.

However, this UHC metric is limited in what it measures. It covers: the percentage of prevalence of hypertension treatment among adults with hypertension, aged 30-79; the age-standardised mean fasting plasma glucose levels for people aged 18 and older (a diabetes indicator); and the age-standardised prevalence of people aged 15 and over currently using a tobacco product.[57]

Syria (a low-income country) has seen the biggest reduction in NCD mortality rates between 2000 and 2019, from 777.8 to 269.6 (a reduction of 65%). It also fares quite well on life span and health span, ranking in the top 50% of LMICs in our Index and ranking 80th for life span and 85th for health span globally. You can view our Index here.

Case study 3: Rwanda – improving healthcare rapidly

Rwanda ranks 130th on our *Healthy Ageing and Prevention Index*, and ranks 108th for life span, and 99th for health span.[58]

After the Rwandan genocide, the country's main health challenges included infectious diseases, maternal health, and resource shortages.[59] In 1999, 13% of the population was HIV positive, but only 202 people could afford anti-retroviral drugs.[60] By 2000, maternal mortality rates were 1,007 per 100,000 live births.[61] Over the last 20 years, we can see significant progress in metrics like maternal health and infectious disease management.

	2000	2021
Overall service coverage	18.7	48.55
RMNCH management	20.71	67.2
Infectious disease management	9.87	70.06
NCD management	30.97	44.01
Service capacity and access	19.33	26.82

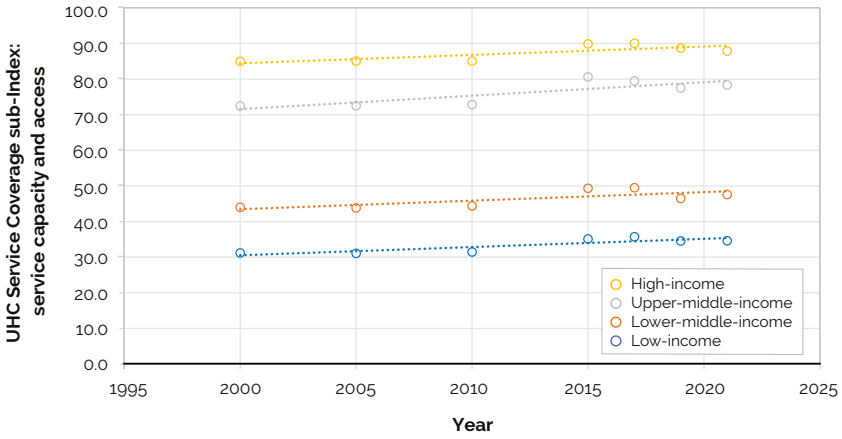
First piloted in 1999 and rolled out nationally in 2004, Rwanda's healthcare system runs through a mutual financing scheme called *mutuelles de santé*. Households pay as little as $2 annually,[62] with government subsidies available for people on lower incomes.[63] In parallel, 58,000 community health workers work within local communities,[64] assisting with a range of services such as antenatal and maternal care, NCD prevention, and HIV and tuberculosis prevention and management.[65] While they were initially volunteers, the Ministry of Health introduced performance-based financing, which also extends to healthcare providers, driving improved service delivery.

This decentralised health system, along with initiatives like medical drone deliveries,[66] has increased healthcare access. 90% of the population is now enrolled in the health insurance scheme and healthcare access has steadily increased in rural areas. Key policies like emergency obstetric care[67] and comprehensive HIV programmes have also improved health outcomes.[68] By 2020, maternal mortality dropped to less than 13%,[69] and in 2023 Rwanda was one of the first countries to meet the UN's 95-95-95 HIV/AIDs goal.[70] HIV testing and prevention efforts have also significantly reduced new infections.

Service capacity and access

Globally, these scores saw the smallest increase of the UHC sub-indices, increasing by only 7% (from 58.2 to 62.1). LMICs fared slightly better than the global average, seeing a 9% increase (from 49.2 to 53.5).

Figure 9: Service capacity and access scores over time, by country income level



Source: Data on UHC Service Coverage sub-Index on service capacity and access from WHO Global Health Observatory

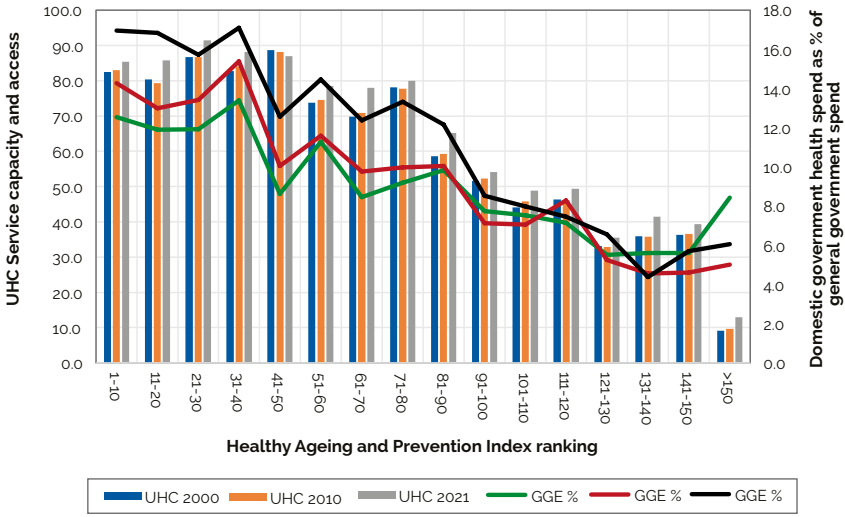
While all countries saw continued improvement against the other sub-indices of the WHO's UHC index across the two decades, scores for **service capacity and access** peaked between 2015 and 2017, and have since seen a slight drop.

