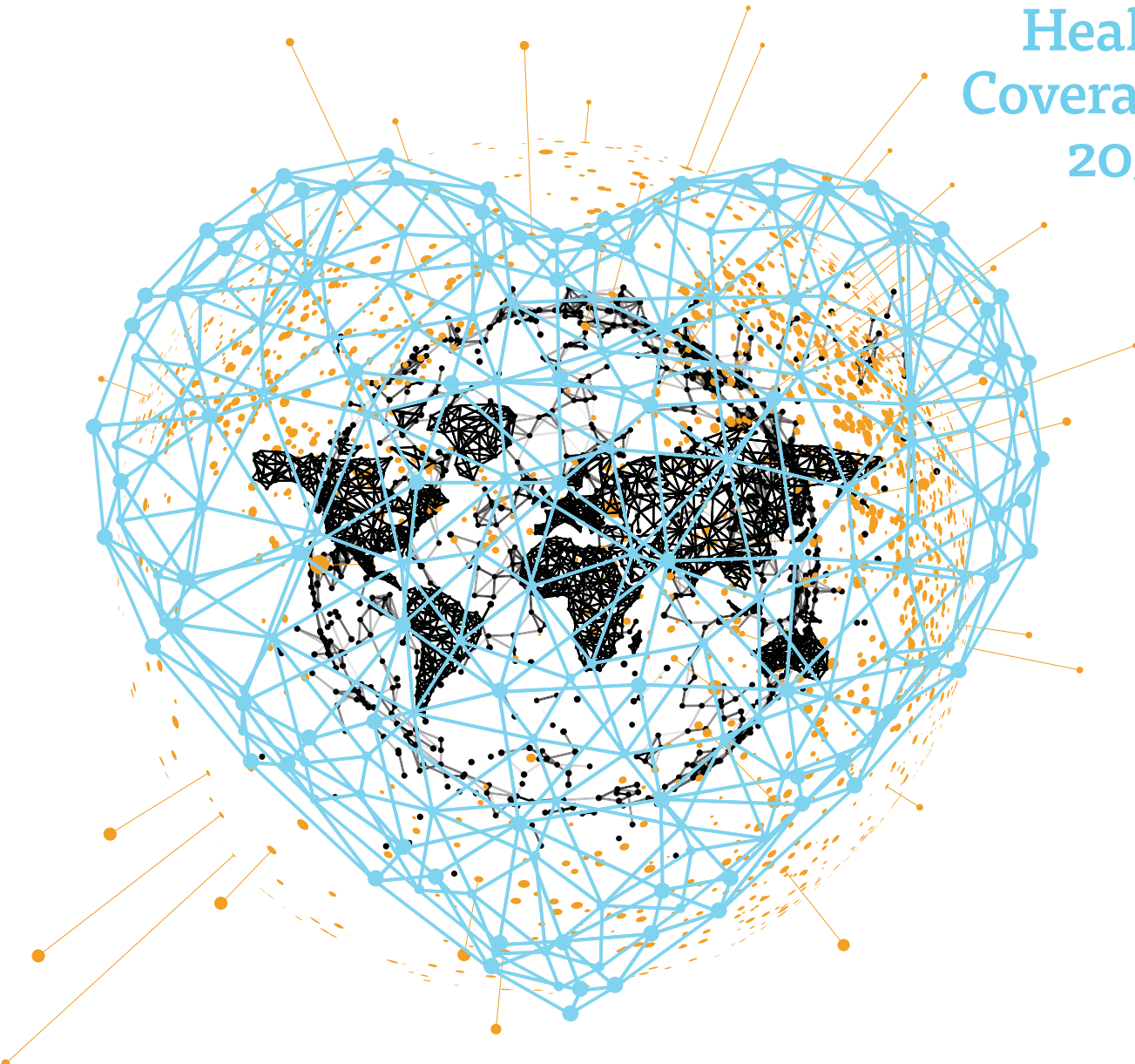


Delivering
Universal
Health
Coverage
2030



Health: A political choice

Edited by
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Global Governance Program,
Munk School of Global
Affairs and Public Policy,
and **Ilona Kickbusch**,
Global Health Programme,
Graduate Institute.



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CONTENTS

1 THE GLOBAL COMMITMENT TO THE SDGS

1.1

The race to achieve universal health coverage

By Her Excellency, María Fernanda Espinosa Garcés, president of the 73rd Session of the United Nations General Assembly

p06

1.3

Health is a political choice

By Dr Tedros Adhanom Ghebreyesus, director-general, World Health Organization

p10

1.2

The UN's role in accelerating health coverage

By Amina J. Mohammed deputy secretary-general of the United Nations

p08

1.4

The ROI on health investment

By Achim Steiner, UNDP administrator

p12

2 EDITOR'S INTROS

2.1

Advancing universal health coverage in 2019 through the gender dividend

By Ilona Kickbusch, co-chair of UHC2030 and director of the Global Health Centre at the Graduate Institute of International and Development Studies

p16

2.2

The political choice for universal health coverage in global governance in 2019

By John Kirton, director of the Global Governance Program

p20

COUNTRY LEADERS SPEAK OUT ON UHC

3.1

New health policies for new health challenges

A speech by Japan's Prime Minister, Shinzo Abe

p26

3.2

Inspiring Global Action

A speech by France's President Emmanuel Macron

p28

3.3

Implementing Sustainable Development Goal 3

A speech by German chancellor, Angela Merkel

p30

3.4

Uruguay's fight against NCDs and tobacco

By Tabaré Vázquez, President of Uruguay

p34

3.5

Kenya's social shift

By Uhuru Kenyatta, President of the Republic of Kenya

p36

3.6

Gender and health: a political choice with major ROI

By the Right Honourable Helen Clark

p38

3.7

Transforming a continent

By Paul Kagame, President of Rwanda

p40

3

4

TOP ECONOMISTS SPEAK OUT FOR UHC

4.1

Financing UHC in low-income countries

By Jeffrey D. Sachs, director of the Center for Sustainable Development at Columbia University

p44

4.3

The economics of universal health

An interview with Lawrence Summers president emeritus of Harvard University

p48

4.2

Financing universal health coverage

By Peter Sands, executive director, Global Fund to Fight AIDS, Tuberculosis and Malaria

p46

4.4

The crises in US health care

An interview with Robert Fauver, president of Fauver Associates

p50

4.5

In numbers

Financing global health and UHC

p52

6

WHAT TO EXPECT FROM THE UN HIGH LEVEL MEETING ON UHC

5.1

Local action driving universal achievements

By Githinji Gitahi, CEO of Amref Health Africa

p56

5.3

The political choice for patient-centric and compassionate universal health coverage

By Kawaldip Sehmi

p60

5.2

Youth as an accelerator to achieve universal health coverage

By Batool Alwahdani and Marian Sedlak

p58

5.4

Protecting reproductive rights

By Suzanne Ehlers, president and CEO of PAI

p62

WHY WE SHOULD BE OPTIMISTIC

6.1

Lessons from Turkey's achievements in UHC

By Recep Akdağ, Former Minister of Health, Turkey

p66

6.2

Strengthening systems for equality

By Agnès Buzyn, Minister of Solidarity and Health, France

p68

6.3

Political choices that transcend borders

By Shinichi Kitaoka, president of the Japan International Cooperation Agency

p70

6.4

Achieving the impossible with vaccines

By Dr Seth Berkley, CEO of Gavi, the Vaccine Alliance

p72

6.5

The technology transforming the future of healthcare

By Houlin Zhao, ITU secretary-general

p74

6.6

UHC in small island developing states

By T. Alafia Samuels, Caribbean Institute for Health Research, University of the West Indies

p76

6.7

Disruptive innovation and multi-stakeholder alliances

By Hiromi Murakami and Kiyoshi Kurokawa

p78

SUPPORTING THE VULNERABLE

7.1

Investing in equitable societies

By Gunilla Carlsson UNAIDS executive director, a.i.

p82

7.2

The role of agriculture, food and nutrition

By Laurette Dubé, Raphael Lencucha, and Nick Drager

p84

7.3

Protecting the brain

By Vladimir Hachinski, professor of neurology and epidemiology at Western University

p87

7.4

Game-changing priorities for UHC

By Françoise Girard, Katja Iversen, Roopa Dhatt, and Kim van Daalen

p90

7.5

Mental health is universal health

By Vikram Patel and Shekhat Saxena

p94

KEEPING THE WORLD SAFE

8.1

Addressing the humanitarian challenge

By Peter Maurer, International Committee of the Red Cross

p98

8.2

An agenda to tackle the politics of real problems and real people

By Mit Philips, Kerstin Åkerfeldt and Caroline Voûte

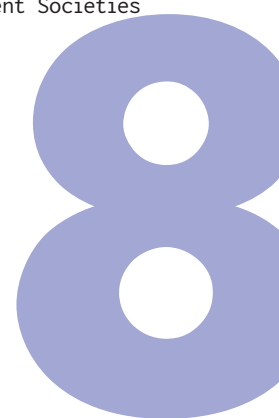
p100

8.3

Reaching the missing millions

By Elhadj As Sy, secretary-general, International Federation of Red Cross and Red Crescent Societies

p102



ADDRESSING THE INTER-SECTORAL CHALLENGE OF THE SDGS

9.1

Health and social justice

By Guy Ryder, director-general of the ILO

p106

9.2

Health and care: more than a family

By Joachim Breuer, president of the ISSA

p108

9.3

Nature is the ultimate healthcare system

By Inger Andersen, UN Environment Programme

p110

9.4

Biodiversity: the foundation of human health

By Cristiana Paşca Palmer executive secretary, UN Biodiversity

p112

9.5

Leaders in health

By C. James Hospedales, executive director of CPHA

p114

9.6

In numbers

Progress and challenges in the health-related SDGs

p116

9.7

Pollution 5.0

By Rolph Payet, executive secretary of the Basel, Rotterdam and Stockholm Conventions p118

9.8

Asia's healthcare evolution

By Woochong Um, Asian Development Bank

p120

9.9

Performance and progress

By Brittaney Warren, Global Governance Project

p122

9.10

Three steps to universal health coverage

By Michel Sidibe, Minister of health and social affairs of the Republic of Mali p127



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THE GLOBAL COMMITMENT TO THE SDGS

1

CHAPTER

1.1

The race to achieve universal health coverage

By Her Excellency, María Fernanda Espinosa Garcés, president of the 73rd Session of the United Nations General Assembly

p06

1.3

Health is a political choice

By Dr Tedros Adhanom Gebreyesus, director-general, World Health Organization

p10

1.2

The UN's role in accelerating health coverage

By Amina J. Mohammed deputy secretary-general of the United Nations

p08

1.4

The ROI on health investment

By Achim Steiner, UNDP administrator

p12



The race to achieve

universal health coverage

The unique opportunity for action that will present itself at this September's high level meeting on health coverage

At least half of the world's population does not have full coverage of essential health services. Health expenses push more than 100 million people into extreme poverty each and every year, forcing them into terrible choices that no one should ever have to make: Buy medicine or food? Education or health care?

These stark statistics make the case for universal health coverage compelling.

Of course, even if each of these reasons alone were not enough for us to continue to push for universal health coverage, we must be clear that health is a human right. Achieving universal health coverage and guaranteeing that everyone has access to quality, essential health services are pivotal steps to ensuring that every individual enjoys their fundamental human rights.

Furthermore, today in the era of the Sustainable Development Goals, universal health coverage must be seen for what it is: a powerful instrument to achieve not only SDG 3 on health but the entirety of the 2030 Agenda. Last September, in the very beginning of my mandate as the 73rd president of the General Assembly, I had the honour to chair two health-related high-level meetings, one on the fight against tuberculosis and one on the prevention and control of non-communicable diseases. Now, on 23 September 2019, when world leaders gather in New York to participate in the United Nations General Assembly High Level meeting, to be held under the theme of 'Universal Health Coverage: Moving Together to Build a Healthier World', we will have a unique opportunity to establish the foundation for achieving the goal of universal health coverage by 2030.

There is no one-size-fits-all approach to meeting this goal. Each country must explore its own tailor-made solutions to strengthen its health systems. In doing so, priority must be given to preventing disease and promoting health, as well as to ensuring access to medicines, vaccines, diagnosis and other health technologies.

The United Nations has always stood ready to offer its expertise and assistance regarding global health. When I am

**By Her
Excellency
María Fernanda
Espinosa Garcés,
President of
the 73rd Session
of the United
Nations General
Assembly**



Each country must explore its own tailor-made solutions to strengthen its health systems. In doing so, priority must be given to prevention”

asked to give examples of the UN’s biggest achievements, I often find myself speaking about the World Health Organization. Consider the eradication of smallpox, for instance – a success we have nearly replicated with polio – the significant reductions in new HIV infections we saw during the first decade of this century, and the advances we have made in the fight against malaria and tuberculosis.

And alongside these targeted campaigns – indeed, because of them – is the growing push for universal health coverage and strengthened primary care services, culminating in the adoption of SDG 3.

HEALTH IS WEALTH

Elsewhere, as so often, women and girls suffer disproportionately when it comes to sexual and reproductive health and also when it comes to accessing other basic services. Persons with disabilities, Indigenous peoples, minorities and people living in rural areas are also more likely to have poor health outcomes.

This is totally unacceptable, and profoundly wrong. It runs counter to our commitment to leave no one behind. It is also economically unsustainable.

The macro-level impact of poor health services is enormous – estimated at trillions of dollars every year in lost productivity, long-term impairment and short-term expenditure. As the saying goes, health really is wealth.

If we look at the full impact and cost of poor health services, the case for prioritising universal health coverage is clear. That Ebola outbreak in West Africa, for instance, showed the world the importance of robust and inclusive health systems. Our aim in September must be to accelerate progress on coverage.

