PROTECTING EVERYONE

Integration of Noncommunicable Diseases into Universal Health Coverage in the Era of COVID-19

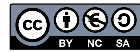
NCD Alliance

Edited by NCD Alliance, December 2020

Cover: © shutterstock

Editorial coordination: Jimena Márquez

Design and layout: Mar Nieto



NCD Alliance | 31-33 Avenue Giuseppe Motta | 1202 Geneva, Switzerland
www.ncdalliance.org

PROTECTING EVERYONE

Integration of Noncommunicable Diseases into Universal Health Coverage in the Era of COVID-19

Acknowledgements 4

Executive Summary **6**

Introduction **7**

Background

Universal Health Coverage (UHC) 8

Noncommunicable diseases (NCDs) 11

COVID-19 14

Features to consider when integrating NCDs into UHC 14

Key challenges to the integration of NCDs into UHC 16

Case Studies **17**

Australia 18

Ethiopia 21

India 25

Jordan 29

Mexico 33

Philippines 37

Rwanda 40

Sweden 44

Recommendations from country experts **48**

References 52

Alexis was diagnosed with T1 Diabetes at the age of two. Click here to learn how the Helmsley Charitable Trust and Life for A Child are helping children living with T1 Diabetes in Mexico by providing access to diagnosis and treatment.

Acknowledgements

This publication was made possible thanks to the NCD Alliance's partnership with The Leona M. and Harry B. Helmsley Charitable Trust. The report was developed by the NCD Alliance and realised through collaboration with eight national NCD Alliances: the Australian Chronic Disease Prevention Alliance, Consortium of Ethiopian NCD Associations, Healthy India Alliance, Healthy Philippines Alliance, Jordan NCD Alliance, Mexico Salud-Hable Coalition, Rwanda NCD Alliance, and Swedish NCD Alliance. Warm thanks to the members of all these alliances for their contributions to the research and write up of this report.

In addition, we are grateful for key informant recommendations provided by NCD Alliance's network of stakeholders, with special thanks to: FDI World Dental Federation, Fred Hollows Foundation, International Federation of Psoriasis Associations, Life for a Child, Partners in Health, NCD Child, and World Stroke Organization.

Acknowledgement of Steering Committee

A Steering Committee comprised of global experts in noncommunicable diseases and Universal Health Coverage reviewed and provided input on the report outline, interview questionnaire and draft. We would like to thank the Steering Committee members for their content guidance and review:

Dr Apoorva Gomber, Lives with Type 1 Diabetes Mellitus, Pathologist, Co-founder of Diabetes India Youth in Action, India

Ms Diana Vaca McGhie, Global Advocacy Director of American Heart Association, United States

Ms Charity Muturi, Mental Health Advocate, Our Views Our Voices Global Advisory Committee, Kenya

Prof Bo Norrving, Professor of Neurology, former-President of World Stroke Organization, Sweden

Prof David Peiris, Director, Global Primary Health Care Program (Better Care), The George Institute, Australia

Dr Kaushik Ramaiya, Consultant Endocrinologist, General Secretary of Tanzania NCD Alliance, Tanzania

Acknowledgement of key informants

Ultimately, we would like to thank the key informants from Australia, Ethiopia, India, Jordan, Mexico, Philippines, Rwanda and Sweden, whose contributions form the backbone of this report. We thank them for their time and expert opinions, and with their permission they are quoted throughout the publication. Below, we include for the majority acknowledgement by name, position and country. For the few wishing to remain anonymous, thank you.

Aca: Academic expert

CSO: Civil society representative

Gov: Government representative

HCP: Health care professional

PLWNCD: Person Living with an NCD

Australia: Mr Murray Turner, advocate living with psoriasis, CEO Psoriasis Australia (PLWNCD); Dr Lisa Studdert, former Deputy Secretary of Population Health for the Federal Department of Health (Gov); Prof Rob Moodie, Nossal Institute of Global Health at the University of Melbourne (Aca); Dr James Muecke, Ophthalmologist, Australian of the Year 2020 (HCP); Ms Eithne Irving, Deputy CEO and General Manager of Policy Australian Dental Association (CSO).

Ethiopia: Mr Tsegamlak Zerihun, advocate living with Type 1 Diabetes Mellitus (PLWNCD); Dr Mahlet Kifle Habtemariam, former NCD Director and former Chief of Staff for the Ministry of Health, current Principal NCD Program Officer Africa CDC (Gov 1); Dr Wubaye Walelgne, Senior NCD Program Advisor for the Ministry of Health (Gov 2); Dr Wondu Alemayehu, National NTDs Advisory Committee, National Committee for Prevention of Blindness (Aca); Prof Abraham Haileamlak, Consultant Paediatric Cardiologist at Jimma University, Co-Chair Ethiopia National NCDI Poverty Commission (HCP); Mr Wondu Bekele, Consortium of NCD Ethiopian Associations (CSO).

India: Ms Jyotsna Govil, Our Views, Our Voices Global Advisory Committee Member, Vice Chair for Indian Cancer Society, Healthy India Alliance (PLWNCD); Prof Anand Krishnan, Centre for Community Medicine at All India Institute of Medical Sciences (Aca); Dr M. R. Rajagopal, Palliative Care Physician, Chairman at Pallium India, Healthy India Alliance (HCP); Ms Radhika Shrivastav, Director of Health Promotion for HRIDAY-Secretariat, Healthy India Alliance (CSO).

Jordan: Dr Suhail Jouaneh, advocate living with cancer (PLWNCD); Dr Sima Kalaldeh, Endocrinologist (HCP); Ms Hanin Odeh, Director General of Royal Health Awareness Society (CSO 1); Ms Nisreen Qatamish, King Hussein Cancer Foundation (CSO 2).

Mexico: Mr Jaime Barba Zozaya, advocate living with chronic obstructive pulmonary disease (COPD), Bioethics Committee of the National Institute of Respiratory Diseases (PLWNCD); Dr Mauricio Hernández Ávila, Director of Economic and Social Benefits at the Mexican Institute of Social Security (Gov); Dr Hortensia Reyes Morales, Joint Director of Health Systems and Health Policies at the National Institute of Public Health (Aca); Dr Hector Carrasco, General Practitioner at Partners in Health (HCP); Mr Juan Núñez Guadarrama, Coordinator at Mexico Salud-Hable Coalition (CSO).

Philippines: Ms Fatima Lorenzo, President, Philippine Alliance of Patient Organizations (PLWNCD); Honourable Mario Villaverde, Undersecretary for Health Policy and Systems Development at the Department of Health (Gov); Ms Ana Maria Nemenzo, National Coordinator for WomanHealth Philippines, Convener of Social Watch Alternative Budget Initiative-Health Cluster (CSO).

Rwanda: Ms Grace Gatera, mental health advocate (PLWNCD); Dr Francois Uwinkindi, Manager of the NCD Division, Rwanda Biomedical Center (Gov); Dr Jean Damascene Kabakambira, Head of Department of Medicine at Kigali University Teaching Hospital (Aca); Mr Gedeon Ngoga, NCD nurse leader at Partners in Health (HCP); Dr Joseph Mucumbitsi, Chair of Rwanda NCD Alliance, Chief Consultant Paediatrician and Cardiologist at King Faisal Hospital (CSO).

Sweden: Ms Cajsa Lindberg, advocate living with Type 1 Diabetes Mellitus, brain cancer, Our Views, Our Voices Global Advisory Committee Member (PLWNCD); Ms Marie Lawrence, Director of the Swedish Knowledge-based System, The Swedish Association of Local Authorities and Regions (Gov); Prof Lars Weinehall, Epidemiology and Global Health at Umeå University (Aca); Prof Mai-Lis Hellenius Cederholm, Lifestyle Medicine at Karolinska Institute (HCP); Ulrika Århed Kågström, Secretary General of Swedish Cancer Society (CSO).

Executive Summary

Globally, 7 out of 10 deaths are due to noncommunicable diseases (NCDs). 85% of premature deaths from NCDs occur in low- and middle-income countries (LMICs). Despite the need, many countries are lagging behind on the integration of NCDs into Universal Health Coverage (UHC) benefit packages, putting the lives of millions of people living with NCDs (PLWNCDs) at risk of or pushing them into extreme poverty and jeopardising the attainment of the Sustainable Development Goals (SDGs). For example, half of people living with diabetes do not have access to the insulin they need to survive and, in some populations, over 60% of people living with NCDs have experienced catastrophic health expenditure. The situation for people living with NCDs has worsened with the coronavirus (COVID-19) pandemic, which has exposed the link between NCDs, communicable diseases and health emergencies. The pandemic has also shown NCDs to be the weak link in health systems worldwide and exposed the damage that neglecting NCDs and underinvesting in health, prevention and essential public health services has done over the years in many countries. In addition to PLWNCDs being at higher risk of severe complications and death from COVID-19, 75% of countries have reported disruptions in NCD care and only 38% of countries have included NCDs in their COVID-19 Preparedness and Response Plan's Essential Health Services.

This policy research report outlines global progress towards integration of NCDs into UHC benefit packages to date. Through analyses of interviews with experts from Australia, Ethiopia, India, Jordan, Mexico, Philippines, Rwanda and Sweden it brokers knowledge by showcasing country-level examples and explores the role of NCD prevention and care to enhance health security in light of the COVID-19 pandemic. It demonstrates that there are tried-and-tested methods to effectively integrate NCDs into UHC at national level in different economic settings, enabling governments to provide care and financial protection to people living with NCDs across the whole population. Such efforts will increase equity and productivity and ensure healthier, more secure populations. Integration of NCDs into UHC as we build back better from the pandemic must be a cornerstone to national and global preparedness for future health threats.

> "I might be scared of relapsing with my cancer but I know I will be taken care of if I do. That is absolutely fundamental."
>
> Person living with T1 diabetes and brain cancer, Sweden

It is urgent that policy makers:

Recognise the pivotal role of NCDs in UHC at national level and lead reform, meaningfully engaging people living with NCDs and civil society organisations (CSOs), in development and enactment of legislation and continual review of essential healthcare packages, including essential medicines and financial protection mechanisms, prioritising the marginalised. They must also strengthen data collection systems for the implementation of accountability frameworks.

Prioritise NCD prevention and care as key to the development of resilient health systems and a vital component of pandemic preparedness and humanitarian responses.

Adopt an integrated, inclusive, person-centred approach to the provision of NCD services, adapted to the country's needs and capacities, which recognises that many people live with multiple diseases that are often chronic and lifelong.

Ensure sufficient funding for NCDs, blending income from tax, community health insurance schemes, development assistance, and double-dividend measures such as taxes on health-harming commodities including tobacco, alcohol, unhealthy foods, and fossil fuels.

Introduction

NCDs are the leading cause of death and disability and account for 71% of deaths globally.(1) However, in many countries, coverage and access to NCD services, including screening, early diagnosis, treatment, rehabilitation and palliative care, is inadequate. Too often, health systems are fragmented and orientated towards single-disease treatments, instead of adopting an integrated, life course approach[i] to health that provides people with the services and care they require for a variety of conditions. In addition, in some populations, over 60% of people living with NCDs have experienced catastrophic health expenditure.[ii](2) Such out-of-pocket payments[iii] for NCD treatment and care often trap poor households in cycles of spending, impoverishment, and illness, particularly amongst those who are un- or underinsured(3). NCDs are systematically underprioritised in many LMICs, in comparison with communicable diseases and maternal and child health conditions, bringing to light the reality that "because of the way people are trained, governments are very often focusing on the problems of the last generation and not the current one." (Prof Chris Murray, Director of Institute for Health Metrics and Evaluation).(4)

As ever during global health crises, COVID-19 has exacerbated existing inequalities in health and hit marginalised groups the hardest. It has exposed the existing link between NCDs, communicable diseases and health emergencies, and has reinforced the need to stop addressing diseases in siloes. The pandemic has also exposed the damage that neglect of NCDs and inadequate public spending on health, prevention and essential public health services have done over the years in many countries.

The COVID-19 crisis is demonstrating the need for strong health systems, resilient, qualified and well-resourced health workforces and healthy populations. At such an unprecedented time, leaders must remember and continue to act on their commitments for UHC, integrating NCDs to ensure that no one is left behind in the vision of 'Health for All'.

This policy research report has been developed for policy makers within MoH tasked with achieving UHC. It outlines global progress towards integration of NCDs into UHC benefit packages to date whilst brokering knowledge by showcasing country-level examples and exploring the role of NCD prevention and care in improving health security during and after the COVID-19 pandemic.

©Eric Sales/Asian Development Bank

The laborary financed by the $3 million grant from the Asia Pacific Disaster Response Fund, can perform up to 3,000 COVID-19 tests daily, significantly increasing the country's testing capacity.

i A life course approach refers to the provision of healthcare services to people across the entirety of their life, from birth to death.

ii Catastrophic health expenditure occurs when a household's financial contributions to the health system exceed 10% of total household income.

iii Out-of-pocket payments is defined as direct payments made by individuals to healthcare providers at the time of service use.

Background

Universal Health Coverage (UHC)

"Universal health coverage is a political choice: today world leaders have signalled their readiness to make that choice."

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, 2019 United Nations High-Level Meeting on UHC.

UHC is a political commitment firmly rooted in the belief that the highest attainable standard of physical and mental health is a fundamental human right, and that all people should have access to quality essential health services without incurring financial hardship. From the adoption of the Alma Ata Declaration on Primary Health Care in 1978, which put health equity on the international political agenda for the first time, through to the most recent United Nations (UN) High-Level Meeting (HLM) on UHC in 2019, which led to the adoption of a political declaration on UHC,(5) political commitments have been plentiful. UHC is reflected in the World Health Organization (WHO)/World Bank UHC Framework, Measures and Targets(6), SDG Target 3.8(7) and WHO's triple billion targets(8). Furthermore, Primary Health Care's (PHC) critical role in the realisation of UHC was recently emphasised in the 2018 Astana Declaration on PHC.(9) Countries are now embarking on translating their global commitments into national responses, developing policy frameworks and committing new resources to expanding health services.

The World Health Organization defines UHC as*:

1

Good-quality essential health services across the continuum of care are available, according to need.

2

There is **equity** in access to health services, whereby the entire population is covered, not only those who can afford services.

3

Financial-risk protection mechanisms are in place to ensure the cost of using care does not put people at risk of financial hardship.

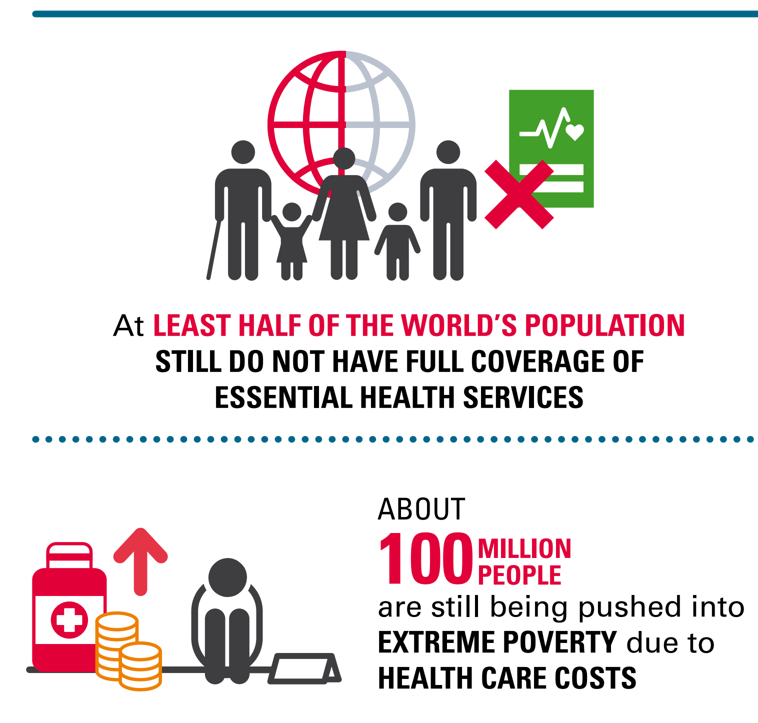
*https://www.who.int/health_financing/universal_coverage_definition/en

SDG Target 3.8

Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

UHC builds on countries' basic health care packages to ensure population-wide access to a broad range of high-quality health services throughout the life course and across the continuum of care, including health promotion, prevention, screening, management, rehabilitation and palliative care services. UHC ensures financial protection from high out-of-pocket payments, which deter people from using health care or cause financial hardship, and aims to leave no one behind, prioritising marginalised communities.(5) PHC[iv] has been called the "engine" for UHC(10), providing a strategic platform for empowering communities, inspiring social accountability and multi-sectoral action, and enabling integration of healthcare services and innovative digital solutions.

