



Agenda Item 5: Universal Health Coverage

People's Health Movement WHO-Watch Team

30 th January – 7 th February 2023

Policy Brief

ACTION POINTS

- Strengthen the public sector and address health worker shortages to accelerate progress in achieving Universal Health Coverage.
- More reliable indicators required to give a complete picture of the extent of barriers to accessing care.
- Prioritising access to health financing is not enough. Need heavier emphasis on service and population coverage through comprehensive primary care that is acceptable, accessible, and affordable to the communities.

1. What is the issue?

Limited progress in achieving Universal Health Coverage

Document EB152/5 reports on progress in the implementation of the 2019 UNGASS declaration on universal health coverage. Progress towards universal health coverage is tracked via two indicators (1) coverage of essential health services; and (2) catastrophic health spending. With respect to indicator (1), it is important to note that the current measurement of “service delivery” is focused on selective healthcare interventions, i.e. a limited package of care. On progress toward achieving even this minimal package of care, the report notes that the world is not on track to achieve the SDG targets on UHC by 2030 (par.6).

This is compounded by the fact that “[t]here is systematic under-prioritization and underinvestment in reducing financial barriers to health care” (par.8) on the part of Member States.

Existing indicators give an incomplete picture of the extent of barriers to accessing care

On catastrophic spending, the report notes that:

“Out-of-pocket spending on health as a share of total household expenditure increased continuously between 2000 and 2017, with the total population facing catastrophic or impoverishing health spending estimated to be between 1.4 and 1.9 billion people in 2017.” (par.6)

Significantly, this data on catastrophic spending on health care does not include the pandemic period (2020-ongoing). Given the socioeconomic impact of the Covid-19 pandemic and the inequalities generated by the global response to it, catastrophic spending and barriers to care have likely deteriorated over the past three years. The report further notes that:

“catastrophic health spending related to essential services does not take into account foregone health care for people who face barriers to accessing those services.”(par.7)

Thus, the catastrophic spending indicator captures the economic impact of patients being able to access care at a relatively expensive price. It does not capture the physical and socio-economic costs of being unable to access care in the first place.

Existing interventions prioritise access to health financing but this may not improve equity or access to comprehensive health care

Universal health coverage consists of three dimensions: service coverage, population coverage, and financial protection. The report notes that amongst Member States,

“Most commitments are focused on service coverage (44%) and population coverage (43%), and on average, commitments and clear targets concerning the financial protection dimension (13%) are lacking.” (par.8) While it is true that the financing dimension is lagging, it is not necessarily true that an increase in financing will improve access to health care.

Increased coverage on financing for health services will have little meaningful impact on access to health care if (1) no service providers are accessible or (2) required services or products are unavailable. For example, if financing for UHC increases but it is mainly directed at purchasing a limited package of “essential services” for everyone, patients may well lack access to the full range of services they need. The most impoverished patients will be the worst impacted by this.

Increased financing for UHC does not automatically translate into greater equity within the health system. If a greater share of public financing for UHC goes to purchasing health care from private providers, this reduces the share of financing going to public sector providers. Over time this leads to a deterioration of public health services and infrastructure, with negative consequences for patients who cannot access private providers (e.g. those in rural areas). This increases inequality within the health system rather than reducing it.

2. What do we want?

Comprehensive primary health care

The report’s recommendation for more selective packages where fiscal space is limited must be contested as opening the door for selective care. We know from many country examples that a comprehensive primary health care approach can ensure that most healthcare needs can be met within district health systems, even where fiscal space is limited.

To cope with inadequate fiscal space, the more vulnerable should receive more comprehensive coverage, not more selective packages. The minimum package of services included in comprehensive primary healthcare should meet over 90% of health care needs.

Strengthening the public sector

Moving towards equity of access, universal coverage, and affordable provision of healthcare is not possible without dominant public provision. Purchasing from private providers or corporate Health Maintenance Organizations (HMO) is not the answer.

Address health worker shortages

A major gap in this report is its silence on the changes in human resources for health policy that is required. A PHC-based UHC approach requires Member States to put in place comprehensive health human resource development plans to ensure:

- adequate numbers and appropriate distribution of health workers with a much larger workforce deployed in primary care,
- that health workers' education is oriented to ward primary health care, that health workers are given the compensation, benefits, and protection they need to be able to work in their own countries and communities, and that health workers have a voice in government decision-making on health policy and primary health care.

More reliable indicators

There is a need to strengthen the primary data recording and collection mechanisms within nations and base projections on such reliable data instead of modelled estimates.

Indicators and their use must be re-examined. Existing measures of progress in achieving UHC are unlikely to reflect the true situation and it is likely that the situation is worse than what the summary indicates.

Given the inequities in progress towards the digitisation of health information, marginalized communities are becoming more invisible within the officially-reported data, leading to an increase in the work burden carried by frontline workers.