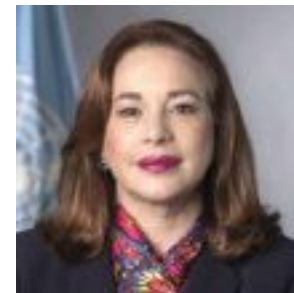
This will be a crucial opportunity for us to address all the ‘key asks’ of the universal health coverage movement, which are:

- Ensuring political leadership and commitment across government and society;
- Pursuing equity in access to quality health services with financial protection;
- Creating a strong, enabling regulatory and legal environment that responds to people’s needs;
- Building high-quality health systems that people and communities trust;
- Increasing and harmonising domestic and international investment; and
- Establishing multi-stakeholder mechanisms – so that conversations continue in all countries.

The Interactive Multi-Stakeholder Hearing, held on 29 April, brought together more than 600 representatives of member states, as well as UN entities, civil society, non-governmental organisations, academia and the private sector, among other stakeholders. It demonstrated that achieving universal health coverage is a collective and cross-cutting challenge.

In this regard, I want to recognise the valuable work of the co-facilitators – the permanent representatives of Georgia and Thailand – as well as the members of the Group of Friends of UHC, under the leadership of the permanent representative of Japan, in helping to lay the groundwork for the high-level meeting. Additionally, I also want to praise the support received from WHO and the UHC2030 coalition, which have proven to be essential in preparing a successful high-level meeting in September.

The Universal Declaration proclaimed the right to health in 1948. Seven decades on, it remains a distant dream for half the world’s people. Let us seize the opportunities we have to change that. Together, we can make universal health coverage a reality by 2030. ■



**HER EXCELLENCY
MARÍA FERNANDA
ESPINOSA GARCÉS**

President of the 73rd Session
of the United Nations General Assembly

Her Excellency María Fernanda Espinosa Garcés, Ecuador’s foreign minister, was elected president of the 73rd session of the United Nations General Assembly in June 2018. She has served as foreign minister twice, and also as minister of national defence and coordinating minister of natural and cultural heritage. Espinosa Garcés chaired the Group of 77 and China until January 2018, and has also chaired the Andean Community. She has been a chief negotiator at the Conferences of the Parties of the UN Framework Convention on Climate Change and the Conference on Sustainable Development. In 2008, she was the first woman to become a permanent representative of Ecuador to the United Nations in New York, where she led and supported negotiations at the Human Rights Council.

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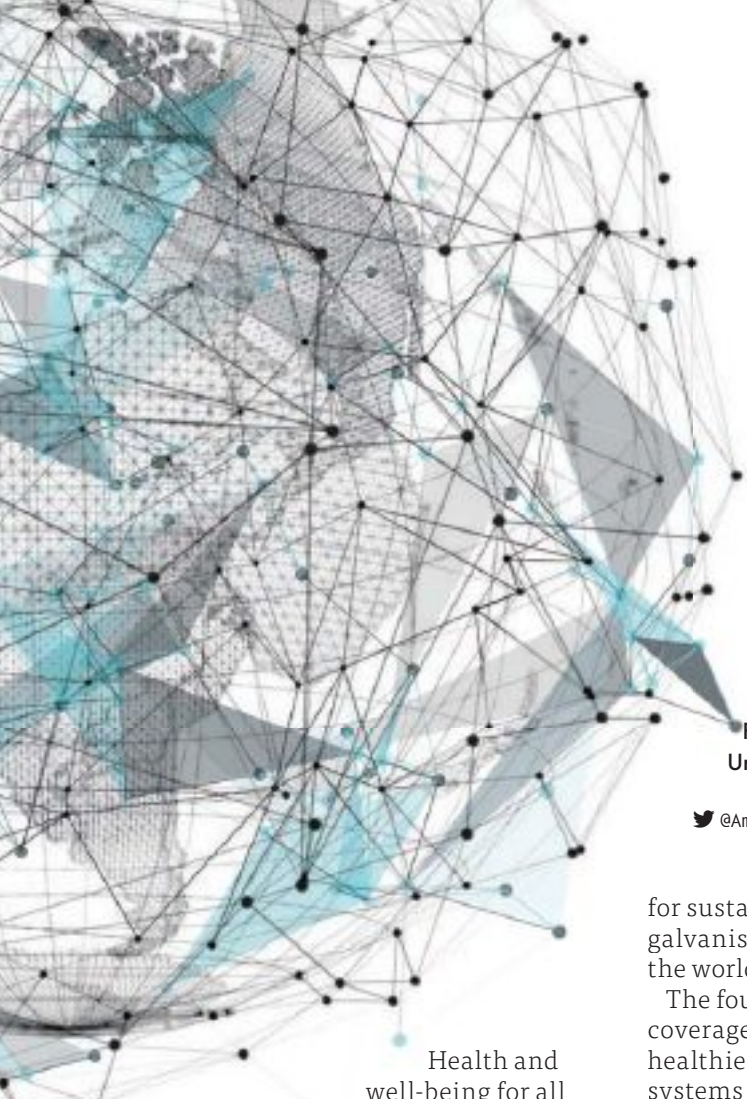
The UN's role in accelerating health coverage

By Amina J. Mohammed,
deputy secretary-general,
United Nations

The world has made impressive progress over the past two decades in improving the health of millions of people, increasing life expectancy, reducing maternal and child mortality, and fighting communicable diseases. But this progress is uneven and today, half the world's population still does not have access to quality health services. More than 800 million people spend more than 10% of their household budgets on health care – creating impossible choices between putting food on the table and seeking life-saving medical care. Millions of people are being denied a fundamental human right: health for all.

Around the world, more than 50 countries still lack the infrastructure needed to provide universal health coverage. In some cases, healthcare facilities lack basic services such as water and electricity. Elsewhere, there are shortages of medicines and medical products, and of skilled staff. In many places where healthcare services are available, demographic changes will put them under severe strain in the coming decades.

Despite our progress to advance health care over the last century, today millions face new risks, including prohibitive costs and unsuitable infrastructure



AMINA J. MOHAMMED

Deputy secretary-general of the United Nations

Amina J. Mohammed was appointed deputy secretary-general of the United Nations in 2016. She was previously minister of environment of the Federal Republic of Nigeria from November 2015 to December 2016. She had previously served as special advisor to secretary-general Ban Ki-moon on Post-2015 Development Planning. She worked for three successive administrations in Nigeria, serving as special advisor on the Millennium Development Goals. Mohammed is also an adjunct professor in development practice at Columbia University, and she serves on numerous international advisory boards and panels, including the UN Secretary-General's High Level Panel on Post-2015 Development Agenda, the Independent Expert Advisory Group on the Data Revolution for Sustainable Development, the Global Development Program of the Bill and Melinda Gates Foundation, the African Women's Millennium Initiative, Girl Effect, 2016 African Union Reform and the ActionAid International Right to Education Project.



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Health and well-being for all are key to building resilient,

secure, prosperous societies on a healthy planet. The globally agreed roadmap to achieve that overriding aim is the 2030 Agenda, agreed by all countries in 2015 and based on the 17 Sustainable Development Goals.

SDG 3 is to ensure healthy lives and promote well-being for all, at all ages. But health is a cross-cutting issue closely linked with poverty, discrimination, education, employment and environmental protection. Achieving quality health care for all can be the foundation for significant gains in other areas of sustainable development.

Health is a political choice that depends on national priorities, not income. Countries at all stages of development can make progress towards quality health services. But it is a choice that is often obscured by other, seemingly more urgent priorities, from security concerns to economic austerity measures.

That is why the United Nations is convening a High Level Meeting on Universal Health Coverage on 23 September here in New York. The aim is to raise the profile of universal health coverage as an accelerator

for sustainable development, and to galvanise action to achieve it around the world.

The foundations of universal health coverage are a global shift towards healthier lifestyles, sustainable food systems and primary health care for all. Health systems founded on primary health care provide quality services that are comprehensive, continuous, coordinated and people-centred. They emphasise prevention and promote well-being. Primary health care is therefore an important way to reduce inequities in health, and is highly effective and efficient, particularly for the management of mental health problems and chronic conditions. When primary health systems are strong, families and communities are empowered, and people are able to fulfil their potential – to move from surviving to thriving.

EMPOWERING ALL OF SOCIETY

Certainly, we have the greatest development opportunity when it comes to how we support and promote young people. Because adolescence is such a unique and formative time, the consequences of not addressing health issues, in particular mental health conditions, are likely to extend and expand to adulthood. Half of all mental health conditions start by 14 years, yet many cases go undetected and untreated. For example, nine-year-old Ahmad from Syria, who has suffered

from post-traumatic stress disorder for two years, still has not received support to overcome the psychological tolls he has faced. With suicide rates increasing among youth, especially in young girls, we cannot afford to ignore these powerful agents for change.

Innovations in health and technology can make universal health coverage easier to implement and expand its benefits. For example, electronic payment platforms can give people better access to health information, hospitals and pharmacies, and can enable people working outside their country to finance health care for their families back home for a whole year with just one click.

There is plenty of evidence that universal health coverage not only leads to stronger economies and more resilient societies: it contributes to equity, social justice and inclusive economic growth. Health is a political choice, but one that makes economic sense. With that in mind, we need sustainable financing and a commitment from leaders to make health a core and priority investment in human capital, and to work across sectors, linking up with policies on education, water and sanitation, and social protection.

Universal health coverage can only succeed with strong political commitment at the highest level. I urge governments and leaders to come to the high-level meeting in September ready to turn the vision of universal

Health is a political choice

By Dr Tedros
Adhanom
Ghebreyesus,
director-
general,
World Health
Organization

The World Health Organization was founded in 1948 with a simple but bold vision: the highest attainable standard of health for all people.

Importantly, the writers of WHO's constitution affirmed that health is not merely a luxury to which states should aspire, but "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

For more than 70 years, WHO, its member states and partners have worked towards that goal. There are considerable achievements to be proud of: global life expectancy has increased by 25 years; maternal and childhood mortality has plummeted; smallpox has been eradicated and polio is on the brink; we have turned the tide on the HIV/AIDS epidemic; deaths from malaria have dropped dramatically and new vaccines have made once-feared diseases easily preventable.

Many of these achievements, especially during the era of the Millennium Development Goals, are thanks to concerted efforts against some of the world's leading causes of death and disease.

But changing patterns in demographics, economics and politics bring changing patterns in health. Communicable diseases have now been replaced by non-communicable diseases as the world's leading killers. Anti-microbial resistance threatens to roll back a century of medical progress. Climate change and pollution are posing new health threats.

These developments have given rise to the dawning realisation that 'the highest attainable standard of health' cannot be achieved one disease at a time. Although disease-specific programmes will always be necessary, they must be built on the foundation of integrated and

The world has made considerable progress against the most common communicable diseases, but today's challenges lie in non-communicable diseases – an unexpected development that calls for political commitment at the highest level

people-centred health systems that address the full range of health needs for individuals, families and communities.

All people, regardless of who they are or where they live, must be able to access high-quality essential health services, without suffering financial hardship.

These three ideas – access to health services, with financial protection, equally for all – are the essence of universal health coverage.

By each of those measures, we have a lot of work to do.

More than half the world's population lacks access to essential health services, including vaccination, the ability to see a health worker or access to treatment for HIV.

Even when services are available, using them can spell financial disaster. Every year, almost 100 million people are pushed into extreme poverty by the costs of paying for care out of their own pockets.

Universal health coverage does not mean that every country must provide free access to every conceivable health service or health product. All countries must make tough decisions about what to cover, based on the resources they have.

Most health funding needs to come from domestic sources. Smart governments are increasingly attuned to ways to do this, including through increased taxation on tobacco and other unhealthy products such as sugar-sweetened beverages. Raising prices on tobacco and alcohol and increasing excise taxes reduces consumption, saves lives and generates additional revenue that countries can reinvest in health.

In all countries, the bedrock of universal health coverage is strong primary health care, with an emphasis on promoting health and preventing

disease. In the Declaration of Astana, all countries have committed to investing in primary health care.

Universal health coverage is not just the best investment in healthier populations. It is also the best investment in health security. Strong health systems are better able to prevent, detect and mitigate outbreaks.

The benefits of universal health coverage go far beyond health. Universal health coverage reduces poverty by removing one of its causes, creates jobs for health professionals, improves productivity and stimulates inclusive economic growth because healthy people are productive people, and improves gender equality because it is often women who miss out on health services. In that sense, universal health coverage is an engine of sustainable development.

I know from my own experience in government, and as director-general of WHO, that the key to making real progress towards universal health coverage is political commitment at the highest level, with the support of parliaments to translate that commitment into law, backed by a whole-of-government approach that addresses the commercial, economic, environmental and social determinants of health.

At this year's United Nations General Assembly, world leaders will meet for the first High Level Meeting on Universal Health Coverage, with the theme of 'moving together to build a healthier world'.

This is a crucial opportunity to catalyse political leadership that can transform the lives of billions of people.

Many G20 and G7 countries are the standard-bearers for universal health coverage with decades of experience under their belts, while others are at the vanguard of a new wave of countries that are making bold strides towards it. Together, these countries are uniquely positioned to provide strong leadership for others to follow, and to demonstrate that health is a political choice that all countries can make. ■

TEDROS ADHANOM GHEBREYESUS

Director-general, World Health Organization

Tedros Adhanom Ghebreyesus was elected director-general of the World Health Organization in 2017, and was the first person from WHO African Region to serve as WHO's chief technical and administrative officer. Dr Tedros served as Ethiopia's minister of foreign affairs from 2012 to 2016 and minister of health from 2005 to 2012. He was elected chair of the Global Fund to Fight AIDS, Tuberculosis and Malaria Board in 2009, and previously chaired the Roll Back Malaria Partnership Board, and co-chaired the Partnership for Maternal, Newborn and Child Health Board.

