NCD-HLC Group 2-Working paper
Making the Global Push in 2019 to include NCDs and Mental Health in Universal Health Coverage frameworks

Recommendations

1. Countries should ensure that NCDs and mental health conditions are essential components of UCH and prioritize interventions that will enable speedier progress to SDG 3.4

2. Scale up more effective action on proven primary prevention policies including implementing accelerators based on national epidemiologic context and evidence-based interventions, particularly taxation, regulation, and legislation (Tables 1 and 2).
   a) WHO should increase assistance to Member States on implementation of highest impact accelerators.

3. Scale up accelerators of effective primary care with adequate support for team-based care and task sharing to improve prevention and management for NCDs and mental health along with coordinated referral and financial protection (Tables 1 and 2)
   a) WHO should provide practical support for countries, including examples of effective primary care.
   b) Primary healthcare must become a powerful vehicle for delivering NCD and MH services through;
      i. Health promotion and disease prevention, including implementing Essential Public Health Functions
      ii. Improving access to care, including access to healthcare professionals and, when needed, medicines, psychosocial support, and interventions based on evidence-based protocols
      iii. Strengthening referral systems to ensure close and effective relationships among all levels of the health system, along with integration and cooperation between social and health sectors

3. Countries must invest in the development of the health workforce and ensure that they are able to work to their full scope of practice:
   a) Healthcare providers (including nurses, community health workers and other health professionals, and, where appropriate lay counselors) should be empowered and enabled to deliver many of the services in primary care and in the community, making increased task sharing a priority.
   b) Healthcare workers skills to prevent and detect major risk factors and make early diagnosis should be ensured by basic and continuous education

4. Increase Accountability for progress on policies, risk factors, and health outcomes (particularly Civil registration and vital statistics CRVS), and provision of timely data for action including to civil society:
   a) WHO should greatly increase the quality and timeliness of monitoring of health policies, risk factors, and health outcomes (particularly CRVS)
   b) Countries should strengthen
      i. National capacity for surveillance and monitoring of NCDs
         i. Vital registration, risk factor data collection, disease occurrence, and health facility data, along with data interpretation and effective use of data.
         ii. Monitoring programme implementation and health impact assessment of policies in health and other sectors that affect NCDs and mental health.
Table 1. Examples of NCD accelerators

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*WHO Best Buy

Table 2. Examples of priority mental health interventions

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1. Introduction

Since 2010, the world has witnessed a surge of interest in the issues of noncommunicable diseases (NCDs), mental health (MH), and universal health coverage (UHC) through political commitment to policy and process. The World Health Report 2010 brought health financing for equity into policy discourse, showing the way for countries to achieve UHC.\(^1\) The political declaration on NCDs, adopted at the United Nations in 2011, ended the long neglect of a major public health challenge by affirming commitment to global action for the prevention and control of these diseases.\(^2\) The WHO Global Action Plan on NCDs, adopted in 2013, provided a framework for action.\(^3\) MH conditions, which contribute to a high burden of disease through disabling morbidity, suicide, and the myriad effects of substance abuse, were largely overlooked as a health priority. Fortunately, this group of disorders has now become very visible and is being addressed in the WHO Mental Health Action Plan (2013-2020).\(^4,5,6\) The Sustainable Development Goals (SDGs) firmly placed all three issues (NCDs, MH conditions, and UHC) on the agenda of global health action,\(^7\) recognising them as priorities that intersect with other development goals.

UHC provides the platform for improving public health and incorporating concerted action against a large array of health disorders. NCDs and MH conditions must be included because they cause profound suffering, impair social functioning and economic productivity, and lead to catastrophic health expenditure and premature mortality; additionally, they often have adverse effects on families and caregivers (a disproportionate number of whom are women). This impact on individuals and their families, when aggregated at the population level, leads to a huge economic cost to society through losses in productivity, healthcare costs, lost livelihoods, and decreased human capital.\(^8,9\) The promise UHC brings to people is the improvement of health through essential public health functions and quality health services to all as needed, with financial protection against hardships caused by healthcare expenditure.\(^1\) The goal of equity is also well served, as the poor are most vulnerable to NCDs and MH conditions as well as healthcare-related impoverishment. Out-of-pocket and catastrophic expenditures associated with these chronic disorders also negatively affect other areas of human development, such as education and nutrition.

