CHAPTER SEVEN

Vulnerable Populations and Universal Health Coverage

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Introduction

Health is now recognized as a driver of economic development. Healthy people are more productive, have higher average incomes, spend less on healthcare, and create savings that are an important source of economic investment. Health, particularly in the early years of life, also contributes to other forms of human capital, such as cognitive ability and higher educational achievement. The importance of health in human capital and economic development makes investment in health critical. In recognition of this, in 2015, the UN General Assembly adopted the 2030 Agenda for Sustainable Development; health is the focal point of Sustainable Development Goal 3 (SDG 3): "To ensure healthy lives and promote well-being for all at all ages." Because the determinants of health include factors beyond coverage of health services, achieving SDG 3 will depend on progress in poverty reduction, education, nutrition, gender equality, clean water, sanitation, and transportation, among others. The UN resolution on SDGs exhorts countries to "achieve universal health coverage (UHC) and access to quality healthcare. No one must be left behind." This places UHC as the central target that underpins the achievement of improved health under the current development agenda.

Countries aspiring to UHC aim for all members of their population to be able to obtain the health services they need without experiencing financial hardship. UHC is built on three pillars—increasing coverage of services so that everyone

has access to needed healthcare, improving quality of services, and ensuring that using health services does not put patients at risk of financial hardship.[1] At its core, UHC means nondiscrimination; policies that exclude certain individuals or groups are inconsistent with the goals of UHC.[2] A growing number of countries are formalizing their political commitments to UHC by establishing a legal mandate for universal access to health services and products in their national laws. Since 2013, at least seventy-three countries have passed legislation on UHC.[3] Yet much remains to be done.

These international declarations and the formulation of national strategies for making progress toward UHC would appear to reconfirm the universal right to health. In practice, however, substantial inequalities persist. Numerous studies on health disparities have affirmed the inverse care law, which states that those with the greatest health needs receive the least healthcare services.[4] This is due, in part, to deficiencies in the formulation and implementation of strategies for health system development. But it also reflects patterns of social and economic inequality and the inability of politically weak and vulnerable groups to ensure that their rights and entitlements are honored by governments and other stakeholders. Strategies for reducing inequalities in access to healthcare need to address the social and political factors that influence the performance of health systems.[5]

Vulnerable populations are a bellwether for the success of UHC policies. One of the biggest challenges to achieving UHC is to find ways to reach vulnerable populations—those who are at risk of poor health and healthcare disparities—with limited health resources. Vulnerable groups have adverse health outcomes compared to others, as they live in hard-to-reach places; are excluded from services because of gender, age, ethnicity, or other characteristics; and may not participate in health programs because they lack awareness of their entitlements, or because of their own beliefs, or due to financial constraints or the legality of their status. In many cases, they are excluded from the formal and informal processes that influence the performance of the health system and its direction of development. Making vulnerable populations a focus of UHC strategies is not without its pitfalls. Attention to vulnerable groups can be politically problematic, because it can be viewed as favoring certain groups over others and because it challenges dominant political arrangements.

This chapter seeks to understand the experience of vulnerable populations in the era of UHC. It begins by discussing how vulnerable populations are defined,

1. World Health Organization (2019a).
2. Ooms and Hammonds (2015).
3. World Health Organization (2019b).
4. Hart (1971).
5. Bloom (2019).

and the intersectionality between different vulnerabilities in relation to health. It then provides a selective review of studies documenting the extent to which vulnerable populations have service coverage and financial protection. The last section is devoted to offering policy options for achieving UHC without vulnerable groups left behind. This chapter argues that progressive universalism is a useful principle to guide a country's UHC strategies. It advocates a bottom-up approach to direct resources to the neediest in society first. In doing so, attention of government action and policy are focused on vulnerable populations.

Vulnerabilities, Vulnerable Populations, and Their Health

The last century has witnessed remarkable improvements in global health. Today, people live an average of thirty-eight years longer than a century ago.[6, 7] Over the last three decades, the number of children who die before reaching the age of five has been reduced by nearly two-thirds.[8] Despite these remarkable overall gains, there are certain regions of the world, especially sub-Saharan Africa and parts of Asia, that have not equally benefited from these global trends. Even in countries that have achieved high levels of average health, there are population subgroups that experience health outcomes far below the national average. People in both of these contexts experience one or more vulnerabilities that constrain their ability to live long, healthy lives.