Serbia (an upper-middle-income country) has seen the biggest increase in **service capacity and access** scores, improving by 40 points between 2000 and 2021 (from 48 to 88 points). It's also one of the top 25% LMICs in our Index, with a global ranking of 63rd.[71]

The **service capacity and access** UHC sub-index looks at three indicators: hospital bed density (relative to a maximum threshold of 18 per 10,000 population); health professionals (physicians, psychiatrists and surgeons) per capita (relative to maximum thresholds for each cadre); and the International Health Regulations core capacity index

(the average % of 13 core attributes).[c] For this reason, we wanted to understand whether there's a positive relationship between investment in health and better **service capacity and access**. In other words, does greater investment result in a healthcare system that meets the needs of its population?

Figure 10: ILC Index ranking and % health spend by UHC sub-index score



Source: Data on domestic government health spend as a % of general government spend from WHO Global Health Observatory

Our analysis found that countries which spend a higher proportion of their budgets on health not only have greater healthcare **service capacity and access**, but also perform better on our Index. For instance, countries ranked in the top 30 of our Index spend an average of 17% of their budgets on health and have an average **service capacity and access** score of 87.5, whereas countries ranked in the bottom 30 of our Index spend 6% of their budgets on health and have an average score of 38.8, visible in Figure 10.

[c]Core attributes: (1) Legislation and financing; (2) International Health Regulation Coordination and National Focal Point Functions; (3) Zoonotic events and the Human-Animal Health Interface; (4) Food safety; (5) Laboratory; (6) Surveillance; (7) Human resources; (8) National Health Emergency Framework; (9) Health Service Provision; (10) Risk communication; (11) Points of entry; (12) Chemical events; (13) Radiation emergencies.

Service capacity and access is the only UHC metric where the most improved country isn't an LMIC – Kuwait has the highest score for this, with an increase of 14.8 points. However, among LMICs, Mongolia's government spends the highest proportion of its overall budget on healthcare, at 14.6%. It's an upper-middle-income country, in the top 50% of LMICs in our Index, ranking 90th globally. Mongolia has expanded its UHC coverage over the last three decades. Since 2014 it has invested heavily in family health centres, telemedicine and mobile health units to reach rural and nomadic populations (see Case study 5). However, it's worth noting that data only exists for 2021.

The LMIC that has seen the biggest proportional increase in health spending is Iran (an upper-middle-income country). It's in the top 50% of LMICs in our Index, ranking 88th globally, and falls in the top 25% of LMICs in our Index for life span, ranking 58th globally.

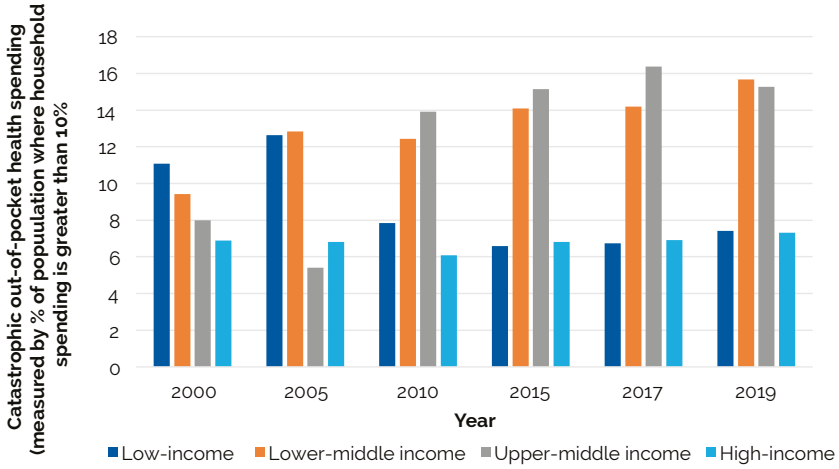
Previous research by ILC also found that countries where the state pays for a greater share of health spending also have higher health spans.[72] Combining these old and new findings further strengthens our understanding. It demonstrates that not only is more investment important to improving population health but also that the state plays a critical role in driving these health outcomes.

Catastrophic health spending

WHO also tracks catastrophic out-of-pocket (OOP) health spending (with one definition in Box 1 being where household spending on health is greater than 10% of income). Although data coverage is an ongoing challenge that prevents any in-depth analysis of LMICs, the data available suggests that this has increased for all income groups between 2000 and 2019, except in low-income countries.

One billion people experienced catastrophic OOP health spending in 2019, with 344 million people sinking deeper into extreme poverty due to health costs. Those living in households headed by people aged 60 or over are more likely to face catastrophic health spending, and, in turn, more likely to be further dragged into poverty. Those in poorer households, along with those living in rural areas, are also at similar risk.[73]

Figure 11: Catastrophic health spending over time, by country income level



Source: Data on Catastrophic OOP health spending from WHO Global Health Observatory

The proportion of the population experiencing catastrophic health spending has increased for all country income groups, except for low-income countries, shown above in Figure 11.

Upper-middle-income country groups have seen the biggest rise in catastrophic health spending (7.3% between 2000 and 2019). Lower-middle-income countries saw an increase of 6.25% over the same period, followed by high-income countries at 0.41%. Strikingly, low-income countries saw a 3.7% decrease in catastrophic health spending.