 @DrTedros  who.int



Universal health coverage does not mean that every country must provide free access to every conceivable health service or health product. All countries must make tough decisions about what to cover, based on the resources they have"





on health investment

Two decades ago, visionary Indian economist and philosopher Amartya Sen argued that freedom from avoidable ill health and ‘escapable mortality’ was one of the most important freedoms that development efforts should guarantee. Underpinning Sen’s statement is the premise that health is a human right – as well as an outcome, indicator and driver of sustainable development.

Today, the right to health is present in several international treaties, declarations and national laws. It is included in at least 115 national constitutions.

However, half of the world’s population still lack access to essential health services. Nearly

Illness is a symptom of poor health, meaning a broad spectrum of causes must also be accounted for if we are to maximise the returns that can be realised through universal health coverage

**By Achim Steiner,
UNDP administrator**

six million children still die before their fifth birthday every year. More than 15 million people cannot access life-saving HIV treatment.

Climate change is changing the frequency, severity and types of challenges faced by health systems, and will disproportionately burden the vulnerable and most marginalised. Additional challenges include ageing, non-communicable

diseases, health emergencies, anti-microbial resistance and growing demands for newer, more effective and higher-cost technologies.

In a time of increased attention to multidimensional inequality, political momentum towards universal health coverage offers leaders a concrete way of advancing equity, access and opportunity. Universal health coverage also delivers upon commitments articulated in the 2030 Agenda for Sustainable Development, and its central pledge to leave no one behind. In particular, the scale-up of universal health coverage can accelerate sustainable development in a variety of critical areas. Improved health reduces poverty and inequalities, including gender inequalities, and advances

educational outcomes. It also strengthens productive capacities and supports inclusive economic growth. One study estimated deaths amenable to high-quality health care globally and then modelled the macroeconomic impact in low- and middle-income countries – it found the value of lost output resulted in a projected cumulative loss of \$11.2 trillion in these countries between 2015 and 2030.

Universal health coverage can also serve as an impetus to address environmental threats. Air, water and soil pollution are clear health risks. Climate change impacts transmission of vector-borne diseases. It affects health through increased heat exposure, loss of biodiversity, reduced water quality and food insecurity. It is crucial to support health systems and communities to manage and mitigate climate-related health risks.

In turn, addressing environmental threats can strengthen health systems, particularly in reaching those who are left furthest behind. For instance, UNDP's Solar for Health initiative assists national governments to work with communities, local authorities and industry to increase access to quality health services by equipping health centres with solar panels. This innovation has contributed to reducing carbon dioxide emissions while providing reliable and clean energy to expand access to health services.

UNDP and Health Care Without Harm are collaborating to bring policy makers, technical experts, as well as United Nations suppliers and manufacturers, together to discuss improving environmental and social sustainability in the production of health commodities and the delivery of healthcare services. In Zimbabwe, South Sudan and Equatorial Guinea, a joint UNDP-HCWH project has promoted new packaging for anti-retroviral medications for HIV. It has resulted in a 55% increase in shipping capacity per container, 29% less packaging waste and a 57% reduction in carbon dioxide emissions.

The global HIV response provides important lessons for universal health coverage in different areas including inclusive governance, innovative financing, integrated

ACHIM STEINER

UNDP Administrator

Achim Steiner became UNDP administrator in 2017. He is also the vice chair of the United Nations Sustainable Development Group, which unites 40 entities of the UN system that work to support sustainable development. Prior to joining UNDP, he was director of the Oxford Martin School and professorial fellow of Balliol College, University of Oxford. Steiner led the United Nations Environment Programme (2006–2016), and was also director-general of the United Nations Office in Nairobi. He previously held other notable positions including director-general of the International Union for the Conservation of Nature and secretary-general of the World Commission on Dams.

🐦 @ASteiner 🌐 undp.org



service delivery, political mobilisation and the importance of human rights, multisectoral approaches and partnerships. To realise the promise of universal health coverage, principles of equity and inclusion, especially in terms of financial protection, must be placed front and centre.

In this area UNDP is working closely with civil society and our UN partners and has supported 89 countries to amend their laws and policies in line with the recommendations of the Global Commission on HIV and the Law.

Achieving and sustaining good health for all requires action within and outside the health sector. Enabling legal, policy and regulatory environments, built upon evidence and rights, can protect populations from exposure to risk, facilitate healthy behaviour, and remove legal, social and economic barriers to service access.

The report of the UN Secretary-General's High Level Panel on Access to Medicines, highlights the urgent need to remedy policy incoherence between the right to health, trade rules and public health goals. Political leadership and foresight are needed to intervene where the

50m

Premature deaths could be averted through increased taxation on sugary drinks, alcohol and tobacco

89

Countries have amended their laws after recommendations from the Global Commission on HIV and the Law

57%

Drop in carbon dioxide emissions following the introduction of new packaging for HIV medications

market-based models of innovation do not produce desired outcomes and where the high cost of some medicines, vaccines and diagnostics render them inaccessible to large segments of society, in rich and poor countries alike, thereby exacerbating inequalities. One of the most urgent examples of this is the global crisis of anti-microbial resistance. If not confronted, AMR could result in the loss of 10 million lives every year by 2050 – and cost the world up to \$100 trillion.

Worldwide, there is significant space to review fiscal and regulatory

policies on health-harming products to ensure coherence and to mitigate their costs and social harm. For example, 6.5% of global gross domestic product goes on subsidising dirty fossil fuels. Air pollution, to a large extent caused by the burning of solid fuels, kills seven million people annually and costs economies over \$200 billion in lost labour income.

The Addis Ababa Action Agenda on Financing for Development specifies the potential of tobacco taxation to avoid poor health and related costs, reduce burdens on health systems, and finance development. Increased

taxation of tobacco, alcohol and sugary drinks could avert 50 million premature deaths and raise \$20.5 trillion in revenue over the next 20 years, while delivering benefits across the Sustainable Development Goals. UNDP and World Health Organization national investment cases on NCDs, also demonstrate the potential economic benefits of scaled-up NCD responses, even in the shorter term. Development assistance to health sectors can also build the capacity of countries to strengthen domestic financing through taxation and other means.



Universal health coverage also requires concerted efforts across the UN Development System, in line with the 2030 Agenda for Sustainable Development. UNDP, fulfilling its role as an integrator in the UN system, is committed to supporting countries and its UN partners to deliver better health and development results for the people we serve. One example of this close collaboration is a 2018 Memorandum of Understanding between UNDP and WHO, with universal health coverage being one of three priority areas. The other two

– environmental health and health emergencies – are closely related to universal health coverage. Another example is the Global Action Plan on Healthy Lives and Well-being, under the leadership of my colleague Tedros Adhanom, WHO director-general.

The figures remain stark. In 2019, 100 million people are still being pushed into extreme poverty because they have to pay for health care. Such situations can destroy people’s futures and often those of their children.

Echoing Amartya Sen’s sentiment that there is no greater inequality

than whether people are afforded the opportunity to live longer lives they value or not – leaders must see health and well-being as an investment in sustainable development with very high rates of return.

All UN member must live up to their promise to achieve universal health coverage by 2030, as part of the Sustainable Development Goals.

Universal health coverage is no longer a political choice – but a concrete promise that millions around the world are waiting impatiently for us to deliver on. ■

EDITOR'S INTROS

2

CHAPTER

2.1

Advancing universal health coverage in 2019 through the gender dividend

By Ilona Kickbusch, co-chair of UHC2030 and director of the Global Health Centre at the Graduate Institute of International and Development Studies

p16

2.2

The political choice for universal health coverage in global governance in 2019

By John Kirton, director of the Global Governance Program

p20

Advancing universal health coverage in 2019 through the gender dividend

By Ilona Kickbusch



In the context of universal health coverage, gender takes on two dimensions and, without due consideration to both, the movement's progress will be severely limited

Universal health coverage, as the essential foundation for attaining health for all, has long been seen as an issue for national or even sub-national governments. At the international level, it has largely been left to the World Health Organization, its regional affiliates and the members' health ministers that govern these bodies to provide the necessary encouragement and practical support.

Universal health coverage is a very tangible thing – its presence (or absence) is experienced by people in a community in so many ways. First, when available, it provides a feeling of security. In its essence, it means that there is support available should a person experience a health problem – support that will not endanger the economic survival of the household, and will not hinder access based on factors such as sexual orientation, ethnicity or migrant status. We look too frequently to health policies only to ensure the right to health, whereas a complex web of policy decisions requires attention as many elements intersect.

That is why it is important that heads of state and government are fully aware of the many political dimensions of universal health coverage. The political choices they must make include many different and often highly controversial policy agendas.

One central and often overlooked policy dimension is gender. Economists and

development specialists highlight the historical opportunity of a youth dividend in many developing countries. Yet the gender dividend – particularly relevant for health – has not yet gained the attention it deserves.

Universal health coverage is inextricably linked to many other features of a society – especially its economic development and social cohesion. The economists in this book argue forcefully for this. That is why the strategy of many health advocates has been to reach out to finance ministers to invest more in health. This is also a key feature of Japan's G20 activities in 2019 to support universal health coverage.

But if we consider that countries must also invest better, there is one defining feature that moves to the centre: gender. It has two key dimensions: addressing gender equality in health systems design and delivery and in the health workforce. 'Women in Global Health' has summarised this in a simple message: universal health coverage will not be achieved anywhere without addressing gender equality, women's rights and the role of women in the global health workforce.

ECONOMIC GROWTH, FINANCE, EMPLOYMENT AND EDUCATION

The World Bank draws attention to the fact that societies can only substantially boost their gross domestic product if they increase female workforce participation. Most of the people working every day delivering health care – front-line health workers, community health workers, community nurses, service delivery providers – are women. Half of women's contribution to global health is unpaid as part of their family duties. Health workers play an integral role in improving health and supporting the wider economy.



A deeper understanding of the gendered composition of the health and social workforce is imperative to achieve efficient, effective, resilient and sustainable health systems. Unless societies invest in the education and workforce participation of their girls and women, they will not be able to resolve the challenges they face in expanding universal health coverage, which in turn relies on being able to meet other demands for economic growth. In health – as in other workplaces – work needs to be decent and well paid and workplaces need to be safe. And a wide range of ministries need to be engaged far beyond the health sector to address social norms – such as the age of marriage, women’s right to decide to work, the gender division of labour as well as many of the other structural barriers that keep women out of the workforce. Ministries of justice and constitutional courts can play a pivotal role in taking these agendas forward.

The World Health Organization recently reported that globally total health spending is growing faster than GDP. It is increasing more rapidly in low- and middle-income countries (close to 6% on average) than in high-income countries (4%). The global health economy is one of the fastest growing investment sectors, and global healthcare expenditures are likely to continue rising as spending is projected to increase from \$7,724 trillion in 2017 to \$10,059 trillion in 2020. In middle-income countries, average per capita public spending on health has doubled since 2000, as these countries progress

in their transition to domestic funding. With this health coverage expansion, the demand for health workers is expected to double to 80 million health workers by 2030. But if present trends continue, that expansion may well be thwarted by a shortfall of 18 million health workers, primarily in low- and lower-middle income countries.

This situation applies especially to nurses and midwives, who account for nearly 50% of the global health workforce. Already today 50% of WHO members report having less than three nursing and midwifery personnel per 1,000 population, and about 25% report having less than one per 1,000. As policies for universal health coverage are put into place, the role of the health sector as among the biggest and fastest growing employers of women – estimated at 70% of the health workforce – must be central to any development plan. Investments in the health and social workforce creates much-needed jobs for women, contributes to their economic independence and is part of a societal dynamic to improve their role in society. This requires the full involvement of the education sector to ensure that girls are provided with the educational opportunities and the professional training to participate in the health labour force.

Ministries of labour also need to be fully involved in addressing the growing demand for health workers in all countries. Effective health labour market policies need to be developed and to consider the root causes – such as gender – of key workforce challenges. There will need to be strategic investment to remove structural barriers that presently do not allow women to take on senior leadership positions. ►

258m **70%**



International migrants lack proper access to health services

Of the health workforce is composed of female staff members

ILONA KICKBUSCH

Co-chair of UHC2030 and director of the Global Health Centre at the Graduate Institute of International and Development Studies in Geneva, Switzerland

Ilona Kickbusch served on a panel of independent experts to assess the World Health Organization's response in the Ebola outbreak. She previously had a distinguished career with WHO and Yale University, and has published widely on global health governance and global health diplomacy.

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MIGRATION, REFUGEES AND ASYLUM SEEKERS

Ministries of labour will also be confronted with regulating an increasing migrant health workforce, with female nurses globally making up the dominant number of health worker migrants. This often includes managing migration and improving the retention of health workers at the same time, or, as in some countries, explicitly training health workers for export. Implementing the 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel requires extensive intersectoral cooperation – including the ministry of foreign affairs, as bilateral agreements are crafted between countries that need to be based on it to ensure fairness and social justice for all health workers

and professionals and to ensure their rights in the receiving and sending countries. New initiatives at the global level such as ‘Nursing Now’ are focusing on the required policies.

Tensions can emerge particularly in countries that receive high remittances from health workers abroad. Gender dynamics play out here as well: a not inconsiderable part of the estimated \$465 billion in remittances flowing into developing countries comes from women health workers abroad. Women migrants tend to remit higher proportions of their income and do so more frequently than do male migrants. They also tend to allocate more resources for the benefit of their children, which is critical for the intergenerational effects of social development. Increasingly tax,



Countries will need to establish supportive working and living environments and opportunities for professional growth so that health workers are less likely to migrate. Unless this is done with a clear understanding of the role and needs of women in the health workforce, no such strategy will be successful”

banking and insurance laws are being adjusted to take these factors into account.