The Many Dimensions of Vulnerability

There are a number of approaches to defining who is vulnerable. National governments and development agencies have traditionally conflated vulnerability and poverty. An individual is considered poor if their income level is below some established threshold or by their relative position in the income distribution. Here vulnerability arises from limited economic means and command over the material goods (e.g., food, housing) required for a basic standard of living. Several other attributes are also used for classifying people as vulnerable. Depending on the context, gender, race, social position, age, disability status, sexual orientation, ethnicity, religion, employment status, geography, and citizenship are other characterizations of vulnerability. In practice, these classifications are used independently; a truly comprehensive approach to characterizing vulnerability must consider the range of factors that contribute to vulnerability.

6. Riley (2005).
7. World Health Organization (2019c).
8. Ibid.

The capability approach, developed by Nobel Prize–winning economist Amartya Sen, provides a broader framework for understanding vulnerability. The capability approach emphasizes individuals' ability to achieve the kind of lives that they value, including being in good health.[9] In this understanding, the focus is shifted from a lack of resources (e.g., income poverty) to the deprivation of the capabilities to achieve a healthy life. It involves the deprivation of a broader set of factors, such as unequal access to resources, rights, goods, and services (including health services) across economic, political, social, and cultural dimensions that operate at individual, household, community, country, and global levels.[10] As such, individuals can suffer deprivation from more than one capability (see box 7-1).

The theory of intersectionality recognizes the coexistence of multiple intersecting factors that can multiply the disadvantages that an individual or group experiences, exacerbating societal inequities and social injustice.[11] Consider the example of a hypothetical migrant in the United States. If the person is an undocumented female, she may be more vulnerable than a documented female, and both may be more vulnerable than a man in their respective situation. The interactions between their multiple vulnerabilities have a direct impact on their overall vulnerability and their ability to access services such as healthcare. However, if the same undocumented female migrant needed to access healthcare in France, she might have fewer barriers to accessing services, as France provides emergency, pediatric, and maternity care to all undocumented migrants.[12] Because a range of individual and contextual factors determine a particular individual's vulnerability, it becomes important to understand how their intersectionality affects health.

The causes of vulnerability can change. For instance, countries are exposed to frequent shocks such as natural disasters, disease outbreaks, and movements of population across borders. These shocks can both exacerbate existing vulnerabilities by disproportionally affecting those who are already worse off, and create new vulnerable populations. Thus, patterns of vulnerability are constantly changing and should be considered a dynamic phenomenon. Health systems that can prevent, reduce the impacts of, and effectively recover from these shocks are said to be resilient and are cornerstones of ensuring universal coverage of health services to vulnerable groups.[13]

9. Sen (2001).
10. Tangcharoensathien and others (2018).
11. Collins (1986).
12. Gray and van Ginneken (2012).
13. Russo and others (2017).

Box 7-1. Operationalizing a Context-Specific Definition of Vulnerability

Some countries have gone to great lengths to describe and collect data on factors that contribute to social exclusion and vulnerability. In the United Kingdom, a number of attempts have been made to define and measure the extent of individual capabilities in order to monitor policy and hold government accountable. One effort is the development of a framework to measure capabilities by the Centre for Analysis of Social Exclusion (Burchardt and Vizard, 2007). This framework considers the interaction of personal characteristics, the level and distribution of resources, and other contextual factors as they relate to ten domains of capabilities that were valued by the population of the country. These domains of capabilities were operationalized through the development of a list of forty-eight indicators that describe progress toward equality in the United Kingdom (Alkire and others, 2009). Through this initiative, research can be done to identify the most vulnerable groups in the country and systematically design and evaluate programs to increase their capabilities. Such an approach can be replicated in other settings with indicators specific to that context.

Service Coverage of Vulnerable Populations

The first component of the SDGs for achieving UHC (SDG target 3.8.1) involves ensuring that people in need of promotive, preventive, curative, rehabilitative, or palliative health services receive them at sufficient quality. The World Bank and WHO have developed a service coverage index to monitor coverage of essential health services based on sixteen indicators that denote performance across a range of health conditions. Based on this index, coverage of essential services has increased by about 20 percent from 2000 to 2015; however, at least half of the world's population still does not have full coverage of essential health services.[14] For example, the median coverage across countries of the satisfied demand for modern family planning methods was recently estimated at 48 percent.[15] Within countries, socioeconomic disparities in coverage of essential services suggest that the progress made has not been equitable.

