Progress in universal health in the Americas

Addressing unmet healthcare needs, gaps in coverage, and lack of financial protection, through primary health care

PAHO Pan American Health Organization
World Health Organization Americas Region

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Contents

PREFACE vii

ACKNOWLEDGMENTS viii

ABBREVIATIONS AND ACRONYMS ix

INTRODUCTION 1

The links between primary health care and universal health 3

Indicators for monitoring universal health in the Americas 4

1. UNDERSTANDING UNMET HEALTHCARE NEEDS 7

1.1. Regional overview and trends in unmet healthcare needs 9

1.2. Higher national incomes correlate with lower unmet healthcare needs 12

1.3. Significant disparities in unmet healthcare needs between income quintiles within countries 13

1.4. Organizational barriers are the most common cause of unmet healthcare needs 14

1.5. The COVID-19 pandemic increased unmet healthcare needs across all income levels 19

2. COVERAGE OF ESSENTIAL HEALTH SERVICES (SUSTAINABLE DEVELOPMENT GOAL 3.8.1) 21

2.1. Overall progress and a mixed landscape of achievements and challenges 22

2.2. Trends over time and recent stagnation in coverage of essential health services 23

2.3. Income and development: predictors of health service coverage 25

2.4. Inequalities in service coverage 26

3. FINANCIAL PROTECTION (SUSTAINABLE DEVELOPMENT GOAL 3.8.2) 29

3.1. Catastrophic and impoverishing out-of-pocket health spending 34

3.2. Household age composition and its impact on catastrophic and impoverishing health expenditures 37

3.3. Disparities in impoverishing health expenses between urban and rural households 41

3.4. Catastrophic and impoverishing health expenditure: relationships with out-of-pocket spending and the poverty rate 43

4. THE INTERPLAY OF UNMET HEALTHCARE NEEDS, COVERAGE OF ESSENTIAL HEALTH SERVICES, AND FINANCIAL PROTECTION 47

5. POLICY IMPLICATIONS FOR PRIMARY HEALTH CARE 53

6. DATA LIMITATIONS AND RECOMMENDATIONS 57

REFERENCES 61

ANNEX 1. METHODOLOGY FOR CALCULATING UNMET HEALTHCARE NEEDS 66

ANNEX 2. METHODOLOGY FOR CALCULATING THE UNIVERSAL HEALTH COVERAGE SERVICE COVERAGE INDEX (SUSTAINABLE DEVELOPMENT GOAL 3.8.1) 71

ANNEX 3. METHODOLOGY FOR CALCULATING CATASTROPHIC AND IMPOVERISHING OUT-OF-POCKET HEALTH SPENDING 72

ANNEX 4. UNMET HEALTHCARE NEEDS AND TYPES OF BARRIERS TO ACCESS, BY COUNTRY, LATEST YEAR AVAILABLE 74

ANNEX 5. UNIVERSAL HEALTH COVERAGE SERVICE COVERAGE INDEX (SUSTAINABLE DEVELOPMENT GOAL 3.8.1), BY COUNTRY, 2021 78

ANNEX 6. FINANCIAL HARDSHIP (SUSTAINABLE DEVELOPMENT GOAL 3.8.2) BY COUNTRY, LATEST YEAR AVAILABLE 81

ANNEX REFERENCES 84

BOXES

Box 1. Trends and inequalities in unmet healthcare needs in Colombia, El Salvador, and Peru 10

Box figure 1.1. Unmet healthcare needs in Colombia, 1997–2022 10

Box figure 1.2. Unmet healthcare needs in El Salvador, 2016–2022 11

Box figure 1.3. Unmet healthcare needs in Peru, 2002–2022 11

Box 2. Trends in unmet healthcare needs by barrier type in selected countries of the Americas 16

Box figure 2.1. Distribution of unmet healthcare needs by type of access barriers in Colombia, 1997–2022 16

Box figure 2.2. Distribution of unmet healthcare needs by type of access barriers in El Salvador, 2016–2022 17

Box figure 2.3. Distribution of unmet healthcare needs by type of access barriers in Peru, 2002–2022 18

Box 3. Out-of-pocket spending as a source of financing for health systems 31

Box figure 3.1. Financing schemes for health systems (percentage share in current health expenditure), 2021 32

Box figure 3.2. Latin America and the Caribbean: trends in public and out-of-pocket health expenditure, 2000–2021 33

Box figure 3.3. Average composition of households' out-of-pocket health spending, available estimates 34

FIGURES

Figure 1. Operational framework for primary health care 3

Figure 2. Unmet healthcare needs by country, latest year available 9

Figure 3. Unmet healthcare needs by income groups, latest year available 12

Figure 4. Income quintile comparison of unmet healthcare needs across countries 13

Figure 5. Inequalities in unmet healthcare needs by type of barriers to access 14

Figure 6. Distribution of unmet health needs by type of barriers to access, latest year available 15

Figure 7. Unmet healthcare needs during the COVID-19 pandemic 19

Figure 8. Service coverage index by country, 2021 23

Figure 9. Changes in index points for service coverage and subindices, 2000–2021 24

Figure 10. Trends in the service coverage subindices, 2000–2021 25

Figure 11. Correlation between universal health coverage service coverage index and Human Development Index by income group, 2021 26

Figure 12. Composite coverage index for reproductive, maternal, newborn, and child health interventions by income quintile, education level, and rural/urban residence 27

Figure 13. Incidence of catastrophic out-of-pocket health spending as tracked by SDG indicator 3.8.2 at the 10% threshold, most recent year, 2004–2021 35

Figure 14. Change in population impoverished by out-of-pocket health expenditure in the Americas (% of the population in the Region and millions of people) 36

Figure 15. Incidence of impoverishing out-of-pocket health spending at the relative poverty line, most recent year, 2000–2021 37

Figure 16. Incidence of catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), by age structure of the household, most recent year 38

Figure 17. Incidence of impoverishing out-of-pocket health spending (impoverished and further impoverished) at the relative poverty line, by age structure of the household, most recent year 39

Figure 18. Incidence of catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), by age of the head of the household, most recent year 40

Figure 19. Incidence of impoverishing out-of-pocket health spending (impoverished and further impoverished) at the relative poverty line, by age of the head of the household, most recent year 41

Figure 20. Incidence of impoverishing out-of-pocket health spending (impoverished and further impoverished) at the relative poverty line, by area of residence (rural/urban), most recent year 42

Figure 21. Incidence of catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), by residence area, most recent year 43

Figure 22. Incidence of catastrophic health spending as tracked by SDG 3.8.2, 10% threshold versus out-of-pocket health spending as a share of private final consumption 44

Figure 23. Incidence of impoverishing health spending versus poverty headcount rates, both at the relative poverty line 45

Figure 24. Relationship between the Human Development Index and unmet healthcare needs, latest available year 49

Figure 25. Relationship between unmet healthcare needs and avoidable mortality, Region of the Americas, latest available year 50

Figure 26. Relationship between unmet healthcare needs and universal health coverage service coverage index (SDG 3.8.1), Region of the Americas, latest available year 51

Figure 27. Out-of-pocket health spending as a share of private final consumption 52

Preface

This report, *Progress in universal health in the Americas: Addressing unmet healthcare needs, gaps in coverage, and lack of financial protection, through primary health care*, underscores the unwavering commitment of the Pan American Health Organization (PAHO) to advancing universal access to health and universal health coverage across the Americas, a Region that is characterized by both remarkable progress and persistent inequalities in health.

The COVID-19 pandemic exposed vulnerabilities within our health systems and highlighted longstanding issues, such as health system fragmentation and barriers to access health services, that impacted disproportionately populations in situations of vulnerability.

In response, this report emphasizes the critical role of primary health care (PHC) as a strategic approach and cornerstone for achieving universal health. PHC not only ensures improved access to health services, but also strengthens the resilience of health systems and promotes equity by addressing the diverse health needs of communities.

To achieve this end, PAHO remains committed to supporting our Member States in their efforts to build resilient health systems based on the principles of equity, solidarity, and the right to health.

This report provides a detailed analysis of the current state of health systems in the Americas and examines the performance aspects of universal health through three key indicators: unmet healthcare needs, coverage of essential health services, and financial protection.

By leveraging the insights and data presented in this report, we can collectively work toward a future where all individuals have access to comprehensive, high-quality health services without financial hardship.

I extend my gratitude to our Member States for their dedication and commitment in advancing toward the achievement of more equitable and resilient PHC-based systems. Together, we can achieve the vision of universal health for all in the Americas.

Dr. Jarbas Barbosa da Silva Jr.
Director of the Pan American Health Organization

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Abbreviations and acronyms

CI	confidence interval
HDI	Human Development Index
NCD	noncommunicable disease
PAHO	Pan American Health Organization
PHC	primary health care
Q1	lowest income quintile
Q5	highest income quintile
RMNCH	reproductive, maternal, newborn, and child health
SCI	service coverage index
SDG	Sustainable Development Goal
UHC	universal health coverage
WHO	World Health Organization


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Introduction

Achieving universal access to health and universal health coverage (hereafter together referred to as universal health) remains an elusive goal for many countries in the Americas. Despite significant advances, the Region continues to grapple with persistent challenges exacerbated by the COVID-19 pandemic. These include health system segmentation and fragmentation, weakened stewardship and governance, and inequitable access to services, particularly among populations in vulnerable situations *(1)*. The pandemic highlighted the fragility of health systems, leading to significant disruptions in essential health services and overwhelming healthcare facilities. Health workers faced high infection rates and mental health consequences, further straining the system. In addition, a third of the population in the Americas continues to face barriers to accessing care, with significant disparities in the availability of human resources for health and access to essential medicines and technologies *(2)*. These challenges have resulted in inequitable access to health services, varying health outcomes across populations, and emerging health threats compounded by social determinants of health *(3)*.

In response, there has been growing momentum across regions toward achieving universal health through primary health care (PHC), driven by international commitments and regional frameworks that prioritize health as a central pillar of sustainable development. The 2030 Sustainable Development Goals (SDGs) address key issues that have significant impacts on health, with SDG 3: Ensure healthy lives and promote well-being for all, specifically prioritizing health. Target 3.8 aims to achieve universal health coverage (UHC), including financial risk protection, access to high-quality essential healthcare services, and access to safe, effective, high-quality, and affordable essential medicines and vaccines for all *(4)*. It reflects a global commitment to ensuring everyone can access the health services they need without facing financial hardship.

In line with this, Member States of the Pan American Health Organization (PAHO) committed to achieving universal health through Resolution CD53.R14 *Strategy for Universal Access to Health and Universal Health Coverage*, approved in 2014 *(1)*. In 2022, based on the impact of the COVID-19 pandemic, the commitment to universal health was reaffirmed through the approval of the *Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains (3)*. To accelerate progress toward universal health, this strategy identifies four strategic lines of action: transform health systems based on a PHC approach, strengthen stewardship and governance through the essential public health functions, strengthen capacities of health service delivery networks, and increase and sustain public financing in health.

Efforts continue in the transformation of health systems based on the right to health, as well as the principles of equity and solidarity within the context of PHC to reorient health systems to address barriers such as geographic accessibility, cultural and language differences, and uneven quality of care. This approach aims to make health services more accessible and equitable by improving service delivery and

community engagement with effective social control mechanisms. PAHO/World Health Organization (WHO) strategies and regional guidelines recognize PHC as fundamental for achieving health equity and building health system resilience *(3, 5–7)*. These commitments are grounded in the understanding that PHC improves health outcomes and enhances the overall efficiency and effectiveness of health systems by comprehensively addressing the population's health needs. PAHO Member States recently approved two strategies to build on the momentum realized through these actions and commitments for universal health. The *Policy on Integrated Care for Improved Health Outcomes* and the *Strategy for Strengthening the Essential Public Health Functions to Accelerate Health Systems Transformation 2024–2034* both aim to support the progress toward universal health by strengthening stewardship and governance capacities and ensuring equitable access to integrated care *(8, 9)*.

Achieving universal health implies that all people and communities have access to comprehensive, appropriate, and timely high-quality health services according to their needs, as well as access to safe, effective, and affordable high-quality medicines, while ensuring that the use of such services does not expose users to financial difficulties, especially those in conditions of vulnerability *(1)*. At its core lies PHC, which includes essential accessible, comprehensive, community-based and culturally appropriate health services *(6, 7)*. Strengthening PHC not only ensures access to care at all levels but is also a vital determinant of health outcomes and health system performance.

An essential aspect of advancing universal health through PHC is the adoption of a territorial approach, which acknowledges the diversity of health needs and contexts within countries. Within this, the life course approach is also important, as it supports the development of PHC, adding a person- and population-centered perspective. By tailoring interventions to local realities and leveraging community strengths and social participation, countries can better address access barriers and improve health outcomes among the most vulnerable populations. This approach promotes inclusivity and ensures that no one is left behind in the path toward universal health *(9)*.

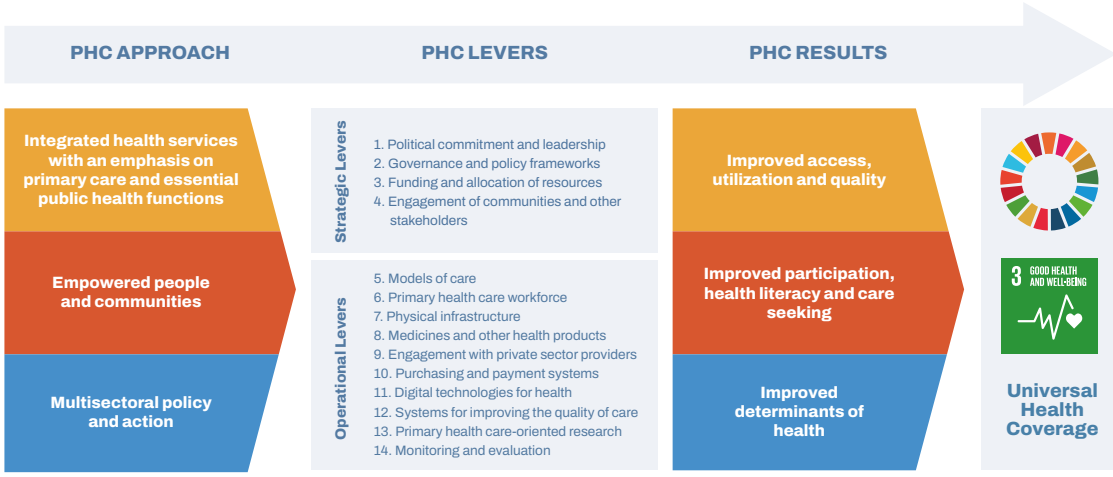
Using the latest data available, this report presents the situation of the Region of the Americas concerning universal access to health and universal health coverage. Strengthening PHC and prioritizing health equity are essential for the Region to continue a path toward achieving universal health that is both sustainable and inclusive, ensuring that every individual can attain the highest standard of health and well-being.

The links between primary health care and universal health

The pursuit of universal health is fundamentally linked to the strengthening of PHC-based systems. The PHC approach, as reaffirmed in the 2018 Declaration of Astana, emphasizes the first level of care and essential public health functions as the core of integrated health services, multisectoral policy and action, and community empowerment to promote health, equity, and efficiency (*10*). The WHO Operational Framework for Primary Health Care provides a comprehensive blueprint for countries to advance toward universal health through a PHC-centered approach (*7*). This framework, rooted in the principles of the 2018 Declaration of Astana, outlines a set of interconnected levers designed to transform global commitments into tangible actions for achieving universal health.

At its core, the framework consists of 17 levers: 4 strategic and 10 operational (Figure 1). The strategic levers encompass political commitment and leadership, governance and policy frameworks, funding and resource allocation, and community and stakeholder engagement. These high-level components set the stage for systemic change. The operational levers, meanwhile, address the practical aspects of PHC implementation, including service delivery models, infrastructure development, and workforce capacity (*7*).

Figure 1. Operational framework for primary health care



Source: World Health Organization and United Nations Children's Fund. Operational Framework for Primary Health Care: Transforming vision into action. Geneva: WHO and UNICEF; 2020. Available from: https://iris.who.int/handle/10665/337641.

To support countries in monitoring their progress, PAHO has developed the Dashboard of Indicators for Health Systems Based on Primary Health Care.[1] This tool facilitates regional monitoring of Member States' efforts in strengthening PHC to achieve universal health. The dashboard compiles key indicators from multiple sources, grouped into three domains: capacity, performance, and impact. By examining how the WHO Operational Framework for PHC supports universal health, this tool aims to provide insights into the mechanisms through which countries can advance their health systems toward universality, equity, and quality. It explores both the performance metrics of universal health and the broader PHC approach, recognizing that comprehensive progress requires attention to both service delivery and the wider determinants of health.

Indicators for monitoring universal health in the Americas

This report presents an analysis of key indicators used to monitor progress toward universal health following PAHO's Monitoring Framework for Universal Health in the Americas *(11)*. In the context of the Americas, universal health, as defined by PAHO Member States *(1)*, encompasses both universal coverage and universal access to health for all. These are distinct yet complementary dimensions essential for progress. Universal access refers to the capacity to use comprehensive, appropriate, timely, high-quality health services when needed, without geographic, economic, sociocultural, organizational, or gender barriers. UHC, on the other hand, ensures that organizational and financing mechanisms are sufficient to cover the entire population without access barriers *(1)*.

While recognizing that the PHC approach encompasses broader elements needed to achieve universal health, this report primarily focuses on the performance aspects of universal health through three key indicators:

1. **Unmet healthcare needs:** This indicator measures the proportion of the population reporting unmet healthcare needs due to various barriers, including availability, geographic accessibility, financial accessibility, organizational issues, and acceptability factors.

1. Pan American Health Organization. Dashboard of Indicators for Health Systems Based on Primary Health Care. Washington, D.C.: PAHO; 2024 [cited 16 October 2024]. Available from: https://www.paho.org/en/tablero-indicadores-aps.

2. **Coverage of essential health services (SDG indicator 3.8.1):** This indicator is measured by the WHO service coverage index (SCI), a composite metric that combines 14 tracer indicators across four key health areas: reproductive, maternal, newborn, and child health (RMNCH); infectious diseases; noncommunicable diseases (NCDs); and service capacity and access.

3. **Financial protection (SDG indicator 3.8.2):** This indicator assesses the extent to which people are protected from financial hardship due to out-of-pocket (OOP) health expenditures.

The three indicators provide a comprehensive view of the care-seeking pathway, from initial need to service utilization and financial impact. Unmet healthcare needs captures the initial stages of the care-seeking pathway by identifying what people do when they are sick or need care and the barriers they encounter. It measures the proportion of respondents who reported needing health care but did not consult an appropriate provider or did not consult at all, for various reasons *(12, 13)*. To provide a more nuanced understanding of the barriers to accessing health care, this indicator is further broken down into five specific categories of reasons for forgone care:

- Availability: unmet needs due to unavailability of resources, such as health personnel or medicines;
- Geographic accessibility: unmet needs resulting from location, distance, or transportation issues;
- Financial accessibility: unmet needs due to financial constraints, including lack of money or absence of health insurance;
- Organizational accessibility: unmet needs arising from issues with health service organization and delivery, such as long waiting times or inconvenient operating hours;
- Acceptability: unmet needs related to provider responsiveness, social and cultural factors, including lack of trust, language barriers, preference for traditional medicine, disbelief in Western medicine, or perceived mistreatment by health personnel *(13)*.

Once individuals overcome initial barriers and access health services, coverage of essential health services (SDG indicator 3.8.1) captures the utilization of those services (realized access) through proxy indicators. The WHO SCI, a composite metric, combines 14 tracer indicators across four key health areas: RMNCH, infectious diseases, NCDs, and service capacity and access.

The index is scored on a scale from 0 to 100, with 100 representing overall coverage of essential health services across the entire population of a country, allowing for standardized comparisons across countries and over time *(14)*.

Financial protection assesses the extent to which people are protected from financial hardship due to OOP health expenditures once they are able to use care. It includes two key metrics: the proportion of the population experiencing catastrophic health spending (SDG indicator 3.8.2), and the proportion of the population impoverished by OOP health expenses. These metrics are crucial for understanding the financial impact of accessing care and the effectiveness of financial protection mechanisms in place *(14)*.

The data for SDG indicators 3.8.1 and 3.8.2 are drawn from the WHO and World Bank's 2023 edition of the global monitoring report on UHC titled *Tracking universal health coverage: 2023 global monitoring report (14)*. The United Nations adopted these two indicators to track global progress toward UHC as part of SDG target 3.8 *(14)*. The unmet healthcare needs indicator aligns with PAHO's commitment to reduce unmet healthcare needs by 30% by 2030, as outlined in the *Compact 30•30•30 PHC for Universal Health* of 2019 *(15)* and is included in Outcome 9 of the *Strategic Plan of the Pan American Health Organization 2020–2025: Equity at the heart of health (5)*.

Importantly, there is growing recognition of the role that both financial and nonfinancial barriers play in hindering universal health outcomes *(16)*. The 76th World Health Assembly in 2023 adopted a resolution to explore the feasibility of using unmet need for healthcare services as an additional indicator for monitoring UHC globally, reflecting this evolving understanding. Efforts are under way to develop standardized definitions and measures to capture these barriers, facilitating global monitoring and comparability across countries *(17)*. Moreover, various methodologies and frameworks are being implemented by PAHO/WHO Member States to measure unmet healthcare needs and barriers to access *(18, 19)*. These initiatives aim to provide a more comprehensive understanding of universal health gaps and inform policy decisions to improve health outcomes *(18, 19)*.

Together, these three indicators offer a balanced view of universal health progress, addressing both the reach of essential health services and the multitude of barriers to accessing health services. They serve as crucial tools for policymakers, health officials, and international organizations in monitoring global health equity and informing strategies to achieve UHC. By tracking these indicators, countries can identify gaps in their health systems, prioritize interventions, and work toward ensuring that all individuals have access to high-quality health services without facing financial hardship or other barriers.

Annexes 1–3 present the methods for calculating these indicators, while Annexes 4–6 provide the estimates by country for each indicator.

1

Understanding unmet healthcare needs

Key findings

- Across 17 Member States, the percentage of the population reporting unmet healthcare needs varied widely, with a range spanning from 3.2% (95% confidence interval [CI] [2.7, 3.6]) to 73.3% (95% CI [72.9, 73.6]) for the most recent data. The regional average for unmet healthcare needs was 35.2% (95% CI [35.0, 35.5]). In most cases, the percentage of unmet healthcare needs has remained relatively stable over the years.

- A clear inverse relationship exists between national income levels and unmet healthcare needs. High-income countries report 23% of their population with unmet needs, compared with 35% in upper-middle-income countries and 49% in lower-middle-income countries.

- Significant disparities exist between income quintiles within countries. The lowest income quintile (Q1) shows higher unmet healthcare needs, averaging 38.5% (95% CI [38.0, 39.1]), than the highest income quintile (Q5), which averages 32.8% (95% CI [32.3, 33.3]). However, the extent of these disparities varies across different countries.

- Organizational barriers are the most common cause of unmet healthcare needs, averaging 21.5% (95% CI [20.8, 22.2]), followed by financial barriers at 14.2% (95% CI [13.5, 14.9]). Different countries face varying challenges, with some primarily facing organizational barriers (e.g., Canada, Costa Rica) and others struggling with financial barriers (e.g., Honduras, the United States of America).