Despite the political commitments, UHC is far from becoming a reality. At least half of the world's population does not have full coverage of essential health services and about 100 million people are pushed into extreme povertyv per year because of the need to pay for health care out of their own pockets.(1)(3)UHC is an ambitious goal but has the potential to transform global health status and contribute to the elimination of poverty. However, this will only be achieved if NCDs are included in national UHC policies.(3)



Figures 1
Source: Tracking Universal Health Coverage: 2017 Global Monitoring Report(11)

iv Primary health care (PHC) is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing.

UHC service coverage index by country, 2015: SDG indicator 3.8.1

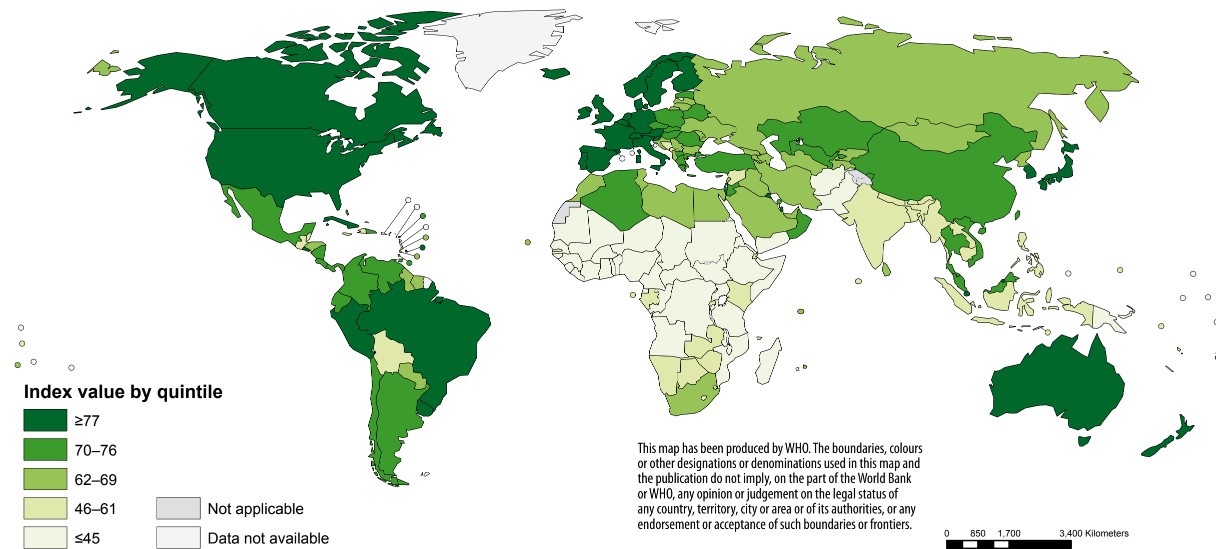


Figure 2. SDG Indicator 3.8.1 Coverage of essential health services (defined as the average coverage of essential services that include reproductive, maternal, newborn and child health, infectious diseases and non-communicable diseases, and service capacity and access, among the general and the most disadvantaged population).

Incidence of catastrophic health spending: SDG indicator 3.8.2, latest year

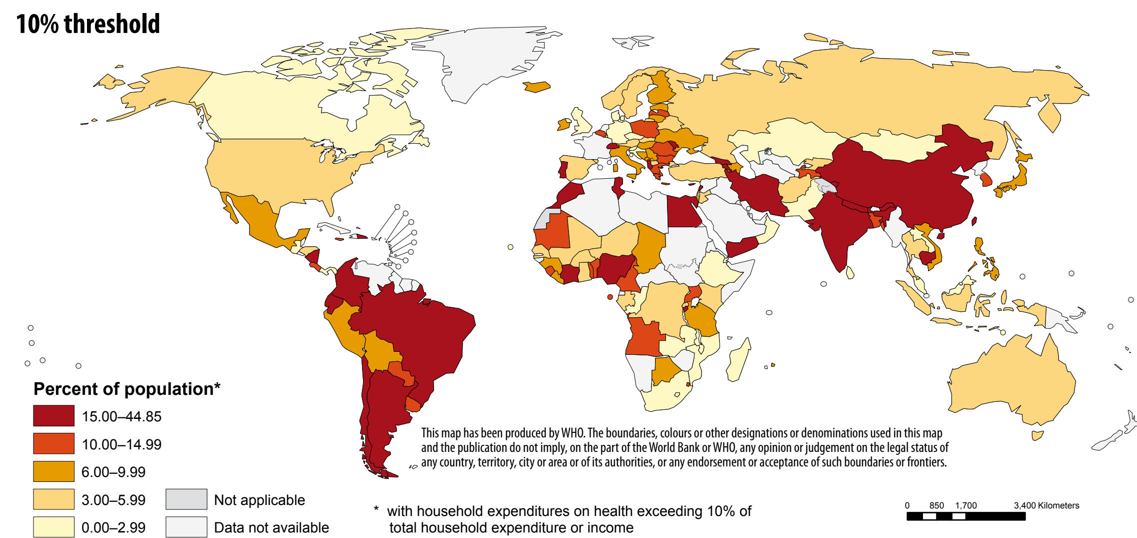


Figure 3. SDG Indicator 3.8.2 Percentage of the population with a catastrophic expenditure on health

Source: Tracking Universal Health Coverage: 2017 Global Monitoring Report.
http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf

Protecting Everyone
Integration of Noncommunicable Diseases into Universal Health Coverage in the Era of COVID-19

Noncommunicable diseases (NCDs)

In 2011, Heads of State and Government came together to "acknowledge that the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the 21st century, which undermines social and economic development throughout the world and threatens the achievement of internationally agreed development goals".(12) Since then, NCDs have increasingly been elevated onto global health and development agendas(12)(13)(14)(15) and were highlighted in the 2030 Agenda on Sustainable Development, particularly in SDG target 3.4.(7)

TARGET 3·4

REDUCE MORTALITY FROM NON-COMMUNICABLE DISEASES AND PROMOTE MENTAL HEALTH

SDG Target 3.4

By 2030, reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and wellbeing.

> "If we strengthen the healthcare system, we will have a healthier, more productive generation. It will give us the opportunity to learn from our older people."
>
> **Person living with T1 diabetes,** Ethiopia

In 2016, there were 15 million premature deaths[v] due to NCDs, 85% of which occurred in LMICs.(1) Mortality rates, however, only represent a fraction of the true NCD burden. Due to the epidemiological transition causing a rising double burden of disease[vi] in LMICs, NCDs now comprise nearly a third of the disease burden among the poorest billion people in our world, half of which impacts children and adults under 40 years of age.(16) These figures are predicted to rise, given that population forecasts estimate 25% of the global population will be over 65 years old by 2100.(17) This will have a huge impact on the prevalence of NCDs, as research demonstrates that likelihood of living with at least one underlying condition increases with age, and over 75% of people over 80 years old live with two or more chronic physical and/or mental health conditions.(18)

Mass distribution of antibiotics is one of the four components of the SAFE strategy, Ethiopia.

v 'Premature deaths' is defined in SDG target 3.4 as deaths in people between 30 – 70 years of age.

vi The double burden of disease refers to the rise of NCDs in addition to communicable diseases within a population.

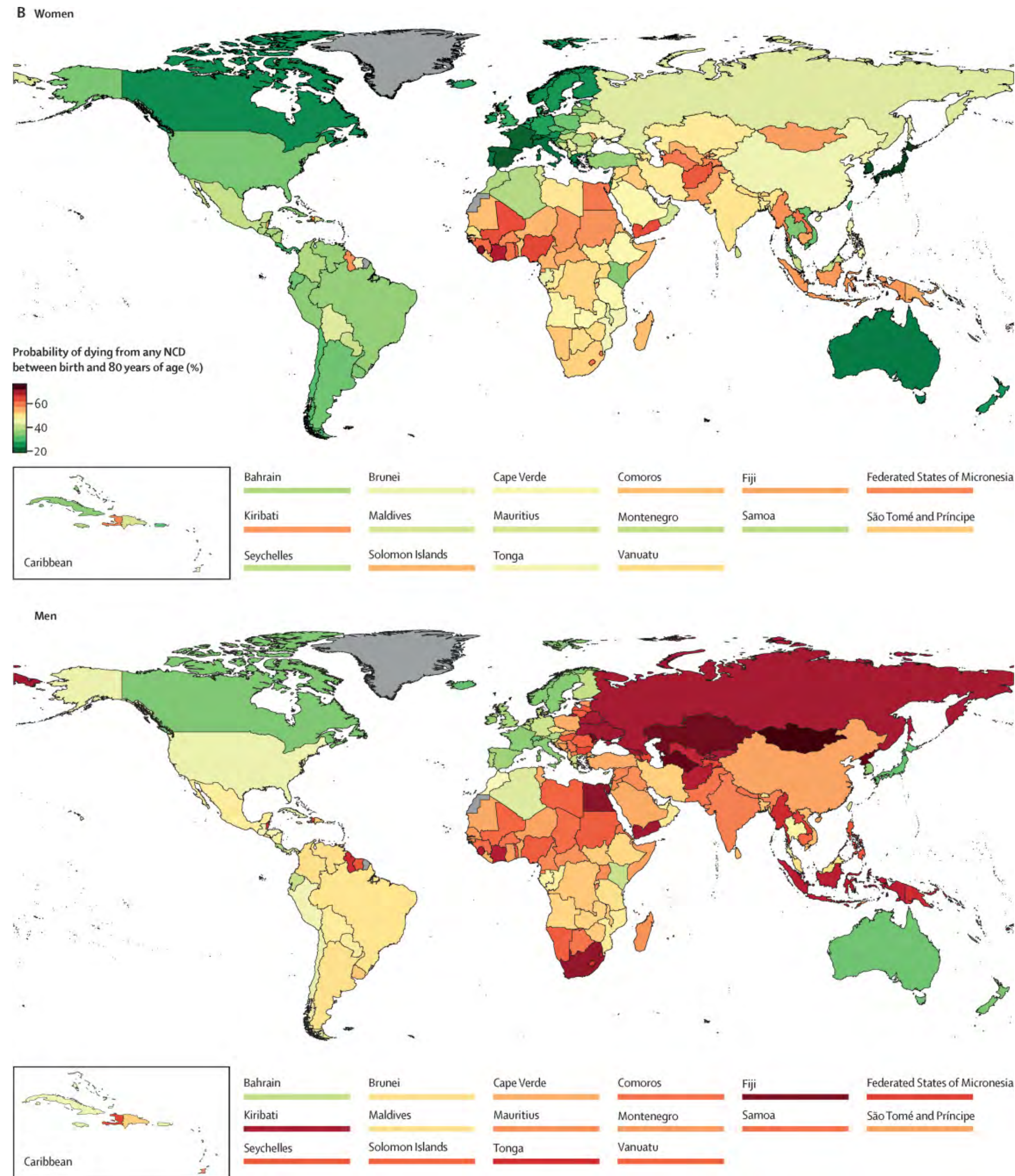


Figure 4. Deaths from NCDs, including cancers; cardiovascular diseases; diabetes; endocrine, blood and immune disorders; non-infectious respiratory, digestive (including liver), and genitourinary diseases; neurological conditions; mental and substance-use disorders; congenital anomalies; and sense organ, skin, musculoskeletal, and oral or dental conditions; by sex for 186 countries and territories from the 2016 WHO Global Health Estimates (including three countries or territories not considered WHO member states, for consistency with the global totals).

Source: Health Policy NCD Countdown 2030: worldwide trends in non-communicable disease mortality and progress towards Sustainable Development Goal target 3.4. (19)

The Political Declaration of Heads of State and Government at the 2019 UN HLM on UHC "reaffirmed the strong commitments made through the political declarations adopted at the high-level meetings on the prevention and control of noncommunicable diseases", emphasising the importance of NCDs being integrated into UHC at national level.(5) This message was reiterated by the second WHO Independent High-Level Commission report on NCDs published in 2019 alongside a recommendation to provide adequate social protection to protect against the cycle of NCDs and poverty.(20)

Premature mortality from NCDs has started to decline in most countries; however, the pace of change is too slow, meaning SDG target 3.4 will not be met without accelerated implementation of tried and tested solutions at national level.(21) Inclusion of NCDs in UHC aim to meet SDG target 3.4 and is crucial if governments are to meet SDG target 3.8 on UHC. However, a systematic analysis for the Global Burden of Disease Study 2019 demonstrated that many countries are lagging behind on effective coverage indicators for NCDs as opposed to those for communicable diseases and maternal and child health.(22) Unsystematic, patchy and weak implementation of UHC, in particular the lack of integration of NCDs into UHC policies, puts the attainment of the SDGs, as well as the ability of health systems worldwide to protect populations from future health emergencies, in jeopardy.

Action is needed to prevent populations from developing NCDs and to construct strong health systems that are structured, equipped and staffed to cope with current and future NCD needs. Cost-effective interventions that have the potential to yield sizable return on investments are available, for example the WHO Package of Essential NCD Interventions.(23)(24) Protecting people living with NCDs from catastrophic health expenditure is also crucial to ensure no one is left behind.

> "It pays off to help people. For example, we know that NCDs are a major driver of poverty and poverty not only affects you, it affects your family. By helping someone early, you will avoid future costs both in terms of suffering as well as economic costs; someone not being able to work, someone having complications for their disease."
>
> **Person living with Type 1 Diabetes Mellitus and brain cancer,** Sweden

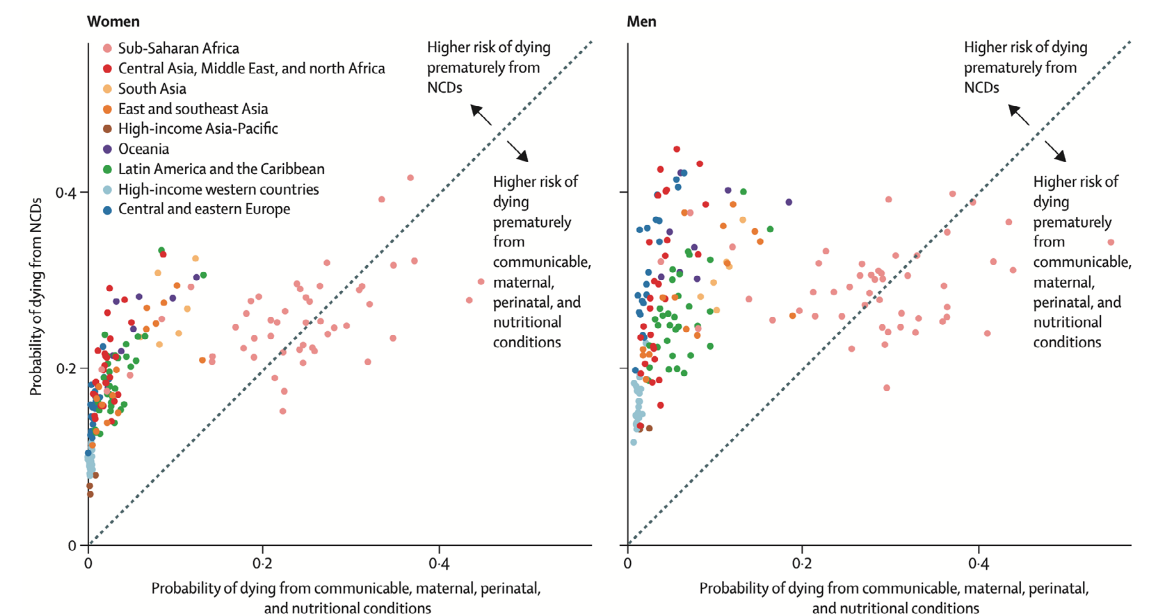


Figure 5. Comparison of the probability of dying, between birth and 70 years of age, from NCDs with that of dying from communicable, maternal, perinatal and nutritional conditions. Each point shows one country.