Many NCDs and MH conditions can be prevented through political and societal action that results in healthier lifestyles. Proper care can lead to recovery but may also require long-term management. People with MH conditions are also at increased risk for other NCDs. At present, many national health systems are not configured to provide such prevention and long-term care, having been designed mainly for acute episodic care. As countries set out to design or reshape national programmes for UHC, there is a clear need to ensure that NCDs and MH conditions are included and that they are addressed through primary healthcare, which is the foundation of a well-functioning health system, as reaffirmed by the Astana Declaration of 2018.\(^10\)

Seamless integration of primary care with more advanced levels of specialist care (secondary and tertiary) must be a feature of efficient health systems that undertake to deliver UHC. NCDs and MH conditions may require both primary and specialist care. Follow-up care should be provided in primary care and community settings. Collaborative care models with case managers are one option to facilitate long-term care and coordination and, through UHC, to provide evidence-based and economically viable care for NCDs and MH conditions.\(^11\) The role of non-physician healthcare

\(^1\) Strengthening essential public health functions in support of the achievement of universal health coverage. WHA 69.1 http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R1-en.pdf
providers, such as nurses, other health professionals, and community health workers will be pivotal for the provision of NCD and MH services in primary care. They need to be trained and enabled with technology and supported by digital delivery platforms. Although such task shifting and sharing will greatly enable and empower non-physician healthcare providers, engaged in primary care also need training to enhance their ability to provide timely and appropriate care for NCDs and MH conditions.

NCDs and MH conditions are frequently associated as co-morbidities, especially in an ageing population. Co-existence of depression with hypertension, diabetes, cancer, and cardiovascular disease is frequent. MH conditions (including substance use disorders) worsen the outcomes of cardiovascular and metabolic disorders, while the latter are major contributors to premature mortality in persons with severe MH conditions. NCDs and MH conditions share common risk factors, such as sedentary behaviours, harmful use of alcohol, and unhealthy diets. Cardiovascular diseases, vascular dementia, and other neurological conditions such as stroke are related to hypertension. Further, medicines used for one condition can provoke or aggravate other conditions.

The burden of death and disability from NCDs and MH conditions are unequally distributed between women and men. Premature death predominates in working age men, and the mortality target of the SDGs cannot be met unless male mortality in particular is reduced. On the other hand, women, who enjoy a mortality advantage, suffer longer from chronic conditions, their illnesses are diagnosed later, and they have lesser access to care in many countries. The prevention and control of chronic diseases among women and men requires attention to cultural, behavioural, and service-related factors and should not be dismissed as the natural order.

Health and wellbeing are critical for people to lead a rewarding life and for children to flourish. Some conditions are associated with significant stigma, discrimination, and human rights abuses, pushing those affected to the margins of society.

2. The promise of UHC is more likely to be realized if the connection between NCDs and MH conditions and human capital is appreciated.

Human capital is a critical asset for the wealth and productivity of countries; NCDs and MH conditions can affect the quantity and quality of that capital. NCDs and MH conditions reduce human capital in the short term, mainly through their impact on adult survival and productivity. They also jeopardize the creation of future human capital, by negatively affecting educational performance. Countries increasingly recognize the critical importance of human capital for economic growth and competitiveness. Since 2017 more than 60 countries have joined the World Bank’s human capital project, signaling high momentum for investment in the creation, protection, and enhancement of their human capital. Today, recognition of the critical importance of human capital represents an unprecedented opportunity to accelerate progress in the prevention and control of NCDs and MH conditions. UHC provides the ideal framework for such action.