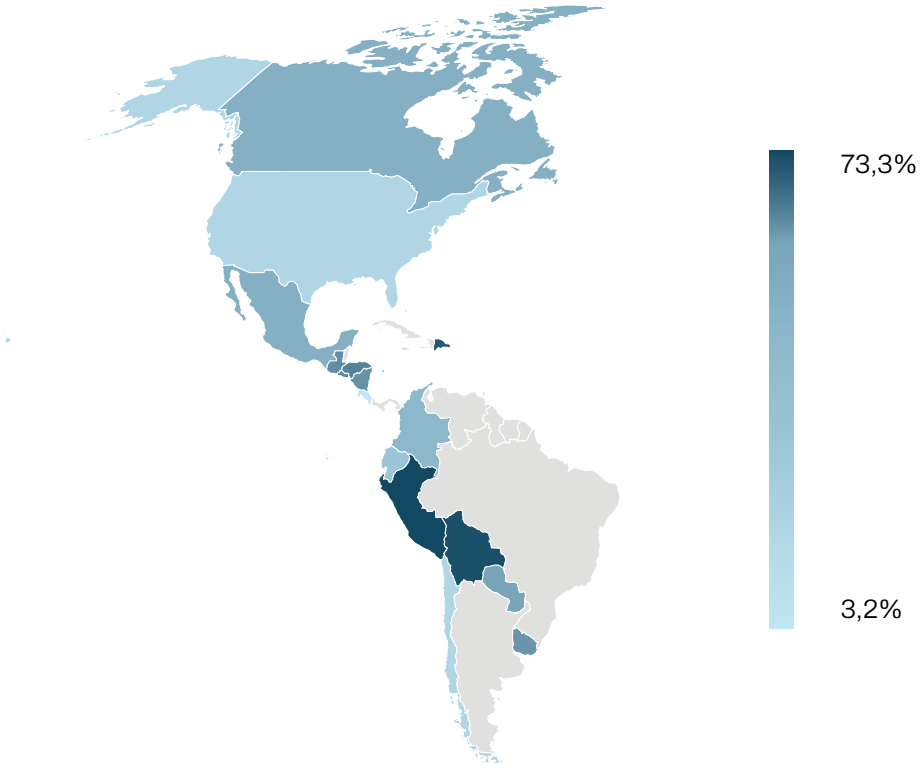
- During the COVID-19 pandemic, all countries experienced an increase in unmet healthcare needs across all income levels. The poorest quintiles generally faced the highest rates of forgone care, particularly in countries such as Colombia, El Salvador, Paraguay, and Peru.

Unmet healthcare needs is a crucial indicator that captures the initial stages of the care-seeking pathway. It measures the proportion of people who needed health care but did not consult an appropriate provider or did not consult at all, due to various barriers. To provide a more nuanced understanding, this indicator is broken down into five specific categories: availability, geographic accessibility, financial accessibility, organizational issues, and acceptability. This section summarizes the updated estimates for this indicator and examines trends, the pace of progress, and aspects of inequalities in unmet healthcare needs.

1.1. Regional overview and trends in unmet healthcare needs

Across the 17 Member States with available data, the percentage of the population reporting unmet healthcare needs exhibited significant variation (Figure 2). The range spanned from 3.2% (95% CI [2.7, 3.6]) to 73.3% (95% CI [72.9, 73.6]) for the most recent data, with a regional average of 35.2% (95% CI [35.0, 35.5]). Notably, the percentage of the population reporting unmet healthcare needs has remained relatively stable in most cases, with some exceptions. Box 1 presents trends for unmet healthcare needs in Colombia, El Salvador, and Peru, showcasing the diverse patterns and challenges faced by different countries in the Region. The change in country-level unmet healthcare needs from baseline to 2022 ranged from –1.6 (Colombia) to 20.5 (Peru) percentage points, highlighting the varying impacts of socioeconomic factors and external events such as the COVID-19 pandemic on healthcare access.

Figure 2. Unmet healthcare needs by country, latest year available

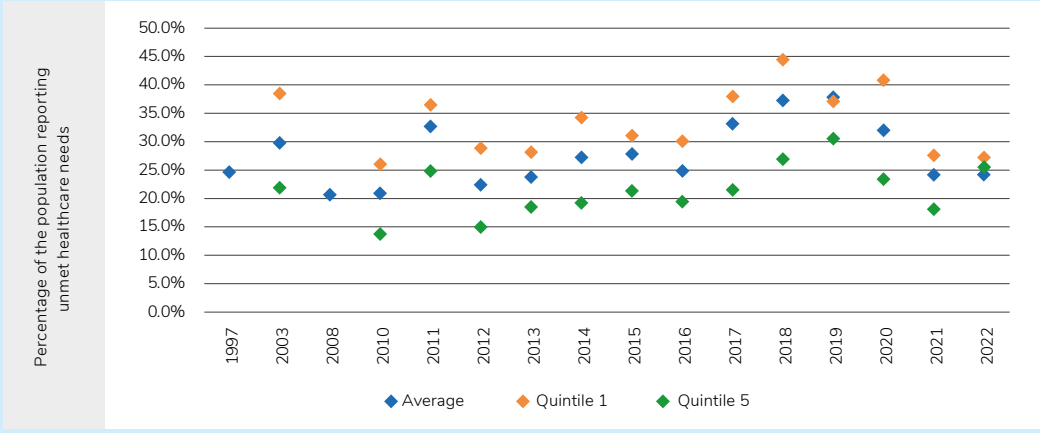


Data source: Household surveys on living conditions and health.
Source: PAHO.

Box 1. Trends and inequalities in unmet healthcare needs in Colombia, El Salvador, and Peru

The analysis of data from Colombia, El Salvador, and Peru highlights a persistent disparity in unmet healthcare needs between the lowest (Q1) and highest (Q5) income quintiles.
In Colombia, the average percentage of unmet healthcare needs from 1997 to 2022 was 27.7% (95% confidence interval [CI] [27.6, 27.8]), with considerable fluctuations, peaking around 2017, 2018, and 2019. The baseline in 1997 was 24.6% (95% CI [24.1, 25.2]), compared with 24.2% (95% CI [23.9, 24.6]) in 2022. Throughout this period, Q1 consistently reported unmet health needs around 30%, while Q5 generally remained below 25%. In 2003, the percentage of unmet healthcare needs in Colombia was 38.5% (95% CI [37.5, 39.5]) for Q1 and 21.9% (95% CI [20.7, 23.0]) for Q5. By 2022, these figures had changed to 27.2% (95% CI [26.7, 27.8]) for Q1 and 25.5% (95% CI [24.5, 26.5]) for Q5.

Box figure 1.1. Unmet healthcare needs in Colombia, 1997–2022

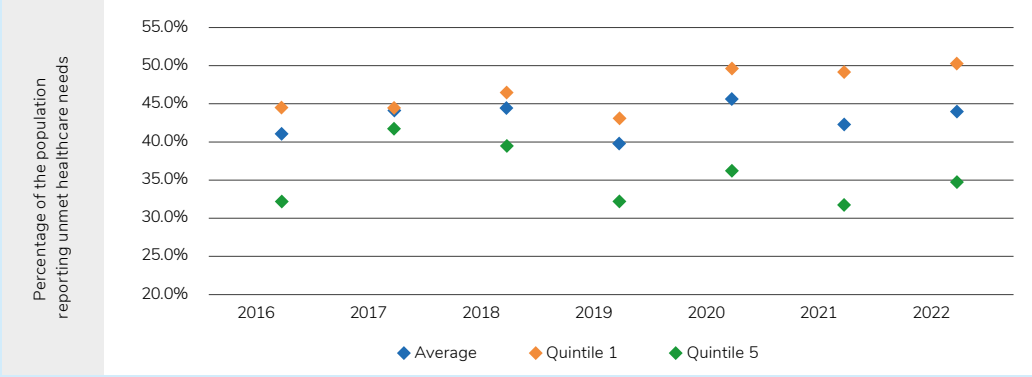


Data source: Encuesta de Calidad de Vida (ECV), 1997–2022.
Source: PAHO.

Data from El Salvador between 2016 and 2022 reveal a similar inequality between income quintiles. Throughout this period, Q1 consistently reported higher unmet health needs, frequently around 45%, while Q5 generally remained below 40%. In 2016, the unmet healthcare needs were 44.5% (95% CI [43.5, 45.4]) for Q1 and 32.2% (95% CI [31.0, 33.5]) for Q5. By 2022, these figures had increased to 50.3% (95% CI [49.2, 51.4]) for Q1 and 34.7% (95% CI [33.6, 35.8]) for Q5. The overall average unmet health need across all years was change to 44.0% (95% CI [43.5, 44.5]). A significant spike in unmet needs occurred in 2020 across all income groups, coinciding with the COVID-19 pandemic. This trend illustrates both the ongoing challenges in healthcare access for lower-income groups and the widespread impact of the pandemic on healthcare systems, affecting even higher-income populations.

Box 1. Trends and inequalities in unmet healthcare needs in Colombia, El Salvador, and Peru *(continued)*

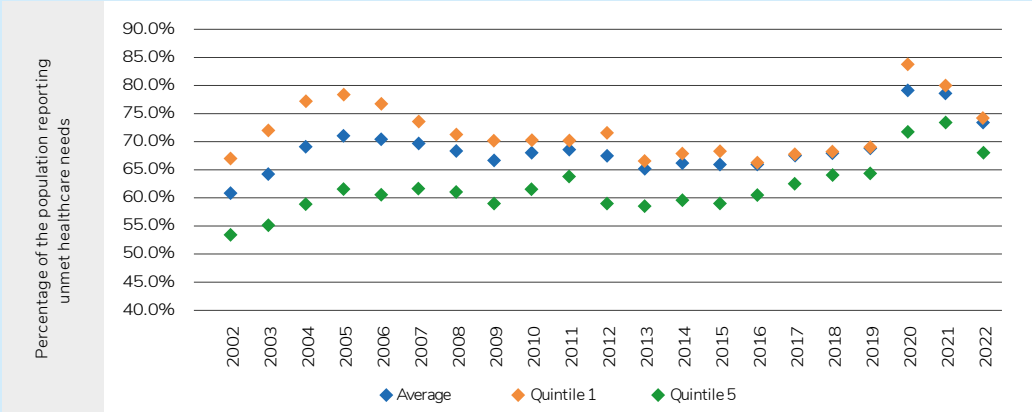
Box figure 1.2. Unmet healthcare needs in El Salvador, 2016–2022



Data source: Encuesta de Hogares de Propósito Múltiple (EHPM), 2016–2022.
Source: PAHO.

Throughout 2002 and 2022 in Peru, Q1 consistently exhibited higher unmet healthcare needs than Q5. In 2002, the unmet healthcare needs were 67.0% (95% CI [65.6, 68.4]) for Q1 and 53.5% (95% CI [50.8, 56.2]) for Q5. By 2022, these figures had increased to 74.2% (95% CI [73.5, 74.9]) for Q1 and 68.1% (95% CI [67.1, 69.1]) for Q5. The average percentage of unmet healthcare needs across all years was 68.7% (95% CI [68.6, 68.8]) with notable peaks in 2005 and 2012. A significant increase in unmet needs occurred from 2020 onward, probably due to the COVID-19 pandemic, which exacerbated existing challenges in healthcare access. The trend between 2020 and 2022 indicates that the rates of unmet need may be declining toward prepandemic levels.

Box figure 1.3. Unmet healthcare needs in Peru, 2002–2022



Data source: Encuesta Nacional de Hogares (ENAHO), 2002–2022.
Source: PAHO.

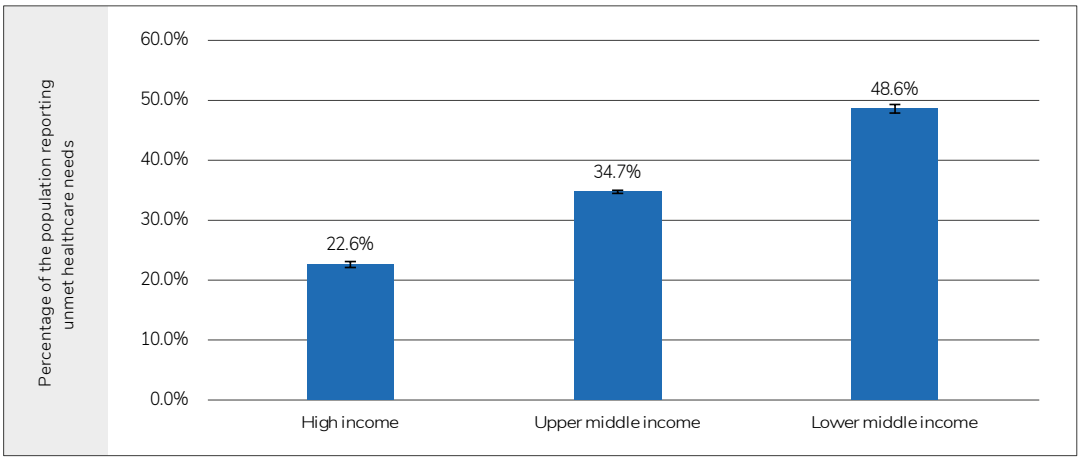
Box 1. Trends and inequalities in unmet healthcare needs in Colombia, El Salvador, and Peru *(continued)*

These country-specific trends highlight the complex interplay of socioeconomic factors, health system capacities, and external shocks such as the COVID-19 pandemic in shaping access to health care across different income groups. The persistent disparities observed in all three countries underscore the need for targeted policies and interventions to improve healthcare access, particularly for the most vulnerable populations. Furthermore, the data emphasize the importance of building resilient health systems capable of maintaining equitable access during crises.

1.2. Higher national incomes correlate with lower unmet healthcare needs

A clear inverse relationship exists between national income levels and the percentage of the population reporting unmet healthcare needs in the Americas. High-income countries report 23% of their population with unmet needs, while upper-middle-income countries show 35%, and lower-middle-income countries reach 49% (Figure 3). This highlights significant inequalities in healthcare access across different income groups in the Region.

Figure 3. Unmet healthcare needs by income groups, latest year available

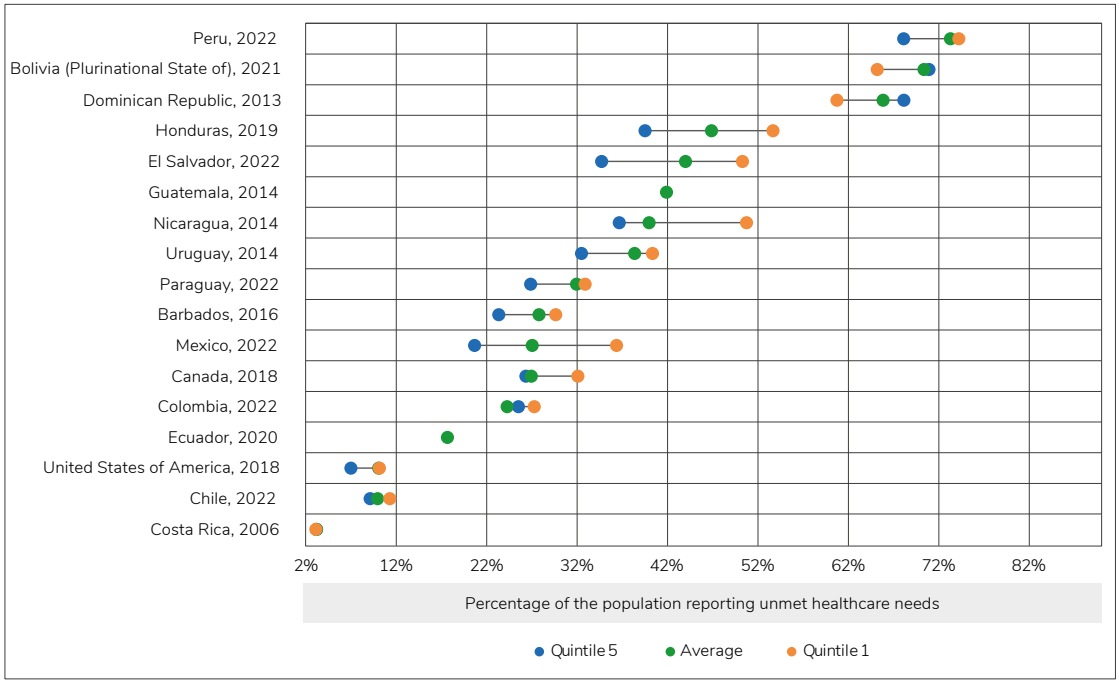


Note: Simple average.
Data source: Household surveys on living and health conditions, and World Bank data on income groups.
Source: PAHO.

1.3. Significant disparities in unmet healthcare needs between income quintiles within countries

The analysis of disparities in unmet healthcare needs between income quintiles within countries highlights inequalities in access to healthcare services. Q1 consistently shows higher unmet healthcare needs, averaging 38.5% (95% CI [38.0, 39.1]), than Q5, which averages 32.8% (95% CI [32.3, 33.3]), except in the Plurinational State of Bolivia, Costa Rica, and the Dominican Republic, which present an inverse relationship. However, the extent of these disparities varies across different countries. For instance, in countries such as Mexico and El Salvador, the gap between Q1 and Q5 is notably pronounced, with differences of 15.7% and 15.6%, respectively, where Q1 exceeds Q5. In contrast, countries such as Chile and Colombia exhibit smaller differences, with Q1 exceeding Q5 by only 2.2% and 1.8%, respectively. These variations indicate differing levels of healthcare inequality across the Americas (Figure 4).

Figure 4. Income quintile comparison of unmet healthcare needs across countries

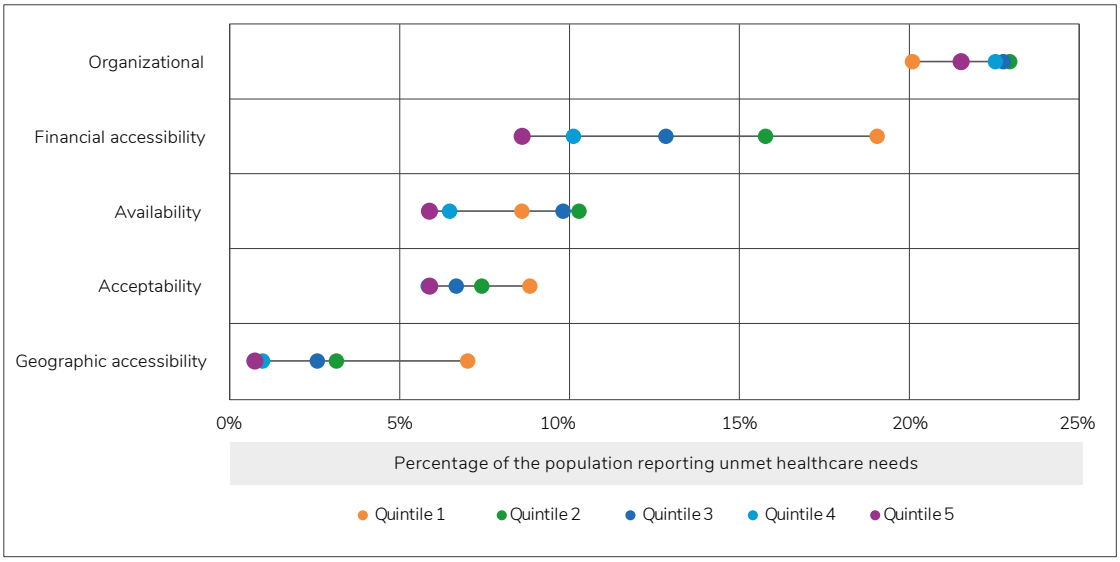


Data source: Household surveys on living and health conditions.
Source: PAHO.

1.4. Organizational barriers are the most common cause of unmet healthcare needs

The causes of unmet healthcare needs are multifaceted and vary significantly by country. On average, organizational barriers are the most prevalent, accounting for 21.5% (95% CI [20.8, 22.2]) of unmet needs, followed by financial barriers at 14.2% (95% CI [13.5, 14.9]). Availability issues rank third at 8.1% (95% CI [7.3, 8.8]), followed by acceptability at 7.1% (95% CI [6.7, 7.5]) and geographic barriers at 3.2% (95% CI [2.8, 3.6]) (Figure 5).

Figure 5. Inequalities in unmet healthcare needs by type of barriers to access

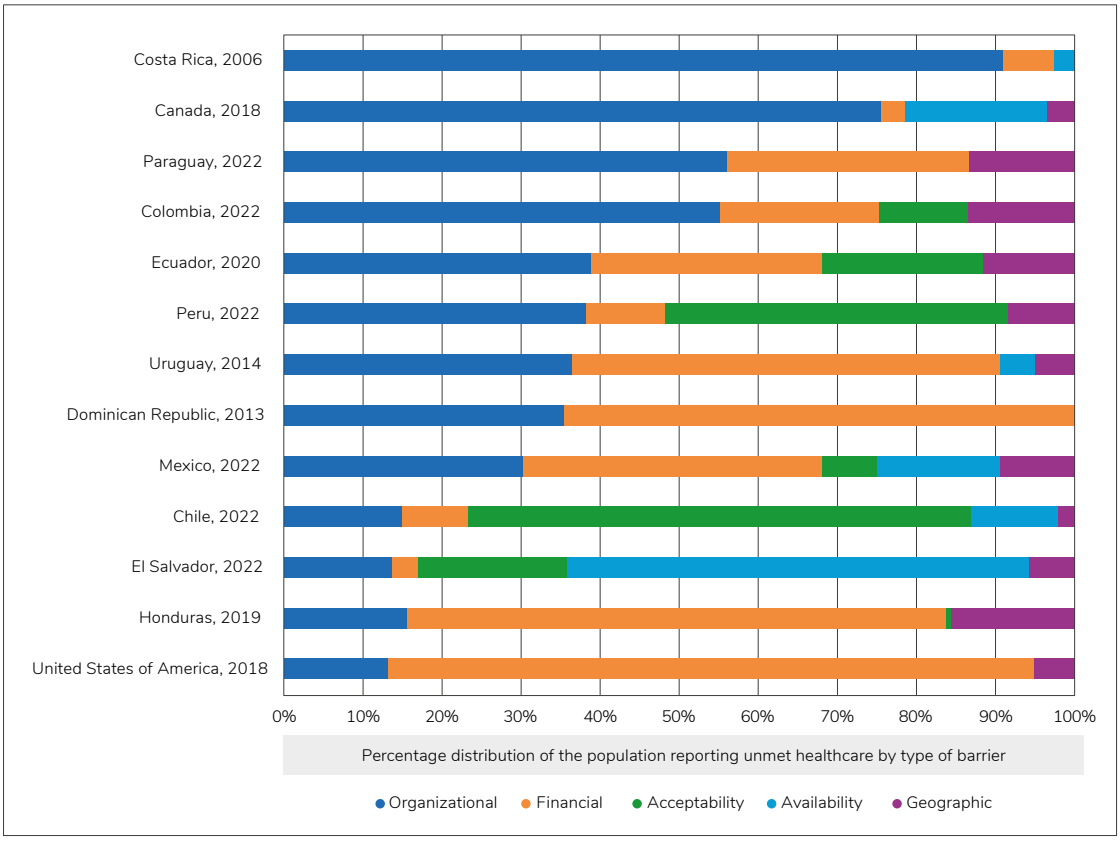


Data source: Compiled from household surveys on living and health conditions.
Source: PAHO.

However, the specific challenges faced by individual countries differ markedly (Figure 6). For instance, organizational barriers are the most prominent in Canada, Costa Rica, and Paraguay. In these countries, issues such as long wait times, inefficient appointment booking systems, and inadequate treatment by health personnel are common reasons for unmet healthcare needs. On the other hand, financial barriers are significant in the Dominican Republic, Honduras, and the United States, where high OOP costs and lack of insurance coverage prevent many individuals from accessing necessary care. Availability issues are particularly notable in Canada, El Salvador, and Mexico, where shortages of health personnel and essential medicines are prevalent. Meanwhile, acceptability barriers are major challenges in Chile, Ecuador,

and Peru; in these countries, factors such as lack of trust in healthcare providers, language barriers, and cultural preferences for traditional medicine contribute to unmet healthcare needs. Geographic barriers, although less common overall, are present in Colombia, Honduras, and Paraguay, where distance and transportation issues hinder access to healthcare services. Box 2 presents trends in unmet healthcare needs for Colombia, El Salvador, and Peru, highlighting the impact of health system transformation policies.