Source: Health Policy NCD Countdown 2030: Worldwide trends in non-communicable disease mortality and progress towards Sustainable Development Goal target 3.4. (19)

COVID-19

COVID-19 has exposed the link between NCDs, communicable diseases and health emergencies and has exacerbated the existing syndemic[vii] between NCDs and poverty. Despite people living with NCDs being at higher risk of severe complications and death from COVID-19, 75% of countries have reported disrupted NCD care(25) and 93% have reported disrupted or halted critical mental health services during the pandemic.(26)

COVID-19 demands renewed and urgent focus on health care systems, in particular UHC, to ensure everyone is protected. NCDs are central to ensuring health security moving forward yet only 38% of countries have included NCDs in their COVID-19 Preparedness and Response Plan's Essential Health Services and only 7% have included diabetes management specifically.(27) Integration of NCDs into UHC as governments seek to build back better must be seen as a cornerstone to national and global preparedness for future health threats.

Features to consider when integrating NCDs into UHC

Chronic

NCDs are chronic in nature and often lifelong. People living with NCDs, for example Type 1 Diabetes Mellitus, often have multiple interactions with the health system over prolonged periods of their lives, and may require screening for complications, disability management and long-term care, including rehabilitation and palliative care. This chronic nature resonates with UHC's focus on PHC. PHC supports the provision of comprehensive care, allowing health promotion and preventive care to be provided alongside clinical care, recognising the interrelated aspects of physical, mental and social health and wellbeing.(28) Chronic diseases also require UHC policies to be tailored to local contexts via consultations with relevant stakeholders including people living with NCDs. The consultations should ensure the adequate representation of population demographics, disease epidemiology, and risk factors, in order for evidence to be translated into impactful, people-centred policies.(29)

Examples

The Government of the Republic of Moldova introduced reforms to decentralise the health care system, shifting financial resources from tertiary care to PHC, alongside the introduction of mandatory health insurance. In addition, Moldova has integrated NCDs into the basic package of essential health care. An assessment of the impact of these reforms has demonstrated an increased availability of NCD-related essential services.(30)

Comorbidities

Many people live with multiple NCDs or live with both an NCD and a chronic communicable disease such as tuberculosis (TB) or HIV/AIDS.(31) This longstanding reality has been emphasised and brought to political attention through COVID-19. As people live longer due to improvements in healthcare, nutrition, sanitation and reduced poverty, and as exposure to the major NCD risk factors (tobacco, alcohol, unhealthy diets, physical inactivity and environmental pollution) reaches all corners of the world, living with multiple NCDs is becoming more common. This creates significant challenges for health systems that, to date, have been configured to treat individual diseases.(32)

Examples

In Kenya, a cervical cancer screening programme was integrated into existing HIV/AIDS services, which resulted in cost savings and increased efficiency relative to stand-alone screening, due to reduction in overheads, patient transport, and calls on provider time.(33)

Life course

UHC enables governments to ensure that populations benefit from a life course approach to healthcare, which is essential for prevention of NCDs, complications and comorbidities. Exposure to risk factors for NCDs can begin as early as in-utero (e.g. tobacco, alcohol, air pollution exposure) and patterns of consumption of unhealthy products may start in childhood, adolescence or in young adults (e.g. tobacco use, harmful use of alcohol, lack of physical activity, and malnutrition – including undernutrition, overweight and obesity). Exposure to both indoor and outdoor air pollution is also a risk throughout the life course due to the global shift towards rapid urbanisation. In addition, with a globally aging population, the NCD burden will require increasing support for older populations who are at greater risk of developing NCDs and related disabilities. UHC enables countries to address critical, interdependent socio-economic and commercial factors impacting both health and development and also emphasises human rights (youth and older people, gender equality and equity) ensuring no one is left behind.(34) UHC enables integration of strong Health Management Information Systems (HMIS) into the healthcare system and allows for collection of data on risk factors, disease and care by age and gender.

vii Syndemic is defined as the aggregation of two or more diseases that interact synergistically within a population. Syndemics are characterised by biological and social interactions between conditions and states, interactions that increase a person's susceptibility to harm or worsen their health outcomes.

Comprehensive

NCDs demand the continuum of care, encompassing health promotion and prevention, screening, early diagnosis, treatment, rehabilitation and palliative care. Comprehensive UHC ensures essential services, including essential medicines such as insulin, are included in national benefit packages in order to improve the health and wellbeing of populations.

Examples

A study in Bangladesh demonstrated health service providers are of the view that the integration of NCD care into primary health care, through government-led "NCD corners", contributed substantially to increasing NCD awareness, delivery of NCD care and referral services.(35)

A recent economic analysis in Bhutan suggested that expanding current screening for diabetes and hypertension into a universal screening programme would be cost-effective, and would support calls to implement WHO's Package of Essential Noncommunicable (PEN) disease interventions for PHC.(36)

Multisectoral

The health sector and health policies alone cannot alleviate the health and economic burden caused by NCDs. The majority of NCD risk factors – tobacco, alcohol, unhealthy diet, physical inactivity and air pollution – are driven by other sectors including finance and taxation, industry, agriculture, trade, education, employment, and transport. Social and commercial determinants, and the environments in which people live, play a crucial role in exposure and vulnerability to the risk factors and consequences of NCDs. A whole-of-government and whole-of-society approach is necessary in order to deliver a comprehensive approach to NCDs. Indeed, given the burden of NCDs, a government-wide focus on prevention is economically essential.

Examples

An economic model developed for Mexico predicted that increasing resources for promotion and prevention of diabetes and hypertension could deliver cost savings of up to 80% of the current economic burden of these diseases.(37)

A situational analysis of China's progress towards UHC recognised that public transport, clean energy and public sports and leisure facilities are important in achievement of health-related SDGs.(38)

Many other countries are acknowledging and acting on this; for example, through the Healthy Cities Initiative in Dar es Salaam and Cape Town.(39). In addition, the Inter-ministerial Taskforce on Health and the Environment in Africa convenes the health and environment sectors to address environmental threats to human health.(40)

Key challenges to the integration of NCDs into UHC

Health systems in LMICs have often been built primarily to respond to infectious diseases and acute conditions and are not yet well-equipped to cope with the epidemiological transition to an increasing burden of NCDs.

- NCDs are being left behind communicable diseases in UHC. For example, a comparative analysis of cost and economic burden of illness in Nepal demonstrated that between 1995 and 2010 out-of-pocket payments for acute illness, brought about by communicable diseases, declined by 1.5%, but the costs for chronic NCDs, increased by 4.6% and injury by 7.3%.(41)
- There is still much work needed to integrate NCDs into health systems in many LMICs. For example, a study in Bangladesh demonstrated health service providers identified lack of specific guidelines/standard operating procedures, lack of trained staff, poor reporting systems and inadequate laboratory facilities and medicines as challenges for integration of NCD care into UHC.(35) A study in Iran demonstrated that, although NCD guidelines were available, medical professionals were not aware of their existence - in part because the Ministry of Health had not involved health professionals' organisations in the dissemination of supporting information.(42)
- Support services such as research and funding also have a role to play in integration of NCD care. A 2020 scoping review of operational research conducted on NCD policy issues demonstrated that the majority of the research studies considered equity as part of their analysis. However, the published research did not fully reflect population needs in terms of the relative burden of disease (in disability affected life years, or DALYs), and the analysis of the different impact of policy on subgroups within populations was rare.(43)
- Bearing in mind the almost non-existent allocations of overseas development assistance (ODA) for NCD prevention and care, LMIC governments have received little support for the integration of NCD care into UHC, particularly given the financial incentives of focusing on communicable and acute conditions in order to align with external funder interests (e.g. The Global Fund to Fight AIDS, Tuberculosis and Malaria or Gavi The Vaccine Alliance).(44)(45)

NCDs affect both poor and rich communities in high-, middle- and lower- income countries. However, they have the most impact on marginalised communities with reduced access to appropriate, timely healthcare. These health inequalities are compounded by poverty and lack of health education.(28)

- There is wide variation in access to quality medicines between countries. As an illustration, there are 17,700 medicines on the Essential Medicines List in the Republic of Korea but only 190 in Mongolia.(46) Even when countries do provide essential medicines, their quality may be inconsistent. Testing of anti-hypertensive medicines in Rwanda for example, demonstrated 20% to be substandard at purchase with 70% being substandard after six months of storage.(47)
- Variation in access to quality care and medicines is not just a problem between countries, but also within countries, with marginalised groups often experiencing reduced access compared to more affluent sections of the population. For example, a 2019 review of NCD care in the Republic of Moldova demonstrated higher quality care in urban facilities than rural facilities.(30) Furthermore, in 2018 a cross-sectional survey of people living with NCDs in Kenya demonstrated poorer households were less likely to have medicines for NCDs at home, face greater availability barriers to access (often due to living farther from their nearest healthy facility and well stocked pharmacies than more affluent households), and consistently pay more for medicines than households of medium wealth.(48)

Lack of financial protection against out-of-pocket expenditures on health exacerbates inequalities.

- Lack of financial protection increases inequalities between countries. For example, in Nigeria, a lower-middle income country, 71.1% of total healthcare expenditure in 2014 was estimated as out-of-pocket, compared to 6.3% in France, a high-income country.(49)
- Despite this, overseas development assistance for NCDs is low, with only 1-2% globally dedicated to NCDs.(44)(45)

Case Studies

Eight countries - Australia, Ethiopia, India, Jordan, Mexico, the Philippines, Rwanda and Sweden - were selected for a case study via systematic non-probability sampling to demonstrate good practice examples of integration of NCDs into UHC policies and ensure representation from across World Bank Atlas categories, and geographic and political situations. Within each of the eight countries, five key informants were selected to ensure representation from government, academic experts, health care professionals, civil society and PLWNCDs. National NCD alliances' networks and the NCD Alliance's global stakeholders were used to identify suitable key informants.

In total, 39 key informants, named in the acknowledgement section of this report, responded to the request for interview and took part in a semi-structured interview exploring common enablers of success for integration of NCDs into UHC policies, alongside challenges through a COVID-19 lens. All interviews took place between August and September 2020, and because of global travel restrictions due to COVID-19, 35 key informant interviews were conducted via teleconference and four key informants provided written responses. 35 interviews were conducted in English and four interviews were conducted in Spanish. All interviews were transcribed in English and coded by key themes using Nvivo, a qualitative data analysis computer software.(50)

The results of the interviews are displayed below as eight country analyses, which explore each country's UHC policy in terms of governance and equity, UHC service coverage and inclusion of NCDs, and financial protection. Key analyses of facilitating factors for integration of NCDs into UHC implementation, impact of COVID-19, and challenges and recommended next steps are also highlighted. Unless otherwise indicated, country statistics are extracted from open access WHO data sets,(49) except for country area, which was extracted from the World Bank database.(51)

Aca: Academic expert
CSO: Civil society representative
Gov: Government representative
HCP: Health care professional
PLWNCD: Person Living with an NCD

Australia

Area
7,741,220 km²

Population
24.1 million

Life expectancy (M/F)
81/84

87%
UHC Index

"There is not a problem in getting people to focus on NCDs... That is where people are dying and people are having major problems."
Aca

Governance and equity

Australia's UHC scheme was set up in 1984. Today the central government, States and Territories and local governments share responsibility for funding and running the country's health care services. The central government provides funding to States and Territories and also oversees the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) (see "Financial Protection"). In 2017, a National Strategic Framework for Chronic Conditions was endorsed which moves away from a disease-specific approach to NCDs, and instead focuses on shared health determinants, risk factors and multimorbidities across a broad range of NCDs.(52)

To ensure equity, safety nets have been incorporated into financial protection mechanisms alongside free access to healthcare and targeted interventions for marginalised populations. In addition, independent, community-governed health services have been established, which enable healthcare to be delivered by Aboriginal and Torres Strait Islander people to their people.

Sydney, Australia. © ILO/Pornsiri Pattanasuntichai.

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	9.1%
Prevalence of normal blood pressure	84.8%
Mean fasting plasma glucose	5.51 mmol/L
Coverage of national cervical cancer screening programme	50-70%
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	16.2%

	POPULATION
Hospital beds	38.4/10,000
Medical doctors	36.78/10,000
Psychiatrists	13.53/100,000
Surgeons	17.34/100,000

There are 31 primary health networks across Australia that coordinate health services in their local areas. Recently, the government established a taskforce to review services provided under the MBS to ensure recommended services and products are evidence-based, up-to-date and cost-effective.

Oral health

There have been huge public health successes in tobacco control, which positively impact dental health, and 85% of the population has access to fluoridated water. 85% of oral health services are provided in the private sector; however, targeted interventions are available through the MBS for marginalised or high-risk groups. For example, a child dental benefit scheme allows children <18 years to access preventative services up to a set price every two years through a voucher system.

Psoriasis

Treatments such as biologic drugs for psoriasis, which is estimated to effect 1.88% of the population(53), are available via the PBS system. Rates of comorbidities are high, but a person-centred approach is patchy and dependent on the specialist health professional in charge of a person's care.

"You do not die of psoriasis, you die of an associated comorbidity. The risk of developing a comorbidity is reduced by going onto a biologic drug, but the benchmark set to get onto these drugs via the PBS is high and is a fairly significant barrier for people to get on the treatment." PLW

Financial protection

Cost for healthcare	9.42% GDP
Proportions with household expenditures on health >10%	3.71%

The MBS provides subsidised health care and the PBS provides subsidised access to over 5,200 medicinal products. Both are funded by the central government and private medical insurance is encouraged as a method to offset costs within the public system. Most providers charge more than government prices, creating a "gap", the costs of which are sometimes covered by private insurance. There are safety nets incorporated into both MBS and PBS to cap out-of-pocket payments and a concession card is available for marginalised populations, enabling free access.

Facilitating factors for integration of NCDs into UHC implementation

Focus on prevention of NCDs, in particular, efforts to reduce smoking rates

"Quit campaigns" against cigarette smoking were underway nation-wide as early as the 1980s and taxes on cigarettes are continually reviewed and increased. There are also bans on cigarette advertisements, introduction of generic/plain packaging with graphic warnings for cigarettes, restrictions on smoking in work places and dining areas, and inclusion of smoking cessation aids in the PBS. This has all led to a decrease in daily smoking rates for those aged 18 years and older from 22.3% in 2001 to 14.7% in 2015.(54)

Aboriginal community controlled health services

Since the 1970s, many Aboriginal and Torres Strait Islander communities have established independent, community-governed health services that enable comprehensive primary health care services to be delivered by Aboriginal and Torres Strait Islander people, for their people.(52) There are around 140 such services in urban, regional and remote settings. Recently, the National Agreement on Closing the Gap has been revised and continues to engage the Aboriginal and Torres Strait Islander people as shared decision-makers at the table for policy development processes.