Countries will need to establish supportive working and living environments and opportunities for professional growth so that health workers are less likely to migrate. Unless this is done with a clear understanding of the role and needs of women in the health workforce, no such strategy will be successful. One way is to involve representatives from the extensive female health workforce in shaping these plans. This means including not only female doctors, nurses and midwives but also the community health workers – paid and unpaid – in decision making. The new initiative ‘Communities at the heart of UHC’ is leading an effort to elevate the visibility of community health in the context of universal health coverage and provide women community health workers with voice and leadership roles. That critical dialogue shines a light on the need to provide paid work for women. As one community health worker said, “In Ethiopia we have managed to push out a very strong community agenda with CHWs at the heart of health care delivery because Ethiopia as a country made a political commitment to integrate CHWs into the formal health system and compensate them. Therefore, we are held accountable by the fact that we are salaried, which in most African countries is not the case; CHWs are volunteers. Why don’t other countries pay their CHWs so that they can be held accountable too and deliver results for UHC?”

Addressing the gender dimension and dividend of universal health coverage lets us understand better the span of the challenge between community health care and the cross-border dimensions of universal health coverage. Such factors – which again are highly gendered – include

in particular the global care chains and the growing number of migrants, refugees and asylum seekers, many of them women. A quick glance shows us that:

- As the absolute numbers of those migrating to work in health and care abroad increases, a ‘care drain’ is created in the global South, in poorer parts of the European Union and other developing regions, and in the rural areas of countries with large internal (rural–urban) migration. This tilts care resources towards cities and the global North, as WHO’s Women on the Move illustrates.

- Many of the 258 million international migrants and 763 million internally displaced people lack proper access to health services as well as financial protection. Many migrant, refugee and asylum-seeking women and girls have been exposed to various forms of gender-based violence. Due consideration needs to be given to their needs and circumstances and gender-responsive measures should be adopted.

CONCLUSION

The UHC2030 global asks call on political leaders to legislate, invest and collaborate with all of society to make universal health coverage a reality. If this is done with keeping the principles of gender equality and equity in access in mind and acknowledging the role of women as 70% of the health workforce when formulating policies, then societies will reap a tremendous gender dividend. Investing in programmes that improve income-generating activities for women can return \$7 for every single dollar spent. Apply this to the health sector, where the social benefits generated can be manifold if they are part of a strategy to build quality health systems that people and communities trust.

The Sustainable Development Goals – especially SDG 5 to ‘achieve gender equality and empower all women and girls’ – reiterate that gender equality is not only a fundamental human right, but a necessary foundation for a peaceful, prosperous and sustainable world. Advancing gender equality is critical to all aspects of a healthy society, from reducing poverty to promoting the health, education, protection and well-being of all. This is an agenda that the upcoming G20, G7, United Nations and other high-level meetings need to take up with determination. ■

The political choice for universal health coverage in global governance in 2019

Much progress has been made in the universal health coverage movement by developed and emerging economies alike, proving that political will is the key driver to achieving the seemingly impossible

Universal health coverage, as the essential foundation for attaining health for all, has long been seen as an issue for national or even subnational governments. At the international level, it has largely been left to the World Health Organization, its regional affiliates and the members' health ministers that govern these bodies to provide the necessary encouragement and practical support.

This has now changed. Universal health coverage is rapidly rising to become an integral part of global governance as a whole. It has become a key political choice at the highest level, and one of the most important ones of all.

This publication thus takes the message about the power and promise of universal health coverage beyond the health community to global governance as a whole, and all the actors that shape its work. Yet the key component of implementation remains at the national and local levels. It must be met by building comprehensive health systems at home, based on local talents, to address in an integrated way all the health harms that people face.

By John Kirton

THE PROPELLERS OF UNIVERSAL HEALTH COVERAGE'S GLOBAL GOVERNANCE ASCENT

Several urgent, unstoppable forces are propelling universal health coverage's rapid global governance ascent.

The first force is globalisation in its many forms, starting with climate change, biodiversity, ecological loss and human migration. They bring escalating harms to human health and ensuing demands for health care on a global scale, anywhere at any time in a complex, often unpredictable, fast-moving world.

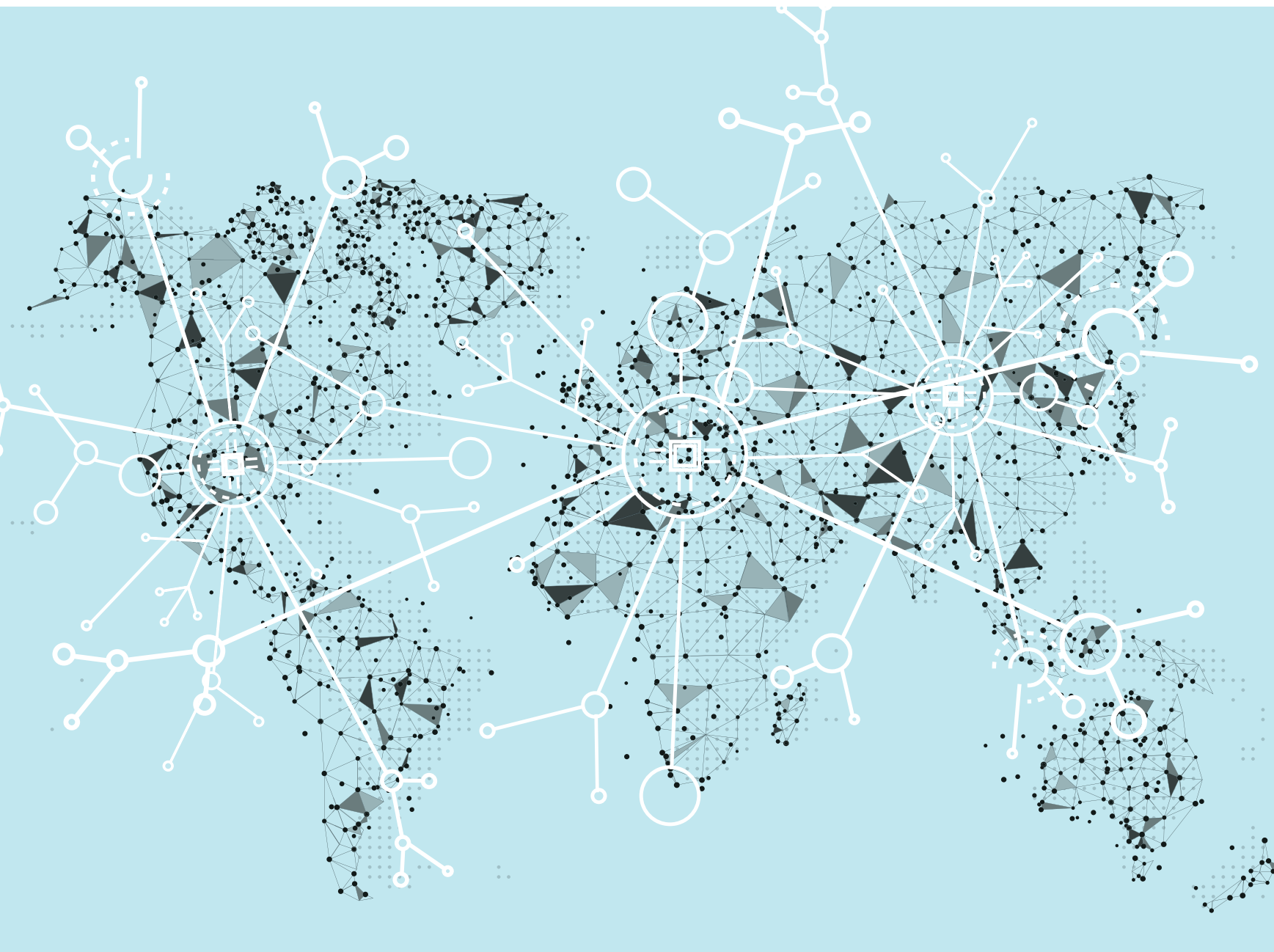
A second force is the return to global economic growth from the great global financial crises of 2008. This brings shifts in the political focus from finance to health, new wealth to meet the needs for health and new digital technologies and scientific innovations to make large, if disruptive, leaps ahead.

A third force is the planet's growing population, which is rapidly ageing in many places. This brings a new scale and type of burden to health systems often already struggling to cope with existing demands.

A fourth force is pressure from people who see governments delivering wealth, health, security and other things for the rich rather than in improved living conditions for all and in particular to those economically struggling individuals whose sudden, spiking healthcare costs could make them poor at any time. With so many people lifted out of poverty in recent decades, the threat of plunging back due to the lack of universal health coverage is a major political driver.

THE PHASES OF UHC'S GLOBAL GOVERNANCE ASCENT

These forces have driven universal health coverage upwards and outwards to the very top of global governance writ large. The launching pad was built long ago, on 10 December 1948 when the United Nations General Assembly, meeting in Paris, created the Universal Declaration of Human Rights. Article



25 declared health to be a human right: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family ... including medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability.”

It was reinforced in Alma-Ata, Kazakhstan, on 12 September 1978 when the International Conference on Primary Health Care affirmed in the opening of its declaration that health “is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose full realisation requires the action of many other social and economic sectors in addition to the health sector”.

The current lift-off came at the historic UN summit in New York on 25–27 September 2015. World leaders launched the 2030 Agenda and its 17 Sustainable Development Goals. SDG 3 on

health contains, for the first time at a UN summit, a target to provide universal health coverage. SDG 3.8 promises to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.

In making universal health coverage an integral part of the 17 SDGs and their 169 targets that bind all countries poor and rich, global leaders recognised that it does not belong in a self-contained health silo, even one supported by related social and economic sectors. Rather, it is an integral, intimately connected part of the sustainable development of everyone in every way. It has thus become a political choice for the whole of governance, for all who live on the precious, precarious planet we share.

To implement this visionary promise, the key institutions and leaders of the UN and Bretton ►

150

Years have passed since Germany first started to develop a UHC system, based on social insurance

Woods bodies started work in a focused, energetic synergistic way.

At the centre stood the World Health Organization, as the central custodian of SDG 3 and target 3.8. It boldly aimed to lift one billion people out of poverty by providing them with universal health coverage by 2030. Under the leadership of Dr Tedros Adhanom Ghebreyesus, on 6 March 2019, it reorganised itself to more effectively reach this goal.

Dr Tedros also declared that WHO would work more closely with the global summits of the G20 and G7 in this cause. He aimed “to strengthen our role in international political fora like the G7, G20 and multilateral negotiations that we were not really exploiting”.

In doing so he was wisely choosing as allies many of the most powerful leaders of many of the most powerful countries in the world, whose summits and ministerial meetings have recently begun to promote universal health coverage.

At their Hamburg Summit in 2017, all G20 leaders declared: “We recall universal health coverage is a goal adopted in the 2030 Agenda and recognise that strong health systems are important to effectively address health crises. We call on the UN to keep global health high on the political agenda and we strive for cooperative action to strengthen health systems worldwide.”

At their Buenos Aires Summit in December 2018 they added: “We encourage the activities of World Health Organization, together with all relevant actors, to develop an action plan for implementation of health-related aspects of SDGs by 2030. ...We reaffirm the need for stronger health systems providing cost effective and evidence-based intervention to achieve better access to health care and to improve its quality and affordability to move towards universal health coverage, in line with their national contexts.”

For the G20 summit that he will host on 28 – 29 June 2019, Japanese prime minister Shinzo Abe has made health a priority and put universal health coverage at the core.

The smaller, older summit of the world’s major market democracies is acting too. At the Ise-Shima Summit, hosted by Prime Minister Abe on 26 – 27 May 2016, G7 leaders promised: “We commit to take concrete actions for advancing global health as elaborated in the *G7 Ise-Shima Vision for Global Health*, highlighting that health is the foundation of economic prosperity and security. We commit to promote Universal Health Coverage (UHC) as well as endeavor to take leadership in reinforcing response to public health emergencies and anti-microbial resistance (AMR) which could have serious impacts on our economies.”

In 2019, French president Emmanuel Macron has put health on the agenda as part of his central

theme of fighting inequality for the G7 Biarritz Summit he will host on 24 – 26 August. To pave the way, G7 health ministers, assembled in Paris on 16 – 17 May, “reaffirm[ed] that primary health care is a cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals, to reduce inequalities and contribute to the improvement of well-being and socio-economic development, as well as social stability and security in all countries”.

At the regional level, other summits have supported and often led the call. The African Union has put health at the centre of its summit agenda and the Caribbean Community has pioneered the global effort to produce the critical component of preventing non-communicable diseases.

The ascent of universal health coverage to the very peak of global summit governance will continue at the United Nations in New York on 23 September 2019, at the UN High Level Meeting on UHC. Its theme is Universal Health Coverage: Moving Together to Build a Healthier World. It will culminate in a UN political resolution to stimulate and shape the path to the achievement of the 2030 goal.

THE BENEFITS OF UNIVERSAL HEALTH COVERAGE

In making universal health coverage so central to the SDGs and global governance as a whole, these global leaders recognise that the benefits brought by universal health coverage are very big and broad. They begin with reduced child and maternal mortality, increased cognitive capacity and learning for children and longer years of life expectancy at birth. They continue with a more productive workforce with more and better jobs, a more innovative economy and enhanced economic growth, development and prosperity.

They include individual and family income security, stability and freedom from catastrophic health expenditures that can plunge people into poverty or even death. They extend to poverty reduction, equality for women and girls, social cohesion and inclusiveness, and happier, better functioning, more stable and secure societies overall. They offer some protection against and mitigation of the compounding climate crisis and ecological devastation, and they help bring the values of dignity, social justice, fairness and equality to life.

PROVEN SUCCESSES

As these enormous benefits of universal health coverage pull world leaders to act, they are also pushed by the proven success universal health coverage has brought when introduced by countries around the world. Such proven



JOHN KIRTON

Director of the
Global Governance Program

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Several urgent, unstoppable
forces are propelling universal
health coverage’s rapid global
governance ascent”

successes in securing universal health coverage provide all a firm foundation, several models and an inspiration on which to build.