For a subset of essential health services for maternal and child health and infectious diseases, disparities in service coverage can be explored across income, education, and geographic settings of mothers (figure 7-1). Individuals who are poor or less educated have worse coverage for every outcome, though the disparities can be small in some cases (e.g., child diarrhea treated). Other analyses have found lower coverage of maternal and child health services among the poor,

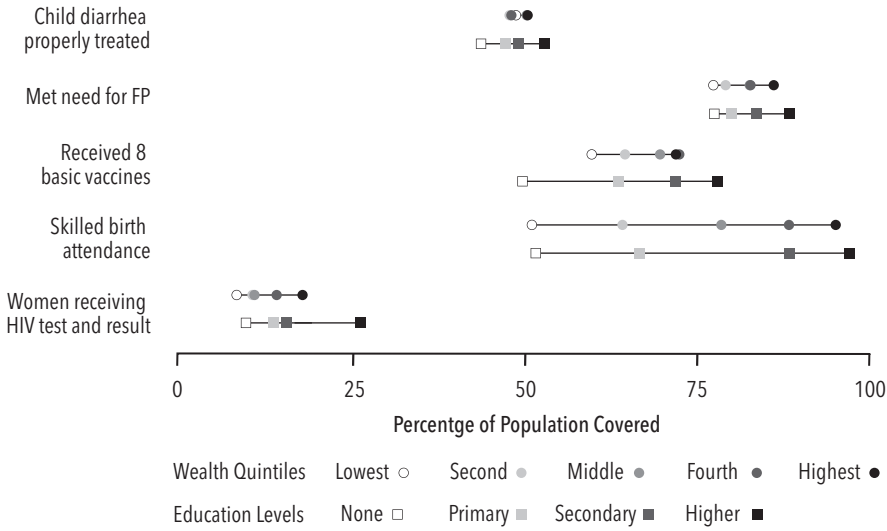
14. World Health Organization and the World Bank (2017).
15. Countdown to 2030 Collaboration (2018).

rural, and less educated women.[16, 17] When vulnerabilities such as being poor, rural residence, and low education intersect, the joint outcome is far worse than for any single vulnerability considered individually (figure 7-2). A systematic review of the impact of vulnerabilities and service coverage found that there is a direct correlation between coexisting vulnerability factors and healthcare disparities.[18] The same study reported that some types of vulnerability are frequently studied, such as poverty, being a racial/ethnic minority, having a chronic physical or mental illness, lack of insurance, and old age; however, there is a paucity of information on other factors such as migrant status or multimorbidity as aspects of vulnerability in the context of health systems.[19]

Little is known about some kinds of vulnerable populations, such as migrants.[20] Migrants—international and internal migrants, refugees, and internally displaced people (IDP)—have received little attention within UHC discussions. There were 258 million international migrants in 2017, representing 3.4 percent of the world's population[21] and 40 million IDP in the same year, according to the UNHCR.[22] The health of all migrant groups is important, though the vulnerabilities and health needs of some (e.g., economic migrants) can be different from those of refugees. Noncitizens such as unregistered refugees and immigrant populations, in particular, are more likely to be afflicted by interacting vulnerabilities emanating from poverty, religion, and ethnicity. Economic migrants present a special case. They often perform jobs that have poor work environments, which places them at higher health risk while they may not have access to care due to government policy, lack of citizenship, or lack of clarity on legal status.[23] According to International Labour Organization (ILO), there were 164 million migrant workers (64 percent of all international migrants) globally in 2017.[24] Only some destination countries extend healthcare coverage to migrant workers and their families in the home country, and offer portability of health benefits when migrant workers return home.[25]

16. Ibid.
17. Victora and others (2018).
18. Grabovschi and others (2013).
19. Grabovschi and others (2013).
20. Ibid.
21. OECD/ILO/IOM/UNHCR (2018).
22. UNHCR (2017).
23. Benach and others (2011).
24. OECD/ILO/IOM/UNHCR (2018).
25. Holzmann (2016).