3. Why is it important?

This year, WHO will celebrate its 75th anniversary. Efforts to implement universal health coverage have prioritised access to financing rather than access to comprehensive health care. As discussed above, a focus on improved financing alone won't bring us any closer to its primary goal: realising the right to health for all. Building health systems that people trust, and that function well, also provides a sound foundation in containing and mitigating the negative effects of public health emergencies.

Agenda item 12.1 Strengthening the global architecture for health emergency preparedness, response and resilience

Issues that must be discussed in the Global Architecture of HEPRR

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- International solidarity, not charity, needs to be at the core of global pandemic preparedness and response.
- Pandemic accord should include provisions requiring implementation of access and benefit sharing of medical countermeasures.
- Issues underlying health workforce crises must be addressed and brain drain prevented.
- The freeze on assessed contributions should be reversed and earmarked funds reduced.
- Global health financing mechanisms must be radically changed to break the prevailing neocolonial financial and economic status quo.

1) Whats the issue?

The WHO's Global Architecture for HEPRR overlaps with the work being undertaken by the INB on the development of an international pandemic instrument, but the EB report (EB152/12) does not include proposals for coordination, nor does it demonstrate a plan to bring together these parallel processes in a coherent fashion. Many critical issues related to the political economy of global public health go unaddressed in the report. Currently, the proposals do not instill confidence that the reforms being developed will bring about the necessary change in pandemic preparedness and response.

a) On GOVERNANCE: Adding divisions and inefficiency instead of fostering solidarity.

The Covid-19 experience has demonstrated that solidarity is a critical core capacity for effective pandemic response, both within and between countries. It appears that there has been no recognition of this, nor any exploration of the root causes of the lack of solidarity that marked the international response to the pandemic. At the international level, we have seen a lack of solidarity in relation to vaccine procurement and in the conflicts over suspending or enforcing intellectual property rights over vaccine technologies.

The lack of sufficient financial support for developing countries to invest in global goods (i.e. improving core capacities), suggests that expressions of concern regarding global health security might be better understood as gated health security (for the global North) than the sentiment that 'we are all in this together'. It is not clear why this insight has not found any place in this package of reports on strengthening emergency prevention, preparedness, and response. It has also not been discussed in any of the expert reviews of lessons learned or pathways for improvement. Because of this, the creation of additional committees/councils appears more like an attempt to circumvent the real issues and risks creating greater division instead of fostering solidarity.

b) On SYSTEMS: Access to medicines and health workforce crisis ignored

The boycott of C-TAP, both by pharmaceutical companies and their nation state sponsors, and the opposition of the European Commission to the original TRIPS waiver proposal speak to the privileging of intellectual property rights over human rights by much of the global North. There is nothing in the current package of reports that acknowledges, let alone addresses, this harmful misallocation of priorities.

The opportunity to clarify the framework for comprehensive and community-led primary care as a vital part of health system preparedness was also missed. There is no acknowledgement of the crisis of health worker shortages as well as the mental health crisis plaguing health workforce in both developing and developed countries, which is likely to get worse in the coming years.

The proposal for a Global Health Emergency Corps is likely to only worsen brain drain and further reduce the capacity of countries most in need of capacity strengthening.

c) On FINANCING: Mandating international financial institutions on health?

For the least developed countries, the opportunity cost associated with implementing the core capacities prescribed in the IHRs can be very significant. For countries with double or triple burden of diseases, the expenditure of domestic resources on what should be understood as a global public good may not be the most rational use of such resources. Debt repayment, loan interests and surcharges, as well as illicit financial flows must be addressed to create the much needed domestic fiscal space for financing HEPRR capacity.

The World Bank and the IMF are not new actors in global health financing, but there is a danger in further legitimizing their involvement in global health governance. The policies that they have promoted and imposed, both health- and non-health related, have contributed to worsening health and social equity, hitting the most vulnerable and marginalized populations the hardest. Even more worrying, these policies have, over time, trapped developing countries in a vicious debt cycle and cemented their dependence on the global North. This is to say nothing of the implications for Member State sovereignty. All of this is reminiscent of the colonial era.

2) What do we want?

PHM urges member states to slow down the rush for accountability regarding global health security pending ironclad financial and social commitments from the global North, e.g. debt cancellation.

PHM urges member states to insist on the inclusion of legally binding provisions on access and benefit sharing of medical countermeasures in the proposed pandemic instrument, to be honored not only by Member States but also, crucially, by commercial entities.

We urge WHO to identify the systemic factors driving workers away from health systems prior to institutionalizing an ambitious plan for a global health emergency corps and to provide guidance for Member States on rectifying the situation.

WHO must explore financing mechanisms that break the neocolonial financial and economic dynamics. It must acknowledge that the funding crisis in the institution has been created as part of a wider project restricting the influence of the Global South on global health governance. WHO should make the necessary steps to reverse the freeze on assessed contributions and the tight earmarking of donor funds, instead of further leveraging the private sector.