Continual process of monitoring and review of policy to address NCDs

The government has needed to employ "relentless incrementalism" to successfully address NCDs. This encompasses data collection and regular monitoring and review of policies.

"It is a slow incremental journey, no single intervention or package of interventions will address NCDs." Gov

Challenges

Persisting inequalities amongst migrant populations and Indigenous groups

Health indicators are lagging for migrant populations and Indigenous groups and the government is learning the need to adapt its messaging and services for these populations in order to facilitate uptake.

"Over the past 40 years, Type 2 Diabetes Mellitus has grown four-fold amongst the general population in Australia but amongst marginalised populations it has grown 80-fold." HCP

"When you are unsafe in your own country it does not do your health any good." Aca

Impact of COVID-19

Actions to reduce NCD risk factors, for example smoking rates, have acted to protect the population

"If we still had a smoking rate of 30%, we would have found people in a much worse state." Aca

Shutdown of NCD services during lockdowns are likely resulting in delayed diagnosis and treatment of people living with NCDs

"All dental practices were shut down for about six weeks. When they re-opened it was only to provide limited services, emergencies only. People are missing out." CSO

"Undoubtedly we will see a third wave of disease burden associated with delayed diagnosis and treatment of NCDs." Gov

Next steps

Continue to focus on prevention, particularly tackling drivers of diabetes and obesity

"We need to be personally aware of the risk factors for diabetes and obesity. We need awareness campaigns to illuminate people to the dangers of sugar and ultraprocessed food." HCP

"Junk food industry and alcohol have learnt a lot from tobacco, they have learnt how to play the game much better." Aca

Ethiopia

Area
1,104,300 km²

Population
102.4 million

Life expectancy (M/F)
64/67

39%
UHC Index

"NCDs constitute a significant portion of the disease burden at the moment (about 45%). In addition, projections show that the NCD burden will surpass the communicable diseases one by 2025. Immediate action is needed to curb the trajectory as well as to ensure equitable access to health services."

Gov 1

Governance and equity

The Government of Ethiopia developed an inclusive and decentralised health policy in 1993. This was implemented through health sector development programmes, which were reviewed every five years. The first 15 years of implementation were almost devoid of specific actions on NCDs. However, since 2010, the NCD agenda started to be included in the national strategies and annual plans. By 2013, a National NCD strategic plan(55) was developed with four key priorities (policy, governance and leadership; health promotion and disease prevention; comprehensive NCD treatment, care and support; and monitoring and evaluation). Equity of care remains a challenge, with specialised NCD services and medicines often concentrated in urban settings with direct and indirect costs often out of reach for the poor. This is exacerbated by the fact that only 15% of total health expenditure is currently allocated to NCDs and injuries.

"It is very hard for those living in the countryside, they have to travel by foot to get their medication. Medicines such as insulin are very expensive in our country and are often not available in the rural areas."

PLWNCD

©Nena Terrell/USAID EThiopia

A group of women meets at a health post to discuss issues of common concern to their community in the south of Ethiopia.

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	**18.3%**
Prevalence of normal blood pressure	**69.7%**
Mean fasting plasma glucose	**4.48 mmol/L**
Coverage of national cervical cancer screening programme	**< 10 %**
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	**4.6%**

	POPULATION
Hospital beds	**3.3/10,000**
Medical doctors	**0.77/10,000**
Psychiatrists	**0.08/100,000**
Surgeons	**0.3/100,000**

In recent years, we have been seeing changes. Together with people in the ministries, we have developed strategies and guidelines to prevent and treat specific NCDs. Last year while the MoH were revising the essential health service package, they included many interventions identified by the NCDs and Injury Commission."

HCP

Primary health care is pivotal to delivery of health care in Ethiopia. There is a four-tiered healthcare system organised into primary health care units, district hospitals, general hospitals and specialised hospitals. In an effort to get close to the community, the Health Service Extension Programme was introduced in 2003, instituting up to five satellite health posts under each primary health care unit, supported by 40,000 trained Health Extension workers.

218 NCD interventions are incorporated into the essential health services package (ESHP) provided through this infrastructure.(56) This includes, for example, diagnosis and comprehensive management of Type 1 Diabetes Mellitus and cataract surgery. The ESHP was informed by the National NCDs and Injury Commission, which included civil society and academic experts.(57)

National cancer control plan

CSOs have seconded staff to the MoH NCD case team to support development of cancer care services. This has facilitated inclusion of a national cancer control plan within strategies and budgets. The country has recently invested in six radiotherapy machines and 1000 cryotherapy machines to enable free screening and treatment for cervical cancer as part of the essential package of care. A cancer centre with over 300 beds is being constructed in Addis Ababa, which will have the capabilities for conducting bone marrow transplants.

Rheumatic heart disease (RHD)

Prevention and management of RHD is integrated into the EHSP. Early identification and treatment of sore throat is emphasised (primary prophylaxis) as well as management of rheumatic fever (secondary prophylaxis). The country endeavours to provide surgical services for those who develop rheumatic heart disease; however, there is only one centre able to provide cardiac surgery in the country.

Financial protection

Cost for healthcare	**4.9 % GDP**
Proportions with household expenditures on health >10%	**4.91%**

NCDs are a development issue affecting our youth, our whole population."

Gov 2

Only 2% of healthcare financing is covered by private insurance and 34% is still covered out-of-pocket.(58) CBHI scheme pilots were started in 2011, demonstrating increased health services utilisation and inclusiveness, and the government is currently scaling up CBHI country wide. The scheme is financed by premium contributions of members with some government subsidies for the poorest population groups.

Investing in NCDs is preventing and averting poverty' as our Minister of Health, Dr Lia Tadesse Gebremedhin, said during the launch of the Global NCDI Poverty Commission report in September 2020."

Gov 2

Facilitating factors for integration of NCDs into UHC implementation

Collection of country level data on NCDs, in particular the NCDI Poverty Commission

"Things are getting better because of efforts from academics in our country who are generating evidence which we can then surface to the policy makers." HCP

Integration of NCD prevention and care services into existing PHC

"We understand the need to work through existing PHC. The last Minister of Health said we needed to stop talking about communicable and noncommunicable diseases, we are serving the same people, the same population." CSO

Collaborative leadership between government and CSOs

"NCDs are growing in our country and are taking our young people… If we join the government we can bring about change. They will listen to us. Even the MoH is now working with civil society, especially for NCDs. CSO has a big role in this change." PLWNCD

©Morgana Wingard, USAID

Much of the population is rural and agricultural, lacking the necessary education and resources to support the health of their families and children.

Impact of COVID-19

Increased inequalities in access to NCD care, including medicines

"Patients living with NCDs from rural areas are not able to go to their hospitals for check-ups or to collect their drugs because of the limited transportation and movement restrictions due to COVID-19." HCP

Stalled implementation of NCD policy

"COVID-19 has affected implementation of the drafted and approved NCD policies and strategies." HCP

Challenges

Inadequate financing

Competing priorities such as HIV, TB, and malaria, mean that NCDs have been overlooked in budgetary allocations for many years. CSOs are calling for the government to increase the health budget to 15% GDP, in line with the Abuja Declaration.(59)

"Finance, wherever you go finance is a challenge." HCP

Next steps

Focus on increasing financing for NCDs

This can be done by expanding the CBHI scheme to improve equity of access to NCD care across the population.

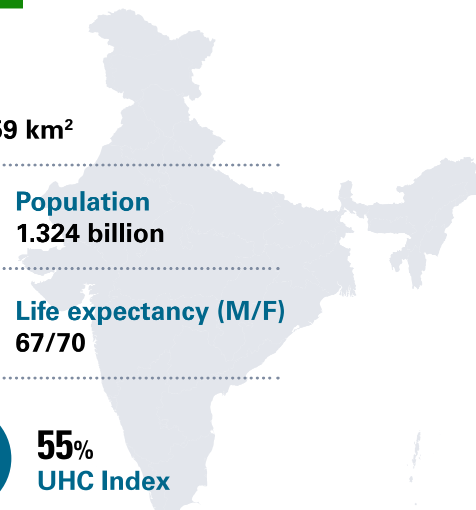
It can also be done through implementation of the recently passed landmark tobacco tax bill, nearly doubling the excise tax rate and instituting a 30% tax on cigarette production.

"When you increase taxation, you get money. I recommend this money is used for health promotion." CSO

Continue efforts to improve quality of NCD care in urban areas whilst decentralising NCD services to ensure equitable access to care and medicines in rural areas

"To effectively treat people living with Type 1 Diabetes Mellitus for example, we need insulin as well as specialised doctors, dieticians and nurses. All these are needed in the rural areas as well as in the cities." PLWNCD

India



Area
3,287,259 km²

Population
1.324 billion

Life expectancy (M/F)
67/70

55%
UHC Index

Governance and equity

As far back as 1946, the Bhore Committee recommended a publicly financed national health system with comprehensive preventive and curative care for all in India.(60) More recently, in 2010, a High-Level Expert Group on UHC was formed by the Planning Commission of India.(61) Following their recommendations, in 2017, the Union Cabinet approved a new National Health Policy, which has led to the set-up of the Ayushman Bharat-National Health Protection Mission (AB-NHPM).(62)(63) The AB-NHPM is leading to the set-up of 150,000 Health and Wellness Centres throughout rural and urban areas by 2022 (services described below) and encompasses a National Health Protection Scheme, providing financial protection for secondary and tertiary care services. AB-NHPM has been set up for marginalised families.

India has a decentralised approach to healthcare delivery with States being primarily responsible for organising health services. Equity in access to treatment is a longstanding challenge in India due to considerable variation in the density of the health workforce across states. Some States such as Goa and Kerala have doctor densities up to three times as high as States such as Orissa, and nurse and midwives density up to six times those of Uttar Pradesh.(64)

Gonoshasthaya Community Health Center (outside Dhaka). Gonoshsthaya Kendra (GK) provides health care and health insurance to undeserved populations in Bangladesh.

© Rama George-Alleyne / World Bank

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	23.3%
Prevalence of normal blood pressure	74.2 %
Mean fasting plasma glucose	5.59 mmol/L
Coverage of national cervical cancer screening programme	≥ 70 %
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	27 %

	POPULATION
Hospital beds	5.3/10,000
Medical doctors	8.57/10,000
Psychiatrists	0.29/100,000
Surgeons	2.29/100,000

Currently the private sector plays a significant role in delivery of healthcare in India and accounted for 75% of total outpatient visits and 62% of inpatient visits in 2014.(65)

The public health system needs strengthening, although it is stronger in some States than others. Since 2010, the Government of India has been implementing the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). This has seen streamlining of NCD services throughout the country including health promotion, screening, infrastructure and surveillance running through 4472 community health centre NCD clinics, 665 district NCD cells, 637 district NCD clinics, 181 cardiac care units and 218 day care units.(66)

The public health system is being strengthened by the AB-NHPM with the establishment of the Health and Wellness Centres. These will be supported to deliver a range of preventive, promotive, curative, rehabilitative and palliative care services, at no cost to users. These services are envisaged to include care for NCDs including oral, eye, and mental health and first level care for emergencies and trauma. Nevertheless, given the limited number of medical professionals living in rural areas, many will be run by community health care workers or health counsellors; therefore, the level of care will be basic.(67) Implementation of the AB-NHPM scheme is under the responsibility of the States; therefore, there are significant inter-State nuances in how these centres are being set up, which has the potential to further exacerbate inter-State inequalities.

India is also in the process of setting up a National Digital Health Mission, where all citizens will have a health ID allowing health records to be accessible through a digital health portal. AP-NHPM beneficiaries are also being integrated into this scheme.

Financial protection

Cost for healthcare	4.69 % GDP
Proportions with household expenditures on health >10%	17.3 %

There are a number of private insurance schemes in India but coverage is low and out-of-pocket payments were estimated to account for 62% of total health expenditure in 2014.(68) To date, government spending on health averages 3% of general government expenditure.(69) The National Health Protection Scheme encompassed by the AB-NHPM provides financial protection from costs for secondary and tertiary care to marginalised groups. It covers approximately 40% of the population, which is close to 500 million people. The scheme is capped at roughly 5,500 euros per family per year.

Facilitating factors for integration of NCDs into UHC implementation

The combination of a global movement calling for UHC and an internal call from CSO

"If you have an internal push and an external push, then things start moving. Both should claim credit for the move towards UHC in India, the global environment and the push from within Indian academia and civil society." Aca

AB-NHPM marks an important paradigm shift as it looks towards prevention as well as cure

"Under Ayushman Bharat, the government is placing emphasis on prevention. They are talking about health and wellness centres and not just looking at illnesses. This is very important when considering NCDs." PLWNCD

© ILO

Beneficiaries enrolling themselves for the Rashtriya Swasthya Bima Yojana (RSBY) or the "National Health Insurance Programme" in Andhra Pradesh

Impact of COVID-19

Severely disrupted NCD services and caused difficulties among people living with NCDs in accessing medicines

"NCD management took a beating when the COVID-19 pandemic struck. Hospitals were closed, health centres shut, home visits cancelled, even medicine availability went down." Aca

There are reports of disruptions in access to essential medicines for people living with NCDs, such as insulin for those living with Type 1 Diabetes Mellitus, which is forcing people to ration their medication and is leading to complications. In addition, there have been reports of surgeries and chemotherapy for cancers being cancelled, resulting in a deterioration in prognosis.

"We have seen horrors in the community. The gap between the man in his hut and the medicines in the PHC have grown dramatically." HCP

Disruptions in roll-out of health services

"Initially, with a complete lockdown declared to tackle the spread of COVID-19, all healthcare services, public and private, came to a grinding halt." CSO

Challenges

Effectively integrating the private sector into UHC strategy

Given the strong private sector, their inclusion in government consultations and plans for UHC are pivotal.

"In the Indian context, the private health sector is critical, without their participation we will not make any progress on UHC but we have failed to involve the private sector so far." Aca

Lack of focus on high quality PHC care

"Ayushman Bharat focuses on hospitalisation, which is important but does not manage the NCD burden for the majority of people living with NCDs. It is only looking at one end of the spectrum." Aca

Next steps

Strengthening the public health system

In order to reduce health inequalities across India and improve health outcomes, public health systems in all States should be strengthened.