Speaking to older people: barriers to accessing and engaging with healthcare systems

While we have seen clear, exponential progress in UHC around the world, these positive effects aren't necessarily being felt by many older people. Older voices are often left out of policy discussions on health, despite this demographic often having the highest disease burden.

To better understand these challenges, we partnered with HelpAge International to conduct 15 focus group discussions in Mongolia (five groups), Zambia (six groups) and Rwanda (four groups) to bring older voices to a global platform and better understand how older people view and access healthcare services and systems in their communities. A total of 125 older people participated. They were aged between 47 and 89 and included 65 women and 60 men.

This section follows the patient's journey of accessing healthcare, highlighting the barriers they face starting with accessing healthcare facilities, to their experiences engaging with the healthcare system, and the wider systemic and societal issues that shape and influence their experiences.

Whilst these challenges have been raised by older people, most aren't necessarily age specific. People of any age can experience mobility challenges that hinder access to care, face financial burdens due to out-of-pocket expenses, or struggle to access specialised health services. Illness and disability aren't confined to older people. Women, children and those on lower incomes are also disproportionately affected when accessing healthcare. The broader impacts of climate change and AMR on health, which are felt more acutely in LMICs, are also indiscriminate when it comes to age. Expanding UHC to address these challenges will have a wider benefit for society as a whole, promoting accessible, inclusive healthcare systems.

Physical barriers significantly hinder access

Barriers to accessing care can begin at home. Long journeys and poor road and public transport infrastructure mean that physically getting to services can prove challenging for older people. Globally, over half of the world's population – 4.5 billion people – lack access to essential health services.[74]

"It's not easy for someone with a disability (using a wheelchair) to reach the health centre because the road is very steep, making it hard to navigate with a wheelchair, and even cars struggle to get there."

Man aged 51, from Musanze, Rwanda

Traveling long distances is also difficult without access to a car or public transport. Healthcare services are often accessed by walking or cycling, but when individuals are unwell, these modes of transport can be more difficult to use. 10% of people aged 60 and over in Sub-Saharan Africa live with a six or more hour walk to a hospital, and a two-hour walk to the nearest health facility of any type.[75] A study from Thailand found that every additional kilometre an older person had to travel to a healthcare service decreased their likelihood of using the service by 30%.[76]

"The health facility is about 4 km from my home, so I use my bicycle to reach there when my condition is not so bad. When I am bad someone has to take me to the health facility using my bicycle, though some ask for payment to undertake this activity."

Woman aged 74, from Chibombo, Zambia

The challenge of distance is especially pertinent in Mongolia, where a lack of specialised services in rural areas means that individuals must travel truly excessive distances.

"Sometimes, we have to travel 180 km to the provincial centre to get our illness checked."

Man aged 67, from Bayandun, Mongolia

When people do get to hospitals or clinics, the services are not always accessible.

"I cannot manage to climb the steps since I use a wheelchair."

Woman aged 75, from Lusaka, Zambia

However, there are certainly differences here between rural and urban areas. For example, in the Kigali and Huye regions of Rwanda – which are urban centres – transport and hospital infrastructures are far better.

"Another positive change is the construction of hospitals in multi-story buildings that are accessible to [older people] and those in wheelchairs."

Woman aged 54, from Kigali, Rwanda

High healthcare costs force a choice between care and financial hardship

One of the biggest issues raised in every focus group discussion was that of money: high costs of healthcare, limited insurance and expensive medicines often make services inaccessible.

In 2019, an estimated two billion people experienced financial hardship due to out-of-pocket spending on health.[77] Globally, the risk of poverty increases with age,[78] and older people face higher rates of catastrophic health spending (see Box 1) than younger age groups.[79] With limited access to comprehensive health insurance that would cover the full continuum of services they need, and high costs that prevent them paying for services out of pocket, many older people have no choice but to forgo or delay seeking healthcare or face impossible choices between health and other basic needs.

National health schemes provide government-funded health coverage, but additional costs for specialists, transport, and overnight stays all pose a financial burden. Whilst national health schemes aim to ensure that health services are free at the point of access, they can vary in coverage, and often there are out-of-pocket costs involved.

"When we use our health insurance, the costs aren't too high, as you might only pay around 300-400 Rwandan Francs [$0.25 to $0.34]. The problem arises when we need a specialist or medication, as those are expensive."

Woman aged 51, from Huye, Rwanda

"Moving from home to the hospital we pay transport costs since we have to hire a taxi. Even when you arrive there you will be told do this test and those tests which cost money."

Woman aged 68, from Lusaka, Zambia

The cost of medicines was an issue raised by focus groups in all countries, but especially in Zambia. Even in countries with high population healthcare coverage like Rwanda and Mongolia (82.3% and 92.1% respectively), not all essential medicines are included in health

insurance schemes, and in those countries where they are, supply often fails to match demand.[80] When public stocks are depleted, people are forced to use private pharmacies at significantly higher prices or forego treatment. One participant mentioned spending 6900 Zambian Kwacha ($263) on cancer medications from a private chemist, highlighting the financial strain that such expenses could impose.

> "Telling the truth, NHIMA [the national health insurance scheme] is restricted to fewer services where most of the services are limited. For instance, cheaper drugs are found under NHIMA but expensive pain killers for people with our conditions cannot be found under NHIMA arrangement."
>
> **Woman aged 75, from Lusaka, Zambia**
>
> "The main challenge is that essential drugs are not available. Therefore, the health workers give us prescriptions to buy expensive drugs from private chemists."
>
> **Man aged 64, from Chibombo, Zambia**

Nevertheless, even in Mongolia, where healthcare coverage is comparatively comprehensive, older people face significant financial challenges. Households headed by individuals aged over 60 ("older households") reported catastrophic health spending (see Box 1 for definition) in 18.6% of cases, compared to only 5.4% of households headed by those headed by individuals under 60 ("younger households").[81] The prohibitive costs associated with accessing care, along with difficulty accessing information on health insurance, meant that they often missed out. Many found the high costs of medicines to be particularly challenging, while the poor quality of services in the public sector led those who could afford them to go to private facilities.

