A Common Cause
Reaching every woman and child through Universal Health Coverage

Universal Health Coverage (UHC) means ensuring all people can access quality essential health services without financial hardship. There is growing consensus that UHC is a smart investment and achievable globally. UHC promotes realisation of the human right to health. Through the Sustainable Development Goals (SDGs), governments have committed to achieving UHC and to *"leave no one behind"* – prioritising the world's most excluded groups.

UHC is needed for ending all preventable maternal, newborn and child deaths

Despite global progress, Millennial Development Goals (MDG) 4 and MDG 5[1] were not achieved globally, or in many countries, and there are huge inequalities in women's and children's health. There has been slower progress in reducing maternal and newborn deaths compared to reducing under-five deaths. Of the estimated 16,000 under-five deaths every day, almost half occurred in the neonatal period.

As countries move towards UHC, they must first focus on ensuring universal access to the most essential services needed by every family and community – prioritising essential sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) as an integrated continuum of care, free at the point of use and accessible to all. The 'continuum of care' requires a well-functioning health system available around the clock, including access to obstetric care and post-natal care for mothers and newborns.

Primary Health Care first

All communities need primary health care close to them and accessible to delivers front line services. Governments need to make quality primary health care for every community the foundation and priority for building UHC.

Paying for Universal Health Coverage

Governments must increase public spending on health, moving away from private and out-of-pocket expenditure towards mandatory, pre-paid and fair-pooled funding mechanisms. Governments should increase public spending on primary healthcare to at least 5% of GDP and a minimum of US$86/person to provide essential services. Progress toward UHC also requires strengthening health systems, including human resources for health.

All countries, irrespective of income level, can and should make progress on UHC; expanding reach, services, and the extent of financial protection. The path countries take will differ but all must ensure equitable access without discrimination. Donor aid can help, but should not be relied on as the primary income for UHC.

RECOMMENDATIONS

We are calling for increased national commitment and investment towards UHC, by building SRMNCAH services at primary health care level as a first priority and prioritising access for the poorest and most excluded groups.

Save the Children calls on governments, donors, development partners and all stakeholders to:

- Guarantee an essential package of SRMNCAH services as the first priority for UHC; free at the point of use and accessible to all
- Establish time-bound equity targets for accelerated progress among the poorest and most marginalised people, so no one is left behind
- Increase public spending on healthcare to at least minimum levels, with governments increasing tax revenue and donors improving official development assistance, to support national health systems
- Improve quality and promote respectful and dignified care in health facilities

	UHC for every woman and child	Spotlight on Zimbabwe[2]
Health outcomes	**25** is the SDG target for under-five deaths by 2030 (per 1,000 live births). Currently, 79 countries have rates higher than this and 47 of them will not meet the target based on current trends.[3] Newborn target is 12/1,000 live births.	**69** is the under-five mortality rate in Zimbabwe (per 1,000 live births). Newborn mortality is 29/1,000. Poorer children are 47% more likely to die before the age of five than wealthy children.
Health coverage	**1/4** of births globally are not attended by a skilled health worker.[4] Half of children with signs of pneumonia are not treated by an appropriate health care provider in low income countries.[5] Deliveries and treatment of pneumonia require 24h services accessible on demand.	**22%** of deliveries in Zimbabwe occur without a skilled health worker present. Skilled birth attendance is 55% higher for wealthy women than poor women.
Health workforce	**4.45** is the minimum number of skilled health workers/1,000 people to deliver UHC. There is a shortage of 17.4 million health workers globally.[6]	**1.4** skilled health workers for every 1,000 people in Zimbabwe.
Paying for healthcare	**$86** is the minimum recommended government spend/person/year to provide primary health services. More than a third of countries globally don't spend this. Average spending/person/year in low income countries (LICs) is $15, with 25 LICs spending $20 or less.[7]	**$21** spent by the government on health per person in 2015. **$18** was allocated to primary healthcare. Zimbabwe has costed its Essential Health Benefits Package at $76 per person at the district level and $16 per person at the rural health clinic level.
	15% is the minimum recommended share of government budget to be spent on health: 'Abuja target'. Based on recent data, only three LICs countries spend this.[8]	**8%** of the government's budget spent on health in 2015. Out-of-pocket expenditure was 25% of total health expenditure in 2015.
	5% is the minimum recommended government spend on primary healthcare as % of GDP. 125 countries globally do not currently spend this. Only two LICs spend 5% or more.	**2.5%** of GDP spent on health by the government in 2014.
Fiscal space for health	**20%** is the minimum recommended intake of taxes, as a share of GDP. Only 13% of LICs achieve this. By reforming tax systems and improving compliance, countries could collect more domestic revenue and to extend health services.[9]	**25%** tax collected in Zimbabwe as a share of GDP in 2015.

[1] MDG 4 aimed to reduce the under-five mortality rate by two-thirds between 1990 and 2015, and MDG 5 aimed to reduce the maternal mortality ratio by three quarters between 1990 and 2015.
[2] Source: National mortality, health coverage and disaggregated data based on Zimbabwe DHS 2015; health financing figures based on data from MoHCC and Zimstat 2015 and MoHCC-NHA; and tax figures based on MoFED data.
[3] See: http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/
[4] WHO Global Health Observatory.
[5] Ibid.
[6] Source: WHO, *Global strategy on human resources for health: Workforce 2030, Draft for the 69th World Health Assembly,* World Health Organization, 2016.
[7] WHO Global Health Observatory.
[8] Ibid.
[9] Cited in: Save the Children, *Every last child: The children the world chooses to forget,* Save the Children, 2016.