Figure 7-1. Median Level of National Coverage by Wealth and Education Groups



Median level of coverage of five health service indicators across wealth quintiles and education levels from the most recent Demographic Health Survey from eighty-three low- and middle-income countries (LMICs) between 1990 and 2017.

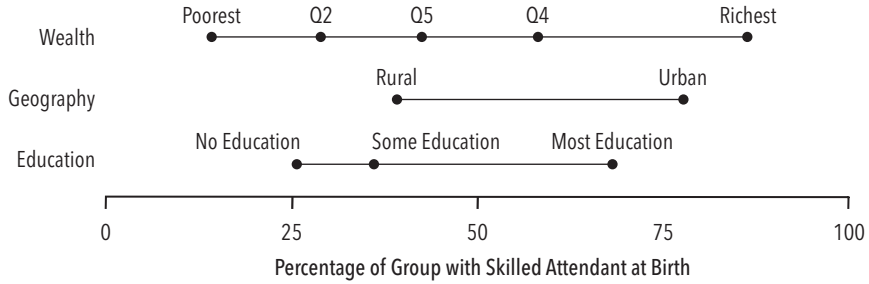
Notes: These five service indicators are, from top to bottom; (i) the percent of live births in the five (or three) years preceding the survey delivered at a health facility; (ii) the percentage of children born in the five (or three) years preceding the survey, who had diarrhea and received either oral rehydration solution or recommended home fluids; (iii) the percentage of currently married or in-union women whose stated need for family planning is met; (iv) the percentage of children from twelve to twenty-three months who had received all eight basic vaccinations; and (v) the percentage of women who had an HIV test in the twelve months preceding the interview and received their test results.

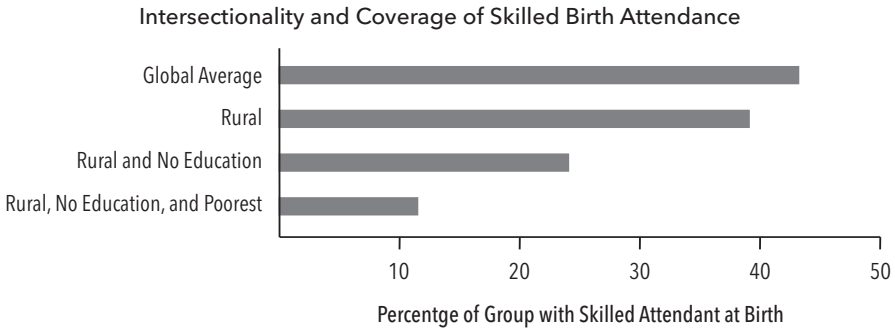
Source: ICF (2019).

Financial Protection of Vulnerable Populations

Ensuring that individuals who get needed care do not suffer undue financial hardship is the second component of the SDG indicator for monitoring progress toward UHC. When out-of-pocket payments (OOP; payments made directly to providers net of any insurance reimbursements) exceed a threshold percentage of household income or consumption expenditure (usually 10 percent), these costs are considered to be catastrophic. Overall, financial protection from high OOP appears to be worsening—the incidence of catastrophic health spending (SDG indicator 3.8.2) rose from 9.7 percent of the world's population in 2000 to

Figure 7-2. Median National Skilled Birth Attendance Coverage by Various Vulnerabilites





Median national percent of births occurring in a facility across wealth, geographic, and education levels within ninety-one LMICs.

Notes: Percent of births that take place in a facility is then examined through the lens of intersectionality, as coverage of facility births is examined across groups with multiple vulnerabilities (location of residence, education level, and poverty).

Source: World Health Organization (2019c).

11.7 percent (about 808 million) in 2010.[26] Such financial hardships are felt at a higher rate by vulnerable groups such as the poor, those with low socioeconomic status, the elderly, or migrants. Nationally, the median annual rate of change of catastrophic payment incidence is increasing, suggesting that despite the progress made by some countries, much work must be done to ensure adequate financial protection against catastrophic health spending.[27] Even in countries such as China and Thailand, which have well-established health financing systems that provide financial protection, there are subpopulations that continue to

26. Wagstaff and others (2018).

27. Ibid.

experience catastrophic household expenditure. One study in China found that 44.9 percent of elderly households experienced catastrophic health expenditure, compared to rates of 26.5 percent in the general public in the same province.[28] In Thailand, certain factors were associated with higher rates of catastrophic health expenditure, mainly having less education, being elderly, or having people with disabilities in the household.[29] Thus, the presence of a supposedly universal health financing system in a country does not automatically ensure that everyone, especially vulnerable populations, has financial protection.