The growing concern for human capital and NCDs and MH disorders creates a window of opportunity for collaboration between WHO and the World Bank to help countries enhance their human capital by tackling NCDs and MH conditions through UHC.
3. **Disease prevention and health promotion are essential parts of UHC**

Many people at risk for NCDs and MH conditions can benefit from public health measures and services geared to health promotion and disease prevention across the life course. The health system must offer specific services for health promotion at community, family and individual levels to promote health and well-being, as well as to prevent the acquisition and aggravation of risk factors and diseases. It is essential to see health protection and promotion and the identification and treatment of risk factors such as high blood pressure, elevated blood lipids, and diabetes as part of UHC. Patients need support for tobacco cessation. UHC must support health protection and promotion activities, including norms and standards setting, taxation and regulation of marketing and promotion of unhealthy products, and community-based approaches to supportive environments for health and health education programmes for promotion of healthy diets, regular physical activity, MH promotion, avoidance of tobacco and substance abuse, harmful use of alcohol, de-stigmatisation of MH conditions, and awareness of risk factors and diseases for self-care and self-referral. Countries must be alert to the danger that medical professionals who select the service coverage components of UHC tend to overlook or undervalue public health services and functions. If UHC is to provide the comprehensive array of services needed for the health and well-being of populations, public health, health promotion, and disease prevention should be regarded as one end of the service continuum that extends to diagnostic, therapeutic, rehabilitative, and palliative services.

4. **Gaps in the detection and management of NCDs and MH conditions must be overcome by UHC**

At present, there are wide gaps between the high disease burdens of NCDs and MH conditions and the ability of health systems to detect and manage them in a cost-effective way, especially in low- and middle-income countries (LMICs). Age-adjusted cardiovascular mortality rates are higher in these countries, even though high-income countries (HICs) have higher levels of cardiovascular risk factors. This is attributable to differences in the ability of healthcare systems to detect and effectively manage these risks. Population surveys of hypertension and diabetes show that the proportion of persons who are aware that they have these disorders and have been started on treatment and are effectively controlled is low in many LMICs. The care received by persons with MH conditions is deficient across all countries. Even in HICs, treatment gaps (which reflect access barriers) often exceed 50% for common conditions such as mood and anxiety disorders, while the gap for these exceeds 90% in LMICs. When advanced care is required, which often warrants hospitalisation and use of expensive technologies treatment gaps are very high in LMICs, owing to the limited availability of services and the extremely high cost of treatment. This is most strikingly evident in cancer treatment and heart surgery but extends across a wide spectrum of care for NCDs and MH conditions in LMICs. This is exemplified by the challenges of ensuring aerosol therapy for asthma, insulin for persons with diabetes, and psychological therapies for those who need them. UHC should overcome these challenges by accommodating the treatment needs for NCDs and MH conditions, while reducing costs and expanding the capacity for early detection and treatment in primary care. UHC must also be highly sensitive to concerns about equity to ensure that those who are least likely to seek care because of disabling conditions or stigma (e.g., persons with schizophrenia or severe depression or stroke survivors) or because of costs (as in treatment for cancer or rheumatic heart disease) can receive appropriate care.
Acute exacerbations and complications of NCDs and MH conditions will require referral care. An effective referral system ensures a close relationship between all levels of the health system and helps to ensure people receive the best possible care closest to home. It also assists in making cost-effective use of hospitals and primary healthcare services. Support to health centres and outreach services by experienced staff from hospitals or district health offices helps build capacity and enhance access to higher quality care.

5. **Healthcare providers (particularly nurses, pharmacists, and other health professionals, and where appropriate, community health workers and lay counsellors) should be empowered to work to their full scope of practice and enabled to deliver many primary care services in the community in an integrated fashion.**

Individuals and communities have a right to receive healthcare from nurses and other healthcare providers whose educational preparation meets their needs, meets the standards of the profession and the scope and demands of practice, for people living with NCDs and MH conditions. A well-equipped multi-disciplinary health workforce is at the core of enabling health systems around the world for the delivery of high-quality, accessible, and affordable healthcare. Without appropriate and extensive use of non-physician health providers (such as community health workers), the goals of UHC will not be met. It needs to be recognized that most of these providers are women.

Scaling up non-physician healthcare providers for NCDs will require protections for the health worker and the patient. This includes enabling legislation; effective policies; accessible, affordable and high-quality education (with formal recognition of programmes); commitment from employers; supportive funding models; leadership; and the collection and analysis of data and information.