Working towards a more collaborative approach to policy making, including CSOs and particularly people living with NCDs in the decision making process

"We need to have a better balance between access, quality and accountability. Ultimately, we need to go for a more consensual approach." Aca

Strengthening the voices of people living with NCDs and CSOs

"The voices of people living with NCDs need to be heard. However, they need to be organised to be heard at the highest levels so they can be involved in policy decisions." Aca

Jordan

Area
89,320 km²

Population
9.5 million

Life expectancy (M/F)
72/75

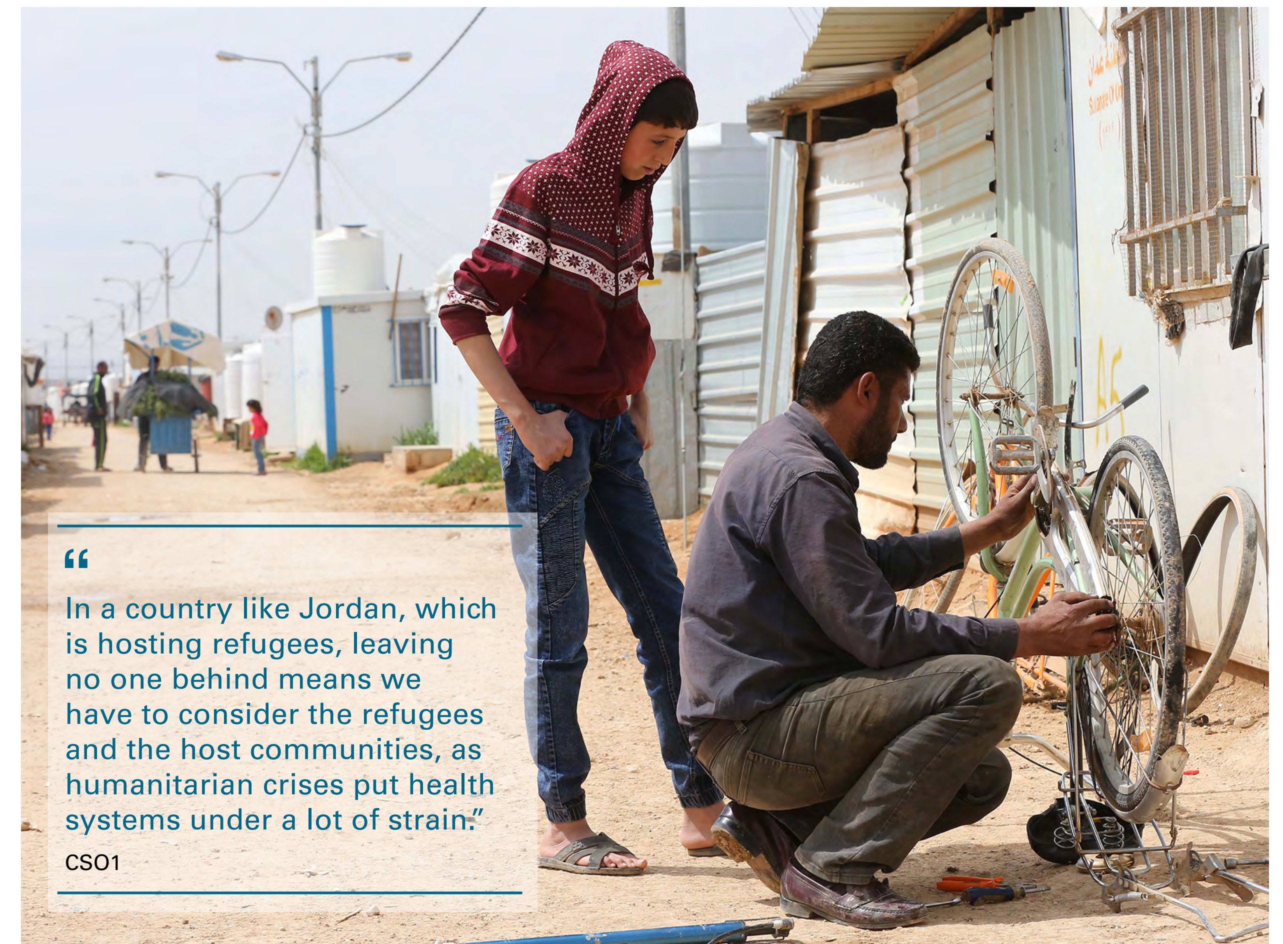
76%
UHC Index

Governance and equity

Currently, the MoH's 2018-2022 strategic plan "Jordan 2025: A National Vision and Strategy" is in force and incorporates UHC. It also prioritises health sector governance, and enhanced human resources for health. The MoH has an NCD department and recently conducted a WHO STEPS survey.

Jordan is known as a centre for high-quality health care in the Middle East. However, 30% of the population do not have health insurance coverage and it hosts a large refugee population. The United Nations High Commissioner for Refugees (UNHCR) and other humanitarian actors provide the majority of support for refugee health. Uninsured people can apply for discretionary government support to cover health care services.

Fixing a bicycle in Zaatari Refugee Camp in Jordan, where nearly 80,000 Syrian refugees are living.



> "In a country like Jordan, which is hosting refugees, leaving no one behind means we have to consider the refugees and the host communities, as humanitarian crises put health systems under a lot of strain."
>
> CSO1

© UN Photo/Sahem Rababah

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	19.2%
Prevalence of normal blood pressure	79 %
Mean fasting plasma glucose	6.25 mmol/L
Coverage of national cervical cancer screening programme	NA
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	Data not available

	POPULATION
Hospital beds	14.7/10,000
Medical doctors	23.24/10,000
Psychiatrists	1.12/100,000
Surgeons	Data not available

> "The public has no more patience to hear us speak of and promise UHC, but to do nothing."
>
> CSO2

Jordan's health system includes a strong private sector presence. For example, the Ministry of Health operates 1,245 primary health care centres and 37% of all hospital beds in the country, the military's Royal Medical Services runs 24% of hospital beds, and the private sector runs 36%.

NCDs are an increasing burden in Jordan, including amongst the refugee population, with draft numbers from the recent STEP survey indicating higher NCD prevalence than in 2014.

> "Even in humanitarian contexts, always look to integrate NCD services."
>
> CSO1

Care for people living with Type 1 Diabetes Mellitus

There are an increasing number of people living with Type 1 Diabetes Mellitus in Jordan. Access to insulin is free for children under the age of six; however, glucose testing strips have to be paid for out-of-pocket. Older children and adults with T1DM can also be treated in the government hospitals at minimal cost. Some of the newer generations of insulins are only available via the private sector, but even covering the cost of glucose testing strips, which are a vital component of care, comes to roughly US$ 70 /month and can be a significant financial burden to families, when compared with average wages of around US$ 550 /month. There is some support available through CSOs, but not from the government at this point.

> "Access to insulin is one of the most basic things, it is the least we can do, there are many other aspects we have failed at but at least we can provide free insulin to children."
>
> HCP

Financial protection

Cost for healthcare	7.45 % GDP
Proportions with household expenditures on health >10%	1.72 %

The government subsidises insurance for children under six years and senior citizens over 60 years of age however the total population coverage of health insurance has stagnated at around 70% since 2007. People who are uninsured (including refugees) can apply for government support to cover medical services, but have to pay for medicines out-of-pocket.

Over the past 20 years, all Jordanians diagnosed with cancer had their treatment costs covered by the Royal Court and the government through treatment exemptions. However, with the rising number of cancer cases and cancer care costs, dependence on treatment exemptions is no longer proving sustainable and is resulting in inequalities in the quality of cancer care provided across the country. Treatment at the King Hussein Cancer Center, the only standalone comprehensive cancer center in Jordan is currently excluded from any private health insurance plans and is exclusively provided by a nonprofit insurance program offered by the King Hussein Cancer Foundation to create a more sustainable model for financing cancer care and engage individuals and corporates in sharing some of the financial burden.

Facilitating factors for integration of NCDs into UHC implementation

CSOs have a strong voice and have encouraged the government to step up action on NCDs

"We have a strong network of CSOs at the grass roots level. They mobilise people and resources and are doing a great job. They present the voices of people living with NCDs at all levels." CSO2

The focus on NCDs in the global agenda

"The global health policy agenda has increasingly focused on NCDs and that has trickled down into Jordan's policies and responses." CSO1

Increasing burden of NCDs mandates attention by policy makers

"The reality mandates itself. The staggering NCD prevalence rates exceeding the current health system capacity makes it not only a matter of interest but an urgent need." CSO1

Impact of COVID-19

Disrupted medical supplies to people living with NCDs

"During lockdown, it was even difficult for people to have access to their regular medicine. The Jordan medical association helped by distributing some medicines to people's homes." Aca

Disrupted NCD services, including cancer care

"New cancer patients had no access to the referral system. Imagine being diagnosed with cancer and having to wait two months to get into the system for treatment." CSO2

©ILO/Richard Lord.

Amman, Jordan, Fulbright Scholar, pharmacist, does rounds with students

Challenges

Lack of coordination

"We have top level political will and determination and we have competence at the grass roots, but we do not have sufficient coordination between the two." CSO2

The increasing presence of the private sector has negatively impacted quality of care at PHC level

"The private sector plays a major role in health service delivery but unfortunately the focus is on secondary and tertiary care. We have a huge network of PHCs but no recent investments in the quality of care, so people have lost trust in the system." CSO2

Next steps

Extend financial protection for medicines including insulin

"I cannot emphasise it enough. We need to extend the financial support for insulin regardless of age. Diabetes is diabetes regardless of age, it has the same impact on the child as on the family. Providing free glucose testing strips would also help." HCP

Strengthening the PHC system

"PHC is the backbone of a health system. We need to provide people centred care and invest in prevention rather than treatment. Prevention can start early, even in pregnancy!"Aca

Strengthen accountability mechanisms around clear priorities to improve coordination

"The MoH needs a clear strategy and a good governance structure which allows for accountability, a roadmap of where we want to take the country, by when, and how." CSO2

Mexico

Area
1,964,375 km²

Population
127.6 million

Life expectancy (M/F)
73/79

76%
UHC Index

Rapid assessment of avoidable blindness (RAAB) is a rapid survey methodology developed at ICEH. It is a population based survey of visual impairment and eye care services among people aged 50 years and over.

Governance and equity

Recently, a new Health Sector Programme for 2020-2024 was published, seeking to expand provision of healthcare services, including medicines and hospital care across a comprehensive set of diseases and conditions, to the 16% of the population that is within the informal economy and not currently enrolled in social security programmes. In addition, a new Institute of Health for Wellbeing (INSABI), which was launched in 2020 to replace the former Seguro Popular (see Financial protection), has the aim of providing social security to those not covered by one of the many existing social security schemes.

The aims of the new programme contrast with the government's investment in health to date, which has steadily decreased over the past 10 years and currently rests at 2.8% of total federal budget.(70) This has resulted in 41% of total health spending being out-of-pocket (and up to 90% of the costs of medicines), despite 42% of the population being classified as poor according to the World Bank.(70)(71)(51)

There is limited availability of health services to rural communities and marginalised populations, including Indigenous ones, experience physical, cultural and language barriers to accessing health care.

"The fact that the government covers at least some of the medicines truly does make a difference. This reduces complications and the patient's general wellbeing is improved. The big problem is that the majority of people are not receiving the benefits that the government is trying to provide because of all the gaps in implementation."
HCP

© Sarah Polack, International Centre for Eye Health

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	15.7%
Prevalence of normal blood pressure	80.3 %
Mean fasting plasma glucose	5.89 mmol/L
Coverage of national cervical cancer screening programme	NA
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	13.9 %

	POPULATION
Hospital beds	9.8/10,000
Medical doctors	23.83/10,000
Psychiatrists	0.21/100,000
Surgeons	20.09 /100,000

A lot of people were affiliated with Seguro Popular, but real access to services did not always exist. Some did not know they were affiliated and others were physically restricted in their access to services."

Aca

The Mexican health care system is fragmented with considerable variation in the quality of services. There are a number of independent, vertical networks of health providers, organised under various insurance institutions (see "Financial protection") who operate in parallel to one another with little coordination. In addition, there is a large and poorly regulated private sector.

NCDs are the leading cause of death in Mexico. In particular, adult obesity increased 42.2% between 2000 and 2018, with 40.2% women and 30.5% men classified as obese in 2018. 13% of the adult population has diabetes, yet 49% of cases remain undiagnosed. Between 2012 and 2017, admissions for diabetes-related amputations increased by more than 10% indicating a decline in quality and coverage of disease control.(70)

People can only access care from the network of health providers associated to their ascribed insurance institution. Prior to 2020, those who ascribed to Seguro Popular (see "Financial protection") were covered for a package of essential NCD interventions and selected catastrophic treatments.

In January 2020, INSABI became operational and seeks to increase human and infrastructure capacity for health provision to marginalised populations. It is also seeking to centralise the medical supply chain. However, due to lack of direct financial mechanisms and to COVID-19, its implementation has been challenging.

Financial protection

Cost for healthcare	6.3 % GDP
Proportions with household expenditures on health >10%	1.55 %

Institutions such as the Mexican Institute of Social Security (IMSS) and Institute of Social Security and Services for Workers (ISSSTE), among others, cover salaried workers in the formal sector. As of 2020, those in the informal sector are covered by INSABI, which now encompasses those previously covered by Seguro Popular, a voluntary system that was subsidised by both Federal and State governments. People often move back and forth between the different institutions depending on their employment status, limiting regular and continuous access to health services, as well as monitoring by the health sector.

"There are workers who leave the formal system, but go back in and out again up to six times." Gov

Facilitating factors for integration of NCDs into UHC implementation

Increasing efforts to prevent obesity, including new food labelling law

Despite industry efforts to block it, in 2020 Mexico passed a law (2020 modifications to the Mexican Norm NOM-051 on FOP labelling) requiring front-of-package warning labels of unhealthy foods and beverages, supporting the government's efforts on NCD prevention. In addition, the State of Oaxaca has recently passed legislation banning the sale of junk food and sugary drinks to children.

Progressive, incremental efforts to include an increasing number of NCDs into UHC packages

"Seguro Popular, over 15 or 18 years, was progressively including different diseases. Each year they expanded the beneficiaries and the coverage. Now with INSABI, they said that all diseases were going to be fully covered." PLWNCD

©PAHO/WHO

Veracruz Initiative for Diabetes Awareness (VIDA Project)

Impact of COVID-19

Existing, weak and fragmented NCD care provision is under increasing strain

"Now with COVID-19, I cannot get within a kilometre of the hospital and I am in a high-risk group. I have nowhere to go but to a private hospital. I heard about a person on hemodialysis, who stopped going for fear of COVID-19 and died." PLWNCD

"Many hospitals were transformed into COVID-19 hospitals and stopped treating patients with cancer, diabetes, cardiovascular diseases, and kidney failure, with chronic respiratory problems." CSO

The pandemic provided an opportunity for health system reform to improve NCD care, but it is being missed

"The pandemic was a very good opportunity to universalise care. However, this didn't happen. The opportunity was lost." Gov

"There are hospitals that have empty operating rooms, while other hospitals are crowded. Why aren't the surgeries done where there are operating rooms available, and then the cost of the surgery is reimbursed? But for that the we would need to have an integrated healthcare system." Aca

Challenges

Fragmented healthcare system resulting in weak PHC and poor patient follow-up

The health system is fragmented and PHC is currently weak. Training of healthcare professionals on NCDs is patchy and treatment protocols are infrequently reviewed due to bureaucratic complications.

"Currently our PHC is not solving the problem of chronic diseases. It does not prevent them, it does not detect them in time and it does not treat them well." Gov

New INSABI system lacks a clear operating system and there are conflicting messages about what it encompasses

"With INSABI, supposedly there were no fees, but if you go to hospitals, they charge fees." PLWNCD

"The financial coverage of Seguro Popular disappeared, but no new clear rules were established. To date it seems that INSABI still does not have operating rules." Aca

Next steps

Strengthened inclusion of CSOs and people living with NCDs in health policy making to facilitate people-centredness, accountability and transparency

"Patient organisations are not included in governance structures of health insurance institutions. I believe there should be a mechanism to incorporate patient organisations." Gov

Embrace a whole-of-government approach to tackling NCDs

Efforts should include increased taxation on unhealthy commodities (such as sugary beverages, tobacco, and unhealthy foods) and aim to increase physical activity. However, increasing the number of people who pay tax, using technology, improving the work environment and reducing crime and corruption are also important tools for improving health service financing and provision.

Increase provision of care to marginalised populations

Promote person-centred care by reorganising medical professionals to work in multi-disciplinary teams, including non-professionals such as CHWs, to encourage shared decision making and improved communication with those living in economically and geographically challenged areas.