Government policies can provide inequitable access to financial protection. In some countries with universal health insurance systems, the healthcare costs (prepayment and/or the copayment at the point of service use, sometimes indirect cost additionally) of the poor are subsidized. However, the benefits covered by such subsidized systems are often minimal, especially when compared to other basic packages within the same country. Further, systems that are based on social health insurance models through payroll deductions often exclude the informal sector from accessing the same benefits as those who are formally employed. The elderly are also vulnerable to healthcare-related financial hardship due to limited income, and greater need for health services due to their experiencing a greater burden of chronic illnesses relative to the general population.[30] A multicountry study found that the elderly were less likely to even be covered by health insurance programs in Africa.[31] This systematic exclusion of certain groups from health financing systems contributes to the increased vulnerability of such subpopulations, and is a considerable barrier to achieving financial protection.

Purposively targeting the most vulnerable populations in health financing reforms is an effective strategy to ensure that financial protection is expanding to all parts of the population. A series of reviews have examined how insurance systems in European, Asian, and Latin American countries define and treat vulnerable populations and have broadly concluded that countries must still make targeted efforts to expand payment subsidies and/or exemptions and service packages to these populations in order to continue progress toward UHC.[32, 33, 34] A core challenge in this effort is the fact that correctly targeting and subsequently reaching beneficiaries is difficult; in several Asian health insurance programs,

28. Yang and others (2016).
29. Somkotra and Lagrada (2009).
30. Lee and others (2009).
31. Parmar and others (2014).
32. Vilcu and Mathauer (2016).
33. Vilcu and others (2016).
34. Mathauer and Behrendt (2017).

only about half of the intended vulnerable target groups are currently covered.[35] This stems in large part from the difficulties in identifying such groups, but also from challenges associated with determining the appropriate mechanisms of providing financial coverage (e.g., reimbursement versus in kind). Where countries have been able to successfully identify and reach vulnerable populations with financial protection schemes, the health gains have been impressive.[36] Such strategies should be designed and implemented according to local context, government political will, and available resources.

Policy Options Available to Achieve UHC for Vulnerable and Marginalized Populations

The principle of progressive universalism is a useful guide for reaching vulnerable populations with UHC. By deliberately directing resources to the neediest in society, it advocates a bottom-up approach: first bringing benefits to those who are worst off. In this section, we argue that operationalizing this principle requires better information on vulnerable populations, health systems oriented toward primary healthcare, adequate financing for health, and the adoption of innovative technologies. It also needs an understanding of the political factors that can impede policies that favor vulnerable and politically weak groups.

Better Understanding and Information on Vulnerable Populations

Understanding the vulnerabilities that affect health in a population and having accurate and timely information on the health of vulnerable populations is critical for directing appropriate health services to these groups. Yet information on the health of vulnerable groups tends to be fragmented. A first step in producing actionable information on vulnerable populations requires understanding the sources of vulnerability in a population and how it relates to the risk of poor health or financial hardship related to use of health services. Household surveys, which are the principal means of collecting information on population health in low- and middle-income countries (LMICs), can be oriented to provide adequate representation of vulnerable populations. Well-functioning national systems of civil registration and vital statistics can provide up-to-date information on population health, including vulnerable groups. Establishing such systems, however, is an ongoing challenge for many LMICs due to, among other things, a lack of technical and financial resources and political pressures to suppress information

35. Vilcu and others (2016).
36. Ruiz and others (2018).

on these groups. There are other options. Some countries, like Brazil and Ethiopia, have successfully used community health workers to collect information on the health and other vital statistics of all households in communities. This "census-based" community approach offers a way of both routinely collecting information on people's health and vital events and directing health services toward vulnerable groups (see box 7-2).