Figure 6. Distribution of unmet health needs by type of barriers to access, latest year available



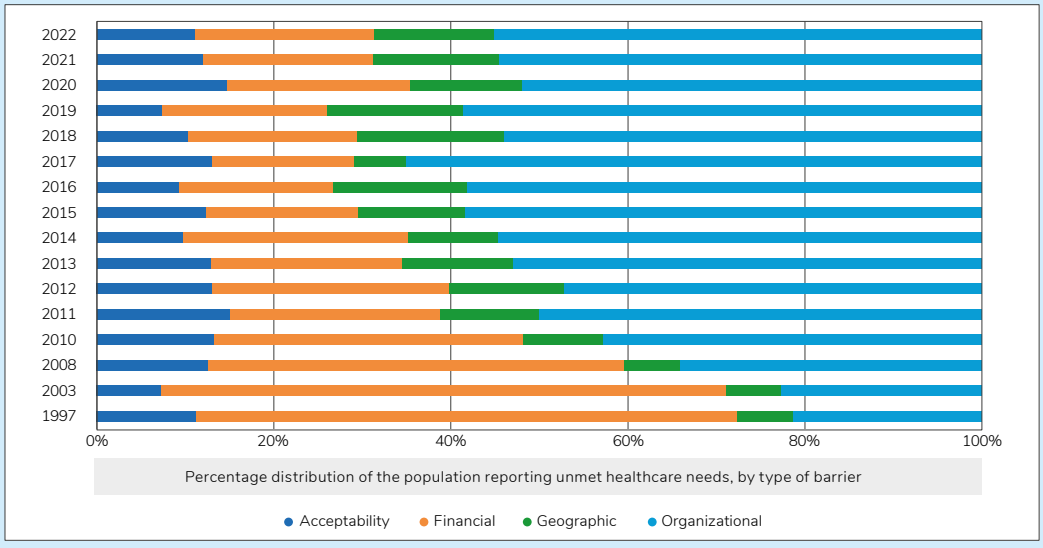
Data source: Compiled from household surveys on living and health conditions.
Source: PAHO.

Box 2. Trends in unmet healthcare needs by barrier type in selected countries of the Americas

Box figures 2.1–2.3 present trends in unmet healthcare needs for Colombia, El Salvador, and Peru, highlighting the impact of health system transformation policies. These case studies reveal that countries focusing on expanding insurance coverage have seen reductions in financial barriers but often experience an increase in organizational and cultural barriers. For example, in Colombia and Peru, long wait times, appointment booking systems, treatment by health personnel, and intercultural skills of health workers have become increasingly frequent reasons for not seeking health services, while unmet need due to financial barriers has declined.

In Colombia, from 2010 to 2022, organizational barriers were consistently dominant, comprising the largest portion of unmet healthcare needs across those years. Financial barriers were particularly evident until the early 2000s but have shown major reductions over time. The importance of geographic barriers fluctuated, peaking around 2016 and 2019, while acceptability barriers have remained comparably similar or higher. This underscores the persistent challenges in healthcare organization in Colombia and highlights the changing nature of barriers to healthcare access.

Box figure 2.1. Distribution of unmet healthcare needs by type of access barriers in Colombia, 1997–2022

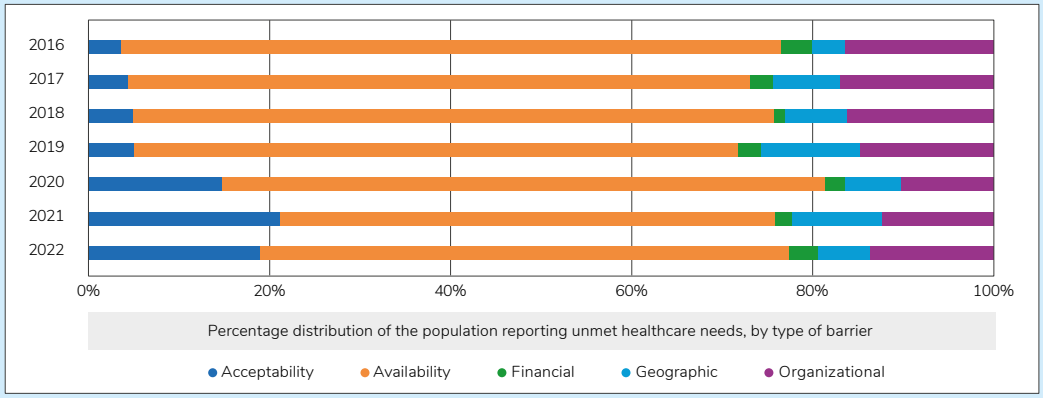


Data source: Encuesta de Calidad de Vida (ECV) 1997–2022.
Source: PAHO.

Box 2. Trends in unmet healthcare needs by barrier type in selected countries of the Americas *(continued)*

In El Salvador, from 2016 to 2022, availability consistently represented the largest barrier to healthcare accessibility. Acceptability and organizational accessibility also play notable roles, with minor contributions from financial and geographic accessibility. Interestingly, there has been a noticeable increase in the acceptability barrier since 2020. This trend underscores the persistent challenge of acceptability of healthcare services in El Salvador during the COVID-19 pandemic.

Box figure 2.2. Distribution of unmet healthcare needs by type of access barriers in El Salvador, 2016–2022

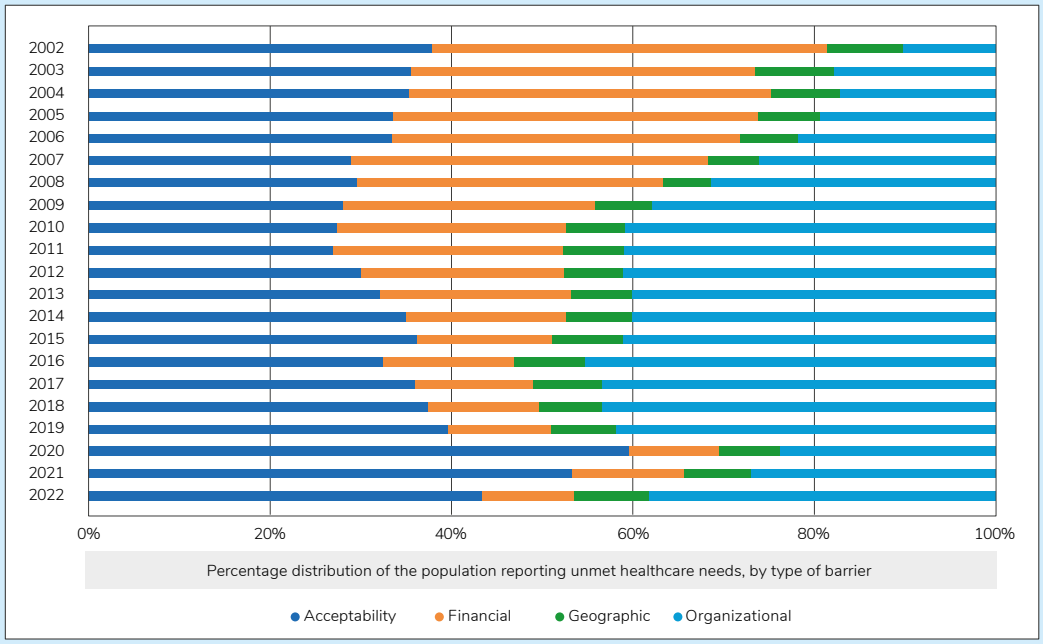


Data source: Encuesta de Hogares de Propósito Múltiple (EHPM) 2016–2022.
Source: PAHO.

In Peru, from 2002 to 2022, there were three phases in which different types of barriers predominated. During 2002–2008, financial barriers were the most significant, showing a steady decline after 2018. From 2009 to 2019, organizational barriers consistently became the most important type of access barrier. Finally, in 2020–2022, acceptability took on greater relevance, presumably due to the COVID-19 pandemic. Geographic barriers remained relatively stable throughout most of this period. This trend suggests that changes in policy focus and resource allocation over time, as well as the emergence of COVID-19, have influenced the types of barriers encountered by the population.

Box 2. Trends in unmet healthcare needs by barrier type in selected countries of the Americas *(continued)*

Box figure 2.3. Distribution of unmet healthcare needs by type of access barriers in Peru, 2002–2022



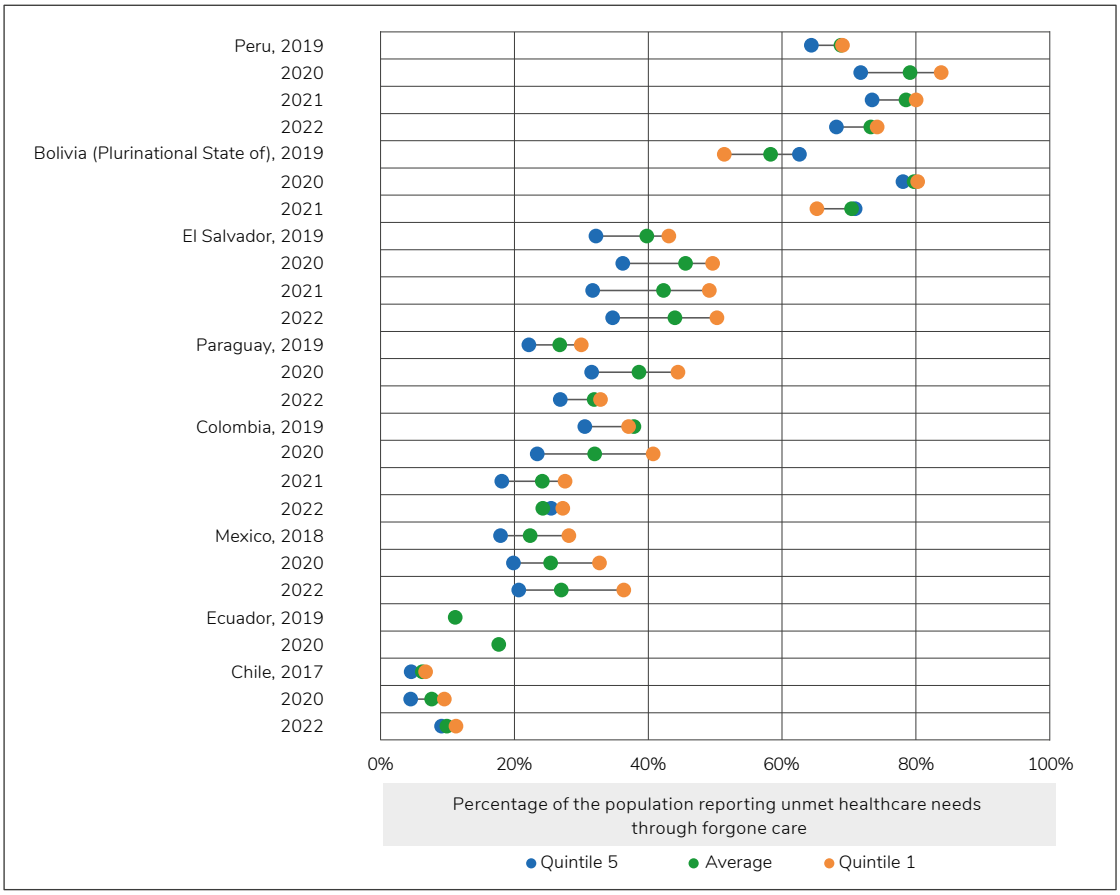
Data source: Encuesta Nacional de Hogares (ENAHO) 2002–2022.
Source: PAHO.

While household surveys provide valuable insights into access problems encountered by the population, they do not capture the full complexity of healthcare challenges. A comprehensive understanding requires complementary qualitative data and mixed-methods approaches. Nevertheless, these survey-based trends underscore the dynamic and multifaceted nature of healthcare access issues in the Americas. They highlight the need for tailored, context-specific strategies to address unmet healthcare needs in each country. The analysis also points to the importance of comprehensive health system reforms that address not only financial barriers but also organizational, cultural, and availability issues to ensure equitable access to healthcare services.

1.5. The COVID-19 pandemic increased unmet healthcare needs across all income levels

During the COVID-19 pandemic, all countries with available data experienced an increase in unmet healthcare needs, regardless of household income levels. On average, unmet healthcare needs rose by 20.1%, from 33.9% before the pandemic to 40.7% during it (Figure 7). This trend was particularly evident among the poorest quintiles, who generally faced the highest rates of forgone care. Countries such as Chile, Colombia, El Salvador, Mexico, Paraguay, and Peru exhibited disproportionately higher levels of unmet healthcare needs among their poorest populations.

Figure 7. Unmet healthcare needs during the COVID-19 pandemic



Data source: Compiled from household surveys on living and health conditions.

Source: PAHO.

In addition, intracountry longitudinal data reveal significant variations in unmet healthcare needs since the onset of the pandemic. In Chile, Ecuador, El Salvador, and Mexico, unmet needs increased in 2020 and have remained persistently high in the years that followed. In contrast, countries such as the Plurinational State of Bolivia, Paraguay, and Peru experienced a sharp increase in unmet healthcare needs in 2020 but have since shown a decline, moving toward prepandemic levels.

Colombia stands out as a unique case where unmet needs only slightly increased in 2020 among Q1, leading to a widening inequity gap. However, since then, unmet healthcare needs in Colombia have sharply declined, particularly among the poorest populations. Interestingly, for Q5, unmet healthcare needs steadily decreased, even during the pandemic years of 2020–2021, reflecting greater resilience among wealthier groups across various countries.

2

Coverage of essential health services (Sustainable Development Goal 3.8.1)

Key findings

- The UHC SCI in the Americas improved from 66 in 2000 to 80 in 2019, reaching 74 in 2021. While 20% of countries achieved a UHC SCI of 80 or higher, 71% fell within the 60–79 range, and three countries lagged behind at 40–59.

- Initial rapid growth in the UHC SCI was followed by deceleration and recent stagnation. The rate of improvement declined from a 10-point increase in 2000–2005 to a 2-point decrease between 2019 and 2021. This negative trend was particularly evident in the infectious diseases subindex.

- By 2019, three subindices (RMNCH, infectious diseases, and service access and capacity) surpassed 80 points. However, the noncommunicable diseases subindex showed slower progress, especially after 2015.

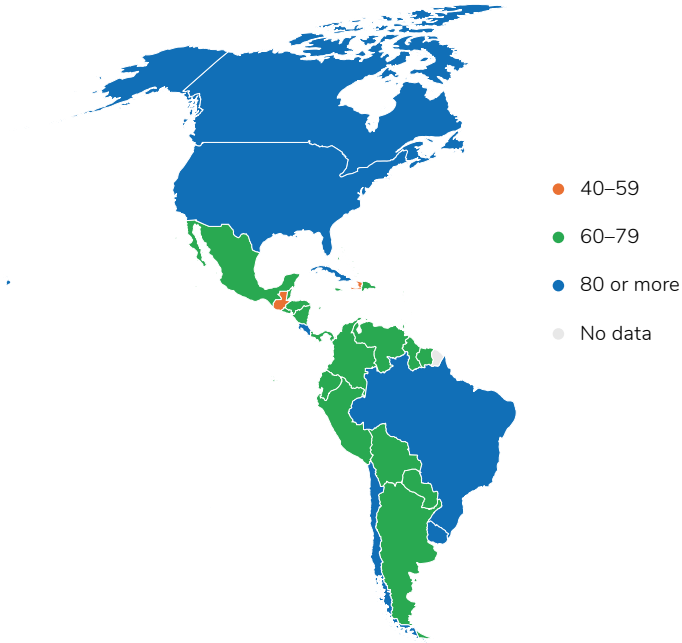
- A positive correlation exists between a country's income level, Human Development Index (HDI), and UHC SCI. High-income countries generally exhibit higher HDI ranks and UHC scores, while lower-middle-income countries cluster at the lower end of both indices.

- Significant inequalities based on income, education, and location are observed for the RMNCH composite coverage index. The lowest income quintile has median coverage of around 65%, while the highest income quintile has median coverage of about 80%.

2.1. Overall progress and a mixed landscape of achievements and challenges

The UHC SCI in the Americas has shown significant improvement over the past two decades, rising from 66 in 2000 to 80 in 2019. By 2021, overall coverage of essential health services reached 74%, one of the highest among the WHO Regions. However, the landscape of UHC in the Americas presented a mixed picture of achievement and ongoing challenges. A select group of countries, including Brazil, Canada, Chile, Costa Rica, Cuba, the United States, and Uruguay, achieved a UHC SCI of 80% or higher, representing 20% of the countries in the Region. Most nations, comprising 71% of the total, fell within the 60–79% range, indicating substantial progress but also room for improvement. Only three countries – Dominica, Guatemala, and Haiti – lagged behind with coverage levels between 40–59%, highlighting persistent disparities within the Region (Figure 8).

Figure 8. Service coverage index by country, 2021

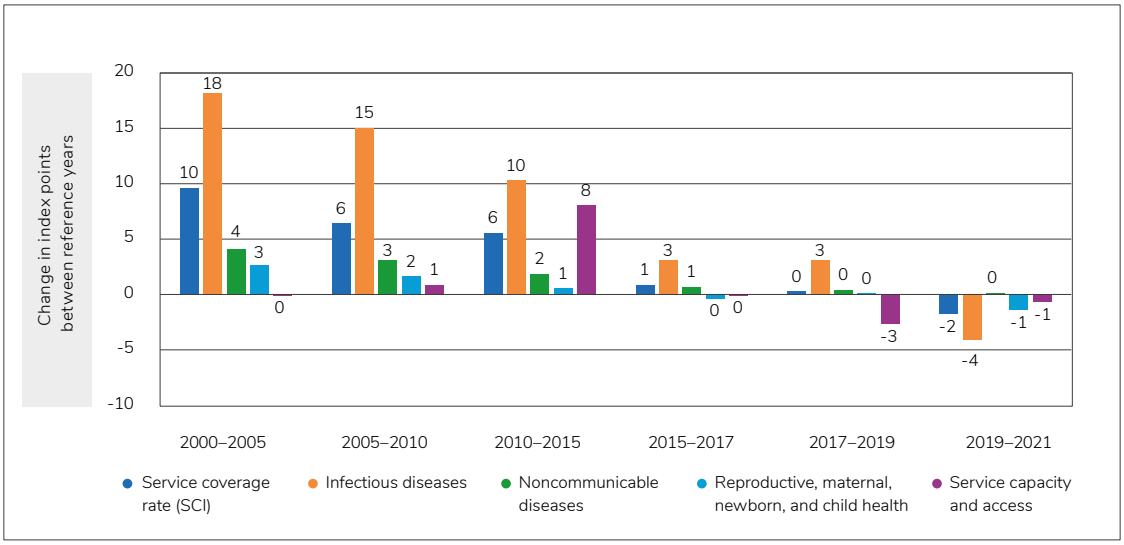


Note: The index is reported on a scale from 0 to 100 and the data are categorized into three index ranges: 40–59, 60–79, and 80 or more. The map includes countries from the Caribbean and Central, South, and North America.
Data source: World Health Organization. The Global Health Observatory UHC Service Coverage Index (SDG 3.8.1). Geneva: WHO; 2022.
Source: PAHO.

2.2. Trends over time and recent stagnation in coverage of essential health services

Examining the trends from 2000 to 2021 reveals a pattern of initial rapid growth followed by a deceleration and recent stagnation. The UHC SCI saw substantial improvements in the early years, with a 10-point increase from 2000 to 2005. However, the rate of improvement has steadily declined, with only a 6-point increase in each of the subsequent five-year periods from 2005 to 2015. The period from 2015 to 2017 saw a minimal 1-point increase, and, alarmingly, there was a 2-point decrease between 2019 and 2021. This recent negative trend is particularly evident in the infectious diseases subindex, which dropped from 76 in 2019 to 72 in 2021, potentially reflecting the challenges posed by the COVID-19 pandemic (Figure 9).

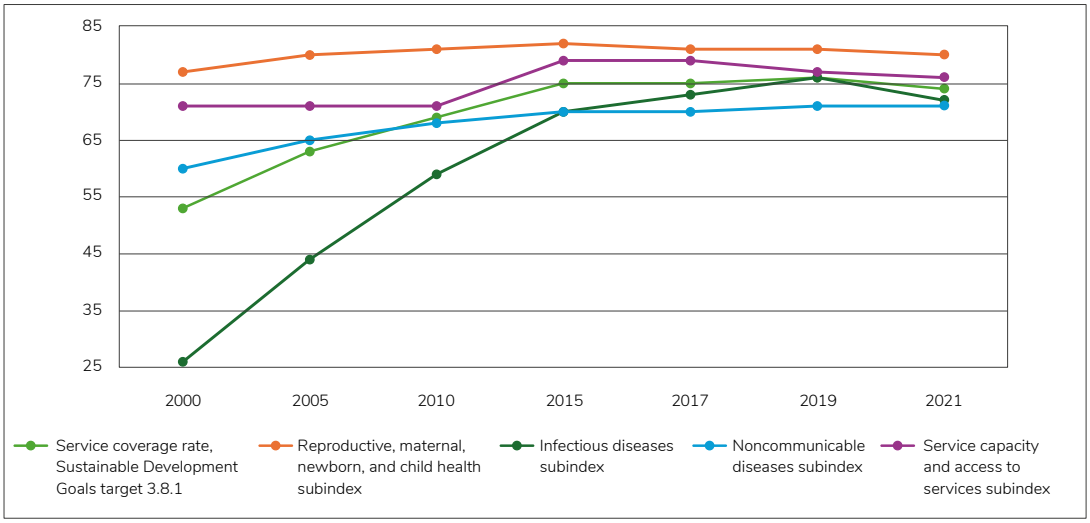
Figure 9. Changes in index points for service coverage and subindices, 2000–2021



Data source: World Health Organization. The Global Health Observatory UHC Service Coverage Index (SDG 3.8.1). Geneva: WHO; 2022.
Source: PAHO.

The analysis of subindices reveals both progress and areas requiring attention. By 2019, three subindices had surpassed the 80-point mark, indicating high coverage levels in RMNCH, infectious diseases, and service access and capacity. However, the NCD subindex, while showing gradual improvement until 2015, has since experienced a slowdown in progress (Figure 10). This trend is particularly concerning given the growing burden of NCDs in the Region. As people live longer with NCDs, they spend more time linked to the health system in order to receive the necessary care. It is becoming increasingly important for more targeted interventions to address this gap in coverage.

Figure 10. Trends in the service coverage subindices, 2000–2021

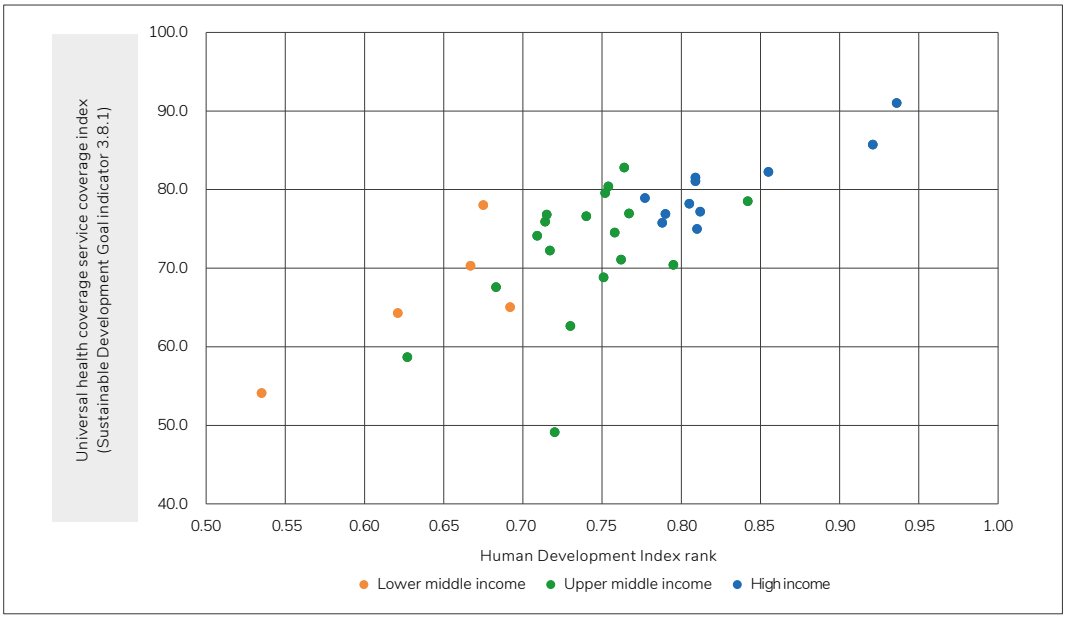


Data source: World Health Organization. The Global Health Observatory UHC Service Coverage Index (SDG 3.8.1). Geneva: WHO: 2022.
Source: PAHO.