Among the advanced economies, Germany looks back on 150 years of developing a universal health system based on social insurance, and remains a global leader to this day. In 1948 an economically exhausted United Kingdom introduced the National Health Service that fuelled its ensuing economic growth and innovation and became a fundamental feature of its social, political and cultural life. In the 1950s a recently devastated Japan started its successful campaign that eradicated tuberculosis and helped put in place the high-quality universal health coverage that its long-lived people enjoy today.

Among the emerging economies, in 2003 Turkey adopted its Health Transformation Programme that achieved universal health coverage a decade later. Uruguay is the first country to become 100% free of indoor tobacco smoke in the Americas, thereby reducing the burdens on its emerging universal health coverage system. Thailand has also been a pioneer.

Among developing countries, China expanded its national health insurance from 317 million people in 2005 to more than 1.3 billion a decade later, to cover 95% of its citizens. India eliminated polio in 2014 through an immunisation programme that formed the basis of a healthcare system now reducing other diseases and fostering high-quality universal health coverage to address them all. Niger is now pointing a path to the future, by pioneering digital solutions for universal technology coverage that could bring universal health coverage to more people.

INVESTING IN UNIVERSAL HEALTH COVERAGE

Amidst these compelling pulls and pushes, global leaders, their citizens and stakeholders remain concerned about the money, asking how much will universal health coverage cost, where

2015

The year 1.3 billion people were covered by national health insurance in China

2003

The year Turkey adopted its Health Transformation Programme, which achieved UHC in 2013

1948

The year the United Kingdom introduced the NHS, powering economic growth in the country

“

Well-designed mandatory systems of social solidarity with a redistributive component can take different shapes as existing examples from all around the world show”

will the money come from and is it the wisest place to invest the limited funds at hand.

As answers to these important questions, the evidence shows that investing in universal health coverage is one of the smartest economic and political choices a country and the global community can make. It is reliably estimated that one dollar invested in immunisation – a critical component of universal health coverage – will bring \$16 back in immediate savings in healthcare expenses and reduced productivity and an ultimate return of \$44 when the broader rewards of longer, better lives are factored in.

To finance this smart choice for universal health coverage, the money can come from many sources. In general, economic growth, budget reprioritisation and efficiency-improving measures are the main drivers of fiscal space for mobilising a country's own domestic resources. This includes the taxes raised by a fair and effective national tax system, in some cases also taxation of unhealthy goods and products such as tobacco.

Public financing is essential for countries to make sustainable progress towards universal health coverage. Well-designed mandatory systems of social solidarity with a redistributive component can take different shapes as existing examples from all around the world show. Many systems still include co-payments and user fees that can deter people from accessing services. External funding (in the form of aid) represents less than 1% of global health expenditure and is a small and declining proportion of health spending in middle-income countries; but it is increasing in low-income countries unable to invest fully in universal health coverage on their own.

Here new aid donors can be mobilised, and all official donors can increase their aid and the share of it devoted to universal health coverage. Such traditional concessional international public resource transfers can be supplemented by several international sources, such as contributions in cash or kind from non-governmental organisations and even a possible surtax on the world's billionaires. ■

COUNTRY LEADERS SPEAK OUT ON UHC

3

CHAPTER

3.1

New health policies for new health challenges

A speech by Japan's Prime Minister, Shinzo Abe

p26

3.2

Inspiring Global Action

A speech by France's President Emmanuel Macron

p28

3.3

Implementing Sustainable Development Goal 3

A speech by German chancellor, Angela Merkel

p30

3.4

Uruguay's fight against NCDs and tobacco

Tabaré Vázquez, President of Uruguay

p34

3.5

Kenya's social shift

By Uhuru Kenyatta, President of the Republic of Kenya

p36

3.6

Gender and health: a political choice with major ROI

By the Right Honourable Helen Clark

p38

3.7

Transforming a continent

By Paul Kagame, President of Rwanda

p40



Shinzo Abe

Prime Minister, Japan

New policies for new health challenges

In Japan's ageing society, health care is forcing difficult political choices. However, Prime Minister Shinzo Abe says a 100-year-life society will enrich, rather than burden, this leading economy. Here, excerpts from two of his most powerful orations on the topic highlight the vision

World Leaders for Universal Health Coverage: A High Level Discussion at the United Nations on Achieving the SDGs through Health for All, at the side event to the 72nd Session of the United Nations General Assembly, 18 September 2017

While the progress of globalisation has brought great benefits to humanity, we have also witnessed growing concern and discontent over widening disparities. Moreover, the international community is facing various threats to human security, such as climate change, terrorism,

refugee issues and infectious diseases. In this context, the promotion of health, especially universal health coverage, is essential for addressing these challenges and achieving the core principle of the 2030 Agenda; that is, the realisation of a society where no one is left behind.

International efforts to achieve universal health coverage have made great progress. At the Sixth Tokyo International Conference on African Development (TICAD VI) held last year under the twin principles of African ownership and international partnership, we introduced universal health coverage in Africa, a policy framework that presents a roadmap and

actions for achieving universal health coverage. In addition, we launched the International Health Partnership for UHC 2030 platform, which facilitates coordination among various efforts for universal health coverage.

However, our journey towards universal health coverage has just begun. There are tremendous challenges ahead of us. It will be by no means an easy path to expand the number of skilled doctors, nurses and community health workers, establish pharmaceutical supply and management systems, and introduce financial systems that ensure affordable access to basic health for all.

In the past year, we have welcomed several new leaders to the global health landscape. With UN secretary-general António Guterres, WHO director-general Dr Tedros Adhanom and UNDP administrator Achim Steiner, we have an unprecedented opportunity to remarkably expand the scope and quality of efforts toward universal health coverage. I am counting on their strong leadership.

Since the G8 Kyushu-Okinawa Summit in 2000, global health has become a top agenda item to be discussed by global leaders. Last year, the Government of Japan set global health as a major pillar of both the G7 Ise-Shima Summit and TICAD VI last year, and has dedicated itself to the promotion of universal health coverage. I would like to lead in-depth discussions on global health, making the most of future high-level meetings at the United Nations and TICAD VII to be held in Yokohama in 2019.

Meanwhile, universal health coverage calls for cross-sectoral approaches. We need to pursue universal health coverage in the context of social changes, such as the concentration of populations in urban areas and the ageing of society, mainly seen in Asia. In this context, Japan formulated the Asia Health and Well-being Initiative last year, and is ready to share the experience of universal health coverage in an aging society with other Asian countries. In addition, sustainable and inclusive UHC requires significant resources. Therefore, I underscore the importance of a framework to mobilise resources to achieve universal health coverage from the private sector and civil society, along with those from

international organisations and donor countries, in order to complement the efforts of countries to mobilise public resources domestically.

In closing, our contribution to achieve universal health coverage is an investment for the future, towards 2030 and beyond. I am firmly convinced that today's event and the UHC Forum in December will provide a great opportunity to take concrete steps toward attaining universal health coverage. I am looking forward to seeing all the leaders from various fields present here today again in Tokyo.

Policy Speech by Prime Minister Shinzo Abe to the 198th Session of the Diet, 28 January 2019

The arrival of a 100-year-life society represents a significant opportunity.

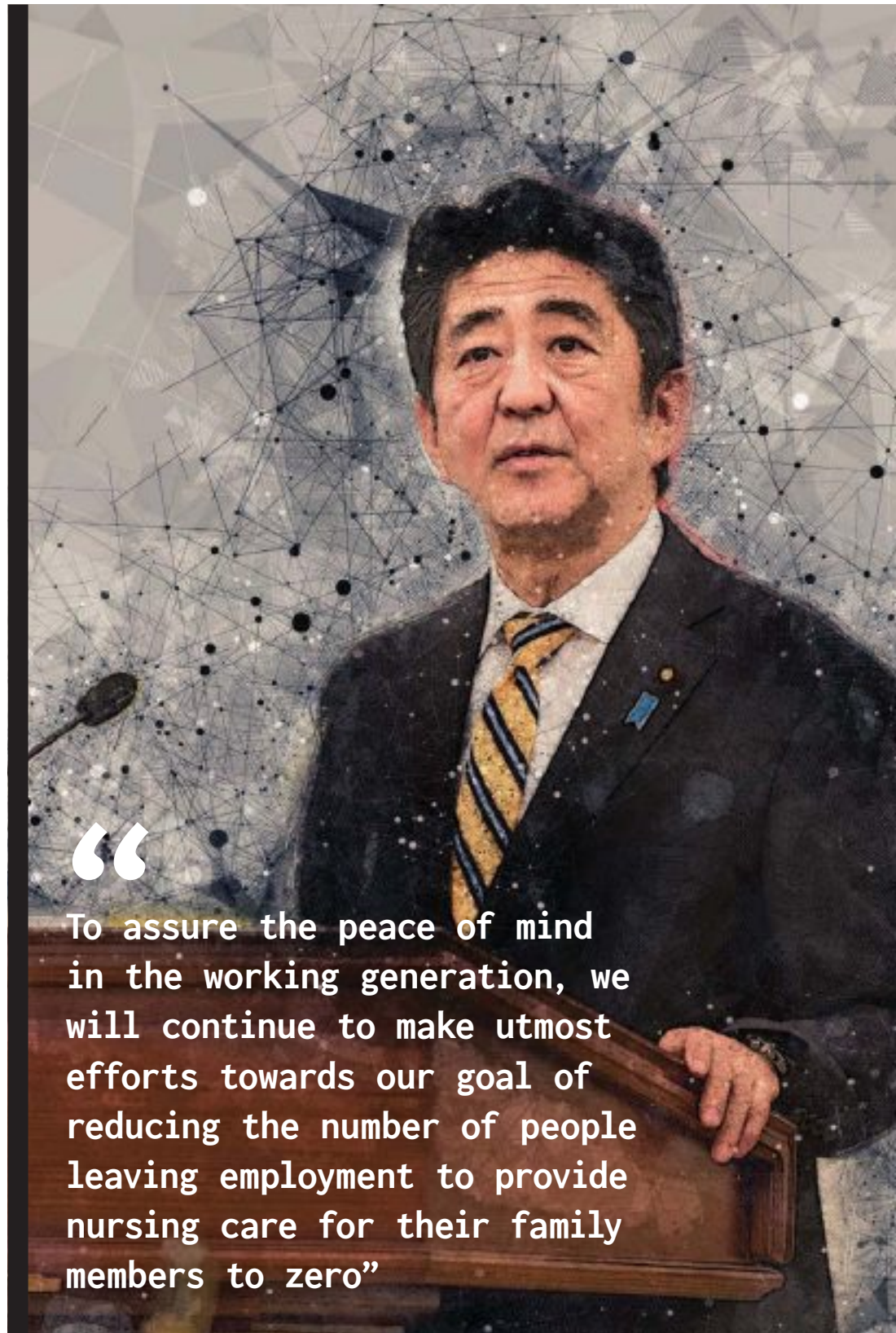
If those elderly, who are healthy and motivated, can make use of their experiences and wisdom, Japan still has much room for further growth. Towards achieving a society where people can play an active role throughout their lives, we will review the existing system that limits continued employment to age 65. We will formulate a plan by this summer and implement it so as to secure employment opportunities until age 70.

We must be able to overcome the declining birthrate and ageing population if all people have opportunities to realise their potential, whether they are female or male, are young or old, or have disabilities or intractable illnesses.

To assure the peace of mind in the working generation, we will continue to make utmost efforts towards our goal of reducing the number of people leaving employment to provide nursing care for their family members to zero.

We will improve the nursing care environment to accommodate 500,000 people by the early 2020s. We also promote measures to reduce the burdens borne by caregivers, such as making use of robots, and improve their working conditions by raising the monthly salaries of staff in a leadership position, by up to ¥80,000 from October.

In order to strengthen our policy related to dementia, we will revise the Comprehensive Strategy to Accelerate Dementia Measures (New Orange Plan) by this summer. We will reduce the burdens of those who have family



“To assure the peace of mind in the working generation, we will continue to make utmost efforts towards our goal of reducing the number of people leaving employment to provide nursing care for their family members to zero”

members suffering from dementia, by supporting them as the entire community through various measures such as setting up a ‘dementia café’ in all municipalities.

We will review traffic regulations entirely, and gradually lift regulations

related to autonomous driving, as the safety improves. We will also review relevant systems to enable bedridden elderly people and others to receive comprehensive services online and at home, from medical examination to medication guidance. ■



Emmanuel Macron

President of France

Inspiring global action

Speaking at the United Nations General Assembly on 25 September 2018, France's President Emmanuel Macron called for radical change and urgent action on the world's health inequalities

Ten years ago, when the financial crisis broke out, we took emergency measures but we did not solve the deepest problem, we did not curb the trend towards the hyper-concentration of wealth on our planet and we did not really provide an answer to all those who were left behind by globalisation. All those who were marginalised and frustrated by the humiliations they had suffered harboured a despair whose price we are collectively paying today.

We owe all these fellow citizens an answer. We owe an answer, my friends, to the 265 million children, more than half of whom live in sub-Saharan Africa, who have no access to schooling; to the girls who enjoy fair access to education in less than 40% of all countries.

We owe an answer to the 700 million children who live in the regions most exposed to the effects of climate change, who are the victims of floods, drought, rising waters, diminishing resources.

We owe an answer to the 200 million women who don't have access to contraception, to the billion-plus who are not protected by the law if they suffer violence in their home. To all the women whose pay gap with men averages 23% worldwide and up to 40% in rural areas. We owe an answer to the 783 million people who live below the poverty line, who suffer from hunger or chronic malnutrition, to those who don't have access to basic care.

We owe an answer when it comes to the aspirations of the largest number of young people in history, our young people, i.e., nearly two billion people between 10 and 24 years old today, 90% of whom live in developing countries.

We owe an answer to all those who look to us because their fate depends on what we can or can't do here together, in this Assembly. And those people who forget that we owe them all an answer are wrong because they're preparing for crises tomorrow, the day after, because they'll leave their successors, because we'll leave our children in a much worse situation than the one we're in right now.