> "It's getting worse. The cost of medicine keeps rising, and so does the cost of treatment. We can't afford to get treated in our local areas with such high costs"
>
> **Man aged 72, from Bayandun, Mongolia**

"The blood pressure medicine that used to cost 500 Mongolian Tögrög (MNT) [$0.15] now costs around 50,000 MNT [$15]. Buying just two medications now costs over 100,000 MNT [$30][d]. This feels like a form of pressure on us. Medication has become a serious issue for us."

Woman aged 59, Ulaanbaatar, Mongolia

The challenge of cost was also recognised by experts at our regional roundtables.

"The coverage in Mongolia is equivalent to $600 – this isn't enough if someone is seriously ill. This means that many people have to use out-of-pocket spending. This is a very serious issue for older people, especially taking into account that 27% of the population live below the poverty line."

Urantsooj Gombosoren, Chairperson, Centre for Human Rights and Development

The Zambian government has recognised these challenges with medication and is working to expand their systems by including private pharmacies in their health insurance schemes. This means that individuals can access medicine from private pharmacies at the same cost they would in public health centres.

"That has been a challenge – the availability and adequacy of drugs and other commodities in health facilities. But with the [National Health Insurance Scheme] now, we have accredited private healthcare providers, including pharmacies."

Herryman Moonoo, Director of Research, Planning & Strategy, National Health Insurance Management Authority of Zambia

However, as with many challenges, this can vary from case to case. Individuals can easily access some essential medicines at no cost.

"I thank the government for introducing the NHIMA scheme because without this scheme, I wouldn't have been managing to buy my cancer drugs which cost about K10,000.00 [$385] that I collect every 3 months."

Man aged 74, Chibombo, Zambia

[d]The annual household income per capita in Mongolia is the equivalent of just $2,139.

Case study 4: Zambia – progress towards health coverage

Zambia ranks 135th on our *Healthy Ageing and Prevention Index.*[82]

By 2000, after a period of mixed social and economic conditions and decreased health and social spending, Zambia's healthcare system was in crisis.[83] The worsening HIV/AIDS epidemic had left one million people HIV-positive, and the maternal mortality rate was 419 for every 100,000 live births.[84]

	2000	2021
Overall service coverage	36.99	68.08
RMNCH management	58.74	80.04
Infectious disease management	12.38	66.9
NCD management	40.3	57.6
Service capacity and access	63.84	69.66

Zambia's healthcare reforms began in 2000. They focused on decentralised care, professional training, and improved resources to enhance infrastructure and health outcomes. These efforts resulted in significant progress but failed to address out-of-pocket healthcare payments.[85]

In 2018, Zambia introduced a National Health Insurance Scheme that required sliding-scale contributions, enabling access to free healthcare at both public and private facilities, with government subsidies available for people on low incomes.[86] Community-level healthcare programmes, which involve community health workers and nurses, also play a crucial role in care provision, particularly for vaccination, nutrition, infectious disease prevention and maternal health.[87]

As a result of these efforts, Zambia has seen a 68% decrease in new HIV cases since 2011. In 2024, it became the first African country to introduce the long-acting HIV prevention injection.[88] Tuberculosis treatment coverage rose from 66% in 2020 to 92% in 2022,[89] and insecticide-treated mosquito nets to prevent malaria were found in 80% of households by 2018, compared to just 38% in 2006.[90] By 2020, maternal mortality had decreased to 135 deaths for every 100,000 live births, which is far lower than both the average for the sub-Saharan region (536) and the country income group average (253).[91]

Systemic gaps in healthcare infrastructure hinder delivery

Staff shortages lead to long wait times and impersonal care

Human resourcing is a prevalent healthcare issue in LMICs: 80% of African countries struggle with a 'brain drain': the mass emigration of skilled workers who seek employment outside of the country which professionally trained them.[92] Low staff numbers has had a negative impact on waiting times to see doctors. Because so many people are waiting to see so few doctors, this also means that consultations and appointments feel rushed and impersonal. Indeed, WHO estimates a projected deficit of 10 million health workers by 2030,[93] with most of that shortfall occurring in LMICs.

> "What greatly discourages older people at hospitals is having to wait in line all day only to receive ineffective medication. This leads those with financial means to seek treatment at private hospitals, while those who can't afford it stay home instead of going to the health centre."
>
> **Woman aged 57, from Kigali, Rwanda**

Additionally, high staff turnover, particularly in Zambia, further affects access to diagnoses and treatments. People see different doctors who display varied levels of understanding and commitment. Inconsistencies like this lead to fragmented care.

> "The worst part is seeing different doctors whenever I go there. There is no continuity."
>
> **Man aged 77, from Lusaka, Zambia**

Lack of resources and poor infrastructure further affect quality of care

Lack of functional medical equipment is also a major challenge. This may mean equipment, such as diagnostic tools, is outdated, poorly maintained, or insufficient. This issue was raised in all our focus groups, but particularly in Mongolia. Many healthcare providers struggle with outdated or insufficient diagnostic tools, which hampers their ability to deliver quality care.