2.3. Income and development: predictors of health service coverage

A notable correlation exists between a country's income level, HDI, and UHC SCI. High-income countries generally exhibit HDI ranks above 0.80 and UHC scores exceeding 80.0, demonstrating a strong positive relationship between high human development and comprehensive health service coverage. Upper-middle-income countries show more variability, with HDI ranks ranging from 0.65 to 0.85 and UHC scores between 60.0 and 90.0. Lower-middle-income countries cluster at the lower end of both indices, with HDI ranks between 0.55 and 0.75 and UHC scores from 50.0 to 75.0, reflecting the challenges these nations face in achieving UHC (Figure 11).

Figure 11. Correlation between universal health coverage service coverage index and Human Development Index by income group, 2021

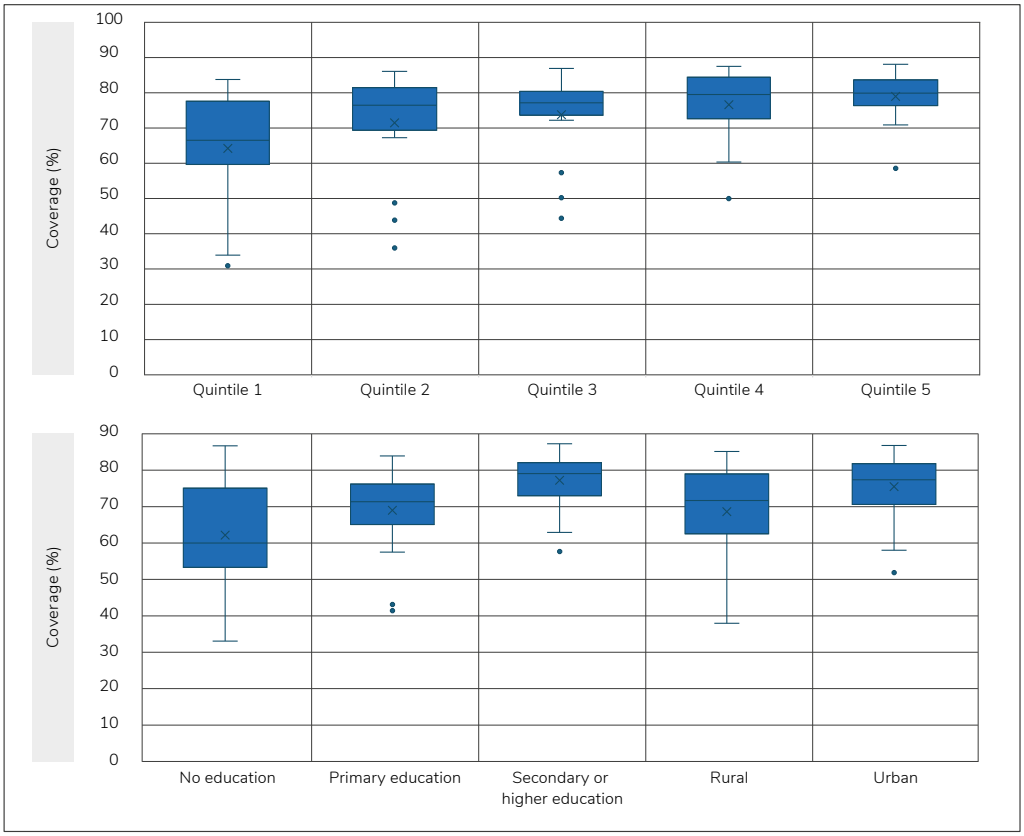


Data sources: World Health Organization. The Global Health Observatory. Geneva: WHO; 2022, and data from the Human Development Index of the United Nations Development Programme.
Source: PAHO.

2.4. Inequalities in service coverage

Despite the overall high coverage rates, significant inequalities persist within countries based on income, education, and location. The analysis of the RMNCH composite coverage index reveals stark disparities. Individuals in the lowest income quintile experience a wide range of coverage, with a median around 65% and notable outliers below 40%. In contrast, the highest income quintile enjoys a median coverage of about 80% with minimal outliers, indicating more consistent and higher-quality care for wealthier populations (Figure 12).

Figure 12. Composite coverage index for reproductive, maternal, newborn, and child health interventions by income quintile, education level, and rural/urban residence



Note: Dots are outliers.
Data source: World Health Organization. The Global Health Observatory. Geneva: WHO; 2022.
Source: PAHO.

Similar patterns emerge when examining education levels, with those who have secondary or higher education achieving the highest median coverage, near 80%, while those with no education face greater variability and lower overall coverage. The urban-rural divide further compounds these inequalities, with urban residents generally experiencing higher and more consistent coverage than their rural counterparts.

3

Financial protection (Sustainable Development Goal 3.8.2)

Key findings

- In 2019, between 1.5% and 7.8% of the population in the Americas faced catastrophic health expenses, affecting 15 million to 79 million people, depending on the income threshold used (25% or 10% of household income, respectively).

- Only some data points are available in the Region for 2020 and later. For instance, in 2020, 4.4% of Mexico's population reported catastrophic health expenses. In 2021, the Plurinational State of Bolivia, Peru, and the United States reported figures of 5.7%, 12.6%, and 4.6%, respectively, highlighting the varying impact of health costs across different regions and income levels.

- In 2000, an estimated 102 million people (12.3%) were pushed further into poverty, whereas in 2019 the estimate rose to 134 million people (13.3%). Meanwhile, those who were not poor and whose OOP health spending brought them below the relative poverty line amounted to 8 million in 2000 (0.9%) and reached 13 million in 2019 (1.2%).

- Households composed solely of older adults face higher catastrophic expenditures, while multigenerational households are more exposed to impoverishing expenditures. For example, in Costa Rica, 16.3% of older adult households faced catastrophic expenses, compared with 4.3% of younger households.

- Rural households consistently face greater exposure to impoverishing OOP health expenses than urban households. For example, in Peru, 48.9% of rural households experienced impoverishment due to health costs, compared with 13.1% of urban households.

- The higher the poverty rate in a country, the greater the impoverishing health expenditure of households, indicating a positive correlation between poverty and impoverishing health expenditure, although this would need to be studied further. Poorer countries are more likely to experience impoverishing health expenditure than richer countries.

OOP expenditure affects health systems' performance at various outcome levels. On one hand, it represents a significant economic barrier to accessing health services and reflects the most inequitable and inefficient health system-funding methods. In addition, this form of spending imposes excessive costs on individuals and households, and increases the risk of catastrophic expenditures and impoverishing when accessing health services (*20*). The inefficiency of OOP spending is evident in its tendency to cause people to delay or forgo needed health care. This delay often results in patients seeking care too late, when treatments become more expensive, or not seeking care at all, negatively impacting health outcomes. Moreover, this method of financing needs to be more equitable, as it disproportionately affects individuals who lack the means to afford the costs associated with accessing care at the point of service. Box 3 presents an in-depth analysis of the Region's current state of OOP spending, examining its implications and the ongoing efforts to address this critical aspect of health system financing.

Box 3. Out-of-pocket spending as a source of financing for health systems

Health systems across the Americas have historically exhibited a highly heterogeneous financing structure characterized by a combination of multiple sources. Box figure 3.1 shows that a significant component of this structure is direct expenditure by households at the point of care, which averaged 29.6% in 2021. The impact of direct household expenditure varies widely among countries. For instance, Grenada, Guatemala, and Honduras report figures exceeding 50% of current health expenditure, while Colombia, Jamaica, and the United States have managed to reduce this figure to below 14%. Notably, the low level of out-of-pocket (OOP) expenditure in the United States, at 10.7%, can be attributed to the effects of the insurance reform implemented in 2010, as it was previously one of the countries with the highest proportions of OOP expenses in the Region.[a,b] Cuba consistently stands out as the country with the lowest level of OOP expenditure in the Region, recorded at 8.9% in 2020.

This reliance on OOP spending occurs within a broader context where government-administered financing schemes are predominant, contributing an average of 40.1% to health system funding through general taxes, often referred to as noncontributory sources. In addition, contributory sources, typical of social insurance systems, account for approximately 20.4% of health financing, derived from deductions from the salaries of formal workers. While other sources of financing, such as mandatory and voluntary private schemes, represent a smaller percentage of overall health funding, they can play a significant role in certain countries, particularly when managing resources from mandatory social security systems.

The current situation reflects the transformation of health-financing systems. The constraints of the formal labor market, the low share of wages in gross domestic product, and job insecurity have led governments to invest a significant portion of tax revenue in health. As a result, the configuration of financing schemes has increasingly included government schemes funded through general taxes. Indeed, the analysis of each country confirms the high level of structural heterogeneity.[c,d]

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[a] Waters HR, Anderson GF, Mays J. Measuring financial protection in health in the United States. Health Policy. 2004;69(3):339–349. Available from: https://doi.org/10.1016/j.healthpol.2004.01.003.

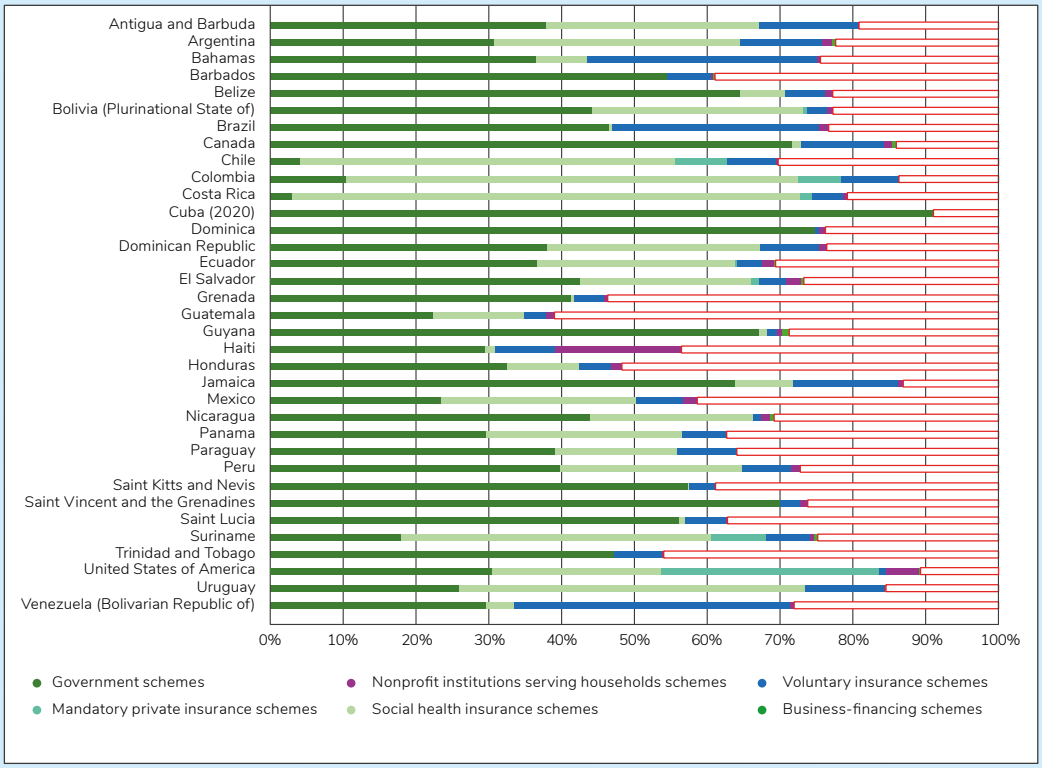
[b] Arrieta A. Seguro de salud y principio contributivo de la seguridad social en los Estados Unidos de América. Rev Latinoam Derecho Soc. 2016;23:3–30. Available from: https://doi.org/10.22201/iij.24487899e.2016.23.10415.

[c] Sojo A. Including informal economy workers in contributory social protection: Current challenges in Latin America. Int Soc Secur Rev. 2015;68(4):69–92. Available from: https://doi.org/10.1111/issr.12088.

[d] Behrendt C, Nguyen QA. Innovative approaches for ensuring universal social protection for the future of work. Geneva: International Labour Organization; 2018. Available from: https://metadataetc.org/gigontology/pdf/Behrendt%20and%20Nguyen%20-%20Innovative%20approaches%20for%20ensuring%20universal%20socia.pdf.

Box 3. Out-of-pocket spending as a source of financing for health systems *(continued)*

Box figure 3.1. Financing schemes for health systems (percentage share in current health expenditure), 2021

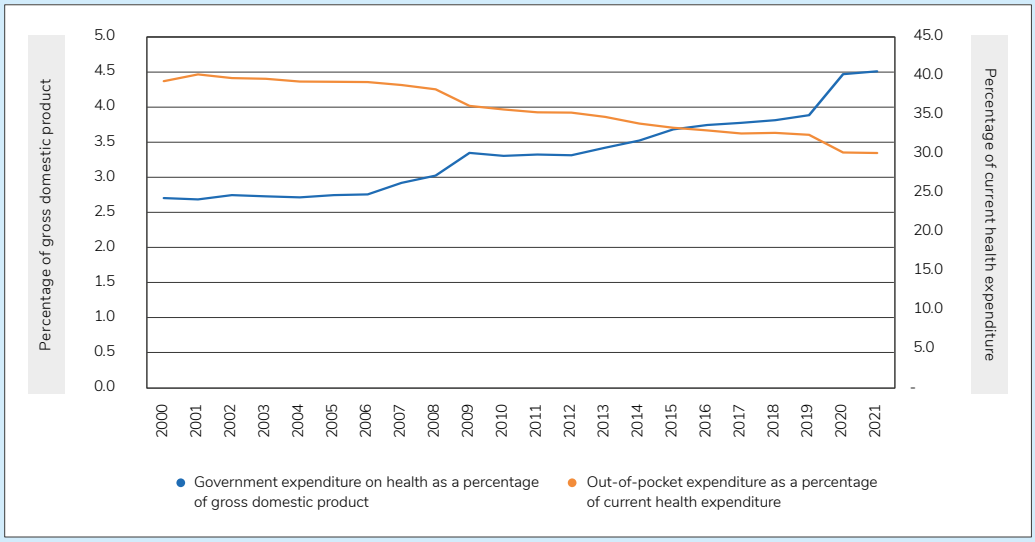


Data source: WHO Global Health Expenditure Database, 2023.

An aggregate analysis of the Region over time confirms some of these observations. Excluding Canada and the United States allows for a clearer reflection of the situation in Latin America and the Caribbean. Since the early 2000s, there has been a downward trend in OOP spending relative to current health expenditure, decreasing from 40.2% in 2001 to 30.1% in 2021 (Box figure 3.2). This trend has been accompanied by an upward trajectory in government spending from general taxes as a percentage of gross domestic product, rising from 2.7% in 2005 to 4.5% in 2020–2021. The notable spike in 2020, which remained consistent into 2021, is primarily attributed to extraordinary funds allocated by governments to combat the COVID-19 pandemic. As the response to the pandemic diminishes, the removal of extraordinary funds is expected to result in lower levels of spending; however, this may not necessarily impact the upward trend observed before the pandemic.

Box 3. Out-of-pocket spending as a source of financing for health systems *(continued)*

Box figure 3.2. Latin America and the Caribbean: trends in public and out-of-pocket health expenditure, 2000–2021



Data source: WHO Global Health Expenditure Database, 2023.
Source: PAHO.

Analysis of the composition of OOP expenditure for those countries where data are available shows that medicines stand out as the main driver, followed by outpatient visits (Box figure 3.3). This is mainly because medications are often not covered by institutional financial protection schemes; outpatient medications are frequently excluded, and, while hospital care may theoretically include them, coverage in practice is often limited to a few commonly used drugs. This issue is exacerbated by the evolving pharmacology of chronic and high-cost conditions, which, although infrequent, have a substantial financial impact on households.[e]

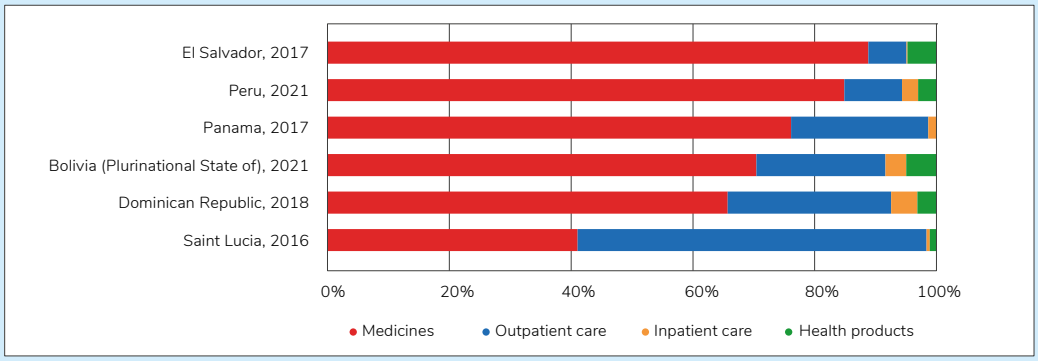
Although spending on hospital services represents a low percentage of OOP expenses, it is important to note that these services are used by a small portion of the population who typically have significant financial coverage. However, even if average OOP spending is lower, it can be highly burdensome for the few households that use these services and encounter coverage gaps. Therefore, a more detailed microeconomic analysis of these issues is required.[f]

[e] Sum G, Hone T, Atun R, Millett C, Suhrcke M, Mahal A, et al. Multimorbidity and out-of-pocket expenditure on medicines: a systematic review. BMJ Glob Health. 2018;3(1):e000505. Available from: https://gh.bmj.com/content/3/1/e000505.abstract.

[f] Wahlster P, Scahill S, Lu CY, Babar Z. Barriers to access and use of high-cost medicines: a review. Health Policy Technol. 2015;4(3):191–214. Available from: https://www.sciencedirect.com/science/article/pii/S2211883715000465.

Box 3. Out-of-pocket spending as a source of financing for health systems *(continued)*

Box figure 3.3. Average composition of households' out-of-pocket health spending, available estimates



Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

3.1. Catastrophic and impoverishing out-of-pocket health spending

This section presents an analysis of the situation in catastrophic OOP health spending, utilizing thresholds of 10% and 25% of household income as defined by SDG indicator 3.8.2, as well as impoverishing OOP spending. The Region of the Americas faced challenges in data collection due to the suspension of household surveys during the pandemic. This has affected the availability of up-to-date and accurate data. Despite these challenges, the 2019 data serve as a critical benchmark for understanding prepandemic trends.

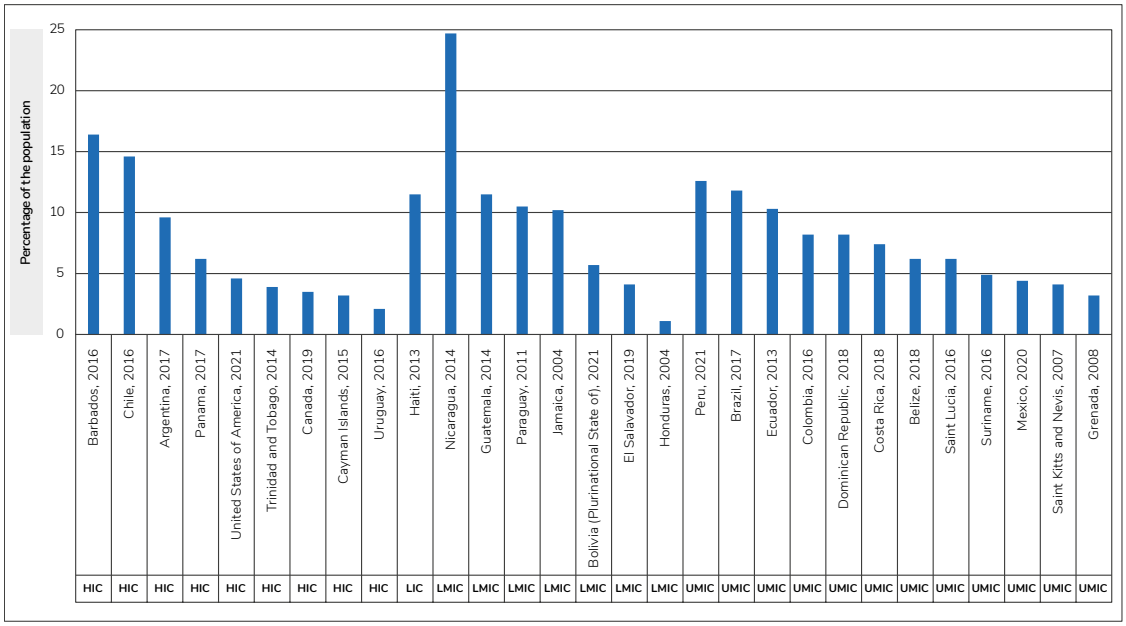
In 2019, between 1.5% and 7.8% of the population experienced catastrophic health expenses, affecting between 15 million and 79 million people, depending on the threshold (25% or 10% of household income, respectively) considered. From 2000 to 2010, the incidence of catastrophic spending at the 10% threshold remained stable at approximately 8.3%, even as service coverage expanded. By 2017, this figure had decreased to 7.4%, but between 2017 and 2019 it rose again to 7.8%, indicating a concerning trend of increasing financial burden on households (14).

At the country level, updated data from 2020 and 2021 provide a more detailed picture (using the 10% threshold). In Mexico, 4.4% of the population reported catastrophic health-related expenses in 2020.

For 2021, the Plurinational State of Bolivia, Peru, and the United States reported that 5.7%, 12.6%, and 4.6% of their populations, respectively, faced catastrophic health expenses. These figures highlight the varying impact of health costs across different income levels and regions (Figure 13).

Considering the available data in the Region from 2004 to 2021, the lowest level of catastrophic spending was recorded in Honduras at 1.1% (2004), comparable only to Uruguay at 2.1% (2016). In contrast, the highest level was recorded in Nicaragua at 24.7% (2014), followed by Barbados at 16.4% (2016).

Figure 13. Incidence of catastrophic out-of-pocket health spending as tracked by SDG indicator 3.8.2 at the 10% threshold, most recent year, 2004–2021

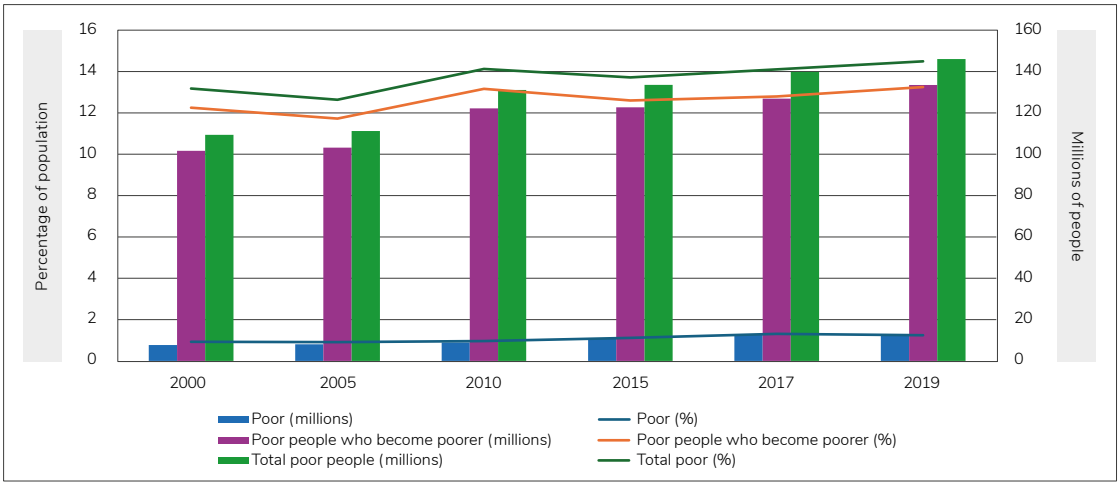


Notes: HIC, high-income country; LIC, low-income country; LMIC, lower-middle-income country; UMIC, upper-middle-income country.
Data source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.
Source: PAHO.