FRENCH G7 PRESIDENCY

But this is also why the fight against inequalities will be the priority of France's G7 summit presidency in 2019. Indeed, after Canada – whose leadership I want to pay tribute to here – France will hold the next presidency of the G7, whose format I would like to thoroughly revise to involve more effectively several other powers, and work at new forms of coordination.

It's at the United Nations first that I want to say this inequalities agenda will be central to the next G7. I am also pledging to you to report back on the results of the Biarritz G7... because the time when a club of rich countries could alone define the world's inequalities is long gone, because the fate of every country belonging to it is inseparable from that of every member of this Assembly.

Yes, we must tackle present-day inequalities today because they're at the root of the evil I was denouncing at the beginning of my speech. We must tackle inequalities of destiny. It's a moral aberration as much as a reality which is untenable. It is unacceptable not to enjoy the same opportunities depending on the country you are born in, not to be able to go to school in some countries because you are a woman, not to have access to certain basic care.

GENDER

We must also fight passionately against gender-linked inequalities. I have made gender parity in France the great cause of my five-year term, and I issue an appeal here to make this a great global cause with you. Women and girls are the first to be affected by poverty, conflict, the consequences of global warming; they are the first victims of sexist and sexual violence, which too



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It is unacceptable not to enjoy the same opportunities depending on the country you are born in, not to be able to go to school in some countries because you are a woman, not to have access to certain basic care”

often prevents them from moving around freely, working or choosing what happens to their bodies.

Our responsibility in the 21st century is to end these kinds of violence, from harassment on the street to femicide. It's time our world stopped making women victims and at last gave them their rightful place – the one where they are leaders too! We must guarantee them access everywhere to education, health care, jobs, and to taking economic and political decisions, and fight every kind of violence they are subjected to.

So France will propose to governments wishing to move forward with us the creation of a coalition for adopting new laws for gender equality. Fifty percent of our development aid will be devoted to projects to reduce gender inequalities.

HEALTH

We must also relaunch efforts to fight health inequalities at international level. We are hosting the Replenishment Conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Lyon in 2019. We will retake the initiative on the fight against fake drugs and step up our action to tackle major pandemics. I call on everyone here to mobilise. ■



Angela Merkel,
Chancellor, Germany

Implementing Sustainable Development Goal 3

Speaking in Berlin on 8 May this year, Angela Merkel reminded world leaders that health is a shared task and that to live dignified lives, we must all collaborate on common goals

Those who do not find time every day for health must sacrifice a lot of time one day for illness.” These words of wisdom by Sebastian Kneipp are still relevant today and should be heeded not only by career politicians. Eat healthy, get enough exercise, don’t smoke, have regular medical check-ups and get vaccinated – and here I am referring to a current public debate in Germany that the Federal Minister of Health is strongly, and I must say rightly, engaged in – all this is key to avoiding the diseases of modern society. We know there is a very close link between living a healthy lifestyle and individual well-being.

Sebastian Kneipp’s helpful advice makes the case for prevention – which should have a permanent and prominent place not only in our individual lives, but also throughout the healthcare sector. Prevention and prudent behaviour by no means apply only to individuals. Rather, diseases always also have an impact on society as a whole. Dealing with them requires time and money, as well as expertise and medical equipment. It would be an overwhelming task for an individual to provide full personal health insurance. That’s as true for each of us as it is for entire countries and regions – especially those that are not the most affluent in the world.

If you think that developing a healthcare system is a task

that stops once you’ve reached a certain development threshold, then think again. We see this every day. If you have visited the poorest countries in the world – and I recently spent three days in Mali, Burkina Faso and the Niger – then you will have seen the range of issues for which director-general of the World Health Organization Dr Tedros is responsible, and how different problems are there compared to our industrialised countries. We must of course make sure that we live healthy lifestyles and maintain good healthcare systems. However, we also must contribute what we learn through research and development. For example, we don’t want to promote anti-microbial resistance through bad livestock farming practices that could have a global impact, and we want our development cooperation efforts to help other regions attain sustainable development and health goals. Another cabinet colleague of mine, Gerd Müller, will rightfully be participating in this congress.

COMMUNICABLE DISEASES

So health is a shared task, in both a national and global sense. This is especially true and evident for communicable diseases. These can cross borders and have devastating effects. The Ebola outbreak in 2014 in West Africa was a particularly painful reminder of this. Currently, in the Democratic Republic of the Congo, we see how political instability and insecurity due to Ebola are forming a disastrous combination. The disease is being used to assert political interests. Aid workers are being threatened and attacked.

In April, such an attack resulted in the death of Richard Mouzoko, an epidemiologist who was on WHO deployment. So it is true that people are sacrificing their lives, or being forced to sacrifice their lives, because in addition to horrible diseases they are caught in the crossfire of political tensions. Dr Tedros, I also want to take this occasion to express our sincere condolences to the family, friends and colleagues of Richard Mouzoko. It is unacceptable – and we must stand up for the cause – that people who simply want to help others must risk life and limb to do so. After all, the only things stopping the further spread of Ebola are the committed and tireless efforts of aid workers.

Unfortunately, the number of infections recently rose again. That is why I want to use this opportunity to repeat my appeal to all those in positions of responsibility in the region that they give aid workers truly unhindered access, so that current infection numbers don’t grow into an even greater epidemic. I know this is much easier said than done – especially in a region where violent outbreaks are a regular occurrence. However, this also underscores the importance of the MONUSCO mission of the United Nations, which aims to stabilise the Democratic Republic of the Congo.

Of course, the best way to help aid workers would be to have far less need for their assistance – that is, if there were more prevention. Merely reacting to health risks is not optimal – especially when aid efforts are



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Strengthening
national healthcare
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country”

obstructed by security risks, often exactly at the time when help is most urgently needed. This is why we must continue to work together to strengthen the healthcare sector – also at times when health risks do not dominate the world’s headlines. We must prepare international systems as best we can to deal with future emergencies.

Here, I want to say that significant progress has been achieved on coordinating the processes within WHO and the United Nations. I want to thank director-general Tedros for his reform efforts, as well as for building a clearly structured system to deal with emergencies. Dr Tedros – this is an area in which we would like to continue providing support. People who are acquainted with this topic will know that, although the words of the director-general of a UN organisation do hold sway, at the UN itself the regions often act independently. Many good arguments and

lots of persuasion are therefore needed to achieve seamless cooperation.

COLLECTIVE RESPONSIBILITY

Of course, international agreements do not relieve individual countries of their responsibility. Strengthening national healthcare systems is, after all, in the vested interest, and incidentally also in the economic interest, of every country – because health is a key prerequisite for national economic development. Here, however, I would like to add the following: My visit to Mali, the Niger and Burkina Faso made clear to me how large the threat of terrorism is in all three countries. They spend between 20% and 30% of their budgets exclusively on security. When that happens, other equally important areas of development are short-changed. These tasks are therefore very much interlinked – guaranteeing security and providing healthcare services, thereby helping to promote economic prosperity. ▶

Germany makes available more than €1 billion annually in economic cooperation funding for health-related projects. Our aim in doing so is to jointly work on finding solutions where they are needed. In this connection, let me say that I very much approve of the WHO approach not to dictate solutions, but rather to travel to the respective regions first to learn what is actually required and what actions will have a lasting effect. Because, for example, it would not make sense to build entire hospital sites at an arbitrary location without also making sure that the respective infrastructure and links are also ensured. That is why cooperation through partnerships is urgently needed to create both acceptance in these regions and to achieve lasting, desired results.

Whether the goals be humanitarian objectives, development policy aims, economic interests or even self-motivation – we must act to limit the spread of diseases. For everyone in the international community, this is a shared responsibility. We have a duty to support poorer countries, so that they can live up to their responsibilities.

This shared responsibility is also reflected in the 2030 Agenda for Sustainable Development. In Germany, we are committed to the Sustainable Development Goals. That, after all, is what's special about the SDGs: rather than targeting the less developed countries, they are part of a joint, global agenda. We have considerably stepped up our engagement on SDG 3 – not only financially. Hermann Gröhe has just said that we very deliberately placed this issue on our G7 and G20 presidency agendas, and we've done everything we can to make sure that it is not forgotten.

I'm therefore most grateful to Japan, which holds the current G20 presidency, for focusing on the issue of universal health coverage. We want to talk about how we can obtain agreement on substantial steps towards universal health coverage. The heads of state and government will also talk about this at the United Nations in September. This will send a very important signal, because we will thereby be highlighting the importance of global and universal health coverage.

Health issues are one of the areas where international cooperation can show what it's capable of. An example that occurs to me is the Pandemic Emergency Financing Facility of WHO

and the World Bank. They are very valuable instruments to make crisis management funds available swiftly and without red tape. In fact, we simulated our health emergency coordination capabilities with an exercise during our G20 presidency. The German government is very active in this regard.

SHARING KNOWLEDGE AND RESOURCES

In my opinion, it is just as important for research progress to also benefit countries with weaker economies. Thanks to the CEPI alliance – the Coalition for Epidemic Preparedness Innovations – we can more effectively deploy new vaccines, and with the Global Antibiotic Research and Development Partnership we can efficiently and fairly distribute new antibiotics. I would like to say the following about antibiotics: possibly one of the most serious problems – although it is often underestimated – is that we often prescribe antibiotics too liberally. It is incredibly difficult and by no means certain that we can constantly develop new antibiotics. This is why we must act very prudently and carefully.

Research often does not devote enough attention to many diseases in poorer countries and the ways that they can be treated – because of the bottom line. There is a significant danger that rich countries will work on addressing their diseases and at the same time overlook the fact that, in other places, there are widespread diseases for which real treatment progress could be achieved with modest investments in research. It is a matter of particular importance to me that we not forget such poverty-related diseases. According to estimates, these affect more than one billion people. So-called neglected tropical diseases are therefore by no means negligible.

This is of course true for the 'big three' – HIV/AIDS, malaria and tuberculosis. In Africa alone, some 250,000 children still die from malaria every year. Knowing what a malaria net costs, and giving some thought to the idea of supplying these, it becomes obvious that we really should take action wherever we can. To combat these diseases, we have the Global Fund, which is due to be replenished for the years 2020 to 2022 this October in Lyon. Germany will again make a substantial contribution. Much hope is being placed in the new malaria vaccine. It is being tested in Malawi, took three decades to develop, and has the potential to prevent 40% of overall cases and 30% of severe cases of malaria. It would be significant progress if we could actually get this vaccine out to where it is needed.

HEALTH AND THE 2030 AGENDA

I think the examples I've given prove that health alone is worth all the effort that we can devote

3

The SDG to ensure healthy lives and promote well-being for all at all ages

40% 30%

Rate of malaria prevention when a new vaccine is administered

Of the national budget in Mali, the Niger and Burkina, spent on security

to it. But there are good reasons that one of the Sustainable Development Goals for the 2030 Agenda is health and well-being. This shows that health is intricately interconnected with other SDGs that affect the well-being of each and every one of us.

Considering the key role of health for a dignified life, I have joined Norwegian prime minister Erna Solberg and Ghanaian president Nana Akufo-Addo in calling for a plan of action to implement SDG 3. I'm very grateful for the committed efforts of WHO in this regard. Dr Tedros, this work is very important, and we will continue to support it. Because if we know what specific measures can help accelerate progress towards, or just help achieve, health-related goals, then we can take more targeted action.

That, after all, is key to delivering on all goals of the 2030 Agenda for Sustainable Development. Just think: There is a large number of recipient countries – there are more than 50 countries in Africa alone. And there are certainly 60 or 70 countries that are able to provide aid for development measures. Yet no one looks at the combined effect – that is, how efficiently goals in the respective country are being met. It is therefore paramount – and WHO indeed does this – to internationally coordinate action. We must pay attention to what assistance is given where, and to how we can make sure that we are on the right track to achieving the SDGs.

A PLAN FOR ACTION

At the World Health Summit last October here in Berlin, a first version of the plan of action was presented. Work on drafting the final version is under way. That will certainly also be one of the topics of discussion here today. Initial results show that the signatory organisations – such as WHO, UNICEF, the World Bank, the Global Fund and Gavi, the Vaccine Alliance – are comparing and deconflicting their programmes of work and unifying their strategies. I am very much looking forward to the final document, which is due to be presented during UN Week in September. Maybe Dr Tedros will give us some examples of these efforts. Of course, we also make a point of working with foundations. The Bill and Melinda Gates Foundation, for example, is represented here today, and representatives of other foundations may be here as well. Here, too, we must make sure that activities to reach our goals are coordinated.

I certainly hope – and here I turn to the head of my parliamentary group – that the German Bundestag will be of assistance in this regard, dear colleagues and Ralph Brinkhaus. Because I would welcome it if our parliaments could help lobby support for the action plan. That is very important. The fact that a subcommittee on global health was newly established this legislative term, is also a



Health financing and service delivery systems need further reform to withstand the strains placed on them by ageing populations and the rising tide of NCDs”

sign that we believe the time has come to again focus on this issue. I am pleased that there is broad consensus on this topic.

That of course is also very important for us in the German government. We know that our budget will be slightly lower this year, maybe also next year. However, we hope that the issue of global health will remain a top priority. I assure you that the German government will remain strongly engaged on this issue. We are working on a new strategy that we intend to present before the end of the year.

Finally, I would like to say that every person on earth should be able to live a healthy life. Also in poorer countries, people must be given access to a functioning healthcare system. With the 2030 Agenda, we made a strong commitment. We are, however, bound not only by the document, but above all by the human imperative. We can accomplish great things by acting as one. I am convinced that today's congress is helping to raise the profile of this issue, and that through coordinated joint action we can make even better progress towards the ambitious goals that we have set. ■

A speech by Federal Chancellor Dr. Angela Merkel at the congress organised by the CDU/CSU parliamentary group on Strengthening Global Health – Implementing United Nations SDG 3 held in Berlin on 8 May 2019. Reprinted with permission.



