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UN High-Level Meeting on UHC

Contents

In focus

At the high-level meeting of the UN General Assembly on Thursday, 21 September the delegates will consider a compromise document on universal health coverage (the 1 September draft political declaration) which a number of countries have already denounced (because of the non-consensual removal of a paragraph deploring unilateral coercive measures).

Nevertheless, the draft political declaration does not obscure the shortfalls with respect to the commitments in the 2015 Sustainable Development Goals regarding access to services and financial protection. Rather, the draft declaration invites the delegates to recommit to those targets without a full analysis of why the UHC goals are not being achieved.

Driving the policy movement for UHC are the denial of access to health care (because of out-of-pocket costs) and the frequency of health care impoverishment. In some degree the concern regarding access barriers and healthcare impoverishment reflects the accountability of governments to their peoples but at the level of high geopolitics, there is also a concern to defend the legitimacy of capitalist globalisation.

Behind the flow of rhetoric around UHC is a deep tension between two models of healthcare delivery: universal access to healthcare through publicly funded and publicly administered healthcare services versus 'universal coverage' (meaning publicly sponsored health insurance with strategic purchasing of a 'basic package of essential services' from a mix of service providers) complemented by a market place of private health insurance plans and private providers for services beyond the package.

In part the proponents of UHC are focused on keeping space for corporate suppliers of services, medicines, and equipment (led by the World Bank, Rockefeller, and various USAID funded think tanks). However, the drive for UHC (rather than universal access) is also about restricting the need for public spending by imposing limits on the basic package. Behind these debates looms the inadequacy, in many L&MICs, of public funding for health care generally (whether for publicly provided services or for subsidised insurance coverage).

What this draft declaration does not do is to ask why public funding for health care is so inadequate in so many L&MICs. References to debt burden (and restructuring or cancellation) and a reference to illicit financial flows in an earlier draft have been removed from the previous draft. There is no discussion of tax avoidance or the extortion of tax concessions as a condition for foreign investment. Most critically there is no consideration of the global economic regime of unequal exchange and deepening inequality.

In view of the repeated use of Section 301 of the US Trade Act to prevent countries from fully deploying the flexibilities allowed for in the TRIPS Agreement, the insistence (by US, UK, EU, Switzerland, Canada, Australia and New Zealand) on the removal of the reference to unilateral coercive measures is cynical in the extreme.

As a policy forum, the UNGA provides space for L&MICs to be heard but, outside the General Assembly, policy implementation is largely driven by the World Bank, the big US philanthropies, the G7, and the big bilateral aid providers.

However, the governors of the global regime remain concerned about the perceived legitimacy of this regime and the need to (at least appear to) address denial of access and healthcare impoverishment. PHM calls upon civil society organisations and social and political movements to amplify their critique of the failures of the UHC promise (and the SDGs promises more broadly) but to link this critique to an explication of the ways the current regime of capitalist globalisation reproduces global inequality and unequal exchange. Political leaders in the global South must be encouraged to stand aside from the shadow boxing and demand real action on health care access, including the structural reforms needed to ensure adequate health care budgets.

Background

On 10 Oct 2019, in A/RES/74/2, the General Assembly adopted The Political Declaration of the High-Level Plenary Meeting on Universal Health Coverage. By way of follow up the PD requested the SG to provide a progress report to the 75th session of the GA (provided 5 Nov 2020 in A/75/577) and a report to the 77th session (provided 5 May 2023 in A/77/876).

The 2019 Political Declaration also decided to convene a further HLM on UHC in 2023 “to undertake a comprehensive review on the implementation of the present declaration to identify gaps and solutions to accelerate progress towards the achievement of universal health coverage by 2030”. It is this follow up HLM which is the focus of the current agenda.