"We need to involve the community. There is no other way to solve NCDs." HCP

Philippines

Area
300,000 km²

Population
103.3 million

Life expectancy (M/F)
66/72

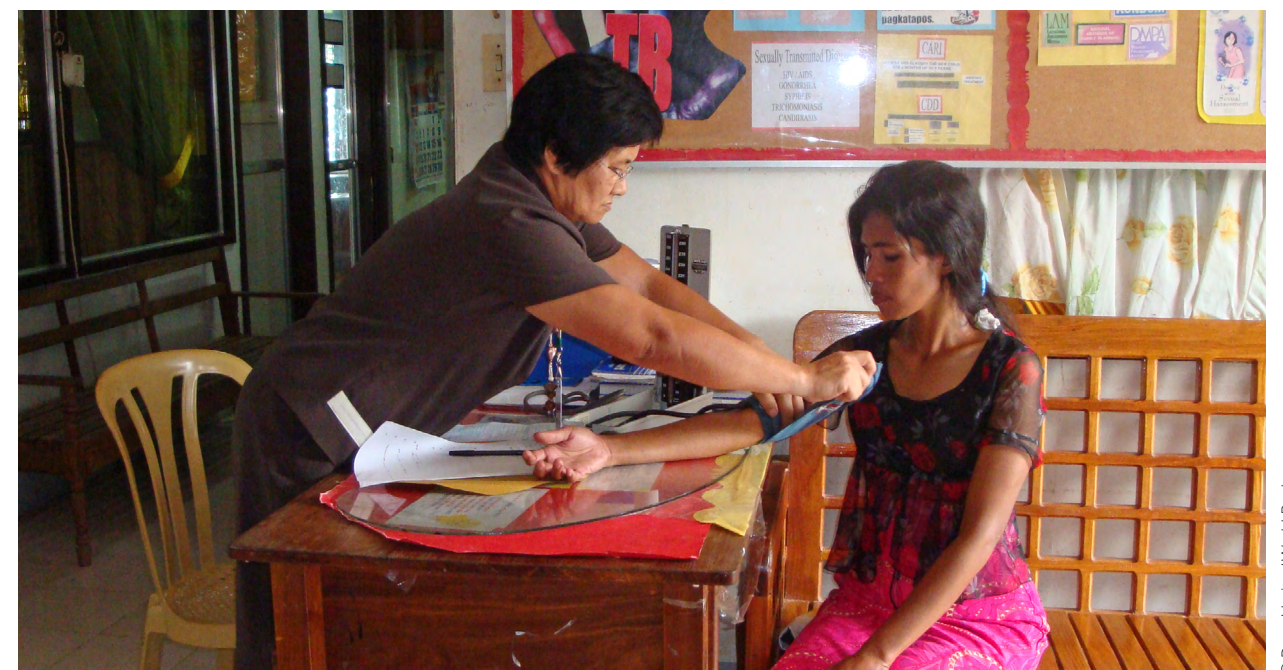
61%
UHC Index

Governance and equity

The Universal Health Care Law or Republic Act 11223 was signed in 2019, automatically enrolling all Filipino citizens in the national health insurance programme and necessitating health system reforms to enable access to a full continuum of health care services. It focuses on PHC, integrates NCD care and is set to improve health service coverage of those living in remote areas. Use of income from taxation of unhealthy commodities has helped the government cover subsidies for the poorer sectors of society. CSOs, such as the Healthy Philippines Alliance, have been a strong advocacy voice calling for approval of the Universal Health Care Law, amongst others.

> "In the last two decades, there has been a transition of the epidemiological pattern of disease in the Philippines. In the last decade, 7 out of 10 of the leading causes or mortality have been NCDs. It has become a financial burden for the Philippines."
>
> Gov

Woman receives a health check-up. Agusan del Sur, Philippines. Social Welfare and Development Reform Program.



© Dave Llorito / World Bank

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	26.8%
Prevalence of normal blood pressure	77.4%
Mean fasting plasma glucose	5.03 mmol/L
Coverage of national cervical cancer screening programme	Low
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	24.3%

	POPULATION
Hospital beds	9.9/10,000
Medical doctors	6.0/10,000
Psychiatrists	0.52/100,000
Surgeons	2.28/100,000

The new Universal Health Care Law integrates screening and check-ups for diabetes and hypertension in PHC and institutes health promotion. Recently a National Integrated Cancer Law(72) and Mental Health Law were also passed to further improve access to and quality of healthcare services for NCDs. The full package of NCD prevention and care incorporated into the UHC system are outlined on the Philippine Health Insurance Corporation website, including inpatient and outpatient benefits, and "Z" or NCD specific benefits.(73)

> Now the government is able to provide support for the worst cases of diabetes. Before there was just no way. Now they even provide support for dialysis and so on."
>
> CSO

Financial protection

Cost for healthcare	4.71 % GDP
Proportions with household expenditures on health >10%	6.31%

Philippine Health Insurance Corporation (PHIC) is primarily funded by premium payments from workers and self-employed individuals. The health insurance premium of the poor or those considered as indigent is subsidised by the national government, which sources these funds from a portion of the excise tax collected from tobacco, alcohol and sugar sweetened beverages, otherwise known as "sin tax". The Sin Tax Act was passed in 2012 and has been revised at regular intervals to keep pace with increases in GDP, with a large proportion of the proceeds of this tax going towards the health response.

Facilitating factors for integration of NCDs into UHC implementation

Taxation of unhealthy commodities supporting NCD financing

"The "sin tax" laws have become instrumental in responding to NCDs. Since the enactment of the "sin tax" law in 2013 there has been a doubling, and even now a tripling, of the budget for the Department of Health." Gov

Regularly review and improve existing legislation based on the needs of people living with NCDs

"We enacted a national health insurance act of the Philippines in 1995 but there have already been amendments to the law to further strengthen the response, particularly for debilitating chronic and catastrophic diseases, which have become very expensive." Gov

Supportive relationships between the Department of Health and CSOs

"We have to be very supportive of CSOs in the same manner that the CSOs are very supportive of the government health agencies. This is a very good counter measure to the industries." Gov

Impact of COVID-19

Implementation of recent legislation, including the Universal Health Care Law, has stalled

"Now all the resources are being sucked in by the requirements of COVID 19." CSO

Stigma associated with COVID-19 has led to PLWNCDs avoiding going to health facilities

"People do not want to go to our frontline health centres because they are afraid that they might be affected by COVID. The stigma is there." Gov

Challenges

Ensuring consistent quality in implementation of policy across regions, given the devolved health governance system

"It is really the local mayors and governance structures who have the say in prioritising programmes. This is what spells the success or failure of UHC." PLW

Industry interference when enacting legislation, particularly legislation related to health taxes

"It's the influence of corporations that is a challenge when passing legislation, those who have vested interest. They do a lot of lobbying and influencing, even down to the mayor's level." PLW

Next steps

Focus on prevention of NCDs

We need to go back to health-related behaviours, to increase our health literacy and health advocacy, because most NCD risk factors are related to unhealthy behaviour." Gov

Creating economies of scale for NCD medicines and related products to ensure cost-effective, efficient medical supply chains

"Our current health system set up is very fragmented. We have many providers and many financing sources. By integrating them, we can gain economies of scale." Gov

Rwanda

Area
26,340 km²

Population
11.9 million

Life expectancy (M/F)
66/69

57%
UHC Index

> There is fear that health care is expensive, they say UHC is a dream, but I think we are close to UHC in Rwanda without having had to invest huge amounts of money. It is about how people work, how they are organised."
>
> Aca

> Our former Minister of Health, Agnes Binagwaho, used to say, "We cannot wait because diseases do not wait. They kill our brothers, sisters, parents ... we cannot wait!" To tackle the need, the government of Rwanda embraces partnership. The Ministry of Health have incorporated partners from the beginning."
>
> HCP

Governance and equity

The right to health is reflected within Rwanda's constitution and UHC is the cornerstone of the Health Sector's Strategic Plan.(74) The government has taken a strong lead in enactment of UHC whilst constructively engaging with partners, civil society and the community. The Rwanda Biomedical Centre (RBC) is the Ministry of Health's (MoH) central health implementation agency, and oversees all NCD activities in the country. Its NCDs Division was established in 2011. In 2020, a second five-year National NCD Strategic Plan was developed in collaboration with civil society and people living with NCDs.

The MoH have been working towards equity through ensuring high coverage health insurance within both formal and non-formal sectors of the population, steady decentralisation of the health system to ensure health service coverage in rural areas, and community engagement within governance processes. After implementation of health insurance for the non-formal sector, utilisation of health services increased from 30.7% in 2003 to 85% in 2008, with many key health indicators improving over the same time period.

Famers in the Gatsibo District of Rwanda have access to enough water through a government sponsored irrigation project, that has greatly impacted their production.

© A'Melody Lee / World Bank

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	**18.2%**
Prevalence of normal blood pressure	**73.3%**
Mean fasting plasma glucose	**4.93 mmol/L**
Coverage of national cervical cancer screening programme	**10%**
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	**13.3%**

	POPULATION
Hospital beds	**16/10,000**
Medical doctors	**1.34/10,000**
Psychiatrists	**0.06/100,000**
Surgeons	**0.32/100,000**

Rwanda has a decentralised health system covering 30 districts with 58,000 community health workers (CHWs), 885 health posts, 510 health centres, 36 district hospitals and four provincial hospitals linked by a referral pathway up to eight national referral hospitals.(54)(75) There are national NCD management and clinical guidelines linked to NCD medicines available on the country's essential medicines list, which are comprehensive and include for example insulin, anti-epileptics, and anti-cancer agents.(76)

Nurse-led NCD clinics

Nurse-led NCD clinics in district hospitals and health centres aim to bring NCD care closer to the community and integrate lessons learnt from the country's experience running HIV clinics. Nurses are trained by specialists to diagnose and manage NCDs. Bringing care closer to the community has reduced patient travel time and costs and increased community acceptance.

> Nurses are now front line in care for NCDs."
>
> HCP

Inclusion of NCD prevention and screening

- Tobacco advertisements are banned in the country and regular health promotion messages – for example promotion of healthy diets, physical activity and breastfeeding – are shown during advertisement slots on television. Exercise programmes were also shown during COVID-19 lockdowns.
- Annual health check-ups, which include screening for NCDs, are covered by the country's health insurance programmes for women over 40 years and men over 35 years.
- Bi-weekly "car free days" in Kigali allow people to exercise and attend free health education and screening sessions. These sessions were initiated by the Rwanda NCD Alliance but have been taken on by the government, and are regularly attended by political leaders who are working with civil society organisations to expand this programme beyond the capital city.

Financial protection

Cost for healthcare	7.53 % GDP
Proportions with household expenditures on health >10%	1.15%

"One of the reasons I came back to Rwanda is because I was receiving no care where I lived before. I was terrified and was experiencing suicidal ideation. When I came back to Rwanda, I went to a psychiatric hospital, got diagnosed and was offered cheap medication."

PLWNCD

91% of the population is covered by health insurance.(77) There are a number of insurance schemes in place including the "Rwandaise d'Assurance Maladie", established in 2001 and integrated in the Rwanda Social Security Board (RSSB) Medical Insurance Directorate since 2015, and the Military Medical Insurance, established in 2005. These two public insurances cover civil servants and the formal private sector and servicemen, respectively. The Rwanda Community Based Health Insurance (CBHI), also under RSSB, covers the non-formal sector, which comprises the majority of the population. There are also a few private insurance options. CBHI was instituted in 2004, updated in 2010 and has strong community ownership, with each village hosting a CBHI mobilisation committee. It integrates community contributions and subsidies from the government and development partners. The CBHI covers 90% health service costs at all levels of the health care system.(78)

Facilitating factors for integration of NCDs into UHC implementation

Decentralisation of NCD care including task shifting or sharing of routine NCD screening and management from doctors to nurses

Until 2011, NCD care was only available in teaching hospitals at tertiary level. Decentralisation and task shifting to nurses has allowed a person-centred approach to NCD care. There are strong referral networks to tertiary hospitals equipped with more specialised equipment and doctors. International humanitarian teams visit regularly, providing some types of care not available in country; for example, heart surgery.

"To come and see me, a specialist, could take patients up to three days. Now they can just go to a health centre close to them and then go about their business. Patients are able to continue to work while also having access to their medication."Aca

Strong focus on the community and people living with NCDs

A community focus is reflected in the structure of the health system and CBHI. For example, CBHI includes a socioeconomic capacity estimation process that that has been regularly revised, following community consultation and adapted to the cultural context. This has been facilitated by a well organised administration system.

"Culturally Rwanda is very community based, we take the "it takes a village approach" very seriously. When you talk about improving the lives of people, the message is never individual." PLWNCD

"Everyone's spirit and work is centred around the patient. First of all, serve the patient, do good for the patient, advocate for the patient." HCP

Strong government leadership which is open to partnership with CSOs

"There is political will to tackle NCDs and it is clearly formulated in the policies - in the MoH policies and strategic planning. NCDs are integrated into national policies at all levels, starting at the highest level." CSO

I recognise the role of partners who have helped a lot in this long journey we have gone through." Gov

Impact of COVID-19

The decentralised health system has ensured people living with NCDs can access care despite lockdowns

"If COVID-19 had happened before the decentralisation policies were implemented, I am not sure how patients could have travelled to the urban area to receive medicine. These policies helped to avail medicine and health care providers at the community level, which enabled a continuum of care regardless of COVID-19." HCP

Limitations in support received from humanitarian actors

"For some of the tertiary level services, like cardiac surgery, we had expert teams that came into the country three to four times a year. Now of course, it has been stopped." HCP

Challenges

Ensuring consistent quality of care

"We still have a lot to do to improve the quality of care. It is an ongoing process." HCP

Limited finances

"We are still struggling. We want to improve quality, we want to reach new areas, but the funding is not adequate for the needs, whether internal or external funding, it is not adequate." HCP

Next steps

Strengthening data collection, monitoring and evaluation

A national STEPS survey[viii] has been conducted and there are disease registries in place. Work is currently underway to roll out an Electronic Medical Record (EMR) system throughout the country.

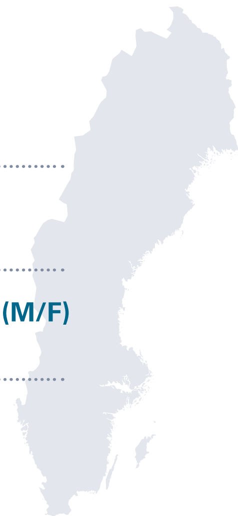
"We are trying to build and set up an EMR system which will include data on NCDs. It is currently being used in the referral and district hospitals, the next step is to extend to health centres." CSO

Strengthening community education, screening and early detection

"There are people in the community with NCDs that do not know they have them. We have to make sure that we are reaching them, diagnosing them early and linking them to care." Gov

viii The WHO STEPS survey, or STEPwise approach to NCD risk factor surveillance, is designed to help countries build and strengthen their surveillance capacity. The assessment includes questionnaires, and physical and biochemical measurements. It can be adapted to allow each country to expand on the core variables and risk factors and to incorporate optional modules related to local or regional interest. For more information, visit https://www.who.int/ncds/surveillance/steps/riskfactor/en/.

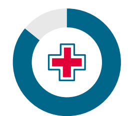
Sweden



Area
447,430 km²

Population
9.8 million

Life expectancy (M/F)
80/84



86%
UHC Index

To Swedish people, the term 'NCD' does not mean much, because most of our diseases are noncommunicable."

PLWNCD

Governance and equity

In Sweden, UHC is underpinned by the Swedish Health and Medical Service Act from 1982, whose objective is to ensure good health to the entire population, health on equal terms, and equitable care based on needs.

Sweden has a health care system with shared responsibility between the national government (National Board of Health and Welfare (NBHW)) and 21 regional authorities. Civil society, including academia, is strong and actively engaged within the policy development and implementation process.

Despite a concerted effort for UHC and improvements in life expectancy over the last 50 years(51), inequalities remain. Recently, 26 disease-specific working groups have been set up with experts, including PLWNCDs, from across the regions to develop care processes with the aim of further improving quality of care and reducing inequalities nationally.