Households' spending on health, when financial protection conditions are insufficient, can lead them into poverty. In 2000, it is estimated, 109 million people (13.2%) in the Region of the Americas fell into poverty for health reasons or worsened their situation even further (using the relative poverty line). By 2019, this figure increased to 146 million people (14.5%), becoming one of the most important concerns in terms of financial protection.

Breaking down these numbers shows that most of them correspond to people who were already poor and whose OOP health spending ended up worsening their situation. In 2000, an estimated 102 million people (12.3%) were in this situation, and in 2019 the estimate rose to 134 million people (13.3%). Meanwhile, those who were not poor and whose OOP health spending brought them below the relative poverty line amounted to 8 million in 2000 (0.9%) and reached 13 million in 2019 (1.2%) *(14)* (Figure 14).

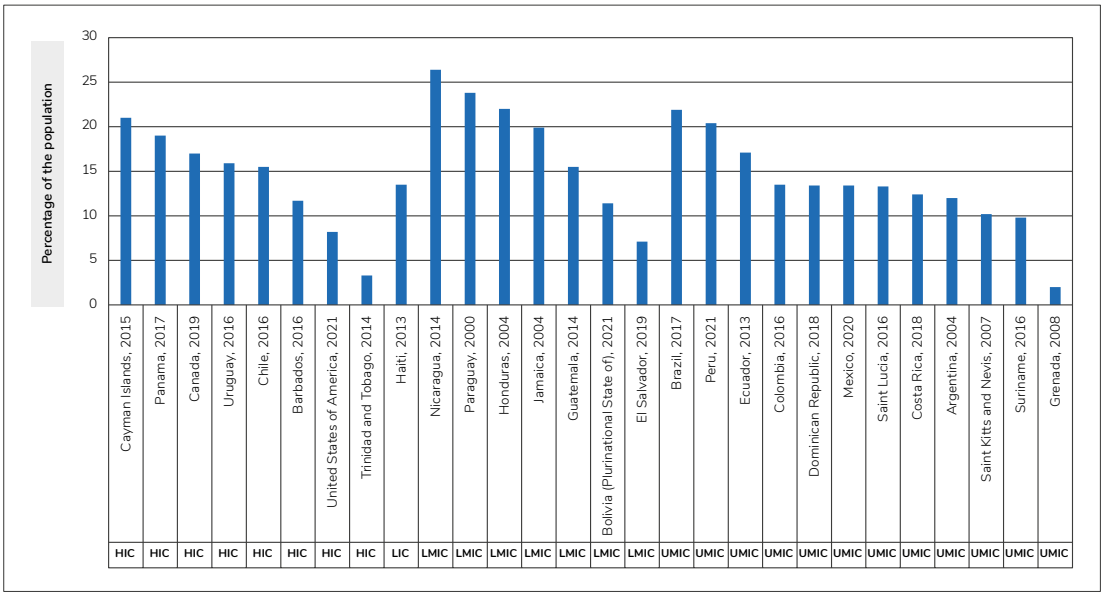
Figure 14. Change in population impoverished by out-of-pocket health expenditure in the Americas (% of the population in the Region and millions of people)



Data source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.
Source: PAHO.

Data at the country level provide further insights into the regional situation. The lowest level is recorded in Grenada at 2.0% (2008), comparable only to Trinidad and Tobago at 3.3% (2014). In Mexico, an upper-middle-income country, 13.4% of the population fell into poverty due to health expenses in 2020. In 2021, the Plurinational State of Bolivia (lower-middle income), Peru (upper-middle income), and the United States (high-income) recorded that 11.4%, 20.4%, and 8.2% of their populations, respectively, fell into or further into poverty for health reasons (Figure 15). On the other end, Nicaragua has the highest level at 26.4% (2014), followed by Paraguay at 23.8% (2000).

Figure 15. Incidence of impoverishing out-of-pocket health spending at the relative poverty line, most recent year, 2000–2021



Notes: HIC, high-income country; LIC, low-income country; LMIC, lower-middle-income country; UMIC, upper-middle-income country.
Data source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.
Source: PAHO.

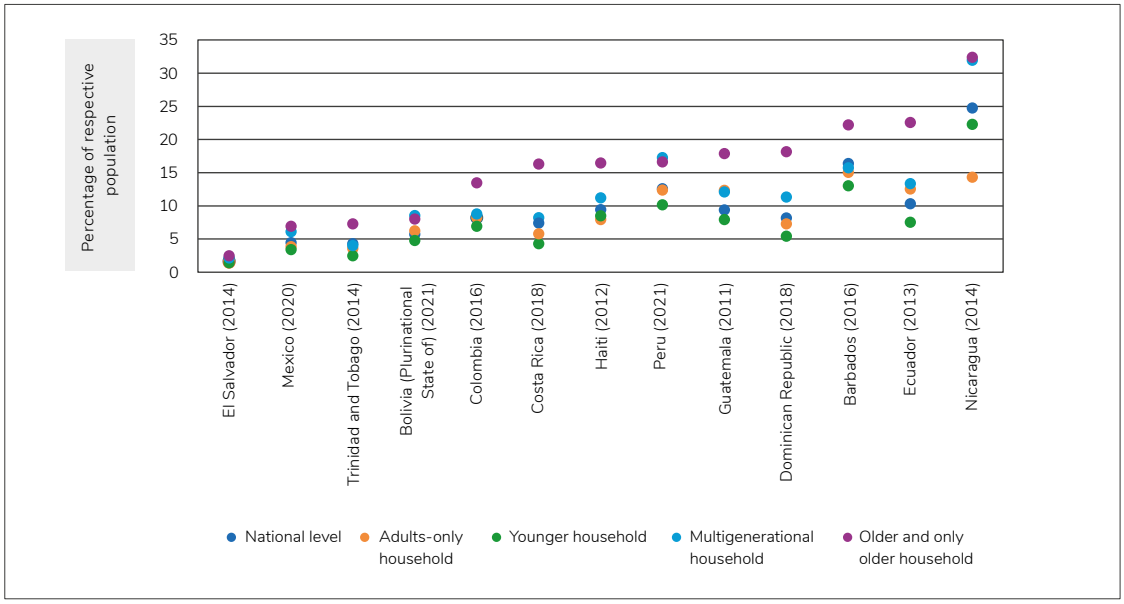
3.2. Household age composition and its impact on catastrophic and impoverishing health expenditures

Various determinants can explain both catastrophic and impoverishing OOP health spending. Those that can be analyzed based on household surveys allow for a detailed disaggregation of the indicators.

The age composition of households shows that those with only older adults face higher catastrophic expenditure, while those composed of young individuals are at the opposite end. For instance, Costa Rica (2018) presents a significant difference between the two categories, registering 16.3% in households with only older adults compared with 4.3% in households with young people. In the Dominican Republic, households composed only of older adults record an 18.1% rate, while households with young people have a 5.4% rate (Figure 16).

Two relevant factors are observed here. On one hand, older adults generally have greater healthcare expenses to bear. At the same time, a significant proportion experience substantial reductions in income due to the end of their working lives and the challenges faced by pension systems. The latter is particularly true in the case of women, who also live longer and suffer more chronic diseases (longer life expectancy while living with poor health) (21). In contrast, young people generally have lower healthcare expenses, and increasingly remain dependent on their parents for longer than they did a few decades ago (22–24).

Figure 16. Incidence of catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), by age structure of the household, most recent year



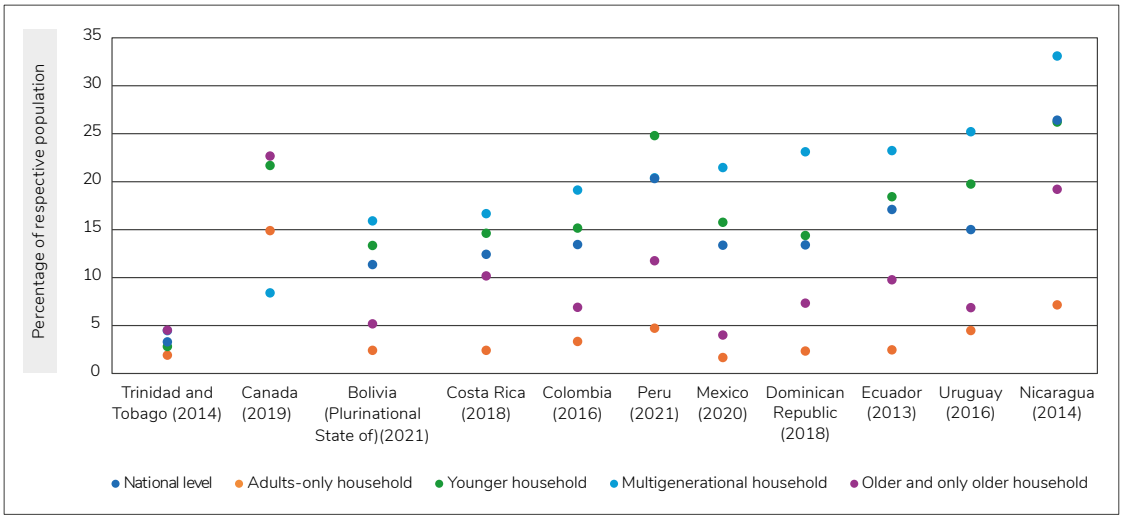
Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

However, the behavior of impoverishing expenditure is different. Households composed of individuals of different ages (multigenerational) are more exposed to impoverishment due to OOP health spending, while those formed of adults are in the opposite situation. In Mexico (2020), there is a notable difference, with 21.5% of multigenerational households facing impoverishment, compared with only 1.7% of households composed solely of adults. A similar situation occurs in the Dominican Republic, where 23.1% of multigenerational households face impoverishment, while just 2.3% of those composed only of adults do (Figure 17).

One explanation for this is that multigenerational households are composed of individuals who, in addition to their economic supporters (adults), may include children and older adults. These groups, which bear high healthcare needs, either do not generate income or, in the case of older adults, generate

limited income. This makes such households more vulnerable to impoverishment for health reasons. In contrast, households composed only of adults are at the opposite end of the spectrum, meaning they generate higher labor income, making them less exposed to health-related impoverishment. It is noteworthy that households composed solely of older adults are not more exposed to health-related impoverishment. On the other hand, many poor people live together precisely to try to improve their situation of poverty. Another case is that of caregivers, who often move in together with someone who needs long-term care, which also implies more costs and healthcare needs. In addition, health systems have developed more targeted financial protection policies for this segment of the population than for multigenerational households (25). There is an important debate regarding the methods for measuring impoverishing spending, as the conclusions can lead to differences in policy design (26).

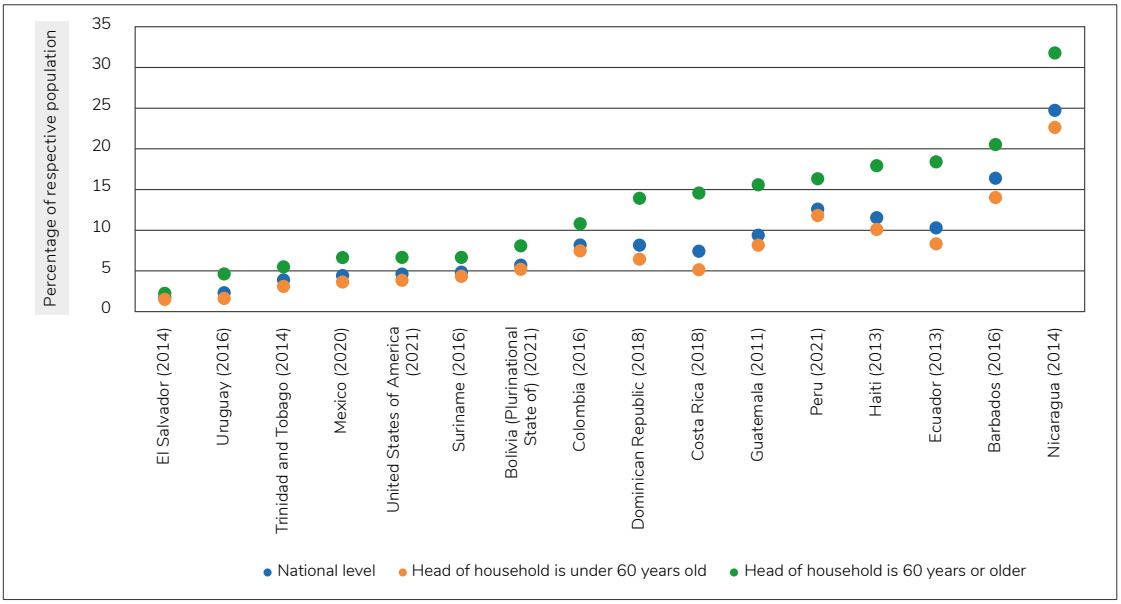
Figure 17. Incidence of impoverishing out-of-pocket health spending (impoverished and further impoverished) at the relative poverty line, by age structure of the household, most recent year



Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

The age of the head of the household also influences financial vulnerability, in a different manner. For instance, in Uruguay (2016), households with heads over 60 years old faced more catastrophic expenses, with 4.6% affected, compared with 1.6% in households with younger heads. A similar situation occurs in Costa Rica (2018), where 14.6% of households with heads over 60 years old were affected, compared with 5.1% of other households (Figure 18). However, impoverishing expenses showed no clear pattern based on the age of the household head (Figure 19). These results are consistent with previous findings, as many households headed by older adults (over 60 years old) are often composed solely of older adults, including single-person households. This reaffirms the extreme exposure of older adults to catastrophic health expenses, which remains a major concern for public policies and health systems in terms of financial protection, and to create health services responsive to older adults' needs (27–29).

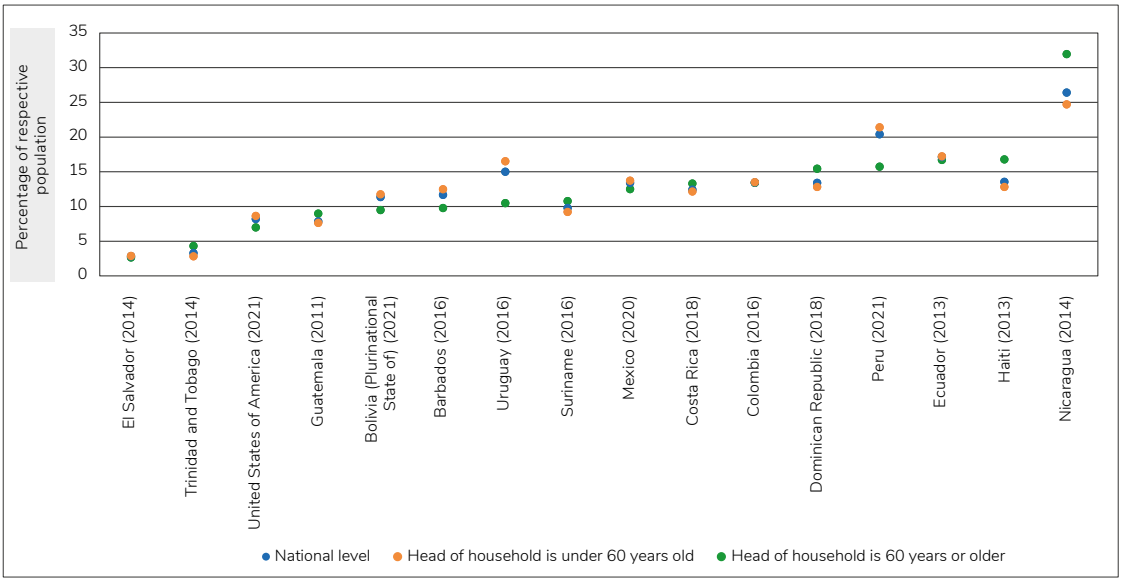
Figure 18. Incidence of catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), by age of the head of the household, most recent year



Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

Similarly, it is confirmed that impoverishing health expenditures do not significantly affect older adults who are heads of households compared with other household structures. It is crucial to highlight the causes of this difference between catastrophic and impoverishing health expenditures to improve the design of financial protection policies.

Figure 19. Incidence of impoverishing out-of-pocket health spending (impoverished and further impoverished) at the relative poverty line, by age of the head of the household, most recent year

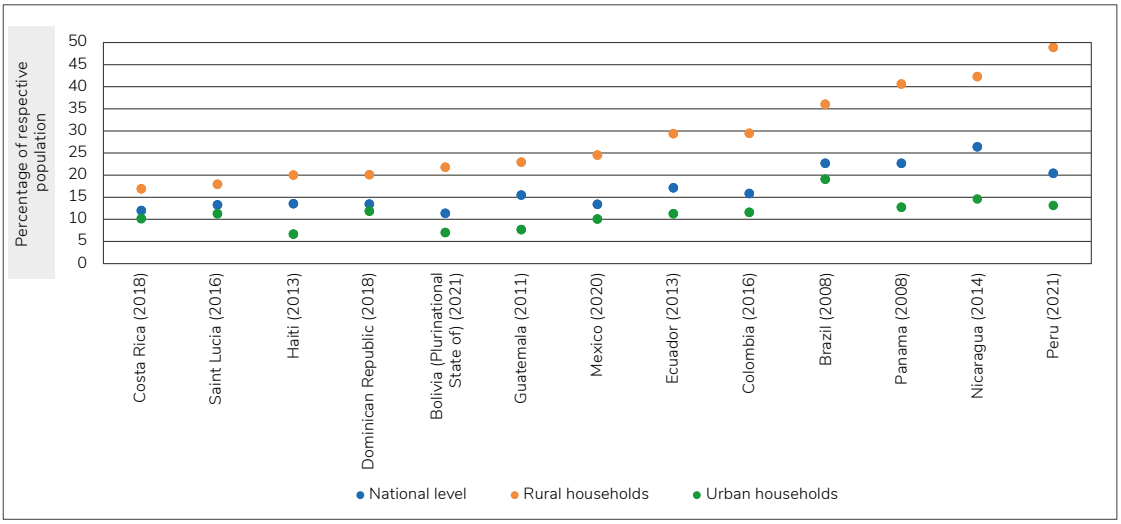


Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

3.3. Disparities in impoverishing health expenses between urban and rural households

Rural households consistently face greater exposure to impoverishing OOP health expenses than their urban counterparts, even though there are no significant differences between the two in terms of catastrophic health expenditure (Figures 20 and 21). In Peru, for instance, 48.9% of rural households experienced impoverishment due to health costs, whereas only 13.1% of urban households were similarly affected. Another relevant case is Panama, where 40.6% of rural households recorded impoverishment, compared with 12.7% in urban households (Figure 20). This disparity highlights the urgent need for targeted interventions in rural areas to mitigate financial hardship and improve access to affordable health services. As observed, in almost all countries in the sample, the differences are quite evident.

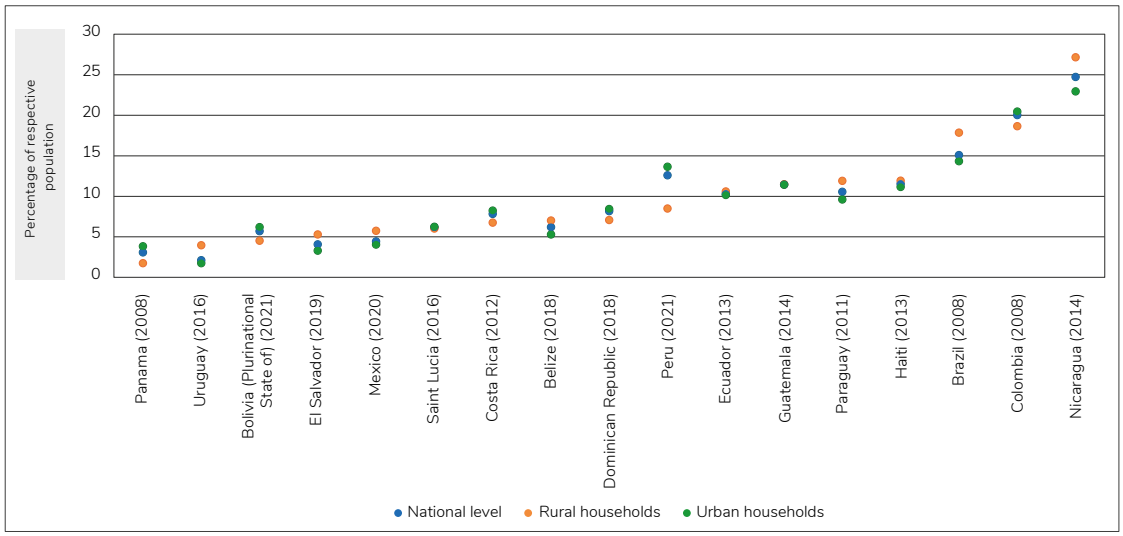
Figure 20. Incidence of impoverishing out-of-pocket health spending (impoverished and further impoverished) at the relative poverty line, by area of residence (rural/urban), most recent year



Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

Disparities in the impacts of impoverishing and catastrophic health expenditures between urban and rural areas have long been a concern, affecting household consumption, well-being, and poverty. Poor households, especially in rural areas, often use coping strategies such as savings, loans, and asset sales to finance health care, rather than relying on current income. These methods cover a significant portion of hospital costs in both rural (three-quarters) and urban (two-thirds) settings, leading many households to prioritize health expenses over future consumption. These dynamics underscore the connection between health spending, consumption, and poverty, with notable differences between urban and rural households (*30*).

Figure 21. Incidence of catastrophic out-of-pocket health spending (SDG 3.8.2, 10% threshold), by residence area, most recent year



Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

3.4. Catastrophic and impoverishing health expenditure: relationships with out-of-pocket spending and the poverty rate

The analysis of available data does not demonstrate a clear correlation between catastrophic OOP health expenditure and the proportion of total household expenditure dedicated to health costs, as measured by private final consumption (Figure 22). This lack of correlation suggests that catastrophic health spending does not directly align with the overall share of household budgets spent on health.

Examining specific cases provides useful insights. Haiti, the only low-income country in the sample, records the lowest OOP spending. Yet its catastrophic spending is significant (11.5%), comparable to those of Brazil (11.8%) and Guatemala (11.5%), which have much higher OOP spending. In Haiti, any health expenditure becomes catastrophic, possibly due to a health system with major weaknesses in financial coverage.