On 26 July 2021 the President of the General Assembly submitted a draft resolution (A/75/L.120) entitled Scope, modalities, format and organization of the High-Level Meeting on Universal Health Coverage. On 28 July 2021 the USA and UK tabled an amendment (in A/75/L.124) which proposed the deletion of a paragraph from the President’s draft which requested the Secretariat to engage with other UN agencies, in particular, the WHO, in

planning for the HLM. The offending para does not appear in A/RES/75/315 which was adopted by the General Assembly on 17 Aug 2021.

In accordance with the modalities resolution co-facilitators were appointed to manage the preparations for the HLM and in a Letter from the President of the General Assembly (31 March 2023) the proposed roadmap for UHC consultations was circulated.

On May 9 a series of interactive multistakeholder hearings on UHC was organised (see Concept note (from letter from President of GA, 28 March 2023). A summary of the discussions was circulated in a Letter from the President of the General Assembly, 2 June 2023).

The Zero draft of the Political Declaration on UHC was circulated on 22 May 2023 in a Letter from President of GA (24 May 2023). The Rev.2 version (dated 17 July 2023) is here.

The Rev.2 version would have been the final version if it had survived the Silence Procedure but it didn't. The final 'PGA Draft" of 1 September is here. The President of the General Assembly refers to this draft as the 'best compromise' achievable.

On 18 July 2023 (in A/77/L.85) a draft decision on the Participation of non-governmental organizations, civil society organizations, academic institutions and the private sector in the High-Level Meeting on Universal Health Coverage was submitted by the President of the General Assembly and adopted by the Assembly.

See also:

- the UN's SDG Report 2023, Special Edition; see 'progress slowed towards UHC' (from page 19);
- Links to previous WHA discussions of UHC including WHA76.4 'Preparation for the HLM of the UNGA on UHC';
- recent commentary on UHC.

PHM Comment

According to the 2019 Political Declaration the purpose of the forthcoming HLM is "to undertake a comprehensive review on the implementation of the present declaration [2019] to identify gaps and solutions to accelerate progress towards the achievement of universal health coverage by 2030". This remains the purpose of this 2023 Political Declaration as well.

These comments are based on Rev.2 version of the draft Political Declaration of 17th July 2023. We begin with a paragraph by paragraph comment that also helps readers understand the issues that are covered and then conclude with an overview of the declaration, its strengths and inadequacies.

A. Introductory Section: Paragraphs 1 to 17

1. The first 17 paragraphs are a re-assertion of the basic premises of the declaration. We appreciate, in particular, the re-assertion of the international commitment to Right to Health (para 1), the political commitment to accelerating commitment to achieving UHC as stated in the SDGs (para 2), the re-affirmation of the 2015 commitment to achieving the SDGs by 2030, and suitable financing for the same (paras 3 & 4). It then goes on to recall and reaffirm the resolutions made by the UN High Level Meetings on HIV/AIDS, antimicrobial resistance (AMR), tuberculosis, non-communicable disease, road safety and elimination of malaria. (para 5). There is a call for coordination across the three HLMs happening in the next month para 6) and the relevant declarations of the recent World Health Assembly 76.

2. In para 9 the political declaration sets out its earlier stated commitment to national ownership with the primary role and responsibility of the government in setting out the road-map, only calling for what is termed a whole-of-government, and whole-of-society approach as well as health in all policies, equity-based, and life-course based approaches. This goes along with the reiteration of the understanding that all of this needs investment in human resources.(#10)

3. Para 11 starts with a working definition of UHC, and reiterates some of its core principles- equity, social justice, social protection (#12, #13, #14, #16, #17), the link with food security and food safety, the action required on NCDs and Mental Health and the health sector role in adaptation to climate changes and natural disasters. (para 15)

B. Progress Towards UHC: Taking Stock (paras 18 to 45)

1. The next paragraphs from paras 18-45 provide for a very sobering situation analysis and call for a major reflection on the strategy thus far. To put it briefly, progress in almost every dimension of UHC outlined in the first 17 paragraphs has been very disappointing. In para 18, the declaration points out that service coverage has stagnated since 2015 and financial protection has worsened. Access to essential services and medicines could be only about 50% of the modest targets set. In subsequent paragraphs it refers to similar poor progress in all the disease specific initiatives- NCDs, mental health, alcohol and substance abuse, visual defects, communicable diseases etc. There is also stagnation reported in reduction of maternal and under 5 deaths. Similar stagnation or set-backs are seen in the action against AMR, in road traffic emergencies, in occupational health, environment related deaths- and in rehabilitation services.