Collecting information on some vulnerable groups, like migrants, requires special effort and care. Despite the high and growing levels of global migration, information systems on migrants, particularly on their health, is weak. Current data on international migration is fragmented and contextually specific. There is no agreed set of standardized migration indicators that source and destination countries collect.[37] Moreover, what data are collected are often not publicly available. Such issues limit efforts to understand the scale of global migration, to develop evidence-based policies to manage migration, and to know the extent to which migrants, particularly refugees and labor migrants, are able to access health and other services.[38, 39] In many cases, this reflects political mobilization to limit the rights of migrants. While there have been efforts to independently collect information on migrants in some countries, it is important that routine national systems for collecting information on populations (e.g., household surveys or surveillance systems) also identify and include migrant populations. Routinely collecting information on migrant populations may not be acceptable to everyone. There is every danger that governments or anti-migrant groups can use such information in ways that is detrimental to the well-being of migrants. Indeed, migrants themselves may be reluctant to participate in such processes. Better information on migrants and their health is necessary to increase their access to health services, and requires involvement of different actors (e.g., national governments) and ministries (e.g., health, labor, foreign affairs, trade and industries, NGOs). However, governments will need to also demonstrate confidence that such information will be used carefully and without prejudice to migrants' well-being.

Progressive Universalism through Primary Healthcare-Oriented Health Systems

Countries with health systems that are built on a strong primary healthcare (PHC) platform have demonstrated improvements in substantially expanding coverage of essential healthcare services, improving population health, and

37. Bilsborrow (2017).
38. OECD/ILO/IOM/UNHCR (2018).
39. Bilsborrow (2017).

Box 7-2. Community Health Workers and Community-Based Census

Primary healthcare programs with strong community-based services have demonstrated health gains, especially in regard to maternal, neonatal, and child health. The Census-Based Impact-Oriented approach and similar strategies aim to understand the most important health needs of a community via community outreach efforts (such as focus groups, meeting, and home visits) and epidemiologic monitoring using community censuses, surveys, and vital events reporting. Community health workers or community volunteers regularly visit all households in their jurisdiction and, depending on the context, provide a range of services from health education to collecting information on family health and providing basic curative services and commodities to the household. Such models are used in Bangladesh, Ethiopia, and Brazil, among others.

reducing disparities in access to healthcare and health.[40, 41, 42, 43] Health systems oriented around PHC offer the potential of providing vulnerable populations with essential health services and financial protection. For one, PHC puts emphasis on addressing the determinants of health—the social, economic and environmental, and individual characteristics that underpin many of the causes of vulnerability in populations (see box 7-3).[44] Community-based services, an important feature of PHC, is often also the only way to identify and reach vulnerable populations, due to their geography or other causes of vulnerability. In particular, the practice of community health workers regularly visiting all households in a community, applied in countries like Bangladesh and Brazil, offers a powerful way to reach vulnerable populations, identify those at risk of poor health, and connect them with appropriate care.[45] For example, community delivery of services is beneficial to older populations, because they may find it difficult to access fixed health services delivery points other than their residences, due to mobility issues. They are also more likely to suffer from chronic illness that requires stronger health promotion, medical treatment or surgery at higher-level facilities, and a sustained engagement over long periods of time with healthcare providers. This issue will grow in prominence as the global population aged sixty years or over, estimated to be 962 million in 2017, is projected to double by 2050, with the majority of the world's older population living in LMICs.[46]

40. Starfield and others (2005).
41. Lawn and others (2008).
42. World Health Organization (2013).
43. Macinko and others (2009).
44. World Health Organization and United Nations Children's Fund (2018).
45. Perry and others (1999).
46. Department of Economic and Social Affairs Population Division (2017).

Box 7-3. Evolution of Primary Healthcare

Primary healthcare (PHC) as an approach to improving population health was first articulated in the 1978 Alma-Ata Declaration. Its essential elements are built around three pillars; meeting people's health needs through comprehensive promotive, protective, preventive, and/or curative services; addressing the broader determinants of health; and empowering individuals, families, and communities to optimize their health. This conceptualization has been redefined repeatedly since Alma-Ata. PHC has been variously defined as the provision of ambulatory or first-contact personal healthcare services; as a set of priority health interventions for low-income populations (also called selective PHC); as basic preventive, promotive, and curative health services delivered by non-specialist health workers; as health services delivered close to communities; or as broader health strategy that focuses on the economic, social, and political aspects of health rather than simply health service provision.