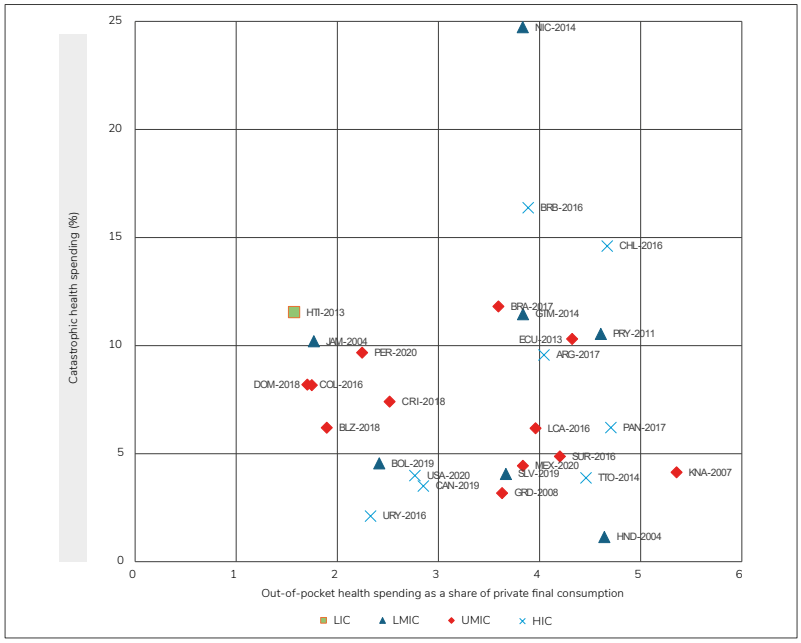
Lower-middle-income countries exhibit varied behaviors. Jamaica (1.8%) and the Plurinational State of Bolivia (2.4%) have low OOP spending, but Jamaica's catastrophic spending is higher than the

Plurinational State of Bolivia's (10.2% versus 4.6%). Conversely, among countries with higher OOP spending, Honduras (4.6%) and Paraguay (4.6%) show different levels of catastrophic spending. Honduras has the lowest catastrophic OOP spending in the sample (1.1%), while Paraguay has the highest (10.5%). Nicaragua stands out with the highest catastrophic spending (24.7%), although its OOP spending is not as high as in the other cases (3.8%).

A similar pattern is observed among upper-middle-income countries. Colombia and the Dominican Republic have low OOP spending (1.7% and 1.8%, respectively) and catastrophic spending of 8.2%. In contrast, Saint Kitts and Nevis, which has the highest OOP spending in the sample (5.4%), has relatively low catastrophic spending (4.1%). Chile and Panama have similar OOP spending levels (4.7%), but their catastrophic spending rates differ significantly (6.2% and 14.6%, respectively).

The interpretation of these findings is complex due to several factors. Countries with varying per capita income levels have different health systems and financial coverage, which affects OOP spending. In addition, high or low OOP spending does not necessarily predict catastrophic spending. Finally, low OOP spending and catastrophic spending do not automatically indicate better utilization and access, as other barriers may be present.

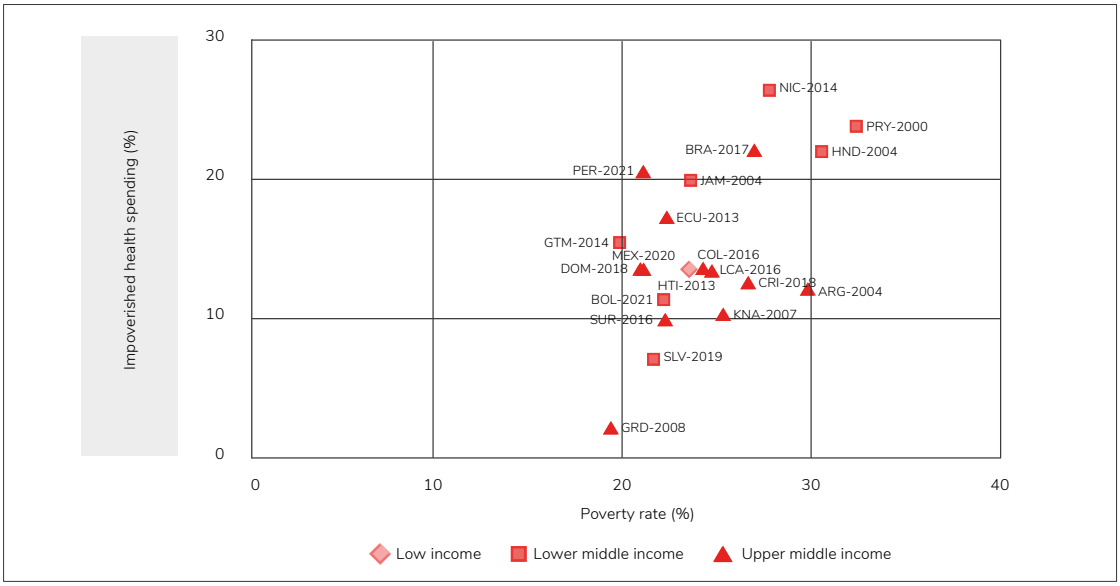
Figure 22. Incidence of catastrophic health spending as tracked by SDG 3.8.2, 10% threshold versus out-of-pocket health spending as a share of private final consumption



Note: ARG, Argentina; BOL, Bolivia (Plurinational State of); BLZ, Belize; BRA, Brazil; BRB, Barbados; CAN, Canada; CHL, Chile; COL, Colombia; CRI, Costa Rica; ECU, Ecuador; DOM, Dominican Republic; GRD, Grenada; GTM, Guatemala; HND, Honduras; HTI, Haiti; JAM, Jamaica; KNA, Saint Kitts and Nevis; LCA, Saint Lucia; MEX, Mexico; NIC, Nicaragua; PAN, Panama; PER, Peru; PRY, Paraguay; SLV, El Salvador; SUR, Suriname; TTO, Trinidad and Tobago; URY, Uruguay; USA, United States of America.
Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.

Instead, there is a clear relationship between higher proportions of impoverishing health spending and higher poverty rates in a country (Figure 23). This pattern indicates that, as households spend more on health to the point of becoming impoverished, the overall poverty rate tends to be higher. This observation suggests a possible causal relationship, whereby higher levels of impoverishing health spending contribute to higher poverty levels. Understanding this dynamic is crucial for policymakers seeking to address financial protection in health care and reduce the economic burden on vulnerable populations.

Figure 23. Incidence of impoverishing health spending versus poverty headcount rates, both at the relative poverty line



Note: ARG, Argentina; BOL, Bolivia (Plurinational State of); BRA, Brazil; COL, Colombia; CRI, Costa Rica; ECU, Ecuador; DOM, Dominican Republic; GRD, Grenada; GTM, Guatemala; HND, Honduras; HTI, Haiti; JAM, Jamaica; KNA, Saint Kitts and Nevis; LCA, Saint Lucia; MEX, Mexico; NIC, Nicaragua; PER, Peru; PRY, Paraguay; SLV, El Salvador; SUR, Suriname.
Source: WHO, based on data from the global database on financial protection assembled by WHO and the World Bank, 2023 update.


PERÚ
Ministerio de Salud
Vacuna

4

The interplay of unmet healthcare needs, coverage of essential health services, and financial protection

Key messages

- Unmet healthcare needs arise when individuals perceive a need for health services but do not receive them. Socioeconomic disparities and systemic barriers significantly contribute to unmet needs, with low-income individuals often experiencing higher unmet healthcare needs.

- The HDI is strongly correlated with unmet healthcare needs, indicating that higher human development levels are associated with fewer unmet needs. High-income countries with HDIs above 0.85 typically show unmet needs below 20%, while lower-middle-income countries with HDIs between 0.6 and 0.75 often have unmet needs exceeding 30%.

- Both financial and nonfinancial barriers prevent individuals from accessing necessary health services. Financial barriers include treatment costs and lack of insurance, while nonfinancial barriers encompass transportation issues, time constraints, and negative experiences with healthcare providers. These barriers persist even in countries with the highest levels of coverage, highlighting that access is not solely dependent on financial factors.

- There is a 53% correlation between unmet healthcare needs and avoidable mortality rates. Countries with unmet needs below 20% typically have mortality rates under 200 per 100 000 inhabitants, while those with unmet needs above 40% often exceed 300 per 100 000 inhabitants.

- While coverage of services is intended to reduce unmet needs, gaps in coverage remain, particularly among vulnerable populations. The UHC SCI shows regional disparities, with unmet needs more prevalent in areas with lower service coverage.

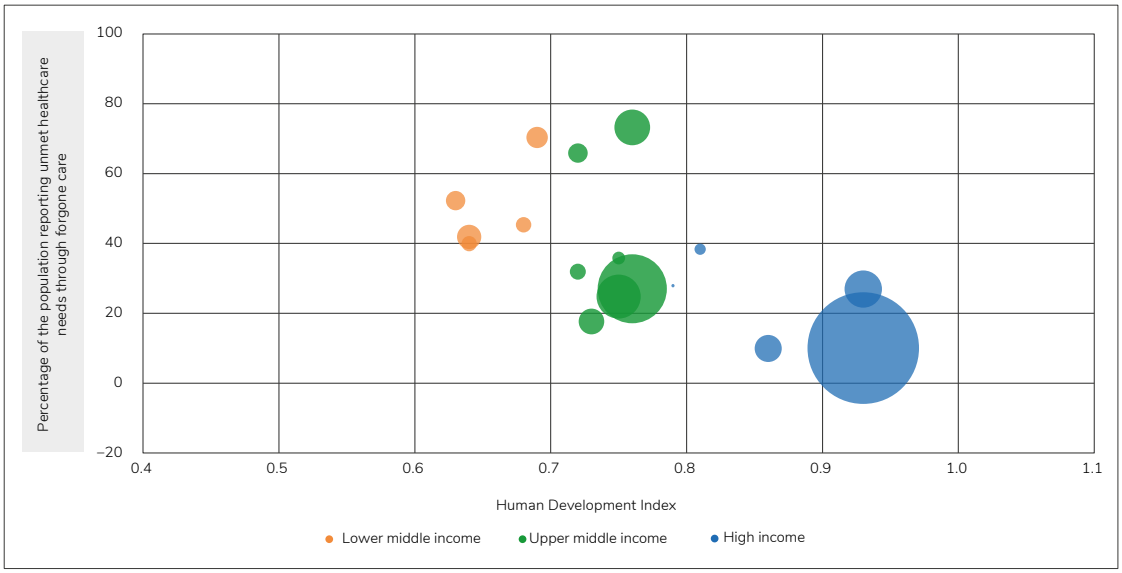
- High OOP expenses occur when individuals lack adequate insurance coverage, leading to financial hardship. OOP health spending varies by income level, with lower-middle-income countries experiencing a range from 1.8% to 4.6% of total household expenditure. Despite appearing low on average, these expenditures are highly concentrated among the lowest consumption quintiles, significantly impacting their economic situation.

- Catastrophic and impoverishing health expenditures are disproportionately borne by a small number of households, often leading to increased poverty rates. This highlights the financial vulnerability of households facing high healthcare costs and the need for improved financial protection mechanisms.

The relationship between unmet healthcare needs, coverage of essential health services, and catastrophic OOP health spending is multifaceted and interdependent. Unmet healthcare needs occur when individuals perceive a need for health services but do not receive them *(18, 31)*. This issue is exacerbated by socioeconomic disparities, with low-income individuals often experiencing higher levels of unmet healthcare needs than those with higher incomes (Figure 5). Socioeconomic disparities, persistent inequalities, and systemic barriers contribute significantly to these unmet needs. The HDI,

which measures a country's average achievements in health, education, and income, correlates strongly with unmet healthcare needs in the Region. High-income countries typically have an HDI above 0.85 and unmet needs below 20%. Upper-middle-income countries show HDI values between 0.65 and 0.85, with unmet needs ranging from 20% to 70%. Lower-middle-income countries have HDI values between 0.6 and 0.75, with unmet needs often exceeding 30%. As HDI increases, the percentage of unmet healthcare needs decreases, underscoring the importance of human development in improving access (Figure 24).

Figure 24. Relationship between the Human Development Index and unmet healthcare needs, latest available year

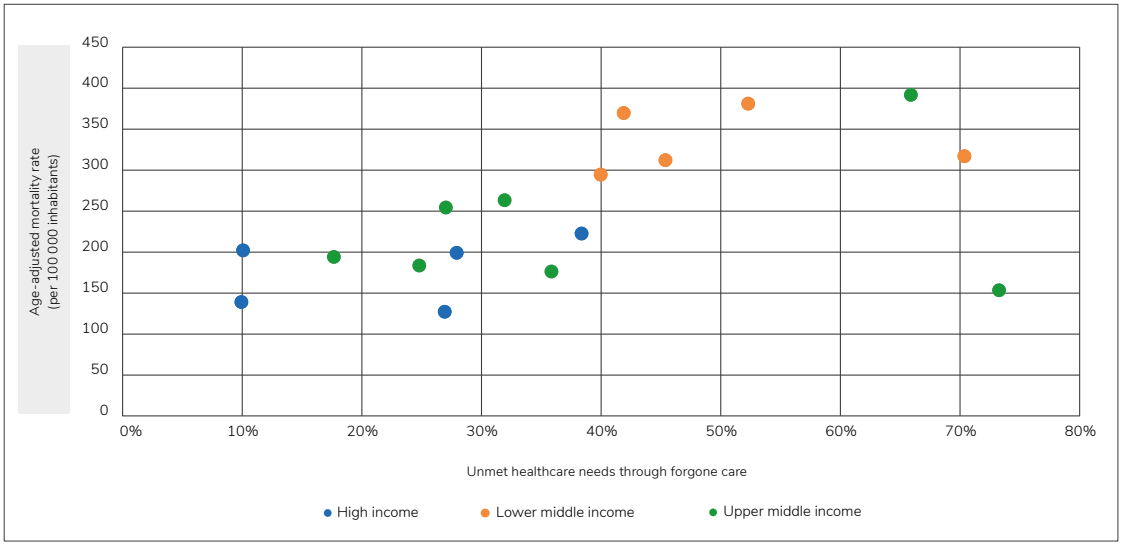


Note: Size of circle relates to population (number of inhabitants).
Data sources: Household surveys on living and health conditions, and Human Development Index data from the United Nations Development Programme.
Source: PAHO.

Unmet healthcare needs are frequently the result of barriers to access, which can be both financial and nonfinancial. Financial barriers include the cost of treatment and lack of insurance coverage. Nonfinancial barriers, such as transportation difficulties, time constraints, communication challenges, differing health beliefs, lack of trust, and negative experiences with healthcare providers, also play a significant role (Figures 5 and 6) (*18*, *32*, *33*). These nonfinancial barriers persist even in countries with universal health systems, indicating that access is not solely dependent on financial factors. For example, in Colombia and Peru, organizational, availability, and acceptability issues are significant nonfinancial barriers, even with universal coverage (Box 3) (*18*, *33*).

Access barriers can prevent individuals from receiving necessary health services, leading to worsening health conditions and potentially higher healthcare costs in the future. Data from the Americas illustrate a 53% correlation between unmet healthcare needs and avoidable mortality rates, with countries that exhibit higher unmet needs often experiencing higher mortality rates. Countries with less than 20% unmet needs typically have mortality rates below 200 per 100 000 inhabitants. In contrast, countries with over 40% unmet needs often have mortality rates exceeding 300 per 100 000 inhabitants (Figure 25). This suggests that addressing both financial and nonfinancial barriers is crucial for improving health outcomes.

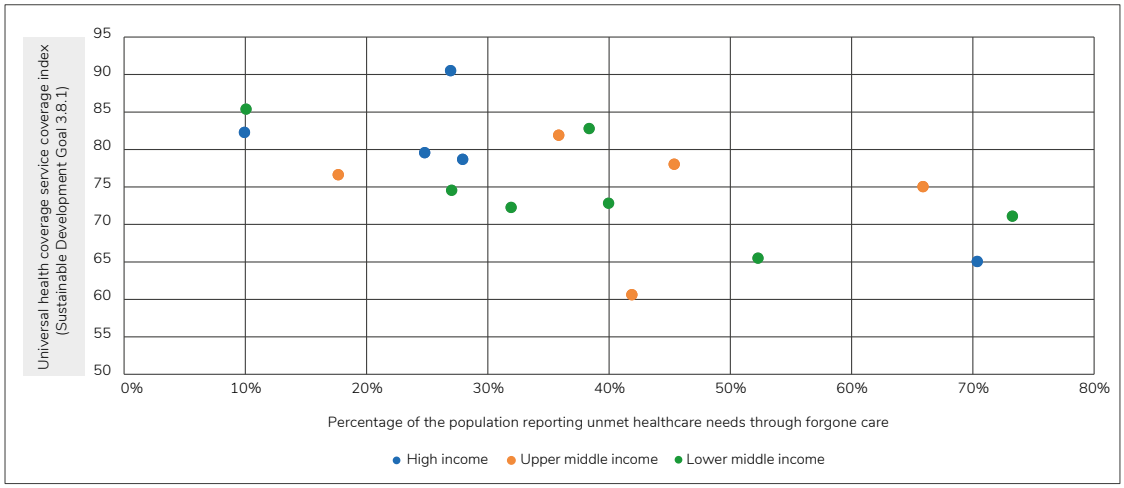
Figure 25. Relationship between unmet healthcare needs and avoidable mortality, Region of the Americas, latest available year



Data sources: Compiled from household surveys on living and health conditions, and Pan American Health Organization. Health in the Americas: Visualizations. Washington, D.C.: PAHO; 2021. Available from: https://hia.paho.org/en/potentially-avoidable-premature-mortality-visualizations.
Source: PAHO.

Coverage of essential health services is intended to reduce unmet healthcare needs by ensuring access to necessary care. However, gaps in coverage can lead to unmet needs, particularly among populations in situations of vulnerability, such as older people or those with chronic conditions (*34*). The UHC SCI (SDG indicator 3.8.1) highlights regional disparities in coverage, with unmet healthcare needs being more prevalent in areas with lower service coverage (Figure 26).

Figure 26. Relationship between unmet healthcare needs and universal health coverage service coverage index (SDG 3.8.1), Region of the Americas, latest available year



Data sources: Data in unmet healthcare needs estimated from household surveys on living and health conditions. World Health Organization. The Global Health Observatory UHC Service Coverage Index (SGD 3.8.1). Geneva: WHO; 2022.
Source: PAHO.

When individuals do seek care, they may face high OOP expenses, especially if they lack adequate health insurance or coverage for essential services. This financial burden, whether paid directly and in full for services not covered by insurance or through copayments and deductibles, can often become a barrier to accessing health care. When households manage to overcome these financial barriers, they may still face expenses that are difficult to cover without sacrificing other essential goods and services, leading to catastrophic expenditure and severely impacting their economic situation. In some cases, households are unable to overcome these economic barriers and simply forgo accessing services, resulting in unmet healthcare needs.

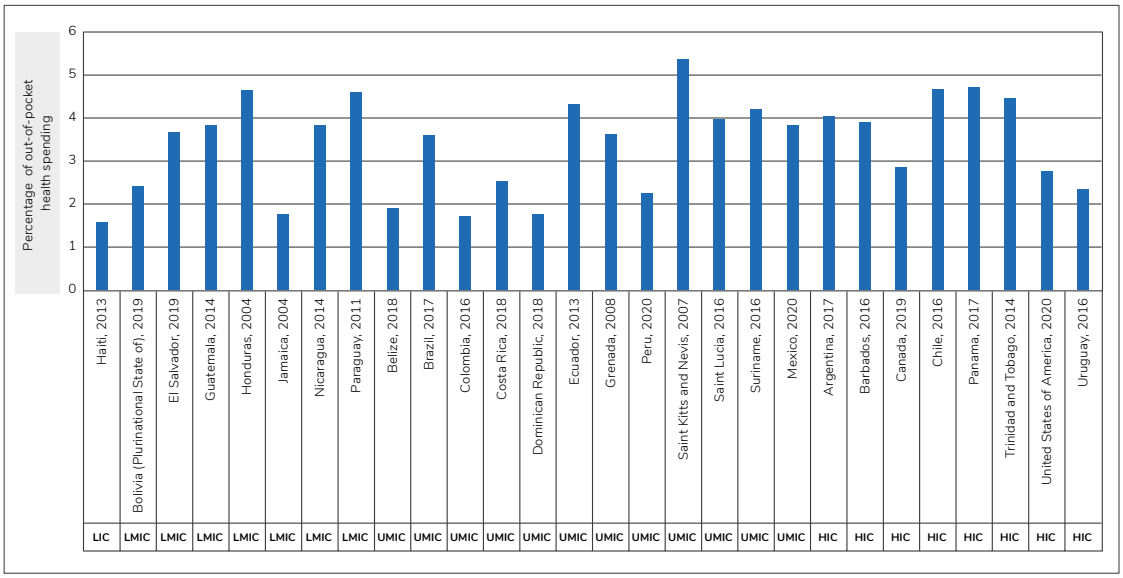
Coverage of essential health services plays a crucial role in mitigating catastrophic OOP spending. When such services are covered, individuals are less likely to face high OOP costs that could lead to financial hardship or impoverishment. Conversely, inadequate coverage forces individuals to pay for services themselves, increasing the risk of catastrophic spending. This occurs when individuals incur OOP costs that are disproportionately high relative to their income, deterring them from seeking needed care and contributing to unmet healthcare needs.

An analysis of OOP health spending as a share of private final consumption, based on available household survey data, reveals that OOP health expenditures typically represent a relatively small portion of total household expenditure, ranging from 1.6% to 5.4% (as shown in Figure 27). In lower-middle-income countries, the share of OOP spending as a percentage of total household expenditure ranges from

1.8% to 4.6%. In contrast, upper-middle-income countries show a range from 1.7% to 5.4%, while high-income countries exhibit a range from 2.3% to 4.7% (Figure 26). These variations suggest that there is no straightforward relationship between a country's income level and its OOP spending.

However, these averages can be misleading, as they only reflect the overall level of household spending within a country over a calendar year. A notable characteristic of health expenditure at the household level is its uneven distribution; a small number of households bear a disproportionately high share of these costs. This concentration can obscure the reality faced by certain groups within each country who are burdened with catastrophic and impoverishing health expenditures, making their financial struggles less visible in aggregate data.

Figure 27. Out-of-pocket health spending as a share of private final consumption



Notes: HIC, high-income country; LIC, low-income country; LMIC, lower-middle-income country; UMIC, upper-middle-income country.
Source: World Health Organization. Global Health Expenditure Database. Geneva: WHO; 2023. Available from: https://apps.who.int/nha/database.

Interpreting these figures is challenging because OOP spending depends on various factors, including household income levels, income distribution, and other socioeconomic variables. For instance, while there is no clear correlation between catastrophic expenditure and the share of OOP health expenditure in total household spending, there is a significant relationship between impoverishing health expenditure and increased poverty rates (Figures 22 and 23). This suggests that higher levels of impoverishing expenditure contribute to rising poverty, underscoring the financial vulnerability of households facing healthcare costs.

5

Policy implications for primary health care

The interplay between unmet healthcare needs, coverage, and OOP expenditure shows that comprehensive strategies are needed to improve universal health outcomes. These strategies should address both financial and nonfinancial barriers, while expanding coverage of essential services. Policymakers should aim to enhance financial protection mechanisms and improve nonfinancial access factors, such as waiting lists and times, acceptability, transportation, and healthcare provider availability, to reduce the economic burden on households and improve overall health outcomes. This underscores the need for a PHC-based approach that strengthens health systems by adopting care models focused on health promotion, community engagement, and multisectoral collaboration.

A territorial approach to PHC is essential for effectively addressing these challenges by organizing services and resources based on defined areas to meet local population needs. This approach integrates public health functions within a population-centered framework, emphasizing territorial coordination and integration with health and other social sectors. While it faces barriers such as regional disparities and compartmentalization between care levels, the success of this approach heavily depends on structural components such as strong governance and financing. Prioritizing investment in PHC, shifting budget allocations, and developing supportive governance structures are crucial for implementation. By adopting this approach, and incorporating a life course perspective, health systems can improve access to care, enhance efficiency, and allow for better resource allocation and more targeted interventions that are adequate for every stage of life.

The high prevalence of unmet healthcare needs in the Americas reflects a persistent problem that requires a multifaceted and systemic approach to address persistent access barriers. These barriers are financial, such as treatment costs and lack of insurance coverage, and also organizational and cultural. For instance, countries such as Colombia and Peru, which have expanded insurance coverage, have seen reductions in financial barriers but face access challenges related to organizational aspects, such as long waiting lists and times, and quality disparities.