2. Disaggregating by life course, there is high persistent, perhaps growing mortality in the 15 to 24 age group, in the elderly, in sexual and reproductive health, in disability, in migrants and indigenous peoples and other vulnerable groups. (paras 20 to 27). These paragraphs also point to delays in surgical care for pregnancy and high prices constraining access and affordability.

3. Paras 32 to 33 reasserts the importance of PHC in all its dimensions for addressing these gaps but remains strategically silent on whether there has been any movement towards this.

4. A similar reiteration of the commitment without any details of progress, is seen in the paragraphs related to building Resilience and One Health, and on government legislation and peoples' engagement for increasing accountability.

5. The deletion of para 31 from the Rev.2 version of the declaration (17 July) is unfortunate. This para proposed to "recognise the importance of refraining from unilateral economic, financial or trade measures not in accordance with international law and the Charter of the UN that impede full achievement of UHC". The para is taken from A/RES/70/1, which is the resolution which launched the SDGs. It is understood that the countries demanding the right to impose illegal unilateral sanctions include the US, UK, Switzerland, Canada, Australia and New Zealand. (In a letter (17 Sept) to the President of the 78th General Assembly a group of countries which have been subject to unilateral coercive measures, put in place by the US, Britain and Europe, challenge the legitimacy of the whole process.)

6. The recognition (in para 83) of the continued dominance of OOP payment for health care and the lack of progress on pooling is welcome. The recognition of the inadequacies of development assistance for health care, and the need to address wastage of resources through inefficiency are also appreciated.

7. In paras 91-93, several important points are made regarding the health workforce: that most LMICs have insufficient workforce and they are losing large numbers through migration (over 15%); second, the need to develop the health workforce with more skills and better terms of employment and third to bring more women into leadership roles.

The Call to Action

This part of the political declaration (from para 46 onwards) is disappointing to civil society and unhelpful to governments. The general tenor of this section is to call for strengthening the resolve to address the above gaps, guided by the earlier resolutions. That is just not good enough. Halfway through to the time period set for achieving SDGs, when we are comprehensively slipping back on the targets, a more searching analysis and fresh ways to address the problems are required. The Call to Action needs to be visionary and more ambitious. It should be specific enough to guide action. There must be an explicit statement that the situation with regard to universal health coverage is getting worse, and that must not be allowed to continue. That universal health coverage has often been misunderstood as competitive private insurance coverage must be acknowledged and one of the correctives that PHM would call for is to change the term, 'Progress towards UHC' to 'Progress towards achieving the Right to Universal Health Care' as a part of the vision of achieving the Right to Health as defined in the Health for All declaration. The Political Declaration must call for a

change of strategies. Just reiteration of earlier commitments as the Call to Action while necessary is not sufficient.

The reiteration of PHC is welcome (paras 49-51). But why has it not taken off? One reason we suggest is a structural policy incoherence. On the ground, as reported by many PHM country circles and allies, UHC has become closely equated with publicly funded (or subsidised) health insurance and “strategic purchasing” of health care. We note that in the text of this declaration there is no mention of it. At one level this non-mention is welcome since we know that these approaches are not working. But the failure to acknowledge this incoherence between policy declarations and practice in the past facilitates such incoherence in the future also.