Vulnerable groups, such as the poor, ethnic groups, migrants, or the socially marginalized, often live in resource-poor areas where facility-based health services are traditionally weak. Further, beliefs, stigma, education, their legal status (in the case of international migrants or refugees), financial constraints, and a lack of language proficiency can limit their ability to participate in health services proactively. By emphasizing outreach services in communities, PHC strategies can better target vulnerable groups with comprehensive essential health services. PHC-oriented health systems can reduce healthcare costs for both the government and patients. The focus on prevention and management of illness at the primary-care level avoids escalation of health issues to more complex and costly conditions; the reliance on basic infrastructure and health workers with basic training offers an affordable way of delivering services. Because out-of-pocket payments for health are primarily comprised of expenditures on outpatient visits and medicines, access to publicly funded PHC services and affordable essential medicines can substantially lower financial hardship experienced by patients.[47]

PHC as the foundation of UHC offers a progressive universalism approach to developing health systems. The advancement of health systems oriented around PHC requires action on several fronts. For one, all levels of care in the health system—primary, secondary, and tertiary—need to be well-functioning and have strong referral linkages. Second, the historical prioritization of communicable diseases and reproductive conditions has largely shaped the organization of PHC services. Important areas for action here include strengthening capacity to also manage noncommunicable diseases and emphasizing preventive and promotive healthcare. Third, primary care services in many countries are challenged by

47. World Health Organization (2010).

issues of low financing, inadequate material resources, and poor quality of care. This often results in patients bypassing primary health centers and seeking care elsewhere.[48] Investing in improving quality of care in health systems is critical to addressing this issue.[49] This can be achieved through better in-service and pre-service training, an appropriate incentive environment that promotes better quality of care by health workers, and adequate financing. Fourth, many LMICs have pluralistic health systems, where there is a large private sector (formal or informal) present. Often the vast majority of outpatient visits is catered by the private sector.[50] Strategies to suitably engage the private sector are necessary to ensure access to quality and affordable health services.

Attention to Financing Healthcare

Providing financial protection to vulnerable populations remains one of the most pressing challenges for achieving UHC. For one, countries lack adequate fiscal space to provide adequate coverage of subsidized healthcare to vulnerable populations. For governments facing fiscal constraints, there are several options, including prioritizing health by increasing the health budget or increasing health revenues by raising general or earmarked taxes in a progressive manner so the burden is on those who can afford to pay. Increasing health budgets or raising general taxes are often difficult, due to competing priorities and political acceptability. However, earmarking taxes, particularly revenue-earmarking by taxing items such as alcohol, tobacco, and sugary drinks offers an important way of raising additional revenues for health to cover vulnerable populations. Besides raising revenues for health, such earmarking also helps to reduce consumption of unhealthy products. Countries like the Philippines have had success with using "sin taxes" to increase funding for health, though the long-term sustainability of revenue streams from sin taxes is questionable.[51] With that in mind, looking for innovative ways to finance healthcare is important.

Countries can also use their available health resources more efficiently. One strategy to achieve this is by integrating packages of cost-effective promotive, preventive, and curative NCD interventions, such as those identified in the Disease Control Priorities, which can be delivered through population-based, community, health center, and hospital platforms.[52] Keeping with the spirit of progressive universalism, countries can adopt an essential set of services that

48. Kruk and others (2009).
49. Rao and Sheffel (2018).
50. Bhatia and Cleland (2001).
51. Kaiser, Bredenkamp, and Iglesias (2016).
52. Watkins and others (2018).

can be offered to all people, and this can be subsequently scaled up. Another strategy to use health resources more efficiently is to control the costs of healthcare. One example is Japan, where close collaboration between representatives of healthcare providers and the Ministries of Health and Finance has resulted in periodic social insurance fee schedule review, enabling the country to control overall expenditure while meeting the health needs of Japan's rapidly aging population. Further, because expenditures on drugs constitute the biggest share of out-of-pocket payments, regulating the cost of medicines or promoting the use of quality-assured generics is another important strategy to lessen the financial hardship on household. Global financing mechanisms on drug research and development, international trade agreements, and the judicious use of compulsory licensing of drugs that are respectful both of patents and of the right to healthcare, can promote greater access to affordable essential medicines. At the same time, increasing numbers of substandard and falsified medical products pose an unacceptable risk to public health. In these areas, government action at the regional and global level can help increase access to affordable medicines through the use of quality-assured generics.