"Our hospital building has become quite worn down. We rely on wood stoves for heating. Sometimes we manage to get equipment, but it often doesn't last long, or it breaks down. The old pipes are also worn out. In winter, the toilets often freeze and become unusable".

Man aged 67 from Bayandun, Mongolia

"The biggest issue is the lack of equipment. Diagnostic tools, machines, and other equipment are inadequate. For example, if someone breaks a leg or gets injured, they have to travel 180 km to the province for treatment. How does a person with a broken leg endure such a journey?"

Man aged 67, from Bayandun, Mongolia

While some people expressed frustration towards healthcare workers themselves, many acknowledged that such challenges were beyond their control.

"There is no equipment and drugs. This also frustrates health workers. They write a prescription when there are no drugs. They recommend an X-ray when the equipment is broken down."

Woman aged 75, from Lusaka, Zambia

Lack of specialised services can leave older people without necessary care

When healthcare workers are overstretched with patients, triage processes and personalised treatments can seem a low priority.

"You wait a month or 45 days to get checked. If someone's in poor health, they might never make it through—they'll just keep deteriorating."

Man aged 82, from Ulaanbaatar, Mongolia

"A number of the health workers do not concentrate on us. They will not look at you, just busy writing without examining you physically."

Woman aged 62, from Lusaka, Zambia

Many of the services in place focus on addressing acute and time-bound conditions. This means there is a lack of specialised geriatric and NCD services for the needs of older people or those with chronic conditions. For example, only 54% of 194 countries surveyed by WHO

in 2021 reported general availability of the 11 essential medicines for NCDs which are more common in later life,[94] Moreover, results from the 2023 *Decade of Healthy Ageing* survey, which covered 134 countries in 2023, found that only 21% of low-income countries reported capacity-building plans to strengthen the geriatric and gerontology healthcare workforce.[95]

> "Where we live, we have basic health services, but we don't have access to prosthetics, eyeglasses, or dental care—those require going to hospitals."
>
> **Man aged 52, from Musanze, Rwanda**

In our expert roundtables, participants highlighted the critical gap in integrated healthcare services for older populations. Current systems are fragmented, which not only complicates access but also diminishes the quality of care, especially considering that older people tend to have more complex medical needs.

> "There are so many limitations related to accessing services. The services themselves aren't oriented to provide care for older people, the capacity for healthcare providers is inadequate to be able to address the needs of older people, and services are not integrated. For example, somebody with diabetes will go to a diabetes clinic. If they have eye problems, they go to an eye clinic. We need to bring these services together to make sure that they are integrated."
>
> **Dr Theopista John Kabuteni, Technical Officer, WHO Rwanda**

However, we can again see variations between regions. In some places, the care people receive is satisfactory and tailored to the needs of an ageing population, but these continue to represent pockets of good practice rather than being the basic standard of care.

> "At my health centre, they treat me well, and I'd give them an 8/10. The problem is when you go to the hospital, that's where the services aren't satisfactory."
>
> **Woman aged 58, from North Rwanda**

"Recently, care for [older people] has also been improving. There's been a lot of discussion about supporting the health of [older people], and the government is making efforts to provide more care. For example, in our province, the Governor allocates 1 to 3 million MNT [$290 to $875] each year to [older people] in the districts."

Man aged 67, from Bayandun, Mongolia

In Mongolia, access has been expanded for different types of care. Screenings, rehabilitation, palliative care and the provision of long-term care and support are all becoming easier to access, and older people feel their healthcare needs are represented and addressed through Soum[e] Livelihood Support Councils. Additionally, a more personalised approach to care supports access for rural and nomadic communities, which make up 30% of Mongolia's population.

"There is also palliative care available. Specialised doctors form a team and travel as a mobile hospital. When this is announced in advance, herders in remote areas have the chance to come and receive treatment. It's much more convenient for them to come to the soum centre rather than traveling all the way to the province or city—it's a significant improvement."

Woman aged 58, from Bayandun, Mongolia

"Our soum has quite a few [older] people who have gone for early detection screenings."

Man aged 67, from Ulaanbaatar, Mongolia

Inadequate information leaves people confused about services offered

Dissemination of health information by healthcare systems to the public is often inadequate, leaving older people confused about which services or medications are freely available to them under their health insurance.

[e]In Mongolia, a soum is a subdivision of a municipal district. The country is made up of 331 soums.

"Does this insurance coverage depend on certain seasons or periods? I had an experience that left me confused. I received treatment, and then two or three months later, when I needed another treatment, they told me, 'Your insurance coverage for this season has run out. You'll need to wait until the next period.' I don't understand how this works at all."

Man aged 73, from Ulaanbaatar, Mongolia

Not everyone has equal access to health information. For example, in Rwanda, health information is not available in all the local languages, while in Mongolia, efforts to digitise health information can fail to reach rural communities.

"Information is provided, but it's not always accessible to everyone. For certain diseases, awareness campaigns are sometimes given in languages that many [older] people don't understand, so they miss out."

Woman aged 57, from Kigali, Rwanda

"People living in remote areas with no network coverage can't access [health] information".

Woman aged 68, from Bayandun, Mongolia

Again, this varies across regions. In some of the more urban areas of Rwanda and Mongolia, participants were satisfied with the information provided by health systems.

"What I'm most grateful for in terms of changes in healthcare is that awareness campaigns have increased, leading to more [older] people seeking medical treatment. Now, fewer people die at home."

Woman aged 62, from Huye, Rwanda

"We receive information directly from the hospital. There's always someone at the hospital, and we have nurses responsible for [older adults]. They also have someone responsible for early detection screenings. The hospital staff keep us informed, and the bag[f] doctors and nurses provide us with information. Overall, it's an easy process."