Nonfinancial barriers, including those related to intercultural adaptation, gender norms, ethnicity, and health literacy, require greater attention. These barriers often intersect, exacerbating access problems, particularly for vulnerable groups such as Indigenous populations, women, and lesbian, gay, bisexual, transgender, queer/questioning, intersex, and other gender nonconforming communities. The cases of countries such as Guyana, Honduras, and Peru illustrate how demand-side factors, such as social and cultural beliefs, interact with supply-side issues, such as deficiencies in transportation and infrastructure, absence of human resources, and challenges in procuring inputs, to hinder healthcare access in rural areas. Therefore, policy interventions must be context-specific and tailored to address the unique challenges faced by different population groups and territories.

The UHC SCI shows regional disparities, with unmet needs more prevalent in areas with lower service coverage. While some countries have achieved high UHC scores, others lag significantly. Policies should focus on expanding service coverage, particularly in regions with lower scores, to ensure equitable access to essential health services. This requires intersectoral approaches, such as improving telecommunications and road infrastructure, to enhance service accessibility, especially in rural and remote areas.

Policies to strengthen household financial protection play a dual role in health policy. They aim to protect individuals and households from the expenses arising from health care or prolonged illness, which can result in catastrophic spending and impoverishment that disproportionately affect certain sectors of the population such as rural households and older adults. Simultaneously, they seek to remove economic barriers to healthcare access, which can hinder and delay healthcare-seeking.

Policies should focus on expanding insurance coverage, direct public provision, and the elimination of copayments, which can be achieved through increased public financing, with a target of 6% of GDP, and efficient allocation of resources. Direct financial protection policies, such as Chile's Zero Co-payment Program and Peru's changes in some public financial management rules that indirectly removed the incentives of public hospitals to apply direct payments at the point of service, could serve as models for reducing financial barriers and preventing catastrophic and impoverishing health spending. The design of financial protection policies must consider the particularities of catastrophic and impoverishing spending, as their behavior differs. Catastrophic spending affects households with older adults, while impoverishing spending is concentrated in multigenerational and rural households, correlating with poverty.

In addition, governments should work toward integrating more population groups into health-financing schemes and expanding the range of services covered. This includes ensuring adequate funding for essential services and medicines, thereby reducing the financial burden on households. Although the financing structure of health systems in the Region is heterogeneous, with a mix of tax-based and contributory sources, public spending efforts are crucial in replacing OOP spending.

Similarly, strengthening regulatory frameworks and social inclusive governance structures is essential for improving health service delivery and ensuring accountability. Policies should enhance strategic planning, social participation, and intersectoral action in health management. The need to mainstream interculturality in health services is critical, recognizing the specific needs of diverse populations and ensuring the quality of care, particularly in organizational aspects of service provision.

Policies that increase the coverage of essential medicines – by prioritizing generic prescriptions, implementing special coverage programs for high-cost medicines related to chronic conditions (NCDs), regularly updating medicine lists, and ensuring good procurement practices – can significantly reduce the financial burden on households, particularly for at-risk groups such as rural households and older people. Addressing all types of barriers to access, including reducing self-medication through unsafe purchases from pharmacies and informal providers, is crucial. These interventions require coordinated action across all levels of government and other economic sectors to ensure effective regulatory systems and functional social protection mechanisms.

To implement these policy changes, resource mobilization is necessary, with increased public investment in health systems. The findings emphasize the importance of regional collaboration, technical cooperation, and resource mobilization to address access barriers. By exchanging knowledge and experiences, countries can adopt best practices and harmonize strategies to improve access with financial protection. This aligns with the strategies adopted by PAHO Member States to achieve universal health *(1)* and protect public health gains by building resilient health systems *(3)*.

The policy implications of this report's findings highlight the need for comprehensive and context-specific interventions to address the multifaceted challenges in primary health care systems. If they focus on both financial and nonfinancial barriers to improving access to services, by enhancing financial protection, expanding service coverage, and strengthening the organization of health services to integrate care, policymakers can be more effective in leading work toward achieving universal health and improved health outcomes for all.

6

Data limitations and recommendations

There are challenges across all three indicators presented in this report that need to be addressed. For unmet healthcare needs, there is no globally agreed definition, making consistent measurements across different regions of the world difficult *(12, 13)*. For this reason, the estimations presented in this report are based on a framework of analysis and standardized definitions across countries included to provide a more comparable picture of unmet healthcare needs in the Region (see Annex 1).

Regarding SDG 3.8.2 on catastrophic health expenditure, other definitions and calculations exist that vary in their thresholds and methods, leading to different results *(35, 36)*. In addition, the two main methodological choices – the definition of household resources and the threshold used to identify whether health expenditures are catastrophic – can lead to different policy recommendations *(37, 38)*. There is also evidence that SDG 3.8.2 does not capture per se the impact of OOP health spending on the poorest, hence the focus in this report on indicators of impoverishing OOP health spending to provide a full picture of the total population facing financial hardship.

The UHC SCI also faces limitations in its comprehensiveness, often missing crucial areas such as mental health and chronic conditions. The UHC SCI relies on a set of tracer indicators that do not reflect the full spectrum of essential health services needed across populations. These challenges not only hinder cross-country comparisons but also make it challenging to track progress over time accurately. Researchers and policymakers are increasingly calling for the development of standardized survey questions and operational definitions that can be applied consistently across different settings *(36, 39)*.

The multifaceted nature of healthcare needs and access presents another significant challenge. Unmet healthcare needs are influenced by a complex interplay of factors, including social determinants of health, individual values, health literacy, and current symptoms *(12, 13, 18)*. Similarly, financial protection measures only capture financial hardship among those who accessed care, missing those who forgo care due to costs or other access barriers. Low levels of catastrophic health expenditure could mask high levels of unmet need *(40)*. The UHC SCI, while aiming to provide a comprehensive measure, often fails to adequately reflect the quality of care received or capture the nuances of healthcare access among different population groups *(35, 41)*. Therefore, even in countries with high SCI values, unmet need can be high for people with conditions that are not captured by the indicators included in the index, such as mental health or other chronic conditions, and can also be high among marginalized populations, who face greater barriers to accessing care *(12, 13, 42)*. This complexity makes it difficult to create measures that are both comprehensive and practical for large-scale implementation.

Many countries in the Americas face significant challenges in data collection. Surveys often lack regular data collection cycles, and detailed questions about unmet healthcare needs or comprehensive data on health expenditures. Longitudinal data, crucial for tracking changes over time, are frequently unavailable *(12, 42)*. Moreover, the reliance on self-reported data introduces potential bias. Interpretation of and responses to questions about unmet needs or healthcare expenditures can vary based on personal characteristics, socioeconomic status, and cultural contexts. This subjectivity can lead to inconsistencies

in data quality across different populations. A critical limitation of current measures is their insensitivity to inequalities and unmet needs. High overall UHC SCI values can mask significant disparities in access and coverage among disadvantaged or marginalized groups. Similarly, low rates of catastrophic health expenditure might obscure high levels of unmet needs if people are forgoing care due to costs *(12, 42)*.

The failure to capture both perceived and unperceived healthcare needs is particularly problematic. Current methods often miss undiagnosed or asymptomatic conditions, leading to an incomplete picture of population health needs. Interpreting these indicators requires a deep understanding of local health system arrangements, cultural norms, and other contextual factors *(12, 40, 42, 43)*. What constitutes an unmet need or catastrophic expenditure can vary widely depending on the specific context of each country or region within the Americas. These contextual variations, combined with differences in methodology and data sources, make comparisons between countries and over time challenging. Policymakers must exercise caution when drawing conclusions from comparative analyses.

Despite the limitations outlined above, it is crucial to emphasize that the results presented in this report remain highly valuable for the Region of the Americas. These indicators provide essential insights into the current state of access, utilization, and financial protection across the Region, serving as a critical foundation for policymaking and healthcare system improvements. The data presented here offer a broad overview of progress toward universal health goals, highlight areas of concern regarding unmet healthcare needs, and identify populations at risk of financial hardship due to health expenses. This information is instrumental in guiding regional and national health policies, allocating resources, and prioritizing interventions to improve healthcare access and outcomes. Moreover, these results serve as a vital baseline for future monitoring and evaluation efforts.

By acknowledging the current limitations, countries can better appreciate the need for and direction of improvements in data collection, data quality, and analysis methodologies. This awareness should motivate countries in the Americas to deepen their monitoring and evaluation efforts at the national level, with the aim of addressing the identified limitations and enhancing the accuracy and comprehensiveness of these crucial health indicators to enhance policymaking. Countries are encouraged to use these results as a starting point for more detailed, context-specific evaluations. This could involve:

- Developing and implementing more comprehensive surveys that capture a wider range of healthcare needs and expenditures;
- Establishing longitudinal studies to track changes in healthcare access and financial protection over time;
- Conducting targeted studies on vulnerable or marginalized populations to better understand and address health inequities;

- Investing in improved data collection infrastructure and capacity-building for health information systems;

- Collaborating with academic institutions and international organizations to refine methodologies and develop more nuanced indicators.

Both PAHO and WHO are calling for the development of standardized survey questions and operational definitions of unmet healthcare needs that can be applied consistently across different settings and populations. In 2023, the 76th World Health Assembly adopted a resolution in favor of improved data collection, standardized metrics, and policy actions to enhance financial protection (*17*). It also requested that the WHO Director-General review the importance and feasibility of using unmet need for healthcare services as an additional indicator to monitor UHC nationally and globally. Moreover, given the growing evidence pointing to limitations with both SDG UHC indicators, WHO and the World Bank have proposed revised definitions for each one of them, as part of the ongoing Inter-Agency and Expert Group on Sustainable Development Goal Indicators (IAEG-SDGs) 2025 Comprehensive Review (*44*).

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Annex 1. Methodology for calculating unmet healthcare needs

Measuring unmet healthcare needs is crucial for assessing progress toward universal health for several key reasons. This approach provides a nuanced understanding of access to health services and utilization. While countries may report high rates of insurance coverage or an extensive network of healthcare facilities, these figures do not always translate to actual care received *(1, 2)*. By assessing unmet healthcare needs, countries can pinpoint populations and areas where individuals are not receiving necessary health services, even if they are theoretically covered. This reveals critical gaps between nominal coverage and actual access, offering a more accurate picture of the health system landscape. Furthermore, unmet healthcare needs provide a comprehensive view of the health system's performance by identifying barriers to access that result in unmet needs *(3, 4)*. These data are invaluable for informing policy and planning, as understanding the extent and reasons for unmet needs – such as cost, distance, or waiting times – can guide policymakers in designing interventions to improve access and reduce barriers to care *(5)*. When combined with UHC indicators such as service coverage and financial protection, unmet needs data offer a more nuanced understanding of universal health progress, ultimately leading to more effective strategies for improving population health *(6)*.

Despite the importance of these metrics, measuring unmet healthcare needs presents challenges, particularly the lack of a standardized definition at the global level *(7)*. Currently, there is no universally accepted operational definition, which complicates consistent measurement across different contexts and populations. In response to this challenge, the Pan American Health Organization and the World Health Organization (WHO) are advocating for the development of a standard operational definition of unmet healthcare needs, along with standardized survey questions *(5–7)*. These tools aim to identify unmet needs that are not confined to specific health interventions or diseases, while elucidating the barriers to access that individuals face. Incorporating data on unmet healthcare needs into universal health coverage (UHC) monitoring is seen as a crucial step toward a more accurate understanding of health systems.

In this report, unmet healthcare needs were measured through the concept of forgone care, expressed as the share of individuals who had a healthcare need but did not consult an appropriate provider or did not seek care at all for any reason. The measurement approach included capturing reasons for forgone appropriate care, which were categorized based on dimensions of access: availability, geographic accessibility, financial accessibility, organizational accessibility, and acceptability (Table A1.1).

Table A1.1 Dimensions of access and examples of access barriers to health services

Dimension	Definition	Examples of barriers to access
Availability	Availability and sufficiency of resources for delivering comprehensive health services	• Insufficient number or density of health facilities • Unavailable health workers, staff absenteeism • Drugs and equipment being out of stock
Geographic accessibility	Availability of high-quality health services within reasonable reach to those who need them	• Health facilities too far from user's home • Long and slow travel to facilities • Lack of transport
Financial accessibility	Ability to pay for services without financial hardship	• Inability to afford medications or copayments • Opportunity costs and transport costs • Lack of insurance or low coverage
Organizational accessibility	Adequate service organization and delivery that allow people to obtain the services when they need them	• Inability to take time off to attend appointments • Inadequate schedules/opening hours • Complex appointment systems and administrative requirements • Long waiting times
Acceptability	Willingness to seek services when they are perceived to be effective or when social and cultural factors do not discourage people from seeking service	• Lack of trust in health providers or prescribed treatment • Language, culture, or religion • Gender norms, roles, and relations • Negative perceptions of service quality • Provider's attitudes and practice • Preference for traditional medicine

Source: Based on: Houghton N, Bascolo E, Del Riego A. Monitoring access barriers to health services in the Americas: a mapping of household surveys. Rev Panam Salud Publica. 2020;44:e96. Available from: https://iris.paho.org/handle/10665.2/52573.

Figure A1.1 illustrates the decision-making process for determining unmet healthcare needs through forgone care. This process follows a logical sequence that categorizes respondents based on their healthcare needs and subsequent actions:

1. Perceived healthcare need: This initial category represents the proportion of respondents who reported experiencing a health problem or identifying a need for health services, including prescribed medication, within a specified time frame.

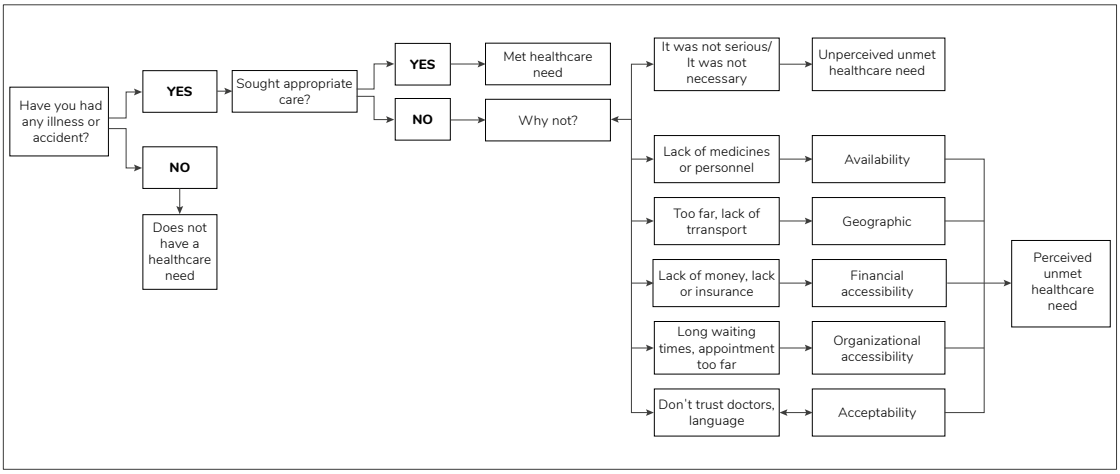
2. Met healthcare need: From those with perceived needs, this category encompasses the proportion of respondents who acted upon their perceived healthcare need by consulting an appropriate healthcare provider.

3. Perceived unmet healthcare need: This category includes the proportion of respondents who, despite recognizing a healthcare need, either did not consult an appropriate provider or did not seek care at all, for any reason.

4. Reasons for perceived unmet healthcare need: This category delves into the specific reasons behind perceived unmet healthcare needs. It quantifies the proportion of respondents who faced barriers related to availability, accessibility (including geographic, financial, and organizational factors), and acceptability of health services.

5. Unperceived healthcare need: The final category represents the proportion of respondents who reported a health problem but did not seek appropriate care, or any care at all, because they did not perceive the need for health care.

Figure A1.1 Framework for understanding unmet healthcare needs through forgone care



Source: PAHO.

Data on unmet healthcare needs were collected by asking individuals about their perceived health needs and related behaviors in the 3–12 months prior to the survey. This included inquiries about whether the individual had sought appropriate health services, had not sought care at all, and the reasons behind their decisions. The following questions (with variations among surveys) were included in the estimations presented in this report:

- "In the last 30 days, have you had any illness or accident?"
  Possible answers: Yes/No/Do not know

- If yes: “Where did you go for care for this illness or accident?”
  Possible answers: Public health facility/Private health clinic/Urgent care/Pharmacy or self-medication/At home/Home remedy/Did nothing/Other

- If you didn’t visit an appropriate health facility or did nothing: “What are the reasons you didn’t go to a health facility?”
  Possible answers: Had no money/It’s far away/Long waiting time/There are no medicines/There are no doctors/Don’t trust doctors/It was not serious/It was not necessary/Prefer to be cured with home remedies/Don’t have insurance/Self-prescribed or repeated previous prescription/Lack of time/Abuse by health personnel/Other

Appropriate care was defined as instances when individuals sought care from qualified medical professionals in government health facilities and private hospitals/clinics during illnesses or accidents. Other types of care, such as purchasing medicines from pharmacies, using home remedies, and visiting temples or traditional healers, were defined as inappropriate care. To focus solely on perceived healthcare needs, those who reported that they did not need care were excluded from the analysis.

For each country, percentages and confidence intervals were calculated, and expansion factors were applied to estimate national totals. When the unweighted number of observations in a specific subgroup was fewer than 25, results were omitted. Wealth status was examined by defining quintile rankings based on income or asset-based wealth levels, with household income. The report encompasses data from 18 countries, with survey years ranging from 1996 to 2022. A list of specific data sources utilized in this report is presented in Table A1.2.

Table A1.2 Surveys and sources, by country

Country	Survey	Year of survey
Barbados	Barbados Survey of Living Conditions (BSLC)	2016
Bolivia (Plurinational State of)	Encuesta de Hogares	2017, 2019–2021
Canada	Canadian Community Health Survey (CCHS)	2016, 2018
Chile	Encuesta de Caracterización Socioeconómica Nacional (CASEN)	2000, 2003, 2006, 2009, 2011, 2013, 2015, 2017, 2020, 2022
Colombia	Encuesta Nacional de Calidad de Vida (ECV)	1997, 2003, 2008, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022
Costa Rica	Encuesta Nacional de Salud (ENSA)	2006
Dominican Republic	Demographic and Health Surveys (DHS)	1996, 2002, 2007, 2013
Ecuador	Encuesta Nacional Multipropósito de Hogares (ENMH)	2018–2020
El Salvador	Encuesta de Propósitos Múltiple (EHPM)	2016–2022
Guatemala	Encuesta Nacional de Condiciones de Vida (ENCV)	2014
Haiti	Demographic and Health Surveys (DHS)	2016
Honduras	Demographic and Health Surveys (DHS)	2006, 2011, 2019
Mexico	Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH)	2016, 2018, 2020, 2022
Nicaragua	Demographic and Health Surveys (DHS)	2001, 2014
Paraguay	Encuesta permanente de hogares continua (EPHC)	2019–2022
Peru	Encuesta Nacional de Hogares (ENAHO)	2002–2022
United States of America	Medical Expenditure Panel Survey (MEPS)	2018
Uruguay	Encuesta Nacional de Salud (ENS)	2014

Source: PAHO.

Annex 2. Methodology for calculating the universal health coverage service coverage index (Sustainable Development Goal 3.8.1)

The methodology for estimating the universal health coverage (UHC) service coverage index (SCI) for Sustainable Development Goal indicator 3.8.1, is detailed in the World Health Organization (WHO) *Tracking universal health coverage: 2023 global monitoring report (8)*. For comprehensive insights into data sources, computation methods, and methodological considerations, readers are encouraged to consult the aforementioned publication. The data for this report are sourced from WHO's Global Health Observatory, which can be accessed here: https://www.who.int/data/gho/data/themes/topics/service-coverage.

The UHC SCI is constructed using a set of 14 tracer indicators that encompass four critical areas of health service coverage. These areas are reproductive, maternal, newborn, and child health; infectious diseases; noncommunicable diseases; and service capacity and access.

To provide a comprehensive overview of health service coverage, the UHC SCI integrates various tracer indicators. In the reproductive, maternal, newborn, and child health category, the indicators include family-planning coverage, antenatal care coverage (specifically four or more visits), child immunization rates (diphtheria, tetanus, and pertussis), and care-seeking behavior for suspected pneumonia. For infectious diseases, the index considers effective treatment coverage for tuberculosis, access to HIV antiretroviral therapy, the use of insecticide-treated bed nets, and the availability of basic sanitation services. The noncommunicable diseases category incorporates indicators such as the prevalence of nonraised blood pressure, mean fasting plasma glucose levels, and rates of tobacco nonsmoking. Lastly, the service capacity and access area evaluates hospital bed density and health worker density, which includes physicians, psychiatrists, and surgeons.

To calculate the UHC SCI, all tracer indicators are first scaled to a range of 0 to 100, where 100 represents optimal coverage. Following this scaling, geometric means are computed for each of the four health service areas. The overall index is then derived by calculating the geometric mean of these four area-specific means. Notably, the health worker density indicator is also calculated as the geometric mean of the rescaled values for the relevant healthcare professionals.

It is important to clarify that, while the index score ranges from 0 to 100, indicating varying levels of coverage for essential health services, it does not directly represent the percentage of the population covered. Instead, the score is interpreted as an indication of the average coverage of the indicators within a country.

Annex 3. Methodology for calculating catastrophic and impoverishing out-of-pocket health spending

This methodology for estimating catastrophic and impoverishing out-of-pocket (OOP) health spending is grounded in the principles outlined in the World Health Organization (WHO) *Tracking universal health coverage: 2023 global monitoring report (8)*. For a thorough understanding of the data sources, computation methods, and methodological considerations, readers are encouraged to refer to that publication. The data utilized in this report are sourced from WHO's Global Health Observatory, which can be accessed here: https://www.who.int/data/gho/data/themes/topics/service-coverage.

OOP health spending is defined as the expenditure incurred by households on goods and services primarily intended for health. This spending is financed through various means, including household income (which encompasses remittances), savings, and loans. Importantly, OOP payments do not include any reimbursements or premiums paid to voluntary or private health insurance, nongovernmental organizations, or government programs. It is also essential to note that conditional cash transfers aimed at covering health expenditures are classified as a specific government health-financing scheme and are not considered part of the OOP health spending incurred by households.

To assess financial hardship, the methodology compares a household's OOP health spending to its ability to pay, which is a critical metric for identifying catastrophic health spending. The concern is with people forced to reduce spending on other needs than health to accommodate health payments. In some cases, such reductions lead to impoverishing health spending. To evaluate the latter, the consumption levels of households before and after accounting for OOP health expenditures are examined in relation to a defined poverty line. In the context of financial hardship, OOP health spending can be catastrophic impoverishing or both. Within the Sustainable Development Goals (SDG) monitoring framework, the incidence of catastrophic OOP health spending is quantified as the proportion of the population whose OOP health spending exceeds either 10% or 25% of the household's total consumption or income.

It is important to recognize that wealthier households may spend more than these thresholds on health care without necessarily compromising their ability to meet basic needs. Conversely, less affluent households may find themselves spending less than these percentages yet still struggle to achieve a decent standard of living. There are various methodologies for monitoring catastrophic OOP health spending. Some definitions classify OOP health spending as catastrophic when it surpasses

a predetermined percentage of total consumption or income, a method known as the "budget share" approach, which is employed in SDG indicator 3.8.2. Empirical evidence suggests that catastrophic spending is often less concentrated among poorer populations when using this budget share approach. It is also crucial to consider that some households may appear financially stable due to borrowing to finance health expenditures, while those in the poorest quintile are likely to be genuinely impoverished.

Alternative studies relate health spending to net consumption or income after deducting expenditures on essential needs, rather than total consumption or income. This perspective acknowledges that everyone must allocate a minimum amount for basic necessities such as food, housing, and utilities. For poorer households, these essential expenses consume a larger share of their resources, limiting their ability to spend on health care. In contrast, wealthier households can afford to allocate a significant percentage of their budget to health care while still maintaining sufficient resources for their basic needs.