6. **What are the accelerators to achieve the SDG 3.4 target (within and beyond the UHC Benefit Package)?**

With only a few years remaining for the SDG target to be met, the world needs to accelerate the NCD response. Although many interventions exist, the most effective and feasible should be considered as a priority—these are known as “accelerators”. Governments should identify and implement a specific set of priorities within the overall NCD and MH agenda, based on their public health needs. Table 1 presents a set of accelerators and the impact they will have on the SDG 3.4.1 indicator. Table 2 presents a list of priority interventions for mental, neurological and substance use disorders. These are not exhaustive lists; countries should choose interventions depending on their context, capacity, and public health needs.

Taxation of tobacco should be increased in all countries, and alcohol and sugar-sweetened beverages taxed wherever these represent significant drivers of NCDs; taxation of salty food and of carbon emissions are newer areas that could have major health benefits. Regulation is an essential component of NCD action, including on tobacco (taxation, bans on advertising, marketing, and promotion, smoke-free laws protecting workers and the public from second-hand smoke, plain packaging), alcohol (taxation, bans on advertising, marketing, and promotion, drink driving, outlet reduction and hours), healthy food in public places and public procurement, and industrially produced trans-fat. Newer regulatory approaches include the possibility of reducing nicotine in tobacco products, implementing front-of-pack warnings on unhealthy (including salty) food, and regulating sodium levels in specific foods. New harmful nicotine products that are addictive and
toxic require regulatory attention. Environmental action to reduce indoor and ambient air pollution could save millions of lives.

Table 1. Examples of NCD accelerators to reach the SDG 3.4.1 target of a one-third reduction of the risk of death from NCDs among people ages 30-69

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Table 2. Priority interventions for mental, neurological, and substance use disorders by delivery platform (Source: DCP 3)

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| **Community platform** | - Life-skills training in schools to build social and emotional competencies  
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- Diagnosis and management of alcohol dependence  
- Opioid agonist treatment for opioid dependence  
- Interventions to support carers of persons with dementia  
- Diagnosis and management of epilepsy and headaches  
- Self-managed treatment of migraine |

Healthcare systems must provide affordable, patient-centred, team-based treatments for NCDs far more effectively than they do now. These include treatment of hypertension; prevention and treatment of cancer (cervical, liver, colon, selected leukemias/lymphomas, breast); treatment of diabetes, chronic lung disease, mental illness, and epilepsy; access to essential medicines, diagnostics, and equipment; and accurate and timely information systems. It is important to recognize the central role of people living with NCDs and MH conditions in guiding priority-setting.
(for types of interventions), their delivery, and evaluating the quality of services. The call of “nothing about us without us” championed by disability activists is equally true of these conditions.

7. How should UHC ensure financial protection for services for NCDs and MH conditions?

The inclusion of NCDs and MH conditions in the service package of a national programme of UHC will be guided by the choices made in the context of the country’s health needs and resources. The selection will need to cover: health promotion and disease prevention; identification and case detection; and treatment, care, and rehabilitation. The delivery platforms will be at several levels: population, community, healthcare facilities at primary health centres, first-level hospitals, and referral centres. The choices may be guided by public health needs; evidence of effectiveness; cost effectiveness; affordability; implementation capacity; feasibility, according to national circumstances; and impact on health equity. Recommendations made in the WHO Global Action Plan for NCDs and DCP 3 are useful guides to making these choices. In addition to cost-effectiveness analysis, DCP 3 also employs extended cost-effectiveness analyses to assess how much financial protection is provided by an intervention. For example, a needed treatment for a cardiovascular condition or a treatable cancer may, even if seemingly expensive, prevent a high level of out-of-pocket or catastrophic expenditures that may induce severe financial hardship or poverty. Health technology assessments are useful for the identification of cost-effective interventions. Equity, especially for vulnerable people, makes treatment for MH conditions such as depression and schizophrenia, and neurological disorders such as epilepsy, as well as highly responsive cancers such as cervical cancer, a high priority.

The resources available at any one time for UHC will determine the number and nature of NCD and MH-related services that can be included in the package. These should progressively increase as more resources accrue. Fiscal measures, such as taxation of alcohol and tobacco products and sugar sweetened beverages, will not only have a population-wide impact that benefits NCDs and MH conditions, but can also raise resources for the inclusion of services in the UHC package.