Man aged 67, from Ulaanbaatar, Mongolia

Clearly, there are significant barriers to accessing healthcare. Across 3000 older people surveyed by HelpAge International and partners across nine countries in Africa, Asia and Latin America between 2014-2017, on average, older people rated the access, affordability and quality of services as only 50 out of 100. A negative correlation to increasing age of the individual, was observed with the oldest age groups rating the quality of services as lower than younger older people. There were also differences in geographical location, with respondents in urban areas reporting higher scores for quality of health services than those in rural areas.[96]

[f]In Mongolia, a bag is a smallest administrative unit within a soum, similar to a village or neighbourhood.

Case study 5: Mongolia – improving healthcare access

Mongolia ranks 90th on our *Healthy Ageing and Prevention Index*, and 79th for life span.[97]

Much of Mongolia's population is rural and nomadic,[98] posing challenges for healthcare access, especially in areas like nutrition, NCDs, occupational illnesses, and maternal and child health.[99] In 2000, the maternal mortality rate was 158 per 100,000 live births; while this is a low score compared to other LMICs, rural communities were disproportionately affected by childbirth complications compared to urban ones.[100]

	2000	2021
Overall service coverage	46.43	64.95
RMNCH management	80.68	82.02
Infectious disease management	10.98	36.89
NCD management	57.56	63.63
Service capacity and access	91.1	92.44

In 1994, Mongolia introduced a National Health Insurance Law, which gradually expanded over the following decade.[101] The scheme covers primary care, surgeries, maternal and child health, and emergency services. While 95% of the population was initially covered, this fell to 80% by 2006, before reworked funding encouraged more sign-ups.[102] By 2014, Mongolia had made significant progress, with family health centres in urban areas providing comprehensive primary care to 66% of the population.[103] In rural areas, district health centres provide primary and inpatient care, with serious cases referred to urban hospitals. Mobile health units and telemedicine have been introduced to improve care for nomadic populations.[104] Telemedicine has greatly improved maternal and child mortality figures. Additionally, key policies now require pregnant women in nomadic communities to come to provincial or district level clinics two weeks before their due date, meaning that by 2018, 99,6% of all births were taking place in a healthcare facility.[105] The maternal mortality rate dropped to 39 per 100,000 live births in 2020 – lower than the regional average.[106]

Broader societal structures can restrict older people's access

Ageism is prevalent

Ageism is one of the most prevalent forms of discrimination in society. Around the world, one in every two is believed to hold ageist attitudes towards older people.[107] Ageism can prevent people from accessing the care they need throughout the full pathway of healthcare provision, from prevention to diagnosis and treatment. It can manifest in many ways, including structural failures in responding to older people's health and care needs within healthcare systems, such as limited funding and exclusion of older people from essential health data reporting. This is in addition to more explicit ageism at the level of service delivery. While most instances of discrimination reported by focus group attendees were of the latter form, understanding all levels in which ageism is present is crucial to improving health outcomes across the life course.

Focus group participants from every country reported age discrimination from healthcare workers. There was a general feeling that they're not prioritised; they also feel that they're made to wait longer to receive inadequate care compared to younger patients.

> "Older people are regarded as second class by the health workers."
>
> **Woman aged 68, from Chibombo, Zambia**
>
> "We older people are made to stand in the queue for longer hours before being attended to, whilst health workers are busy on phones. They don't prioritize us even with our debilitating conditions."
>
> **Woman aged 61, from Lusaka, Zambia**

Ageism can have a long-lasting impact on older people's health. Some older attendees mentioned that bad experiences had pushed them to disengage from the healthcare system altogether.

> "Recently, some [older] people have refused to go to the hospital because of the poor reception they received in the past. Doctors made them feel like their illness was just old age and couldn't be treated, leading them to vow never to return."
>
> **Woman aged 61, from Huye, Rwanda**

"I have suffered at the hands of the health workers in health facilities. I have regretted many times I have gone to the health facility when my condition is bad because of how heartless some health workers are towards older people."

Woman aged 74, from Chibombo, Zambia

Certainly, there was evidence of unfair stereotyping: older people felt they were viewed as deficient, or incapable.

"When we explain our pain to the doctor, they quickly get annoyed, thinking [older] people are just rambling. They give you medicine to get rid of you because they have many other patients to see."

Woman aged 48, from Musanze, Rwanda

Discriminatory attitudes towards older people can also prove to be harmful and prevent them from accessing care. When people are refused care based on their age, they either turn to expensive private healthcare or fail to treat the problem. In 85% of 149 studies, WHO found that age determined who received certain medical procedures or treatments.[108]

"I once went to a public hospital because I had a leg problem that required a metal implant. The doctor asked me why they should bother putting in the implant since I was no longer of any use. Since I had the means, I went to a private hospital instead."

Man aged 52, from Musanze, Rwanda

While our findings demonstrate the direct impact of ageism, to address these barriers at a systemic level, we need to ensure that older people are properly counted in global data. Under UHC, coverage of essential services relies on age-limited data sources which exclude women over the age of 49 and men over the age of 54. These services include those that are relevant to older people's health needs, such as hypertension and diabetes. Comparably, the measure to track NCD mortality (and the associated SDG 3.4 target of reducing premature mortality by one-third by 2030) only includes deaths between the ages of 30 and 70.[109] Without properly measuring healthcare outcomes in older people, it's extremely difficult to uncover and understand the barriers they face, whether due to ageism or otherwise.

