Feedback and comment on this item page - and in particular the PHM comment section - would be most appreciated. Please write to editor@phmovement.org

Item 6. UHC

Contents

In focus

The Director-General will submit a report (EB154/6) that summarizes the present situation for universal health coverage and the outcomes of the seventy-eighth session of the United Nations General Assembly, with the release of the global monitoring report for 2023, published jointly with the World Bank, and the second High-level Meeting on Universal Health Coverage, with the adoption of a new political declaration on universal health coverage. The report (EB154/6) will highlight the commitments made to achieve universal health coverage by reorienting health systems and investments to a primary health care approach. The Board will be invited to note the report and identify ways to implement the political declaration before the third high-level meeting scheduled to be held in 2027.

Background

Link to previous discussions (WHO and UNGA) about UHC.

Priority setting for UHC (2016)

KEI statement on Universal Health Coverage (24 Jan 2024)

PHM Comment

This report by the DG on progress towards the achievement of UHC is made at the halfway point of the commitment made in 2015 to reach UHC by 2030. This Report is also a repeat and reiteration of the Political Declaration on UHC that was adopted in the High Level Meeting on UHC, adopted by the United Nations General Assembly at its 78th session on 5th October, 2023.

Based on the WHO's global monitoring report for 2023 on tracking UHC, released on 18th September 2023, the world is well off track on the road map to achieving the 2030 targets and the report spells out clearly how far off it is. Almost 2 billion persons, or about one fourth of the world's population, experienced catastrophic health spending or impoverishment due to healthcare costs according to the most recent data available (2019). When it comes to universalization of essential services that can be accessed, there has been a stagnation since 2015. This means stagnation on the objective of increasing access since 2019 and consistent

worsening with respect to financial protection since year 2000. The report adds that this dual lack of progress on service coverage and financial protection is consistent across all geographic regions and countries (see para 3 to 12 of the report). In para 14 of EB154/INF./1 the document warns*: "*Emerging evidence shows increased financial hardship, especially among the poorest, with an uneven recovery post-2020/2021. A notable concern is the higher public spending on national debt over health in developing countries."

Clearly the Covid 19 pandemic was one cause of this lack of progress. That is itself a problem, since one of the reasons for achieving UHC is to better cope with pandemics. But the pandemic is not the entire story. The worsening of financial protection has been a constant, before, during and after the pandemic. The policies that are called for, include: (a) an increase in health funding, (b) the efficient and equitable use of such funding, (c) the strengthening of the health and care workforce, and (d) the expansion of primary health services and the orientation of health systems towards a primary healthcare approach. These have not been put in place or taken to the scale required.

The report does not dwell on why such a failure occurred. It contents itself with a call for "re-doubling efforts to accelerate progress towards UHC" and repeats all the earlier policy calls and concludes with a report on the next round of progress reports to the UN at its 2024 session and the next high-level meeting to be convened in 2027 (referring to paras 13 to 21 of the report). Implicitly, it is stating that the WHO and global agencies have done what they can do, and now it is up to the member states to take it further. It explicitly asks member states to spell out how better WHO can help. Further in paragraphs 24 and 26 it names a number of mechanisms it is putting together in partnership with other global institutions allegedly to strengthen primary health care and UHC.

PHM holds that this is not just a failure of implementation but a failure of strategy as it was rolled out in practice across most low- and-middle-income countries. What was required was strengthening publicly funded and publicly administered healthcare services, where the services are provided as public goods. Such a strategy finds little space in the UHC discourse. Instead 'universal coverage' has been used to promote publicly sponsored health insurance with strategic purchasing of a very selective package of essential services from a mix of service providers, complemented by a marketplace of private health insurance plans and private providers for services beyond the package. The drive for UHC, (rather than universal access) is also about restricting the need for public spending by imposing limits on the basic package and this in turn reflects the reality of very limited public funding for health care generally. A large part of the limited funding available is then dedicated to vertical programs of disease control, most of which involve the purchase of large quantities of increasingly expensive medicines, diagnostics and vaccines from big pharma. This leaves less and less funding for strengthening comprehensive primary healthcare. The collateral consequences of such policies are that financially protected care that the poor can access remains limited and there is a huge growth of an unregulated private sector. This then is the rational explanation for the figures and trends that the report places before us. What we need is a change of strategy, not more of the same.