Countries whose health budgets depend on donor contributions constitute an important case. While aid per capita for health more than doubled across low-income countries from US$4 to US$10 from 2000 to 2016, public spending on health increased only slightly (by about US$3 per capita).[53] Consequently, for these countries, the share of health in overall domestic public spending declined during the same period.[54] Within a decade, more than fifty countries will transit away from depending on external donors for financing healthcare.[55] The extent to which these countries can smoothly transition depends on the political choices of government leaders, as well as the nature of the transition process executed by donor agencies. It is also important to recognize that improvements in national income do not necessarily translate into improvements for all—there are likely to be sub-national regions or population groups that have not benefited from increases in average income. As such, withdrawing donor support on the basis of changes in average national income may be detrimental for many. Establishing donor coordination mechanisms is important to ensure that global health assistance contributes to the establishment of long-term, sustainable health-financing solutions.

53. World Health Organization (2018).
54. Ibid.
55. UHC 2030 (2017).

The Potential of Technological Innovations

Innovations in digital health technology can play an important role in providing vulnerable populations with increased access to healthcare. Technological innovations, such as mobile phones and portable diagnostic devices, among others, have demonstrated effectiveness in increasing the availability of basic diagnostic services in underserved geographies, enhanced the capacity of lay health workers to monitor the health of their communities, improved their ability to provide quality care, and to provide health-related messaging to their clients. Telemedicine has enabled patients in underserved geographies to access specialist care remotely.[56]

Several recent innovations in digital health technologies offer the potential of increased healthcare access to vulnerable populations. Mobile money technology, by which money can be easily transferred using mobile phones, offers the potential of users being reimbursed by insurance companies more efficiently or of directly receiving financial benefits from government programs, such as conditional cash-transfer programs in health. This can help to better target beneficiaries, improve the reputation of government programs by ensuring timely receipt of benefits, and reduce opportunities for corruption. The use of drones in Rwanda is also an example of improving service access.[57] Here, drones have been used to carry blood and life-saving supplies over long distances where supply routes are traditionally difficult to navigate. Such new technology holds enormous potential to reach vulnerable populations, particularly those living in hard-to-reach areas. The use and adaptation of such technologies, along with ensuring necessary regulatory frameworks, can help vulnerable populations overcome barriers to accessing essential health supplies and services.

Conclusion

Providing vulnerable populations with affordable, quality healthcare remains a pressing challenge even as an increasing number of countries are formalizing political commitments to UHC. This is true both of countries that have established UHC systems or have yet to do so; and whether the groups considered vulnerable are the poor, the elderly, individuals with low socioeconomic position, or individuals who live in particular geographies. This difficult task of providing coverage to vulnerable populations is constrained by several factors: understanding vulnerabilities, identifying who the vulnerable are, having adequate resources—financial, human and material—to provide affordable quality

56. Shea and others (2009).
57. Ackerman and Koziol (2019).

services, and effectively directing health resources at these groups. This chapter has attempted to highlight some potential solutions to address these challenges.

The principle of progressive universalism is a useful guide to frame UHC strategies while recognizing the importance of reaching vulnerable populations. By deliberately directing resources to the neediest in society, it advocates a bottom-up approach to first bring benefits to those who are worst off. Information on vulnerable populations is critical to understanding their health needs, as well as to empowering them and to directing services toward them. Orienting health systems to have a strong PHC foundation offers a way to reach vulnerable populations with affordable and integrated essential preventive, promotive, and curative health services. Health systems oriented toward PHC can offer important population health gains, in an affordable manner, to governments and patients. However, linkages with secondary and tertiary care levels, and quality of services, and adequate financing are necessary conditions for this. For certain neglected vulnerable groups, such as migrants, special efforts need to be made to collect information on their health. Migrant workers should be offered access to health and social security benefits in the country where they work, comparable to those of local workers.[58, 59] To reach this point, health benefits of migrant workers must be coordinated by both source and destination countries through mechanisms such as bilateral social security agreements.[60]

Efforts to provide vulnerable populations with affordable, quality healthcare need to be cognizant of the political impediments that lie along this path. These policies may not be favored by those with power in government or within society. For instance, issues like intolerance of foreigners, ethnic and racial xenophobia, and subsidizing the economically weak using public funds have become major political issues. Civil society and development partners are an important resource in advocating for and directing global health funds to vulnerable populations, and to make access to affordable, quality health services a reality for all.

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