Different methods exist for determining how to deduct spending on basic needs. Some approaches deduct all actual food spending, while others apply a standard deduction to represent essential food expenditures. Some methods consider the prevailing poverty line as a benchmark for basic needs, while others focus on specific categories of essential spending, such as food, housing, and utilities. These various measures indicate that catastrophic health spending is more likely to be concentrated among poorer households than when using the budget share approach. The last method above, which accounts for specific basic needs, is particularly sensitive to the financial hardships faced by low-income households.

Annex 4. Unmet healthcare needs and types of barriers to access, by country, latest year available

Table A4.1 Unmet healthcare needs

Country or territory	Mean (95% confidence interval)	Lowest income quintile mean (95% confidence interval)	Highest income quintile (95% confidence interval)	Latest year
Barbados	27.8% (26.5, 29)	29.6% (26.7, 32.5)	23.3% (20.6, 26)	2016
Bolivia (Plurinational State of)	70.4% (69.8, 71)	65.2% (63.8, 66.5)	70.9% (69.7, 72.1)	2021
Canada	26.9% (26.5, 27.4)	32.1% (30.4, 33.8)	26.3% (25.7, 27)	2018
Chile	9.9% (9.7, 10.1)	11.3% (10.9, 11.6)	9.1% (8.5, 9.7)	2022
Colombia	24.2% (23.9, 24.6)	27.2% (26.7, 27.8)	25.5% (24.5, 26.6)	2022
Costa Rica	3.2% (2.7, 3.6)	3.1% (2.2, 4.1)	3.2% (2.2, 4.1)	2006
Dominican Republic	65.8% (64.9, 66.7)	60.7% (58.8, 62.6)	68.1% (66, 70.3)	2013
Ecuador	17.7% (16.4, 18.9)	–	–	2020
El Salvador	44% (43.5, 44.5)	50.3% (49.2, 51.4)	34.7% (33.6, 35.8)	2022
Guatemala	41.9% (38.6, 45.2)	36.8% (29.9, 43.6)	24.6% (17.8, 31.3)	2014
Haiti	6.9% (6.3, 7.5)	7.9% (6.5, 9.4)	2.3% (1.6, 3.1)	2016
Honduras	46.8 (46.4, 47.2)	53.7% (52.9, 54.4)	39.5% (38.6, 40.5)	2019
Mexico	27% (26.8, 27.2)	36.4% (35.8, 36.9)	20.6% (20.2, 21.1)	2022
Nicaragua	40% (39, 40.9)	50.7% (47.7, 53.8)	36.7% (35.3, 38)	2014
Paraguay	31.9% (31.1, 32.8)	32.9% (31.2, 34.6)	26.8% (25, 28.7)	2022
Peru	73.3% (72.9, 73.6)	74.2% (73.5, 74.9)	68.1% (67.1, 69.1)	2022
United States of America	10.1% (9.5, 10.7)	10.1% (7.4, 12.8)	7% (4.9, 9.1)	2018
Uruguay	38.4% (36.4, 40.3)	40.3% (35.5, 45.1)	32.5% (28.7, 36.3)	2014

Note: – data not available.

Table A4.2 Unmet healthcare needs by type of barrier to access

Country or territory	Type of barrier to access	Mean (95% confidence interval)	Lowest income quintile mean (95% confidence interval)	Highest income quintile (95% confidence interval)	Latest year
Canada	Acceptability	0% (0, 0)	0% (0, 0)	0% (0, 0)	2018
Canada	Availability	18.3% (14.7, 21.8)	19.5% (8.5, 30.6)	16.2% (10.5, 21.8)	2018
Canada	Financial accessibility	3.1% (1.5, 4.7)	–	–	2018
Canada	Geographic accessibility	3.6% (1.9, 5.3)	8.6% (0.8, 16.4)	2.4% (0.1, 4.7)	2018
Canada	Organizational accessibility	76.8% (72.9, 80.7)	61.7% (48.2, 75.2)	79% (72.7, 85.2)	2018
Chile	Acceptability	22.6% (20.3, 24.9)	26.4% (22.5, 30.2)	19.7% (11.4, 28)	2022
Chile	Availability	3.9% (2.8, 5)	6.3% (4.2, 8.4)	–	2022
Chile	Financial accessibility	2.9% (2, 3.9)	3% (1.5, 4.5)	–	2022
Chile	Geographic accessibility	0.7% (0.3, 1.2)	1.2% (0.3, 2.2)	–	2022
Chile	Organizational accessibility	5.3% (4.1, 6.5)	6.1% (4, 8.2)	4.2% (0, 8.3)	2022
Colombia	Acceptability	3.9% (2.1, 5.7)	3.7% (0.7, 6.7)	–	2022
Colombia	Financial accessibility	6.6% (4.3, 8.9)	15.1% (9.4, 20.8)	–	2022
Colombia	Geographic accessibility	4.6% (2.7, 6.5)	9.2% (4.6, 13.8)	–	2022
Colombia	Organizational accessibility	19% (15.4, 22.6)	18.3% (12.1, 24.4)	11.4% (3.1, 19.8)	2022
Costa Rica	Availability	2.5% (0.4, 4.6)	0% (0, 0)	–	2006
Costa Rica	Financial accessibility	6.1% (2.9, 9.4)	–	–	2006
Costa Rica	Organizational accessibility	88% (83.5, 92.4)	94.9% (87.8, 101.9)	87.7% (77.6, 97.8)	2006
Dominican Republic	Financial accessibility	2.7% (2, 3.3)	4.7% (2.9, 6.5)	1.7% (0.4, 3.1)	2013
Dominican Republic	Organizational accessibility	1.5% (1, 1.9)	–	–	2013
Ecuador	Acceptability	30.2% (25.7, 34.6)	–	–	2020
Ecuador	Financial accessibility	43.7% (38.9, 48.4)	–	–	2020

Table A4.2 Unmet healthcare needs by type of barrier to access *(continued)*

Country or territory	Type of barrier to access	Mean (95% confidence interval)	Lowest income quintile mean (95% confidence interval)	Highest income quintile (95% confidence interval)	Latest year
Ecuador	Geographic accessibility	17.3% (13.6, 20.9)	–	–	2020
Ecuador	Organizational accessibility	57.8% (53.1, 62.6)	–	–	2020
El Salvador	Acceptability	5.5% (4.7, 6.4)	5.4% (3.8, 6.9)	6.2% (3.6, 8.7)	2022
El Salvador	Availability	19% (17.5, 20.5)	18.4% (15.8, 21.1)	17.5% (13.4, 21.5)	2022
El Salvador	Financial accessibility	1% (0.6, 1.3)	1.4% (0.6, 2.2)	–	2022
El Salvador	Geographic accessibility	1.8% (1.3, 2.3)	2.9% (1.7, 4)	–	2022
El Salvador	Organizational accessibility	4.2% (3.4, 4.9)	2.4% (1.3, 3.4)	4.5% (2.3, 6.7)	2022
Guatemala	Financial accessibility	15.3% (4, 26.6)	27.7% (2.3, 53.2)	–	2014
Guatemala	Geographic accessibility	0% (0, 0)	0% (0, 0)	0% (0, 0)	2014
Guatemala	Organizational accessibility	11.8% (1.7, 22)	–	0% (0, 0)	2014
Honduras	Availability	0.5% (0.3, 0.6)	0.5% (0.2, 0.8)	–	2019
Honduras	Financial accessibility	0.6% (0.4, 0.8)	0.8% (0.4, 1.1)	–	2019
Honduras	Geographic accessibility	0.2% (0.1, 0.3)	0.4% (0.2, 0.7)	–	2019
Honduras	Organizational accessibility	0.4% (0.3, 0.6)	0.5% (0.2, 0.7)	0.4% (0.1, 0.7)	2019
Mexico	Acceptability	0.7% (0.6, 0.8)	0.6% (0.5, 0.8)	0.8% (0.5, 1)	2022
Mexico	Availability	1.6% (1.5, 1.7)	3.3% (3, 3.6)	0.7% (0.5, 0.9)	2022
Mexico	Financial accessibility	3.9% (3.7, 4.1)	7.3% (6.9, 7.8)	0.9% (0.6, 1.1)	2022
Mexico	Geographic accessibility	1% (0.9, 1.1)	2.5% (2.2, 2.7)	0.2% (0.1, 0.3)	2022
Mexico	Organizational accessibility	3.1% (3, 3.3)	2.7% (2.4, 3)	3.2% (2.7, 3.6)	2022
Paraguay	Financial accessibility	1.5% (0.8, 2.3)	3.3% (1.3, 5.4)	0% (0, 0)	2022

Table A4.2 Unmet healthcare needs by type of barrier to access *(continued)*

Country or territory	Type of barrier to access	Mean (95% confidence interval)	Lowest income quintile mean (95% confidence interval)	Highest income quintile (95% confidence interval)	Latest year
Paraguay	Geographic accessibility	0.7% (0.2, 1.2)	1.5% (0.2, 2.9)	–	2022
Paraguay	Organizational accessibility	2.8% (1.8, 3.8)	2.4% (0.7, 4.1)	–	2022
Peru	Acceptability	23.7% (23.1, 24.2)	34.5% (33.4, 35.7)	16.6% (15.2, 18)	2022
Peru	Financial accessibility	5.5% (5.2, 5.8)	7.1% (6.5, 7.7)	2.8% (2.1, 3.4)	2022
Peru	Geographic accessibility	4.6% (4.3, 4.9)	9.4% (8.7, 10.1)	2% (1.4, 2.5)	2022
Peru	Organizational accessibility	20.8% (20.3, 21.4)	19.2% (18.3, 20.2)	19.1% (17.6, 20.5)	2022
United States of America	Acceptability	0% (0, 0)	0% (0, 0)	0% (0, 0)	2018
United States of America	Financial accessibility	60.7% (57.6, 63.8)	69.8% (55.3, 84.3)	47.8% (32.5, 63.2)	2018
United States of America	Geographic accessibility	3.8% (2.6, 5)	–	0% (0, 0)	2018
United States of America	Organizational accessibility	9.9% (8, 11.7)	–	21% (8.4, 33.5)	2018
Uruguay	Availability	2.8% (1.2, 4.4)	–	–	2014
Uruguay	Financial accessibility	34.2% (29.5, 38.9)	46.8% (36.4, 57.2)	22.1% (12.7, 31.5)	2014
Uruguay	Geographic accessibility	3.1% (1.4, 4.9)	6.5% (1.3, 11.6)	–	2014
Uruguay	Organizational accessibility	23% (18.9, 27.2)	24.4% (15.4, 33.3)	24.5% (14.7, 34.2)	2014

Note: – data not available.

Annex 5. Universal health coverage service coverage index (Sustainable Development Goal 3.8.1), by country, 2021

Country or territory	Reproductive, maternal, newborn, and child health				Infectious diseases				Noncommunicable diseases			Service capacity and access			Service coverage index subindices				
Country or territory	Family-planning : demand satisfied with modern methods	Antenatal care, 4+ visits	Child immunization (diphtheria, tetanus toxoid, and pertussis)	Care-seeking behavior for suspected acute respiratory infection	Tuberculosis treatment coverage	HIV antiretroviral treatment (ART) coverage	Insecticide-treated nets use	Population with access to at least basic sanitation	Prevalence of treatment for hypertension	Mean fasting plasma glucose (FPG)	Tobacco nonuse	Hospital bed density	Health workforce	International Health Regulations core capacity index	Reproductive, maternal, newborn, and child health	Infectious diseases	Noncommunicable diseases	Service capacity and access	Universal health coverage service coverage index (Sustainable Development Goal indicator 3.8.1)
Antigua and Barbuda	79	≥80	≥80	≥80	≥80	62		≥80	50	67	≥80	≥80	74	52	≥80	≥80	66	73	76
Argentina	≥80	≥80	76	≥80	≥80	72		≥80	41	≥80	65	≥80	≥80	65	≥80	≥80	61	≥80	79
Bahamas	≥80	≥80	75	≥80	≥80	68		≥80	53	66	≥80	≥80	≥80	55	≥80	≥80	67	≥80	77
Barbados	77	≥80	≥80	≥80	≥80	60		≥80	60	71	≥80	≥80	71	56	≥80	≥80	72	73	77
Belize	71	≥80	≥80	67	63	48		≥80	45	≥80	≥80	57	78	46	78	64	71	59	68
Bolivia (Plurinational State of)	58	≥80	70	≥80	53	56		68	49	≥80	≥80	75	47	56	72	59	73	58	65
Brazil	≥80	≥80	68	50	76	73		≥80	62	≥80	≥80	≥80	≥80	≥80	73	≥80	76	≥80	≥80
Canada	≥80	≥80	≥80	≥80	≥80	≥80		≥80	73	≥80	≥80	≥80	≥80	≥80	≥80	≥80	≥80	≥80	≥80
Chile	≥80	≥80	≥80	≥80	≥80	68		≥80	58	≥80	58	≥80	≥80	73	≥80	≥80	67	≥80	≥80

Country or territory	Reproductive, maternal, newborn, and child health				Infectious diseases				Noncommunicable diseases			Service capacity and access			Service coverage index subindices				Universal health coverage service coverage index (Sustainable Development Goal indicator 3.8.1)
Country or territory	Family-planning : demand satisfied with modern methods	Antenatal care, 4+ visits	Child immunization (diphtheria, tetanus toxoid, and pertussis)	Care-seeking behavior for suspected acute respiratory infection	Tuberculosis treatment coverage	HIV antiretroviral treatment (ART) coverage	Insecticide-treated nets use	Population with access to at least basic sanitation	Prevalence of treatment for hypertension	Mean fasting plasma glucose (FPG)	Tobacco nonuse	Hospital bed density	Health workforce	International Health Regulations core capacity index	Reproductive, maternal, newborn, and child health	Infectious diseases	Noncommunicable diseases	Service capacity and access	
Colombia	≥80	≥80	≥80	64	65	74		≥80	55	≥80	≥80	≥80	≥80	69	≥80	77	76	≥80	≥80
Costa Rica	≥80	≥80	≥80	80	65	66		≥80	70	≥80	≥80	65	≥80	67	≥80	75	≥80	76	≥80
Cuba	≥80	79	≥80	≥80	66	72		≥80	61	80	74	≥80	≥80	≥80	≥80	76	71	≥80	≥80
Dominica	≥80	≥80	≥80	63	1	62		80	46	55	≥80	≥80	59	63	79	17	60	72	49
Dominican Republic	≥80	≥80	≥80	≥80	67	55		≥80	53	≥80	≥80	79	≥80	65	≥80	69	75	≥80	77
Ecuador	≥80	80	72	≥80	66	74		≥80	49	≥80	≥80	72	≥80	66	79	76	73	78	77
El Salvador	≥80	≥80	79	≥80	62	59		≥80	63	≥80	≥80	65	≥80	≥80	≥80	69	79	≥80	78
Grenada	77	73	72	77	50	62		≥80	47	77	≥80	≥80	62	66	75	66	68	74	70
Guatemala	70	≥80	79	52	65	73		70	36	79	≥80	24	55	45	71	69	62	39	59
Guyana	54	≥80	≥80	≥80	62	63		≥80	47	77	≥80	≥80	75	≥80	79	71	67	≥80	76
Haiti	48	67	51	35	57	≥80		37	28	≥80	≥80	≥80	22	54	49	57	63	49	54
Honduras	80	≥80	77	70	62	56		≥80	58	≥80	≥80	37	34	58	79	66	79	42	64
Jamaica	≥80	≥80	≥80	≥80	61	47		≥80	51	≥80	≥80	≥80	61	≥80	≥80	63	71	79	74
Mexico	≥80	≥80	78	73	68	61		≥80	50	76	≥80	57	≥80	≥80	≥80	72	67	78	75
Nicaragua	≥80	63	≥80	67	60	53		73	61	≥80	≥80	50	70	78	76	61	≥80	65	70
Panama	73	≥80	74	≥80	80	49		≥80	55	79	≥80	≥80	≥80	76	80	69	74	≥80	78
Paraguay	≥80	78	70	≥80	≥80	66		≥80	38	≥80	≥80	56	79	56	80	≥80	67	63	72
Peru	68	≥80	≥80	50	59	80		78	40	≥80	≥80	≥80	≥80	39	72	72	71	70	71
Saint Kitts and Nevis	75	≥80	≥80	78	≥80	62		≥80	49	74	≥80	≥80	≥80	66	≥80	≥80	68	≥80	79

Country or territory	Reproductive, maternal, newborn, and child health				Infectious diseases				Noncommunicable diseases			Service capacity and access			Service coverage index subindices				Universal health coverage service coverage index (Sustainable Development Goal indicator 3.8.1)
Country or territory	Family-planning : demand satisfied with modern methods	Antenatal care, 4+ visits	Child immunization (diphtheria, tetanus toxoid, and pertussis)	Care-seeking behavior for suspected acute respiratory infection	Tuberculosis treatment coverage	HIV antiretroviral treatment (ART) coverage	Insecticide-treated nets use	Population with access to at least basic sanitation	Prevalence of treatment for hypertension	Mean fasting plasma glucose (FPG)	Tobacco nonuse	Hospital bed density	Health workforce	International Health Regulations core capacity index	Reproductive, maternal, newborn, and child health	Infectious diseases	Noncommunicable diseases	Service capacity and access	
Saint Lucia	76	≥80	80	69	≥80	62		≥80	52	76	≥80	≥80	≥80	59	79	≥80	70	79	77
Saint Vincent and the Grenadines	≥80	70	≥80	79	55	62		≥80	45	≥80	≥80	≥80	≥80	22	≥80	67	69	60	69
Suriname	67	68	72	≥80	50	17		≥80	50	79	≥80	≥80	≥80	46	73	43	68	72	63
Trinidad and Tobago	65	≥80	≥80	74	≥80	65		≥80	47	65	≥80	≥80	≥80	53	≥80	≥80	64	75	75
United States of America	≥80	≥80	≥80	≥80	≥80	≥80		≥80	70	73	67	≥80	≥80	≥80	≥80	≥80	70	≥80	≥80
Uruguay	≥80	≥80	≥80	≥80	≥80	71		≥80	55	75	69	≥80	≥80	65	≥80	≥80	66	≥80	≥80
Venezuela (Bolivarian Republic of)	≥80	≥80	56	72	69	58		≥80	63	≥80	≥80	55	≥80	75	73	73	80	74	75

Note: – data not available.

Data source: World Health Organization. Global Health Observatory: Coverage of essential health services (SDG 3.8.1). Available from: https://www.who.int/data/gho/data/themes/topics/service-coverage.

Annex 6. Financial hardship (Sustainable Development Goal 3.8.2) by country, latest year available

Table A6.1 Sustainable Development Goal-related indicators of impoverishing out-of-pocket health spending by country, most recent year available

Country or territory	Latest year	Impoverishing out-of-pocket health spending			
		At the 2017 purchasing power parity US$ 2.15 a day poverty line		At the relative poverty line of 60% of median consumption or income	
		Increase in poverty headcount (pushed into poverty)	Poor spending on health (pushed further into poverty)	Increase in poverty headcount (pushed into poverty)	Poor spending on health (pushed further into poverty)
Argentina	2004	–	–	2	10
Barbados	2016	0.3	0.4	1.8	9.9
Bolivia (Plurinational State of)	2021	0.1	1	0.8	10.5
Brazil	2017	0.2	0.9	2	19.9
Canada	2019	0.2	0.4	0.9	16.1
Chile	2016	0	0	2	13.5
Colombia	2016	0.3	1.1	1.2	12.2
Costa Rica	2018	0	0.1	1.2	11.2
Dominican Republic	2018	0	0.1	1.7	11.7
Ecuador	2013	0.7	1	2.3	14.8
El Salvador	2019	–	–	0.6	6.5
Grenada	2008	0	0	0.3	1.7
Guatemala	2014	0.9	2.2	2.2	13.2
Haiti	2013	3.9	9.7	3.8	9.7

Table A6.1 Sustainable Development Goal-related indicators of impoverishing out-of-pocket health spending by country, most recent year available *(continued)*

Country or territory	Latest year	Impoverishing out-of-pocket health spending			
		At the 2017 purchasing power parity US$ 2.15 a day poverty line		At the relative poverty line of 60% of median consumption or income	
		Increase in poverty headcount (pushed into poverty)	Poor spending on health (pushed further into poverty)	Increase in poverty headcount (pushed into poverty)	Poor spending on health (pushed further into poverty)
Honduras	2004	–	–	0.2	21.8
Jamaica	2004	0.5	0.8	2.4	17.5
Mexico	2020	0.1	0.8	1.1	12.3
Nicaragua	2014	2.8	3.7	5	21.4
Panama	2017	0	0	1.3	17.7
Paraguay	2000	1.3	7.2	1.5	22.4
Peru	2021	0.1	1	1.8	18.6
Saint Kitts and Nevis	2007	–	–	0.9	9.2
Saint Lucia	2016	0.3	0.4	1.4	11.8
Suriname	2016	0	0	1.1	8.7
Trinidad and Tobago	2014	0.8	0.3	1	2.3
United States of America	2021	0	0	0.6	7.6
Uruguay	2016	0	0	1.1	14.8

Note: – data not available.

Data source: World Health Organization. Global Health Observatory: SDG 3.8.2 Catastrophic health spending (and related indicators). Available from: https://www.who.int/data/gho/data/themes/topics/financial-protection.

Table A6.2 Sustainable Development Goal universal health coverage indicator 3.8.2, latest year: incidence of catastrophic out-of-pocket health spending (%)

Country or territory	At 10% of household total consumption or income	At 25% of household total consumption or income	Latest
Argentina	9.57	2.54	2017
Barbados	16.37	3.82	2016
Belize	6.2	3.1	2018
Bolivia (Plurinational State of)	5.69	1.19	2021
Brazil	11.81	1.88	2017
Canada	3.5	0.8	2019
Cayman Islands	3.24	0.58	2015
Chile	14.6	2.08	2016
Colombia	8.19	2.23	2016
Costa Rica	7.41	1.13	2018
Dominican Republic	8.17	0.94	2018
Ecuador	10.31	2.44	2013
El Salvador	4.06	1.38	2019
Grenada	3.17	0.5	2008
Guatemala	11.45	3.77	2014
Haiti	11.54	3.98	2013
Honduras	1.14	0.1	2004
Jamaica	10.2	2.88	2004
Mexico	4.44	1.22	2020
Nicaragua	24.73	9.1	2014
Panama	6.2	0.65	2017
Paraguay	10.54	0.81	2011
Peru	12.59	2	2021
Saint Kitts and Nevis	4.13	0.3	2007
Saint Lucia	6.17	1.77	2016
Suriname	4.87	1.35	2016
Trinidad and Tobago	3.88	1.93	2014
United States of America	4.61	0.89	2021
Uruguay	2.11	0.15	2016

Note: – data not available.

Data source: World Health Organization. Global Health Observatory: SDG 3.8.2 Catastrophic health spending (and related indicators). Available from: https://www.who.int/data/gho/data/themes/topics/financial-protection.

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Achieving universal access to health and universal health coverage (universal health) means ensuring that all people and communities have access without facing any type of discrimination or access barrier to comprehensive, appropriate, and timely quality health services.

This publication utilizes the most recent data to provide a detailed analysis of the current state of universal health in the Region of the Americas. It focuses on three key indicators, unmet healthcare needs, coverage of essential health services, and financial protection, and identifies key policy implications and recommendations for future action. The data presented not only provide a broad overview of progress toward universal health goals but also highlight significant areas of concern regarding unmet healthcare needs and identify specific populations that are at risk of experiencing financial hardship due to health expenses. In addition, the results establish a vital baseline for future monitoring and evaluation efforts.

Strengthening primary health care (PHC) and prioritizing health equity are essential for the Region's pursuit of a sustainable and inclusive path toward universal health, ensuring that every individual is able to attain the highest standard of health and well-being. A critical aspect of advancing universal health through PHC is the adoption of a territorial approach, which recognizes the diverse health needs and contexts that exist within countries. The information presented in this publication is instrumental in guiding regional and national health policies aimed at enhancing universal health outcomes throughout the Americas.

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