Older people struggle to be heard about their care

Older people aren't always given autonomy over their own care decisions, due to a number of factors, usually culturally bound. This is a global issue: worldwide, only 14% of countries have public health policies that help individuals feel empowered in their decision-making, when dealing with families and doctors alike.[110] Our focus group attendees felt that healthcare workers did not listen to their concerns and treat them appropriately.

> "[Older] people have no say in the services they receive. They don't even feel free to express what's on their minds or explain what they need. The doctors just tell us what they want and give us what they want, and we have to accept it."
>
> **Man aged 67, from Kamonyi, Rwanda**

But a lack of autonomy also exists outside of hospitals and clinics. Family and community members also tend to make healthcare decisions for older people. Part of this is certainly due to cultural norms and expectations, but while our attendees recognised this, they also felt sidelined in discussions about their own health.

> "In everyday life, sometimes our children or leaders make decisions about our health without consulting us."
>
> **Woman aged 58, from Musanze, Rwanda**

Participants also stated that this problem is compounded when individuals have less money.

> "It's clear that if you don't have money, you have no rights. You can't make any decisions for yourself because the person supporting you makes all the decisions. Many [older] people have decisions made for them as if they were children who don't know what to do"
>
> **Woman aged 60, from Kamonyi, Rwanda**
>
> "Older people without financial means have no right to make decisions because the person supporting them makes all the decisions. When poverty and old age combine, the situation becomes even worse."
>
> **Man aged 73, from Kigali, Rwanda**

Community health workers are vital in promoting access and support

At a local level, community health workers are an integral part of health promotion. They're also key intermediaries when it comes to helping older people access healthcare.

> "It's easy to get to our health centre, and patients are sometimes accompanied by a community health worker. These workers help people access medical care and ensure they are attended to because when they accompany a patient, they are given priority."
>
> **Woman aged 57, from Kigali, Rwanda**
>
> "We appreciate the work of community health workers because they've encouraged people, especially [older people], to seek treatment instead of staying home. We also thank them for helping us navigate the hospital when we arrive."
>
> **Woman aged 58, from Musanze, Rwanda**

Additionally, community health workers assist with treatment at home, which can mitigate some of the physical barriers highlighted above.

> "The health services available to us include assistance from community health workers who help us with prevention, testing, and treatment of diseases like malaria and malnutrition-related conditions."
>
> **Woman aged 62, from Huye, Rwanda**

Education and dissemination of information at a local level has also resulted in health improvements.

> "Community health workers have made it easier for us to get treatment and have helped in preventing and fighting malaria. In the past, malaria used to kill many [older] people, but now we know how to prevent it, and they spray insecticides to protect us."
>
> **Man aged 70, from Huye, Rwanda**

But community level information and educational services are not always targeted towards older people and there is a sense that some community health workers lack the training needed for them to better support older people.

"Information should mainly be provided during community service (umuganda) because that's when most people are present, but [older people] are rarely mentioned. The focus is often on children, youth, women, government programmes, and development issues."

Woman aged 62, from Kigali, Rwanda

"We used to have health promoters passing through our villages educating us about many diseases that affect us older people. Now our government has neglected us, the aged."

Man aged 69, from Chibombo, Zambia

One of the barriers to widening community health programmes is that these roles can be under-funded and under-resourced - there can be failures to meet minimum working standards. This challenge was also raised by experts in our policy roundtable.

"We need to ensure health workers, including community health workers and other community health actors, are appropriately compensated and granted fair and decent conditions."

Dr Marthe Essengue, Regional Head, Africa Region, Gavi

Case study 6: Senegal – pioneering community health workers

Senegal ranks 123rd on our *Healthy Ageing and Prevention Index*, but 105th for life span, and 111th for health span.[111]

By the end of the 20th century, a number of economic challenges left Senegal's health infrastructure, spending and outcomes inadequate.[112] Diseases like malaria, and tuberculosis, as well as nutrition-related issues, posed the greatest challenge. Unlike many other African countries, HIV/AIDS is less of a health concern for Senegal.[113] Maternal health was another challenge, with a mortality rate of 638 per 100,000 live births in 2000.[114]

	2000	2021
Overall service coverage	21.15	50.09
RMNCH management	32.33	59.11
Infectious disease management	11.01	63.69
NCD management	40.85	55.65
Service capacity and access	18.66	30.05

Senegal has long prioritised preventative and primary care; it was one of the first African countries to introduce a community health worker programme in the 1980s.[115] Community health workers have supported a multitude of public health efforts, including management of infectious disease. Following the first reported HIV case in 1986, the country set up a national and regional strategy that effectively curbed the spread of disease.[116] Policies around emergency obstetric care and free childbirth services helped improve access to maternal health services.[117] Inspired by Rwanda's model, Senegal implemented a health insurance scheme in 2013 called *Couverture Maladie Universelle* (CMU), where local communities pool money[118] and those on low incomes have the cost subsidised by the government.[119]

Senegal's health outcomes demonstrate the success of these programmes. In 2020, their maternal mortality rate was 261 per 100,000 live births. By 2013, diagnostic testing for malaria increased by 307%.[120] Senegal's levels of HIV/AIDS infection remain among the lowest in the world – lower than those in HICs like Chile and the USA[121] – and membership of the CMU is steadily increasing.[122]

While these insights were raised by older people, many of the challenges described aren't age-specific; people of all ages can encounter similar barriers. Addressing these interconnected challenges will help build more inclusive healthcare systems that serve everyone.