Tabaré Vázquez,
President of the Oriental Republic of Uruguay



Uruguay's fight against non-communicable diseases and tobacco

In Uruguay, a leading anti-tobacco policy has allowed the country to transform its treatment of non-communicable diseases

Chronic poisoning provoked by the abusive use of tobacco creates an important addiction that causes people to lose control of themselves due to the physiological and psychological dependence generated by nicotine.

We are facing one of the most important challenges met by our society – a challenge that kills men and women

by the minute, destroys families, and causes health and economic problems around the globe.

Statistics speak for themselves when they show us that developing countries are the most affected by smoking. For this reason and more than ever, it is necessary for all the nations of the world to come together in the implementation of active, responsible public policies, which are socially committed to our

peoples, who are the ones suffering from this disease. We cannot give up or quit the fight.

In Uruguay, we have taken the fight against cardiovascular diseases, respiratory diseases and lung cancer very seriously. Because of our anti-tobacco policy, we have managed to place ourselves as the first country in the Americas that is 100% smoke-free in closed environments. We have recently approved immediate application decrees related to packaging and flat labelling of tobacco products and labelling of packaged foods.

We have been working on comprehensive legal regulation since 2006 by means of laws and decrees that also cover issues such as the prevention and control of alcohol, cannabis and other drugs. We have armed our country against non-communicable diseases.

However, the legal framework is not enough. We must adopt policies and implement measures that also require participation and consensus.

This is why dialogue has been established with the participation of the political system, the scientific academy, health specialists, business and union sectors, among others.

TABARÉ VÁZQUEZ

President, Oriental Republic of Uruguay

Tabaré Vázquez assumed the presidency of the Oriental Republic of Uruguay in March 2015, having previously served as president from 2005 to 2010. From 1996 until he assumed the presidency, Vázquez served as president of the Frente Amplio coalition. Dr Vázquez was mayor of Montevideo from 1989 to 1994. A physician who specialises in oncology and radiology, he continued to practice medicine even as president, dedicating one morning a week to a Montevideo clinic. Among the reforms enacted under his presidency, health care has become more accessible to the poor through an increase in the personal income tax.

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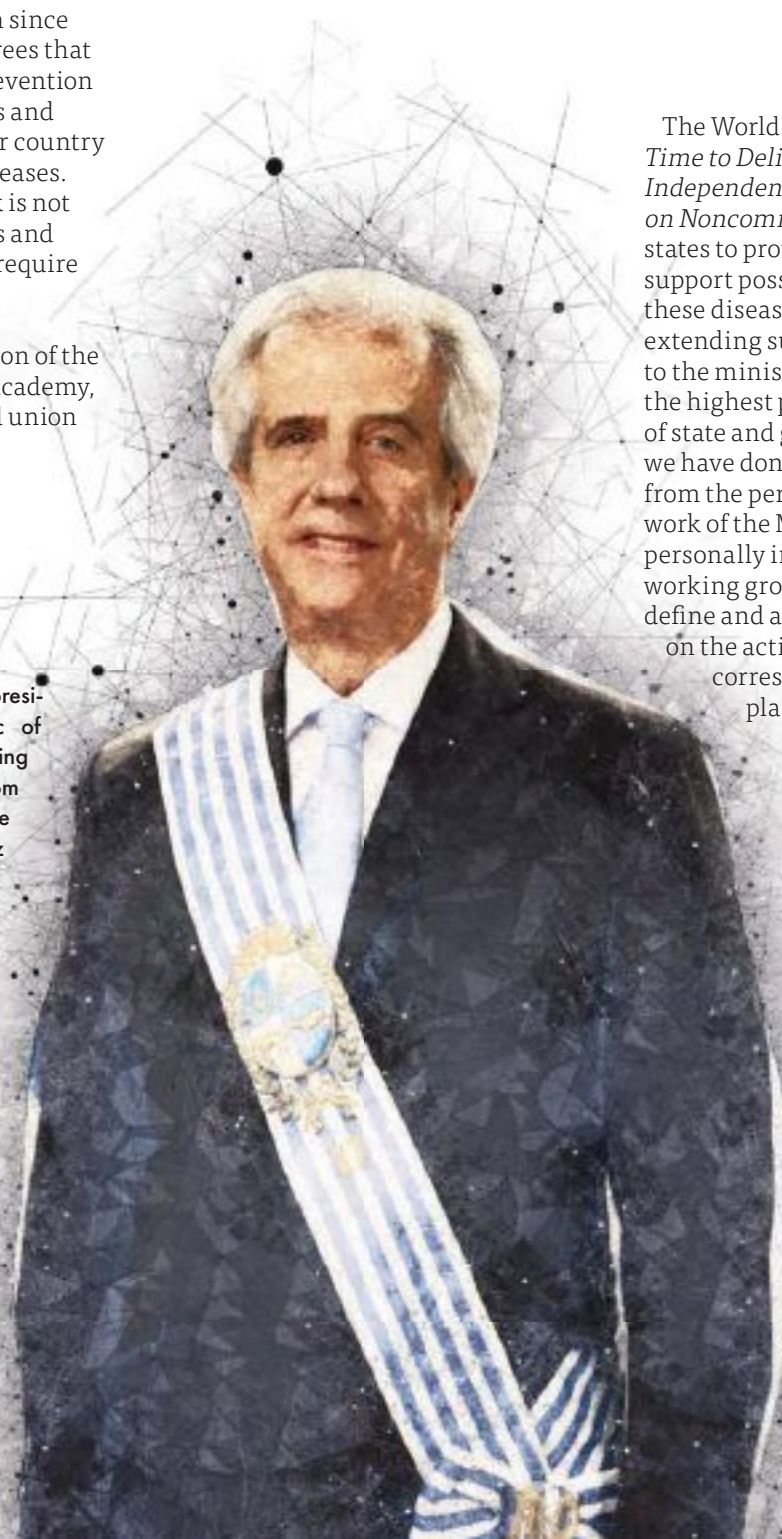
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The best intentions, the best legislation and the best policies mean nothing if they do not have citizen support, if people do not embrace them and they are not regarded as useful for their quality of life”

The World Health Organization's *Time to Deliver: Report of the WHO Independent High Level Commission on Noncommunicable Diseases* urges states to provide the greatest political support possible for the fight against these diseases. It goes even deeper by extending such responsibility not only to the ministries of health but also to the highest possible level: the heads of state and government. This is what we have done in Uruguay, where apart from the permanent and outstanding work of the Ministry of Public Health, I personally integrate and participate in working groups that meet monthly to define and articulate policies, follow up on the actions in progress, make the corresponding adjustments and plan future actions.

But that is still not enough. The best intentions, the best legislation and the best policies mean nothing if they do not have citizen support, if people do not embrace them and they are not regarded as useful for their quality of life.

For that to happen there are several factors that can be summarised in a few words: information, education, communication and health promotion. Because health is a universal right, but it is also everyone's responsibility. ■





Uhuru Kenyatta

President of the Republic of Kenya

Kenya's social shift

Over recent years, Kenya has tackled literacy, per capita income and life expectancy. Emboldened by its progress, the country is now rising to a new challenge

It has been more than 50 years since Kenya's founding fathers made their independence pledge to address the three challenges that plagued our people: poverty, disease and ignorance. In the years gone by, Kenya has one of the highest adult literacy rates on the African continent, the life expectancy of its people has increased from 48 years to 67 years, and the average per capita gross income has grown from \$100 to \$1,460.

While this progress is something that we reflect on with pride, we recognise that with the advent of the Sustainable Development Goals for health, the aspirations of our founding fathers are now to be measured using refined parameters that have been adopted across the world and embodied in the global agenda for universal health coverage. We recognise that even as we take stock of our wins, the journey is far from over. Kenyans continue to bear the costs of the rising burden of communicable and non-communicable diseases. These diseases are eroding the gains that have been made over time and risk driving more than one million of our most vulnerable citizens into poverty every year.

As I am the custodian of the dreams and aspirations of my people, my administration has committed to guarantee all Kenyans access to affordable health care through the universal health coverage pillar of the Big 4 Agenda. This commitment can be summarised by three basic expectations: first, to ensure that every Kenyan can access affordable good-quality health services closest to where they live; second, to ensure that Kenyans do not have to deplete their savings in order to access these services; and third, most importantly, to ensure that we improve even further the average life expectancy of every Kenyan to above 70 years.

Since 2013, I have instituted significant health sector reforms that have resulted in increased access to health services by our citizens, particularly the most vulnerable. We have removed user charges at all government primary healthcare facilities. We have introduced free maternity services at all government facilities under our Linda Mama

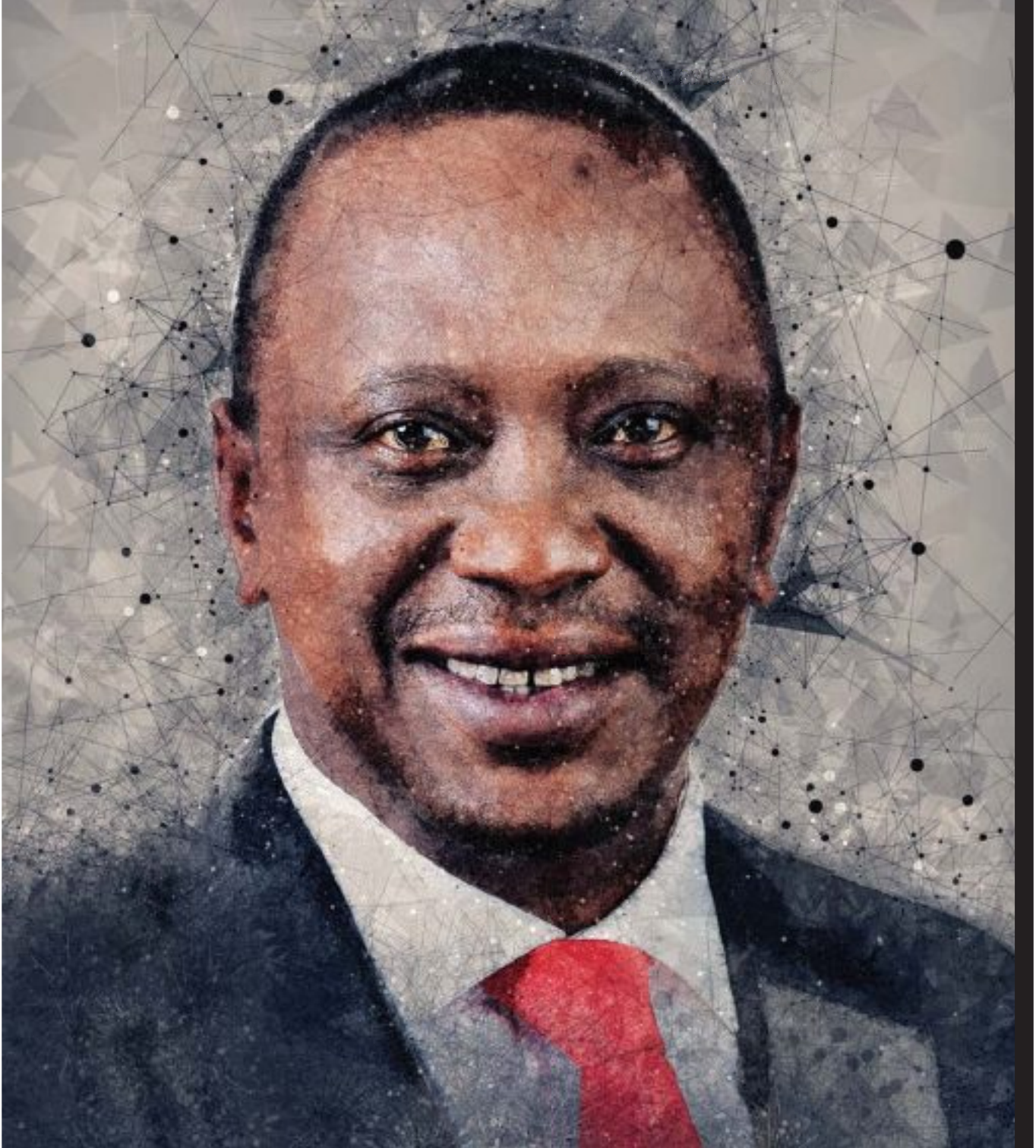
programme, which translates to "protect our mothers". This programme is well complemented by the Beyond Zero campaign, an initiative of Kenya's First Lady that targets the safety and well-being of our mothers and children before, during and immediately after delivery.

In addition, my administration has championed the roll-out of the new, acclaimed managed equipment services programme that has seen the government equip more than 100 hospitals across the country with equipment for renal dialysis, intensive care, operating theatres and radiology services. This means that Kenyans across the country now have access to these lifesaving interventions that were previously a preserve of those residing in our big cities. To date more than 3.5 million patients have benefitted from these services.

THE NEXT STEP

In order to achieve the aspiration of universal health coverage, we started a pilot programme in four counties. The counties were selected for displaying characteristic disparities in disease profiles and in access to health services that would form representative samples for the rest of the country. The pilot places interventions in both preventive and curative health services, with more focus on primary health care. Resources have been invested to reactivate the community health strategy through training and kitting community health workers and facilitating public health services. Kenyans in these four pilot counties are now able to access health services and essential medicines in primary care and secondary care hospitals. With the lessons learned from this pilot phase, we have now embarked on plans for gradually scaling up universal health coverage to the entire country.