In an apparent response to the lack of financing for PHC, para 26 presents a new initiative called Health Impact Investment Platform. This is being rolled out as a solution when in fact it is only likely to aggravate the problem. This initiative consists of four banks, the African Development Bank (AfDB), the European Investment Bank (EIB), Islamic Development Bank (IsDB) and the Inter-American Development Bank (IDB), joining hands to make an initial €1.5 billion available to LICs and LMICs in concessional loans and grants to expand the reach and scope of their PHC services. WHO country offices are being incentivized with liberal project funds to write-up financing proposals that countries will then sign on to. While it comes with very high sounding politically correct descriptions of the importance of primary healthcare, it overlooks the fact that most LMICs are already deeply indebted, and this will only add to their indebtedness. Most countries are paying more for debt servicing than on welfare.

We also remind member states of the experience with structural adjustment and its associated health sector reforms, when all such loans were linked to overt and covert conditionalities, many of which have led to the problems we face today. Past policies having successfully privatized secondary and tertiary care, the game now is to move publicly funded and administered primary healthcare into the very same failed strategic purchasing options, that we hold as contributory to the lack of progress towards UHC. Instead, member states should call for the cancellation of debts, which could be linked to national governments investing more in primary healthcare on their own terms. We note that some of these banks are supporting corporate investment in healthcare, through private sector arms – like IFC for the World Bank. We also note that in many bilateral and plurilateral treaties, investor state dispute settlement clauses are applicable to healthcare services. This can greatly reduce the policy space available to governments for promoting quality, efficiency and equitable resource allocation. Under such conditions an open door to foreign for-profit investment for primary healthcare, which is in the nature of a public good, is most undesirable and needs to be opposed.

PHM also cautions against a number of international consultancy agencies, some of whom also occupy the civil society space, like ACCESS - Health International, as being promoters of some of these privatizing strategies that we hold responsible for the failure to progress towards UHC. The very fact that a platform like UHC 2030 (mentioned in para 26) runs in collaboration with OECD and World Bank gives reason to be cautious. Moreover it is the multinational commercial consultancy agencies, whose main income is from corporate clients, who are increasingly hired by such initiatives to plan the country strategy. While member states are primarily accountable for progress towards UHC or the lack of it, one must also measure and comment on the accountability of promoters of these failed strategies, even after they have been shown to fail.

The UHC Report is also remarkable for its silences. The most notable of these is in the challenge of access to essential medicines at affordable rates within the current global policy structure.

PHM calls on EB members to initiate a re-examination of WHO's rhetoric on UHC and its efforts to shape the role of government away from the provision of services as a public good, to one of purchasing services from a mix of providers based on market mechanisms. This has not

worked for secondary and tertiary care and for primary healthcare it is a non-starter with almost no examples of success. We caution Member States that given the past experience with development bank loans for health care, the Health Impact Investment Fund could become a vehicle to persuade nations to accept market based solutions for primary health care which are unlikely to work, but could pave the road for corporate penetration into public services. Primary health care is NOT a bankable investment. What LMICs require is debt cancellation and debt swaps; not more debt in the name of PHC and UHC.

MS should also call upon WHO to work on alternatives that progress towards universal coverage based on a conceptualization of primary health care as a public good. This will require the delivery of care being dominated by public providers with public accountability for promoting quality, efficiency, equitable resource allocation and population health-oriented health care. Financing must remain tax based or social insurance with a progressive movement towards single payer funding.

Notes of discussion

Universal Health Coverage Has Wide Support But is Undermined by Lack of Financing and Health Workers HPW, 25/01/2024 (Disha Shetty)