8. Monitoring

Monitoring is critical and includes the major risk factors, medicines access and affordability, and vital registration, with optimal additions for healthcare quality, cancer registries, and newer surveillance modalities.

The indicators for tracking progress in UHC include the extent of the population covered by the programme (access) and the level of financial protection. The choice of additional indicators that are NCD- and MH-specific depend on burden of disease, risk factors and financing and provisions of services chosen for the country’s UHC programme. The indicators proposed by WHO for tracking progress on UHC provide a useful guide. The monitoring of the quality of services must include assessments by people who have come into contact with these services.

9. Communication to Policymakers

Although policymakers have committed to SDG 3.4, the critical importance of incorporating the prevention and control of NCDs and MH disorders needs to be effectively communicated to health ministers, finance ministers, and heads of state. Key messages that will facilitate such communication are presented in Appendix I.
Appendix I

Key messages to be communicated to policy makers

NCDs and MH conditions impose high disease burdens in all countries
- NCDs and MH conditions are major contributors to the global burden of disease, through premature mortality and prolonged morbidity and disability.
- The poor in all countries bear the greatest burden. Disease burdens are now rising, with higher burdens in low- and middle-income countries.
- The UN High-level Political Declaration (2011) and the WHO Global Action Plans for NCDs and mental health (2013-2030) recognise these burdens and call for urgent and effective actions for prevention and control.

NCDs and MH conditions also impose high economic and social costs
- NCDs and MH conditions impose high economic costs on all countries (projected USD $47 trillion globally 2011-30).
- High out-of-pocket and catastrophic expenditure push affected persons (and families) into poverty.
- Expenditures on NCDs and MH conditions divert family income from education and nutrition, countering many SDGs.
- NCDs and MH conditions diminish people’s quality of life and their wellbeing.
- Human capital is diminished in quality and quantity by NCDs and MH conditions.

Prevention and control of NCDs and MH conditions are central to the success of UHC
- Effective actions for prevention and control of NCDs and MH conditions are proven, available, and essential if the objectives of UHC (access, equity, quality, and financial protection) are to be achieved.
- Measures such as norms and standards setting for quality, availability, and marketing, higher taxes on and regulation of harmful products, and public subsidies for healthy products are essential for the prevention of NCDs and MH conditions.
- These actions should combine population, community, and health service-based approaches to deliver a range of services covering health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative care, as well as to fulfil essential public health functions. Early childhood care is an important element.
- People with the lived experience of these conditions must be empowered to play a central role in the design, delivery, and evaluation of interventions.

NCDs and MH conditions have several common features
- Common features include overlapping risk factors; high potential for prevention; need for chronic continuous care; frequent occurrence as co-morbidities; potential for negative interactions (when neglected) and synergistic benefits (when managed together); wide gaps in awareness, treatment, and control across all health systems; and health system gaps in LMICs that result in high case-fatality rates and morbidity.

There is a pivotal role for primary care in addressing NCDs and MH conditions
- The greatest health and economic gains in achieving effective prevention and control of NCDs and MH conditions through UHC will accrue by strengthening the capacity to deliver and support comprehensive prevention and primary healthcare.
- Health systems must achieve efficient integration between primary care and advanced care.
- Health professionals are supported and encouraged to make every opportunity count in addressing risk factors and early identification of NCDs.

A multidisciplinary approach to care will be the great accelerator
- Healthcare providers should be empowered and enabled to deliver appropriate services in primary care.
- Supervised non-physician healthcare providers are among the most effective contributors to the prevention and control of NCDs and MH conditions and are essential to achieving the goals of UHC. UHC must invest in them as a high priority.
- The development of Advanced Practice Nurses and other health professionals should be sought as an effective means of increasing access to quality and affordable healthcare. This will require investment in education and continuing education programmes.

Benefit packages will be set by national priorities on a path of ‘Progressive Universalisation’
- The WHO Global Action Plan (Appendix 3) and DCP 3 provide guidance for selection.
- Within the national context, choices for inclusion in the package may be based on: resource availability; impact on human capital; evidence of effectiveness and cost-effectiveness of interventions; implementation capacity; and impact on health equity.
- During the development of UHC benefit packages, countries should prioritise accelerators that will enable speedier progress to SDG 3.4.
References: