A civil society assessment of the political declaration of the UN High Level Meeting on Universal Health Coverage

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On 23rd September 2019, Heads of State and Government and representatives of States and Governments will meet for the UN High Level Meeting (HLM) on Universal Health Coverage (UHC). A political declaration[1] has been prepared, to be approved at the meeting. Though the declaration has attempted to incorporate a range of issues related to health and healthcare, we have a number of concerns regarding certain specific commitments and actions as well as important issues that the declaration omits to mention.

Concerns regarding specific commitments and actions proposed

1. Para 9 and Para 25 provide inadequate definitions of healthcare and healthcare access which is also open to multiple interpretations. The emphasis of the declaration is on "nationally determined sets" of health services to be provided, rather than articulation of access to healthcare as an entitlement. This runs counter to Para 1 of the declaration which reaffirms "the enjoyment of the highest attainable standard of physical and mental health" as a right of every human being.

There is the danger of "nationally determined sets" being interpreted to mean a limited range of health services by governments. Further, there is a danger that a reduction of the meaning of healthcare as a right would limit the national set to interventions consisting of marketable commodities and leave a significant proportion of healthcare needs to private markets.

[1] We refer to the final draft of the Political Declaration of the High-Level Meeting published by the President of the UNGA dated 10th September: see https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/09/UHC-HLM-silence-procedure.pdf

There are many essential services which the poor cannot access due to financial barriers and social and other reasons of exclusion and marginalization. If universality is interpreted to mean a few select services provided so as to reach even the poor, while many services are left to the market, then it is iniquitous. Even if the “nationally determined set” of services is defined narrowly due to resource constraints, it should be based on the principle of equity in provision, and the access of the poor must be to a much larger set of services than the non-poor. Indeed, the more marginalized the people, the more comprehensive should be the range of services for which access and financial protection is provided.

The obligation of the state to provide quality health services should include all services that people need in fulfilment of the larger goal of access to healthcare as a fundamental right. The commitment therefore should be to implement a comprehensive range of services by all countries, with differing national timelines for achieving the goal. If UHC is to be transformative and not just an empty promise, it must address the full extent of health needs of the population, with special attention to the poorest and most vulnerable communities.

2. In Para 13 and Para 46, the formulation conflates primary health care (which is an approach to the organising principles of healthcare as well as integration of action on the social determinants of health, all of which are required for attaining Health For All) with primary level healthcare which is limited to first contact care.

This would only be a semantic issue if in practice UHC had the same scope as PHC in the Alma Ata approach. However, the dominant discourse on UHC tends to emphasise the financing of curative healthcare services. In this declaration too, though the importance of SDH and need for intersectoral convergence find mention in some paras, UHC reads as if it were limited to curative care and its financing.

We are extremely concerned that instead of acknowledging that PHC, as espoused by the Alma Ata Declaration, represents a much broader articulation of universal access, health and wellbeing, the declaration attempts to subsume it under UHC.

3. Para 43 suggests an additional 1 percent of GDP, which is very concerning as there are countries with different levels of needs and public health expenditure. It is also not clear what this 1 percent is additional to. In most LMICs, much higher allocations for public health are required.

4. Para 54 suggests involvement of the private sector in the development of health and social related policies and also mentions “addressing and managing conflicts of interest and undue influence". The experience in many countries has shown that while not-for-profit private organisations that work for vulnerable populations can be brought on board to advocate for public interest, it is nearly impossible to mitigate conflicts of interest in relationships with the for-profit private sector. While dialogue with for-profit private sector is needed for better regulation of its practices, they certainly should not be present at the policy table or be involved in assessing health and other social policies. Such a provision can be misused to further private rather than public interests.

5. We are extremely disappointed at the deletion of the mention of ‘sexual and reproductive health’ in Para 29 in the final draft. We emphasise the need for universal access to sexual and reproductive health and rights and reiterate that their access must be ensured for all. Gender equality and realization of human rights must be recognised without any compromise through qualifying them.

6. Para 31 brings together and conflates two entirely different domains- one of public health surveillance and the other of vaccination. Though surveillance is important for vaccination, the mandate for public health surveillance is much larger. Vaccination at best provides protection against a very limited number of diseases.

7. Para 71 qualifies the addressing of particular needs and vulnerabilities "in accordance with relevant international commitments, as applicable and in line with national contexts and priorities", which is unacceptable and in gross violation of the human rights of migrants, refugees, internally displaced persons. The approach of the right to health, as proclaimed in the international human rights law of the United Nations, recognises that all people must have this right independent of their nationalities,. Moreover, the declaration fails to comment on the structural drivers of migration - which include immiseration of many millions by an inequitable economic system and conflicts driven by plundering of resources - and the health effects of migration policies.

Concerns regarding the omissions

Though the Final Draft of the Political Declaration covers, often confusingly and repeatedly, a large number of areas, it is important to note its silences. The major omissions are as follows:

1. Governments, especially in LMICs, cannot have fiscal space unless there is an international economic order that promotes policies favourable to their environmentally-sustainable industrial growth, sustainable agriculture, cleaner environment and fair trade, involving affirmative actions that help weaker nations. Fiscal spaces will not open up unless there is a global push to curb the arms race, reduce defence expenditure, reduce sale of arms within and across nations and promote nuclear disarmament. It needs to be reiterated that free trade is not fair trade. The adverse impacts of ‘free’ trade agreements on health have been recognised by the Commission on Social Determinants of Health and by the Doha Declaration. Much of the global aid has failed to address the resource gap in a meaningful way and instead has been used to further the interests of the powerful. However, the Declaration remains silent on these issues.

UHC will not be achieved without significant and sustained funding. And, in an era of globalization, there needs to be an increasingly globalized notion regarding who bears responsibility for protecting and fulfilling the right to health. In this regard, we believe that the methods and practices of external aid should be considered as a responsibility to fellow human beings rather than a charity.

The achievement of health for all requires HICs and other global duty bearers committing global resources to close the gap between what LMICs countries can mobilize domestically and what is required for high-quality healthcare for all. Official development assistance needs to be significantly increased through the use of more participatory and representative funding mechanisms, which are less hegemonic, not tied to other bilateral deals, and equity and rights focussed.

The political declaration fails to address this need to transfer resources from the Global North to the Global South for the achievement of the right to health for all. The status quo of global health funding is woefully inadequate.

2. There is no mention of profiteering corporates and multinationals which are destroying health. These range from corporate hospitals to Big Food and from pharmaceutical corporations to extractive industries. In healthcare the corporate hospitals and private health insurance industry are intervening in public policy-making for their own profit and utilising public funds. There is need to ring- fence public health and clinical decision-making from profit considerations, rather than promoting monetary provider incentives. The declaration needs to recognise that the notion of profit maximisation is incompatible with the notion of health as a public good and a human right.

3. Significantly, there is no commitment to strengthening government health services in the declaration. The public provision of health care is a requirement for achieving health equity. However, in the dominant discourse on UHC, little emphasis has been given to the importance of public provisioning of healthcare and it continues to be so in this declaration. At any given level of development, given the nature of health markets, public financing without public provisioning will not adequately address either distribution of services or necessary prioritisation of preventive, promotive and essential curative services.

There is enough evidence globally to show that undermining and neglect of the public sector in providing healthcare exposes the more vulnerable populations, such as the poor, informal workers, indigenous people and women to market and other powerful forces and increases inequity in access to health care. In many countries, especially in LMICs, UHC is often conflated with coverage by state funded health insurance schemes. These schemes have brought in the private sector in a big way to provide healthcare services using public funding. Evidence from around the world shows that these schemes may not have led to financial protection from healthcare expenses, nor universal access and may have exacerbated exiting health inequities. Global evidence also shows that countries with strong public health systems and publicly provided healthcare have done much better in terms of financial protection and equity in access than countries with a dominant private sector. Moreover, there is enough evidence of the good results of implementing the PHC strategy. A UHC oriented approach towards strengthening public sector provisioning and ‘care’ not ‘coverage’, can contribute to improving people’s health.

The failure of the global community to call for and provide assistance to strengthening the delivery of public sector services is one of the main reasons behind the current crisis in healthcare. Much of this weakness was also driven by Structural Adjustment Programmes

that were forced on countries by international financial agencies. Health sector reforms promoted by global health organisations in this context addressed selective priorities, but more often than not failed to see the necessity of robust government health systems. Indeed, a premature and misdirected push to privatisation in this period is one of the reasons for the current crisis in access to health care that the world is facing today. A failure to acknowledge this could lead to a repeat of the previous mistake. Just as selective PHC compromised comprehensive PHC of Alma Ata, this declaration's "nationally determined sets" has the potential to undermine the goals of not only UHC but also Health for All.

UHC dominates the discourse on global health policy today. It can be interpreted in multiple ways, but its dominant discourse seems to be favouring market based neoliberal reforms. We are concerned that the HLM may end up reinforcing the same. Therefore we urge those discussing UHC at the UN HLM to engage with the concerns expressed in this assessment by civil society.

This assessment is open for endorsements. To endorse

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