Solutions

As we approach the UN's 2030 targets for UHC, it's clear that many of these goals are unlikely to be met within the original time frame. Governments will soon need to establish new targets for the next 15 years, extending beyond 2030 into 2045. This is due to the fact that UN global targets, such as the MDGs and SDGs, are developed in 15-year increments.

A new set of targets will guide both global development (following the SDGs) and UHC efforts. While meeting the 2030 targets remains essential to beginning work on further goals, we must also begin preparing for the next set of commitments to ensure sustained progress.

One of the most significant drivers that keeps the world off track from achieving UHC is demographic change. Changing population structures are having a profound impact on healthcare access and health outcomes. It is critical that governments acknowledge and integrate the effects of demographic change into their healthcare policies and strategies. This must form the basis of any future approach to UHC.

To ensure the next set of targets is achievable, we must consider demographic change and population ageing throughout the UHC pathway, from identifying challenges, to implementing solutions and tracking progress.

Looking ahead to new global UHC and post-SDG commitments for 2030-2045, ILC calls for:

Governments to commit to identifying the challenges to achieving UHC that arise from demographic change, and embedding solutions that will address them.

We have identified three key solutions that we strongly urge governments and international organisations to implement. They will have the biggest positive impact on accounting for the impact of demographic change in LMICs, and ensuring UHC for all, at all ages.

1. What: Invest in national health schemes[9] to strengthen and expand the provision of healthcare and prevent catastrophic out-of-pocket spending on health.

Why: Well-designed national health schemes are essential for achieving UHC. Gaps in coverage can result in inefficiency, inequity, and worsened health outcomes. Policies and programmes must ensure that individuals can access care without enduring financial hardship.

How: Governments can address this challenge by:

- Focusing on coverage for the most high-burden diseases over the next 20 years
- Implementing targeted subsidies and expanding financial protection to alleviate economic barriers for those most at risk of financial hardship
- Strengthening procurement and supply chain systems to ensure sustainable access to essential medicines

2. What: Position primary healthcare as the cornerstone of UHC

Why: 90% of essential UHC interventions can be delivered through primary healthcare. Scaling up existing systems is vital to support provision of primary healthcare while also reducing burdens on hospitals and clinics.

How: Governments must:

- Establish or expand community healthcare programmes focused on primary care, preventative care, and NCDs, ensuring that community health workers receive standardised pay
- Expand rural care through innovative solutions like telemedicine, drone delivery and community health hubs
- Allocate 6% of health budgets to prevention, phased in through gradual annual increases of 0.5%-1% depending on fiscal capacity
- Expand and improve the training of healthcare professionals to deliver person-centred, inclusive care that meets our diverse needs across the life course

[9]Including but not limited to models that include different types of national health insurance, community-based health insurance and social health insurance.

3. What: Build a data-driven, life course approach to UHC

Why: Older people are often left out of data collection, even though accurate data on health trends among older people can support better targeted policies and health interventions. What isn't recorded doesn't get done.

How: International organisations and governments must

- Reform data collection to include populations of all ages
- Establish sustainable mechanisms for meaningful citizen engagement in shaping UHC policies and policies for national health schemes
- Leverage data to account for changing demographics and disease burdens, and set health targets for all ages within a global framework

What happens next?

Older people are often left out of policy discussions on global health security. But population ageing is a global phenomenon which no country is exempt from. This very much includes LMICs.

Improvements in UHC are commendable, especially the significant strides that LMICs have made in the last two decades. But we are not where we ought to be.

If we continue to ignore the implications of demographic change, we won't be able to ensure UHC for all. The time limits for the UN SDGs are fast approaching, and while it's unlikely we will meet the UHC targets by 2030, policymakers will need to carefully think about why this is the case and how and when these targets can be met. Achieving UHC for all has significant benefits for population health and economies but only if we meet the health needs of older people.

Using data from ILC's *Healthy Ageing and Prevention Index*, analysed against the WHO Global Health Observatory's *UHC Service Coverage Index*, we've very clearly demonstrated the health, wealth and societal benefits of investing in UHC. The contributions we sought from older people provide a clear picture of some of the issues driving suboptimal UHC. This starts with whether individuals can even access their healthcare system due to physical barriers. They must further overcome a lack of essential medicines and medical equipment, specialised services, staff shortages, accessible information on what services and/or medicines are available to them, and pervasive ageism, to receive the right care. Moreover, having to advocate for autonomy over their own healthcare, along with the current high costs of healthcare, further puts them at risk of being left behind.

With the upcoming UNGA High-Level Meeting on NCDs in 2025, global health leaders have an opportunity to take bold action. With NCDs constituting 74% of all deaths, despite 80% being preventable, UHC has a vital role to play in ensuring people live well for longer.

It's crucial to ensure that the impact of demographic change is front and centre in future global discussions as we look ahead to new global UHC and post-SDG commitments for 2030-2045. As is supporting that work with strong health insurance schemes, as well as investment in strong primary healthcare, and ensuring that older people are counted in data and have their voices heard.

Improvements in UHC have largely stalled since 2015. It's time to reverse this trend and ensure the impacts of longevity and the health needs of older people are at the heart of discussions. In doing so, global action towards achieving UHC for all can be achieved.

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About ILC

ILC is the UK's leading authority on the impact of longevity on society. We combine evidence, solutions and networks to make change happen.

We help governments, policy makers, businesses and employers develop and implement solutions to ensure we all live happier, healthier and more fulfilling lives. We want a society where tomorrow is better than today and where future generations are better off.

ILC wants to help forge a new vision for the 100-year life, where everyone has the opportunity to learn throughout life, and where new technology helps us contribute more to society.

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