UHC service coverage and inclusion of NCDs

Probability of premature death from an NCD	9.1%
Prevalence of normal blood pressure	80.7%
Mean fasting plasma glucose	5.36 mmol/L
Coverage of national cervical cancer screening programme	>=70%
Age-standardised prevalence of current tobacco smoking among persons aged 15 years and older	7%(79)

	POPULATION
Hospital beds	21.4/10,000
Medical doctors	39.8/10,000
Psychiatrists	20.9/100,000
Surgeons	38.7/100,000

PHC is the basis of the healthcare system and quality of care is recognised as high. Use of data has been ingrained into the system with 90 national disease registries in place. National clinical guidelines were introduced in 2000, and over the last 5 years, there has been increased collaboration across the regions, coordinated by the national government. This system is known as "knowledge-based healthcare".

Stroke prevention, management and rehabilitation

The national quality registry for stroke "Riksstroke" was established in 1994 and the first evidence-based national clinical guidelines for stroke was published in 2000 by the NBHW and revised in 2005, 2009 and 2011. First stroke incidence rates in southern Sweden decreased by 33% between 2001 and 2015.(80) In 2019, the clinical guidelines were expanded to include standardised "care processes" for acute care of stroke patients, which are currently being implemented throughout the country.

Prevention of cardiovascular disease

Swedish population-based studies on preventive interventions were started in the 1980s and have demonstrated a decrease in incidence of cardiovascular disease, cardiovascular death and total mortality. The NBHW has published a guideline on prevention and is working on care processes. Regions have started to integrate specific preventive services, for example health check-ups have been integrated at PHC in 50% of the regions, so-called "lifestyle" clinics run in some hospitals and pilot infrastructure projects considering social and commercial determinants of health have been started.

© Kristin Lidell/imagebank.sweden.se

Most health care in Sweden is provided in health centres, where doctors, nurses and other staff work together. The health centres sometimes refer a patient to a larger hospital with more specialized doctors.

Financial protection

Cost for healthcare	11.9% GDP
Proportions with household expenditures on health >10%	5.5%

The Swedish healthcare system is tax funded. Co-payment is often required from people who access care or medicine at primary, secondary and/or tertiary level, although age-related exemptions, annual caps (roughly 130 Euros/year per person) and targeted social assistance schemes are in place to protect against high out-of-pocket payments.

I think one of the reasons that I am here today is because we have UHC. If I did not have access to free healthcare, I would be ruined today; I would be indebted or dead."

PLWNCD

Facilitating factors for integration of NCDs into UHC implementation

Strong collaboration between NBHW, regional authorities and civil society

"Looking at cancer care, the NBHW and regional authorities have worked together to ensure a systematic approach on a number of cancer care treatments and pathways. It has been extremely successful and has closed many of the equity gaps allowing more standardised care. Yet, a lot of policies are initiated from civil society. The national cancer strategy was well developed because of strong patient involvement. It would have been impossible to produce such a strategy otherwise." CSO

Data and guidelines are used to monitor and ensure equity in access and quality throughout the regions

"Our excellent data, the resources that track every individual, is a huge strength. We can show down to the community level any differences in order to pick up the patterns. In the 1980s, when computers started to be used in health planning, it became possible to develop new plans based on the actual situations in the population and I know that it stimulated a preventive programme. One reason why decision makers have become interested in NCDs has been the possibility to measure their impact in a much better way." Aca

Consistent high-level political and civil society support

"UHC makes such a difference in terms of morbidity, in terms of what we expect from society. You do not hear of it being questioned, even from the most conservative politicians." CSO

©Elisabeth Edén/imagebank.sweden.se

Child health care centres are special care centres for new-born and young children. They are part of the primary care and visits are free of charge.

Impact of COVID-19

Negative impacts on prevention and screening services

"Some PHCs have seen a 50% decrease in patients. PHC is the first point of contact for 70% of people who suspect they have a cancer, so we are expecting a lot of people will be diagnosed at a later stage, leading to higher mortality rates." CSO

Standard treatment pathways have been adapted

"Cancer patients have been given treatment despite COVID-19, but often, treatment has been adapted. For example, patients have been given treatments which are more expensive but are quick to administer and have fewer side effects, meaning they have to spend less time in hospital." CSO

Challenges

Persistent inequalities

If we look at the social gradients, it is quite obvious that there are differences and gaps. For example, between low educated and high educated people. To be able to change that we need to do something quite early, the pattern is from the childhood. We have to find ways to intervene before the risk factors mature into diseases. By then it is too late." Aca

Next steps

A focus on prevention which integrates a whole-of-government approach, tackling the social and commercial determinants of health

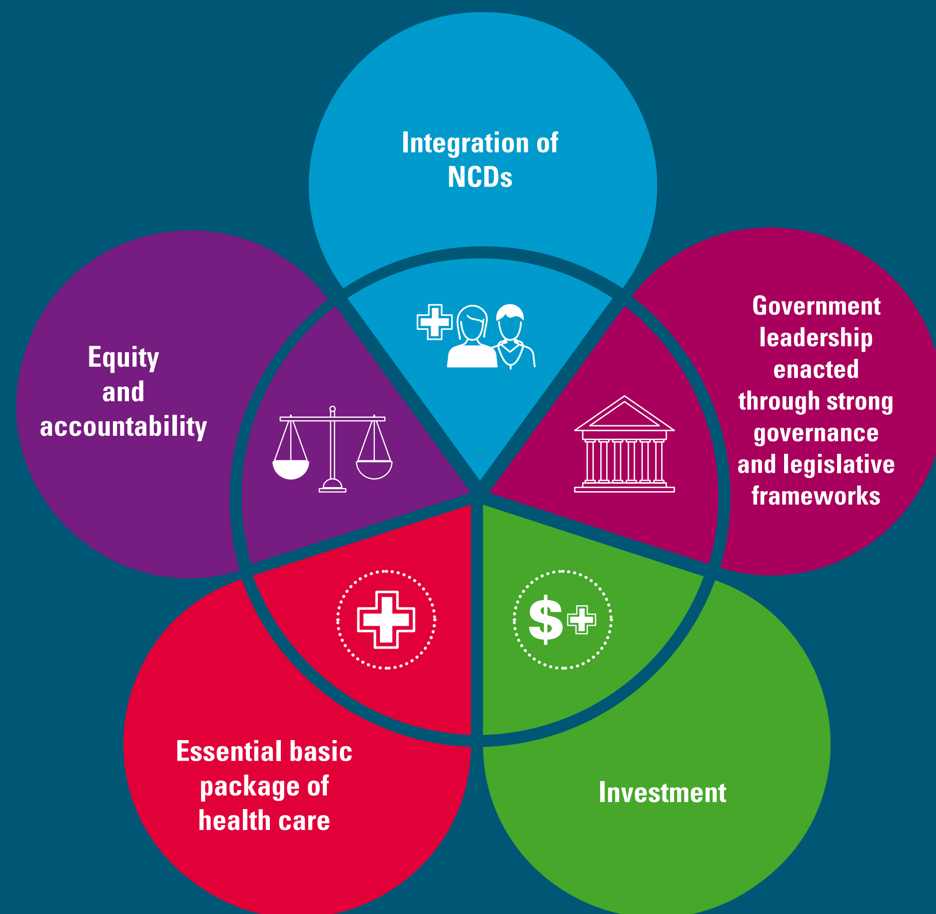
For example, work has started on national guidelines for physical activity and pilot social construction projects are underway.

Further strengthening of collaboration between stakeholders

Collaboration between national government and working groups for new care processes as well between the national government and regional authorities should continue to be improved.

Recommendations from country experts

NCD Countdown 2030 has demonstrated that, for the majority of countries, the decline in premature deaths from NCDs is currently too slow to achieve SDG target 3.4. However, many options still exist for countries to accelerate the mortality decline. (21) Professor Ezzati emphasised, "To move forward we must learn from those countries that are doing well and replicate their strategies for NCD prevention and healthcare." (81) The key informants from across Australia, Ethiopia, India, Jordan, Mexico, the Philippines, Rwanda and Sweden, encompassing a range of political and economic contexts, were asked what recommendations they would give to policy makers in other contexts tasked with implementing UHC. Their voices of experience and recommendations are summarised below.



Integration of NCDs

Given the epidemiological transition and increasing prevalence of NCDs, NCD prevention and care, tailored to population demographics and disease profiles, is required as a fundamental, fully integrated aspect of UHC in all countries. This report has demonstrated the burden that COVID-19 has placed on people living with NCDs and the negative impact it has had on NCD services. Policy makers should ensure:

Lessons are learnt from the COVID-19 pandemic and integration of NCDs into UHC is seen as a pillar of health security

"A pandemic brings harm, but it can also bring benefits. The pandemic is a very good opportunity to universalise health care." Gov Mexico

NCD care is person-centred, inclusive and tailored for marginalised and Indigenous populations

"There must be mindfulness and attention given to disparate elements of the populations and the different risk factors that exist in different subpopulation groups; that is culture, language, historical injustices, disadvantage. Any NCD intervention or response or understanding of the problem has to grapple with that." Gov Australia

NCD care is evidence- and guideline-based and cost-effective

"It has to be evidence-based." HCP Sweden

NCD care is provided across the continuum of care, from health promotion to palliative care, with an emphasis on prevention, early detection of cases and access to essential medicines such as insulin

"Many NCDs are preventable, so we have to work on prevention. Policy makers must consider prevention in their policies." PLWNCD Ethiopia

"We need to ensure essential medicines are available in PHC, and that they actually reach the people who need them." HCP India

Government leadership enacted through strong governance and legislative frameworks

High-level political leadership is needed to drive UHC development and implementation at country level. UHC should be enacted through strong governance systems that include meaningful consultation and involvement of civil society and people living with NCDs, and needs to be established by national legislation. Legislation must call for equity of access to both healthcare services and essential medicines and vaccines, and put the last mile first. A national UHC plan, which includes NCDs within its budget and is adapted to population needs and the existing health system structure, is the cornerstone of implementation. Policy makers should ensure:

Top-level government leadership, support and investment

"A political push from the topmost is one of the critical aspects for these policies." Gov Philippines

A whole-of-government approach[ix]

"It cannot only be under the responsibility of MoH, you cannot talk of NCDs as being the responsibility of one sector. It has to be a multisectoral collaboration, involving Minister of Local Government, Minister of Education, etc. Make sure that you are working with other sectors to address NCDs." Gov Rwanda

Anchor national vision and objectives in legislation

"If health as a human right is a constitutional mandate, everything will start to move in the right direction." HCP Mexico

"Countries must use legislation." Aca Sweden

ix Joint activities performed by diverse ministries, public administrations and public agencies in order to provide a common solution to a particular problem or issue.

Investment

Adapted to the country context, financial support which covers an essential basic package of health care including NCD services and medicines, and is drawn from a mixture of domestic and, where appropriate, international sources, is crucial for the realisation of UHC. Domestic financial mechanisms should include community health insurance and government support schemes to provide financial protection to marginalised populations. Governments should consider using additional revenue-generating measures, such as taxation of (and/or removal of subsidies from) unhealthy commodities (tobacco; alcohol; ultra-processed foods high fat, sugar and salt; fossil fuels and other pollutants). Policy makers should ensure:

Funding is adapted to national / local context

"The first basic lesson is efficiency. Countries should determine who pays for what within the different health packages. There are often a lot of overlaps between what is being paid by the social insurance and what is covered by tax-based money, so there are duplications and overlaps which will lead to inefficiency in the financing system, as well as provision of services at the front line. Determine who pays for what in your country." Gov Philippines

Sufficient allocation of government funds and instigation of community health insurance including integration of government subsidies for marginalised populations

"In our country, most of the health promotion and the HMIS are funded by tax-based money because we consider this as a public good. The actual clinical care package, whether inpatient or outpatient, is being financed by social health insurance. Enshrined in our UHC act is that those who cannot afford to pay the premium for social insurance are subsidised by national government." Gov Philippines

"Policy without resources is poetry. It is useless." CSO Ethiopia

Integration of complementary approaches to investment

"Introduce taxation for unhealthy commodities like tobacco, alcohol, etc. and use the revenue to support NCD control initiatives." Gov Ethiopia

© Marcel Crozet / ILO 18-11-2013

The 41-year-old says the benefits and health insurance he now receives with the help of the ILO AusAid emergency employment programme is like a gift.

Essential basic package of health care[x]

This is the core set of services that the government decides is essential to meet the demographic and health needs of the population. This should include comprehensive and integrated NCD services across the continuum of care throughout the life course. Services must be built around the country's health system infrastructure, which includes community services, primary health care, and secondary and tertiary hospital care. Policy makers should ensure:

A strong primary health care system

"Distance is a big barrier to disease control. Try to provide a minimum of care as close as you can to the communities. If the providers are well trained, they will know how to screen and refer. We can solve the problem of distance, of patients having to walk a long distance to see the doctor." Aca Rwanda

An integrated health care system that recognises multimorbidity and which enables a life course approach

"Do not work in siloes. Whilst most people have one disease to work with, a lot of people have several." PLWNCD Sweden

"Something that we see has worked well is trying to integrate NCD prevention and control into other well-established and well-financed programmes. We are working together with the HIV, TB and maternal and child health programmes. It has helped us to move quickly, because worldwide NCDs are underfunded." Gov Rwanda

A strong health workforce regularly trained and equipped to provide NCD services across the continuum of care. In LMICs, task shifting to nurses and CHWs is crucial

"Make use of whatever work force is there, in Australia we have remote area nurses who can prescribe from a formulary because they are the only healthcare worker there." CSO Australia

Equity and accountability

Equity in access to NCD care underpins UHC and is to be progressively realised in all countries. Implementation of an accountability framework, which includes civil society and PLWNCDs, will allow continual review, revision and stepwise improvement of non-discriminatory and equitable UHC implementation. Policy makers should ensure:

PLWNCDs, CSOs and academia are central in consultation and decision making processes

"Top down is never good, so you need to involve people from the floor… choose those that are trusted and known, that is absolutely key. Something that comes from above and hasn't involved those that are supposed to use it, does not help." Gov Sweden

"We need to engage the community and people living with NCDs to make sure they understand the issues and actively participate in the policy development process." Gov Rwanda

Effective data collection systems including health, social and financial indicators, adapted to country context

"You need to develop data systems that mean you can follow what you do. If you do not know what you do, how do you know what you should change? Data driven improvement is key." Gov Sweden

"Generate evidence at the country level." HCP Ethiopia

A continual review process for UHC policies impact and efficiency

"It is a slow incremental journey, no single intervention or package of interventions will go a long way to integrate NCDs into UHC. It has to be done over time with an array of interventions, whether that is tobacco, alcohol, obesity, healthy food, nutrition. Relentless incrementalism is key." Gov Australia

x Essential basic package of healthcare may also be called health benefit package, minimum health benefit package, essential health benefit package or universal health coverage service package.