One of the other reasons why even public provision of primary health care has not done well is the persistence of selective, fragmented, vertical silo approaches. For example PHM raised its concern on the NCD resolution in WHA76 stating that NCDs are being limited to a set of fragmented vertical interventions in the 4*4 framework, and we do not see any horizontal integration with the PHC approach. This can be said of most other disease control programs also. In paras 57-59 we find that each specific disease is named and a call is given to address it, and by implication each of these are stand-alone vertical programs. If this has not worked in the first 8 years, why will it work in the remaining seven? Unless there is a recognition of the fragmentation of primary health care that these vertical approaches are causing, progress on establishing UHC will be impossible. Nor will the vertical programs do better- as is seen in the failure of the tuberculosis elimination programme where over a third of patients with symptoms never access any effective care.

A related strategy failure is the persistent equation of primary healthcare approach with primary level approach. This fails to recognise that the primary health care approach includes the issue of access to free, good quality secondary and tertiary care support. Some vertical disease control programs see this link, but these are not seen as part of establishing universal primary health care.

In paras 61 & 62 the articulation of gender rights is weaker than in earlier drafts and this requires it to be amended. It is not adequate to merely mention that “the human rights and specific needs” of women should be considered. In the earlier 2019 draft the call was for “the realization of their human rights, consistent with national legislations and in conformity with universally recognized international human rights, acknowledging that the human rights of women include their right to have control over and decide freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence” This earlier articulation is essential and should be retained. Similarly in para 62 it is important to state that integration of reproductive health into national strategies and programmes, is fundamental to the achievement of universal health coverage, while reaffirming the commitments to ensure universal access to sexual and reproductive health and reproductive rights.

In paras 69-77, the political declaration breaks fresh ground with respect to access to medicines, especially paras 72 to 75, where it calls for making technology affordable, encouraging domestic manufacture and transfer of technology. Also reiterates the implementation of TRIPS flexibilities and Doha declaration. It is important for participating LMICs to support and strengthen these paragraphs. The PHM notes with concern that para 74 still appeals to voluntary licensing. The Covid-19 pandemic has once again demonstrated that mild, unclear and voluntary approaches are neither sufficient nor suitable for managing public investments aimed at equitable access to medical products. Instead, time-limited waivers of IP rights, as well as the mandatory transfer of technology and expertise, are crucial to ensure that no one is left behind. These can and should be conditions when public funding has been invested

On digital health tools, paras 78 to 82, there is a call for improving its use while safeguarding privacy. No mention is made as to whether this is happening and the dangers of the surveillance state, and our understanding is that in most countries the legal and administrative framework to ensure this is not in place. Additionally, reports from PHM LMIC country circles are of huge investments in digital tools that only increase the burden on the frontline worker, but provide little actionable information for addressing the problems of access, equity or quality of care. But there is little reflection of the ground situation in the highly techno-optimist formulations of these paragraphs.

On healthcare financing, paras 83 to 90 make a general call for increased public health expenditure. However the target it sets for increase in expenditure in primary health care, 1% of GDP, is far too modest for most LMICs that are lagging far behind. Again the problem is the lack of any specific analysis of past failure or actionable solutions, or even examples of countries that have made up the deficit. Most low and middle income countries have inadequate taxation, of wealth and corporate income in particular, and unsustainable levels of debt servicing, especially to external creditors which constitute formidable drains to the public purse. Without systemic solutions to address these drains, countries cannot hope to make good progress towards UHC. The Political Declaration could have called for a UN tax framework and tax body, building on the recently adopted milestone resolution (A/RES/77/244) on ‘inclusive and effective international tax cooperation’; It could also have called for a debt resolution framework under UN aegis, that binds all creditors and offers timely, fair and comprehensive debt cancellation and restructuring to all countries in need. (Source: based on report A/77/169 and UN resolution (A/RES/77/244)). But these opportunities are lost.