Protecting Everyone
Integration of Noncommunicable Diseases into Universal Health Coverage in the Era of COVID-19

References

1 WHO. World Health Statistics 2020: Monitoring Health For The Sustainable Development Goals. Available from: https://apps.who.int/iris/bitstream/handle/10665/332070/9789240005105-eng.pdf

2 Jan S, Laba T, Essue BM, Gheorghe A, Muhunthan J, Engelgau M, et al. The Lancet Taskforce on NCDs and economics 3 Action to address the household economic burden of non-communicable diseases. Lancet. 2018;391(10134):2047–58. Available from: http://dx.doi.org/10.1016/S0140-6736(18)30323-4

3 Niessen LW, Mohan D, Akuoku JK, Mirelman AJ, Ahmed S, Koehlmoos TP, et al. Tackling socioeconomic inequalities and non-communicable diseases in low-income and middle-income countries under the Sustainable Development agenda. Lancet. 2018;391(10134):2036–46. Available from: http://dx.doi.org/10.1016/S0140-6736(18)30482-3

4 Nurith A. How To Reduce Human Suffering: 3 Lessons From A Seminal Public Health Study. NPR. 2020. Available from: https://www.npr.org/sections/goatsandsoda/2020/10/16/924458813/how-to-reduce-human-suffering-3-lessons-from-a-seminal-public-health-study?t=1603795581290

5 UN. Political declaration of the High-Level Meeting on Universal Health Coverage (74th sess.:2018-2019). 2019.

6 WHO, WB. Monitoring Progress towards Universal Health Coverage at Country and Global Levels: Framework, Measures and Targets. 2014. Available from: https://www.who.int/healthinfo/universal_health_coverage/report/2014/en/

7 UN. Transforming our world: the 2030 Agenda for Sustainable Development (70th sess.:2014-2015). 2015.

8 WHO. WHO unveils sweeping reforms in drive towards "triple billion" targets. 2019. Available from: https://www.who.int/news/item/06-03-2019-who-unveils-sweeping-reforms-in-drive-towards-triple-billion-targets

9 HO. Declaration on Primary Health Care Astana, 2018. Available from: https://www.who.int/teams/primary-health-care/conference/declaration

10 WHO. 2019 UHC Monitoring Report: Primary Health Care on the Road to Universal Health Coverage. Available from: https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/

11 WHO, WB. Tracking Universal Health Coverage: 2017 Global Monitoring Report. Available from: https://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.pdf;jsessionid=7D4CE548113495B296B8C8E0B5BE5E91?sequence=1

12 UN. Political declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Disease (66th sess.:2011-2012). 2011.

13 UN. Outcome document of the High-Level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases (68th sess.:2013-2014). 2014.

14 WHO. Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013-2020). 2013. Available from: https://www.who.int/publications/i/item/9789241506236

15 UN. Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Disease (73rd sess.:2018-2019). 2018.

16 Bukhman G, Mocumbi AO, Atun R, Becker AE, Bhutta Z, Binagwaho A, et al. The Lancet NCDI Poverty Commission : bridging a gap in universal health coverage for the poorest billion. 2020;6736(20):1–54.

17 Vollset SE, Goren E, Yuan CW, Cao J, Smith AE, Hsiao T, et al. Fertility, mortality, migration, and population scenarios for 195 countries and territories from 2017 to 2100: a forecasting analysis for the Global Burden of Disease Study. Lancet. 2020;1–22.

18 The Academy of Medical Sciences. Multimorbidity: a priority for global health research. 2018. Available from: https://acmedsci.ac.uk/file-download/82222577

19 NCD Countdown 2030 collaborators. Health Policy NCD Countdown 2030: worldwide trends in non-communicable disease mortality and progress towards Sustainable Development Goal target 3.4. Lancet. 2018;392. Available from: https://www.thelancet.com/action/showPdf?pii=S0140-6736%2818%2931992-5.

20 WHO. News release: WHO gets new advice on curbing deadly noncommunicable diseases. 2019; Available from: https://www.who.int/news/item/10-12-2019-who-gets-new-advice-on-curbing-deadly-noncommunicable-diseases

21 Countdown NCD. Health Policy NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. Lancet. 2020;396(10255):918–34. Available from: http://dx.doi.org/10.1016/S0140-6736(20)31761-X

22 GBD 2019 Universal Health Coverage Collaborators. Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories , 1990 – 2019: a systematic analysis for the Global Burden of Disease Study 2019. 2020;1990–2019.

23 Bertram MY, Sweeny K, Lauer JA, Chisholm D, Sheehan P, Rasmussen B, et al. The Lancet Taskforce on NCDs and economics 5 Investing in non-communicable diseases: an estimation of the return on investment for prevention and treatment services. Lancet. 2015;391(10134):2071–8. Available from: http://dx.doi.org/10.1016/S0140-6736(18)30665-2

24 WHO. Tools for implementing WHO PEN (Package of essential noncommunicable disease interventions). Available from: https://www.who.int/ncds/management/pen_tools/en/

25 WHO. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic. 2020. Available from: https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic

26 WHO. The impact of COVID-19 on mental, neurological and substance use services: Results of a rapid assessment. 2020. Available from: https://www.who.int/publications/i/item/978924012455

27 World Health Organization, #NextGenNCD Department, Review of COVID-19 Preparedness and Response Plans through an NCD Lens. 2020.

28 Haque M, Islam T, Rahman NAA, McKimm J, Abdullah A, Dhingra S. Strengthening primary health-care services to help prevent and control long-term (Chronic) non-communicable diseases in low- and middle-income countries. Risk Management and Healthcare Policy. 2020;13:409–26.

29 Liu H, Huffman MD, Trieu K. The role of contextualisation in enhancing non-communicable disease programmes and policy implementation to achieve health for all. Heal Res Policy Syst. 2020;18(1):1–4.

30 Blake C, Bohle LF, Rotaru C, Zarbailov N, Sava V, Sécula F, et al. Quality of care for non-communicable diseases in the Republic of Moldova: A survey across primary health care facilities and pharmacies. BMC Health Serv Res. 2019;19(1):1–13.

31 NCDA. Improving quality of life for communities living with HIV / AIDS, TB and Malaria. 2020. Available from: https://ncdalliance.org/sites/default/files/resource_files/NCD Alliance Briefing Note_Global Fund Strategy 2023-2028_FINAL%5B1%5D.pdf

32 NCDA. The Need for a Person-Centred, Inclusive NCD Agenda: A Discussion Paper. 2020. Available from: https://ncdalliance.org/resources/the-need-for-a-person-centred-inclusive-ncd-agenda

33 Nugent R. Insights: How Does Integration of Noncommunicable Diseases Really Work in the Universal Health Coverage World? RTI International; 2020. Available from: https://www.rti.org/insights/how-does-integration-noncommunicable-diseases-really-work-universal-health-coverage-world

34 uruvilla S, Sadana R, Montesinos EV, Beard J, Vasdeki JF, Carvalho IA De, et al. A life-course approach to health: Synergy with sustainable development goals. Bull World Health Organ. 2018;96(1):42–50.

35 Rawal LB, Kanda K, Biswas T, Tanim MI, Poudel P, Renzaho AMN, et al. Non-communicable disease (NCD) corners in public sector health facilities in Bangladesh: A qualitative study assessing challenges and opportunities for improving NCD services at the primary healthcare level. BMJ Open. 2019;9(10).

36 Dukpa W, Teerawattananon Y, Rattanavipapong W, Srinonprasert V, Tongsri W, Kingkaew P, et al. Is diabetes and hypertension screening worthwhile in resource-limited settings? An economic evaluation based on a pilot of a Package of Essential Non-communicable disease interventions in Bhutan. Health Policy Plan. 2015;30(8):1032–43.

37 Arredondo A, Azar A, Recaman AL. Challenges and dilemmas on universal coverage for non-communicable diseases in middle-income countries: Evidence and lessons from Mexico. Global Health. 2018;14(1):1–10.

38 Chen S, Guo L, Wang Z, Mao W, Ge Y, Ying X, et al. Current situation and progress toward the 2030 health-related Sustainable Development Goals in China: A systematic analysis. Vol. 16, PLoS Medicine. 2019. 1–33 p.

39 WHO. Healthy Cities Initiative: Approaches and Experience in the African Region. Regional Office of Africa. Brazzaville. 2002.

40 Oni T, Mogo E, Ahmed A, Davies JI. Breaking down the silos of Universal Health Coverage: Towards systems for the primary prevention of non-communicable diseases in Africa. BMJ Glob Heal. 2019;4(4):10–3.

41 Thet Swe K, Mizanur Rahman M, Shafiur Rahman M, Saito E, Abe SK, Gilmour S, et al. Cost and economic burden of illness over 15 years in Nepal: A comparative analysis. PLoS One. 2018;13(4):1–14.

42 Katibeh M, Kalantarion M, Mariotti SP, Safi S, Shahraz S, Kallestrup P, et al. A stakeholder perspective on diabetes mellitus and diabetic retinopathy care in Iran; A qualitative study. Arch Iran Med [Internet]. 2017;20(5):288–94. Available from: http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L616123441

43 Gibbs N, Kwon J, Balen J, Dodd P. Operational research to support equitable non-communicable disease policy in low-income and middle-income countries in the sustainable development era: a scoping review. BMJ Glob Heal. 2020;5(6):e002259.

44 Rahman MS, Rahman MM, Gilmour S, Swe KT, Krull Abe S, Shibuya K. Trends in, and projections of, indicators of universal health coverage in Bangladesh, 1995–2030: a Bayesian analysis of population-based household data. Lancet Glob Heal. 2018;6(1):e84–94. Available from: http://dx.doi.org/10.1016/S2214-109X(17)30413-8

45 Allen LN. Financing national non-communicable disease responses. Glob Health Action. 2017;10(1). Available from: https://doi.org/10.1080/16549716.2017.1326687

46 WHO. How pharmaceutical systems are organized in Asia and the Pacific. Manila: World Health Organization Regional Office for the Western Pacific. 2018.

47 Twagirumukiza M, Cosijns A PE. Influence of tropical climate conditions on the quality of antihypertensive drugs from Rwandan pharmacies. Am J Trop Med Hyg. 2009;(81):776–781.

48 Rockers PC, Laing RO, Wirtz VJ. Equity in access to non-communicable disease medicines: A cross-sectional study in Kenya. BMJ Glob Heal. 2018;3(3):1–7.

49 WHO. The Global Health Observatory. Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/

50 NVIVO. Available from: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

51 The World Bank: DataBank. Available from: https://data.worldbank.org/indicator/

52 Australian Government. Australian Institute of Health and Welfare. 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW. Available from: https://www.aihw.gov.au/getmedia/6bc8a4f7-c251-4ac4-9c05-140a473efd7b/aihw-aus-221-chapter-3-3.pdf.aspx.

53 Parisi R, Iskandar IYK, Kontopantelis E, Augustin M, Griffiths CEM, Ashcroft DM, et al. National, regional, and worldwide epidemiology of psoriasis : systematic analysis and modelling study. BMJ 2020;369:m1590. Available from: https://www.bmj.com/content/369/bmj.m1590%20

54 Australian Government. Department of Health. Tobacco Control Key Facts and Figures: Smoking prevalence rates. 2018. Available from: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/tobacco-control-toc~smoking-rates

55 Federal Democratic Republic of Ethiopia. Ministry of Health. National Strategic Action Plan for Prevention and Control of Non-Communicable Diseases in Ethiopia. 2014 - 2016. Available from: https://www.iccp-portal.org/system/files/plans/ETH_B3_National Strategic Action Plan %28NSAP%29 for Prevention and Control of Non-Communicable Diseases - Final.pdf

56 Ministry of Health. Essential Health Services Package of Ethiopia. 2019. Available from: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/essential_health_services_package_of_ethiopia_2019.pdf

57 Ethiopia NCDI Commission. Addressing the Impact of Noncommunicable Diseases and Injuries in Ethiopia. 2018. Available from: http://www.ncdipoverty.org/ethiopia-report/

58 Ethiopia Federal Ministry of Health. Ethiopia's Fifth National Health Accounts 2010/2011.

59 WHO. The Abuja Declaration: Ten Years On. 2011. Available from: https://www.who.int/healthsystems/publications/abuja_declaration/en/

60 National Health Portal. India. Bhore committee, 1946. Available from: https://www.nhp.gov.in/bhore-committee-1946_pg

61 PHFI. Universal Health Coverage Initiative for India. Available from: http://www.uhc-india.org/reports.php

62 National Health Policy. India. 2017. Available from: https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf

63 National Health Portal. India. Universal Health Coverage. Available from: https://www.nhp.gov.in/universal-health-coverage_pg

64 PHFI and The World Bank. India's Health Workforce: Size, composition and distribution. 2009; Available from: http://documents1.worldbank.org/curated/en/928481468284348996/pdf/702410BRI0P1020k0Final000Vol010no03.pdf

65 Zodpey S, Farooqui HH. Universal health coverage in India: Progress achieved & the way forward. Indian J Med Res. 2018;147(4):327-329. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6057252/

66 Government of India. Ministry of Health & Welfare. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke. Available from: https://dghs.gov.in/content/1363_3_NationalProgrammePreventionControl.aspx

67 Government of India. Ministry of Health and Family Welfare. Ayushman Bharat - Health and Wellness Centre. Available from: https://ab-hwc.nhp.gov.in

68 Pandey A, Ploubidis G, L C, L D. Trends in catastrophic health expenditure in India: 1993 to 2014. Bull World Heal Organ 2018;9618-28. Available from: https://www.who.int/bulletin/volumes/96/1/17-191759/en/

69 WHO. Regional Office for South-East Asia. Health financing profile 2017. India. 2017. Available from: https://apps.who.int/iris/bitstream/handle/10665/259642/HFP-IND.pdf?sequence=1&isAllowed=y

70 Observatory GH. Country Focus Obesity in Mexico : rapid epidemiological transition and food industry interference in health policies. 2020;8(September):746–7.

71 OECD. Health Policy in Mexico by Directorate for Employment, Labour and Social Affairs. 2006;1–7.

72 NCD ATLAS. Briding the Gap on NCDs Through Civil Society Action. Initiatives of national and regional NCD alliances. 2020. Available from: https://ncdalliance.org/sites/default/files/resource_files/NCDatlas_NCDalliance_Feb2020_FINAL.pdf

73 PhilHealth: Benefits. Available from: https://www.philhealth.gov.ph/benefits/#gsc.tab=0

74 Government of Rwanda. Ministry of Health. Third Health Sector Strategic Plan. 2012-2018. Available from: http://www.moh.gov.rw/fileadmin/templates/Docs/HSSP_III_FINAL_VERSION.pdf

75 Republic of Rwanda. Ministry of Health. Health Facilities. 2020. Available from: https://moh.gov.rw/index.php?id=547

Protecting Everyone
Integration of Noncommunicable Diseases into Universal Health Coverage in the Era of COVID-19

76 Ministere de la Sante. La liste Nationale des Médicaments essentiels, 5e edition. 2010. Available from: https://www.who.int/selection_medicines/country_lists/RWA_LNME_2010.pdf?ua=1

77 WHO. Rwanda: the beacon of Universal Health Coverage in Africa. 2019. Available from: https://www.afro.who.int/news/rwanda-beacon-universal-health-coverage-africa

78 Government of Rwanda. Ministry of Health. Rwanda Community Based Health Insurance Policy. 2010. Available from: https://rbc.gov.rw/fileadmin/user_upload/Rwanda_Community_Based_Health_Insurance_Policy.pdf

79 Daglig tobaksrökning. Available from: https://www.folkhalsomyndigheten.se/folkhalsorapportering-statistik/tolkad-rapportering/folkhalsans-utveckling/resultat/levnadsvanor/tobaksrokning-daglig/

80 Aked J. Temporal Trends of Stroke Epidemiology in Southern Sweden: A Population-Based Study on Stroke Incidence and Early Case-Fatality. 2018;174–82.

81 Press Release: The NCD Countdown 2030 report shows slow progress towards UN SDG target 3.4. 2020. Available from: https://ncdalliance.org/news-events/news/new-ncd-countdown-2030-report-shows-slow-progress-towards-un-sdg-target-34

This policy research report outlines global progress towards integration of NCDs into UHC benefit packages to date. Through analyses of interviews with experts from Australia, Ethiopia, India, Jordan, Mexico, Philippines, Rwanda and Sweden it brokers knowledge by showcasing country-level examples and explores the role of NCD prevention and care to enhance health security in light of the COVID-19 pandemic. It demonstrates that there are tried-and-tested methods to effectively integrate NCDs into UHC at national level in different economic settings, enabling governments to provide care and financial protection to people living with NCDs across the whole population.

MAKING NCD PREVENTION AND CONTROL A PRIORITY, EVERYWHERE

Website: www.ncdalliance.org Twitter: @ncdalliance E-mail: info@ncdalliance.org