PHM appreciates the deletion of what was OP42 in the July Rev.2 version of the declaration. This para would have called for “mobilization of additional financial resources through the use of innovative financing approaches and mechanisms, including private sector financing, with appropriate regulatory oversight” to close financing gaps for health.” Too often innovative financing approaches only mean different market mechanisms and resort to private financing. There is simply no evidence that such mechanisms help, and on the contrary, there is evidence that many of these harm progress towards UHC and equity. Harmful effects observed include

cost escalations, commercialization of essential healthcare, especially in public-private partnerships, which not only reduce access but can also lead to direct human rights violations such as hospital detention. Also not every type of partnership or innovative financing mechanism is automatically helpful and good. Member States need to be critical in choices regarding the channeling of external finances.and that only those that contribute to UHC and health equity and are governed in the public interest are considered.

It is unfortunate that the call for debt relief and debt restructuring in OP 44 of the July Rev.2 version has been watered down (to 'debt financing as appropriate' in para 89 of the 1 September version. On the contrary it should have been strengthened to include debt cancellation.

Health workforce call to action is covered in paras 91-95. These reiterate past WHO resolutions in this area and the World Health Organization Global Code of Practice on International Recruitment of Health Personnel. While a reminder and reiteration of this code is welcome, the reasons for its current non-implementation and required correctives need to be stated. Reducing the pull factor (requirement for more health workers in developed nations) by retaining their health staff better, and reducing the push factor (health workers wanting to leave developing countries) by less precarious, better employment conditions both require to be addressed. The political declaration loses the opportunity to make the case for countries to shift away from precarious, unsafe, contractual employment to regular employment using participatory management methods to address performance issues. There was a need for a much stronger advocacy to close the gaps noted in human resources for health.

In health emergency preparedness (paras 96 to 99) the main emphasis is a call for action on all those areas flagged as areas of concern in the first section. This theme is dealt with better in other declarations, but in this declaration, it bears repeating that without universal access to healthcare in place, as different from mere insurance coverage) there can never be any significant level of emergency preparedness.

The reiteration of the importance of monitoring and accountability (paras 100 to 107) is welcome, but a better engagement with the problems faced in measuring equity of access is needed. There is a welcome mention of the measurement of unmet needs as one of the indicators for measuring access to healthcare- but this requires much greater emphasis and follow up.

The Report closes with the call for the next HLM in 2027 to be held in New York.

In conclusion:

Re-thinking UHC as a strategy:

The PHM understands from the Political Declaration that the world is NOT on course to achieve UHC. In fact, on both key concerns that were the basis of introduction of UHC-

coverage and financial protection, there has been stagnation and setbacks in the past seven years. This is not merely the failure to implement strategies- it is also the choice of wrong strategies and the structural policy incoherence.

Though global institutions solemnly state that countries are free to choose their own road-maps to achieve UHC, what most countries have seen is a push from the global health and financial institutions to equate UHC with financial protection and financial protection with publicly funded market based insurance schemes or other forms of purchasing from private providers. The insurance schemes being introduced are largely forms of commercial insurance that financially protects the subscribing individual or household from the cost that they would have to pay out of pocket to receive care when required. Most such insurance schemes very inefficiently target coverage to administrative definitions of poor and vulnerable households, and expend a lot of effort in maximizing private sector participation, often at the cost of undermining public services. There has been almost no mention of single payer systems and expanding social protection to reach all organized and unorganized workers.

Given the unwillingness to expand on public resources, the search is for limiting coverage to so-called cost-effective interventions. Cost-effectiveness studies have a role in selection of appropriate technologies for an intervention, but not as a back-door to selective care. This strategy in combination with the vertical disease control program approach limits primary health coverage to packages that have included some additional diseases as compared to the nineties , but still has left the major part of care to private markets. Such an understanding makes us recognize the causes of our failure much better. In effect UHC became another route for the increasingly intense and extensive privatization of medical care in all countries of the world, but its limitations to guarantee the right universally was demonstrated with the COVID-19 pandemic.

Further this UHC logic focuses on the care of the disease when it occurs, not on the prevention of the disease and, much less, on the promotion of health, understood as the achievement of the best living conditions to carry out individual and collective projects. of people, families, and communities.

An approach to achieving Universal Access to Health Care as a right and as a sub-set of the Right to Health, requires to be based on networks of publicly administered healthcare facilities at all levels of care, provided integrated comprehensive packages of care where only exclusions are specified along with justifications, and health human resource policies, access to technology policies and digital health policies

Addressing the Structural Constraints to Universal Health Care and Health for All

Much of the limitations of this political declaration arise from its working within the assumptions of capitalist economic growth and unsustainable development policies, and its adoption of a deeply Eurocentric and biomedical approach to health, based on disease/mortality

interventions. There is no commitment to address the increasing poverty and social inequalities in health accelerated by the Covid-19 pandemic. Further it continues to exclude ancestral, emancipatory, and decolonial visions of health issues. A global debate in another direction is required if we really want to advance in the effective enjoyment of the right to health, within the framework of the interdependence of human rights and the rights of nature, and decisively reverse the ongoing environmental and climate crisis.

To address growing global inequities the Political Declaration must also call for global solidarity to help low and some middle income countries in investing in PHC through a global initiative. These initiatives would need to prioritise vulnerable groups, especially migrants and war affected populations. Recently, the WB and some other development banks are proposing financial support for strengthening health systems through loans but these are already highly indebted and poor countries and repayment of such loans becomes a further burden. Moreover these loans come with conditionalities that explicitly or by more indirect means promote privatization. What is required is a robust program of debt restructuring and cancellation along with the creation of a global fund that supports investments for UHC in LMICs and which is administered by an inter-government mechanism where LMIC interests lead, and which is kept free of corporate influence. The Political Declaration must give much further support to LMIC governments for raising the required resources through a) tax justice and b) exemption from debt linked to expanded expenditure on health care, c) reduction in inequity in development policies.

There has to be a much clearer articulation that all health services should be seen as a global public good and not as a commodity that promotes capitalist accumulation. The challenge is not only public financing, but how best provisioning of services is organized. This requires state investment in public health infrastructure and human resources. The excessive focus on financing assumes that supply side already exists or will emerge in response to demand side financing, when this is far from true. Purchasing care from a market based private sector has been tried extensively under UHC and is not working. Often it is worsening the situation, and it is the poor who are affected most. It is not only health services, but medical and professional education that requires to be de-privatized and re-oriented to serve the public good. If professional education is high-cost then graduates by selection and financial compulsion will not opt for public services or serving under-privileged communities. Encouraging super-profits in some sections of the private health care sector would drain human resources internally . There is also a need for better regulation of the private sector in health and in many countries active de-privatization may be required.

The logic of capitalist economic growth accepts that goods and services that circulate in biomedical care are expensive, because they are increasingly based on science and technology, which is naturally expensive. And this high cost depends on the intellectual property rights (IPR) that are considered necessary to drive innovation. However, this relationship between innovation and IPR is part of a profound transformation of the capital accumulation regime in the global sphere that has been called “cognitive capitalism” and that

crosses all sectors of the economy, including biomedical care services. In this way, both IPRs and UHC turn out to be subordinate to the needs of this enormous accumulation of capital, concentrated in the Global North and in certain monopolies, which is what really explains the accumulated inequalities and the persistent frustration with the measures proposed in the Declaration.

Bilateral and plurilateral trade agreements must be examined for provisions that limit access to medicines and self-reliance in domestic manufacture and innovation. IPR regimes must be subordinate to ensuring healthcare as a right. Bilateral and plurilateral trade and/or investment agreements with ISDS (Investor State Dispute Settlement) provisions should never be allowed to cover any aspect of the health sector. There is a need for a global agreement that bilateral, plurilateral and multilateral trade agreements including- ecommerce having provisions regarding trade in services should not adversely impact health equity or the strengthening of public services, or efforts to establish health services as a public good.

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Notes of discussion