Given that we require interventions for sustainable universal health coverage, additional investments and efficiency will be required. In this regard, we plan to undertake reforms in the National Hospital Insurance Fund to transform and reposition it as a strategic purchaser

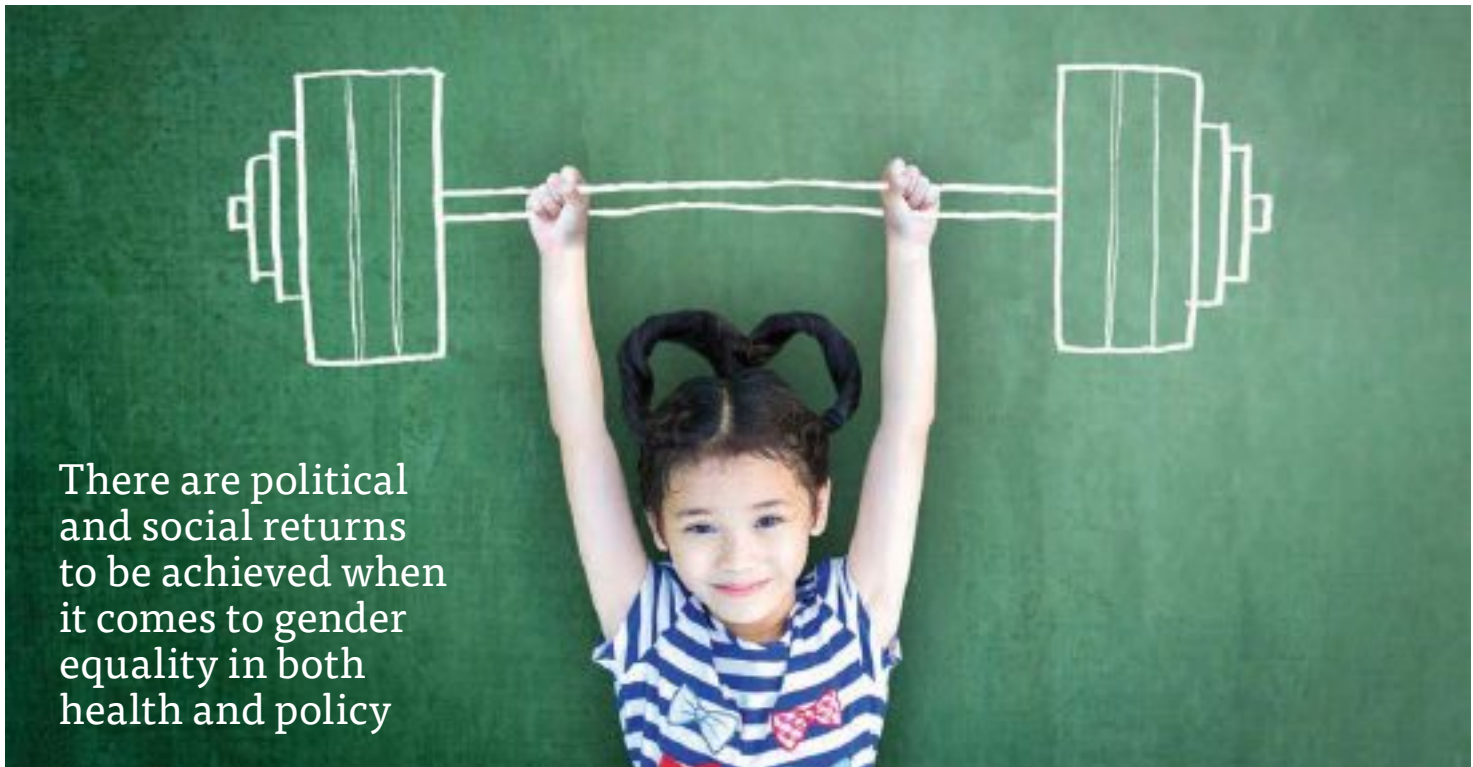


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Kenyans across the country now have access to these lifesaving interventions that were previously a preserve of those residing in our big cities. To date more than 3.5 million patients have benefitted from these services”

of health services while improving efficiencies offered by pooling resources. We are also undertaking reforms in the Kenya Medical Supplies' Authority to ensure that the medical commodities we procure are of the highest quality but within affordable prices. In this spirit of efficiency, my administration will continue to enhance collaborative efforts between the national and devolved county governments to fully realise the gain of decentralised health services. Further still, we shall require efficiency from our development partners. It is imperative that they align with our strategies as well as our resources. Our partners in the private sector and civil society all have a strong complementary role to play through favourable public-private partnerships.

Finally, I urge all leaders in developing countries to make the highest political commitment towards health, to pursue the attainment of universal health coverage as a critical driver of national cohesion and economic prosperity. ■



There are political and social returns to be achieved when it comes to gender equality in both health and policy

The Right Honourable Helen Clark

Patron, Helen Clark Foundation

Gender and health: a political choice with major ROI

As a former prime minister and former minister of health, I am fully aligned with the premise of this publication – namely that advancing health is a political choice. Heads of state and government can choose to prioritise the right to health, healthy environments and universal health coverage, heeding the evidence that investing in health is both the right thing to do and the smart thing to do.

The returns on such investments are incontrovertible. Every dollar invested in vaccines over a decade, for example, is estimated to return \$44 in benefits.

Similarly, it is a political choice for government leaders to convene ministers and hold them accountable for implementing policies in their respective sectors to protect and promote health. It takes political courage to address the drivers of ill health – often in the face of powerful interests, whether they be commercial or cultural.

I commend the G20 for the wise and strategic choice of prominently positioning health in this year's G20 Osaka agenda, articulated by Prime Minister Shinzo Abe as part of the human-centred future society, Society 5.0.

THE GENDER LENS

At their G20 summit, I urge leaders to make another wise and strategic choice: to embrace the opportunity to agree to grow their health investments exponentially by filtering them through a gender lens.

Investing in gender equality in the health sector means delivering not only more health for the funding provided, but also shaping a more just and inclusive future.

It is widely appreciated that gender equality in the workplace could add a further \$28 trillion to the annual global gross domestic product by 2025. The G20 deserves

recognition for embracing this evidence and committing to mainstream gender across its agenda, as does France, which holds the presidency of this year's G7 summit to be hosted by President Emmanuel Macron in Biarritz.

What is less widely appreciated is that gender is among the most powerful determinants of health. Gender influences the distribution of power and privilege and defines roles considered appropriate for women and men respectively in societies. Gender norms shape health outcomes through differential exposure to health risks, health-seeking and health-harming personal behaviour, and the gendered provision of health services.

We see the dramatic influence of gender norms on the high rates of smoking, alcohol consumption and early death among men. We see the pernicious impact of gender inequality experienced by the hundreds of millions of women and girls who are unable to protect their own health. We also see it reflected in rising numbers of adolescent pregnancies, disproportionately high rates of HIV among young women and endemic gender-based violence.

DELIVERING SUSTAINABLE IMPACT

Global health organisations – which include the international development organisations of some G20 countries – are meant to guide the global response to such challenges of health inequity. Global organisations too can make the political choice to commit to gender equality and apply a gender lens to health. But, too often, organisations opt to remain blind to gender. A narrow focus on the health of women and girls, without confronting systemic issues of power, will not deliver sustainable impact. A health response that does not address the drivers of disproportionately high rates of ill health among men will not deliver healthy societies.

Equality Works, the recent report published by Global Health 50/50, reveals the extent of gender blindness in global health. It looks at the gender-related policies and practices of 200 global organisations active in health from a range of sectors. Although stated commitments to gender equality have increased over the past year since GH5050 issued its inaugural report – from 50% to 75% of organisations sampled – far fewer define gender in a way that is consistent with global norms (33%).

Approximately 60% of organisations mention gender in their strategy documents. Seventy-seven organisations (41%) focus primarily on the health of



RIGHT HONOURABLE HELEN CLARK

Patron, Helen Clark Foundation, and member, Advisory Council, Global Health 50/50

Helen Clark, ranked by Forbes as one of the most powerful women in the world for many years, is a New Zealand politician who served as the 37th prime minister of New Zealand from 1999 to 2008, and was the administrator of the United Nations Development Programme from 2009 to 2017, where she was the highest ranking woman in the United Nations. Helen is now an independent advocate for global public good.

[@HeLenClarkNZ](https://twitter.com/HeLenClarkNZ)

women and girls, yet the majority of these organisations (61%) do not mention gender. Furthermore, fewer than half disaggregate their programme data by sex, which identifies where resources can deliver the most effective and equitable returns in improving people's health.

I encourage the G20 and the G7 to bring together the Sustainable Development Goals on gender (SDG 5), health (SDG 3) and strong institutions (SDG 16) during their discussions in Osaka and Biarritz, and beyond at the United Nations High Level Meeting in September.

Even more importantly, leaders should take those discussions home and commit to mainstream gender across domestic health programmes; to apply a gender lens in G20 and G7 development cooperation policies and programmes, including but not limited to the health sector; and to use the findings of the GH5050 report to encourage global health organisations to be more gender-responsive so as to reap the gender and health dividend that the Sustainable Development Goals promise. ■

\$44

The value of the return generated in benefits for every \$1 that is spent on vaccines

33%

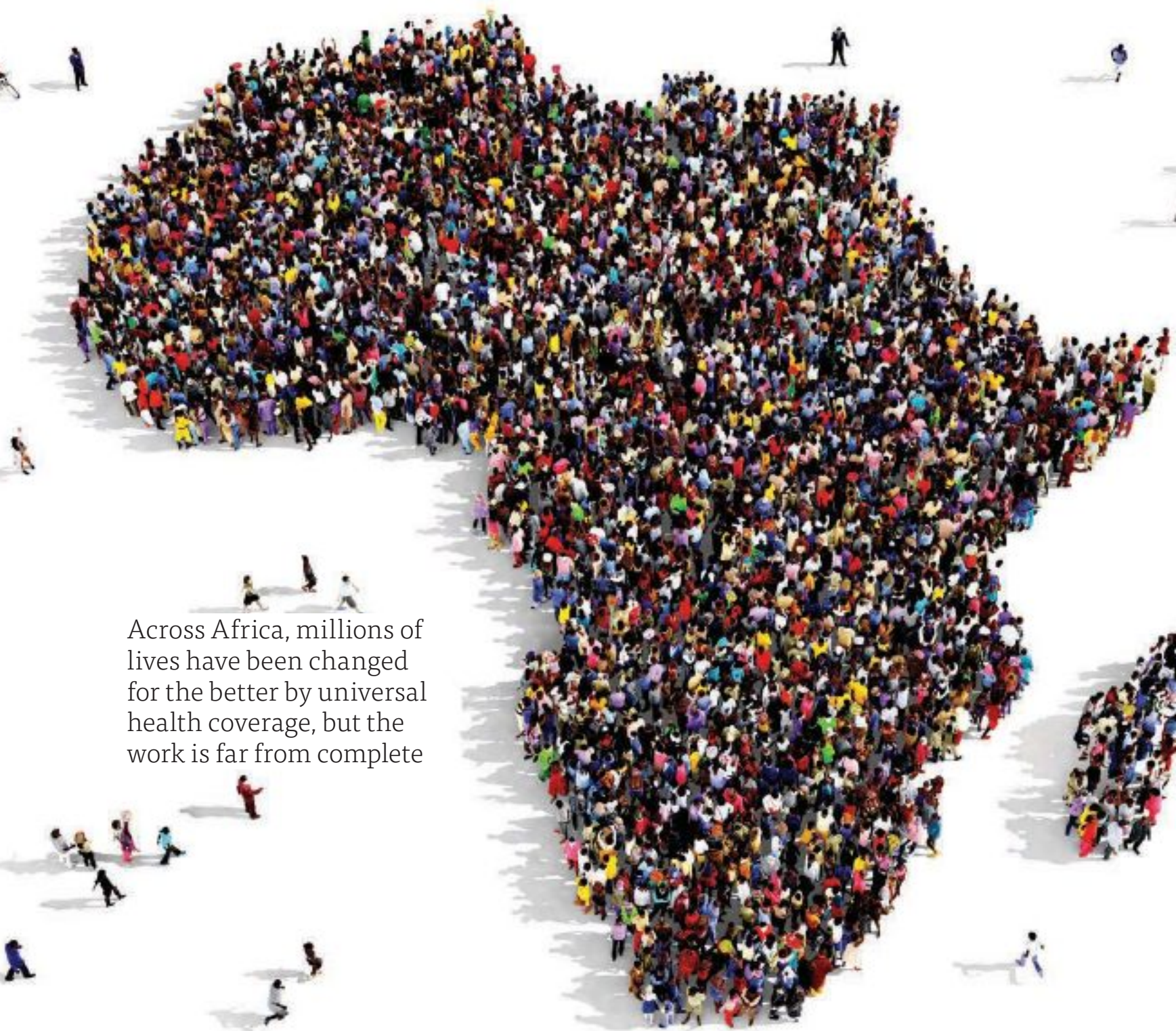
Of global health organisations define gender consistently with global norms

60%

Of global health organisations from multiple sectors, mention gender in their strategies

Transforming a continent

Across Africa, millions of lives have been changed for the better by universal health coverage, but the work is far from complete





Paul Kagame, President, Rwanda

Achieving universal health coverage by 2030 is Africa's top strategic objective in the health field, as defined by the African Union in the context of Agenda 2063. The Sustainable Development Goals include the very same target. There is also a clear framework for measuring progress.

The World Health Assembly in 2018 was an opportunity to recall that these developments have created an unprecedented political opportunity to anchor the past generation's tremendous global public health gains in national health systems that are both sustainably financed and people-centred.

Around the world, the greatest variation in health systems is in service capacity and access. Africa lags furthest behind with insufficient personnel and facilities to deliver universal health coverage.

The data also show that catastrophic out-of-pocket health expenditures are an increasing source of impoverishment in Africa, though not yet to the extent seen in other regions. However, that may simply reflect the fact that many life-saving procedures are not yet widely available on our continent. As service coverage in Africa expands, the financial risks for citizens will also increase unless adequate protection measures are in place for the most vulnerable.

Whenever countries have put universal, community-based primary health systems in place, the results have been positive. For example, in Rwanda, a combination of community-based health insurance, community health workers and good external partnerships, together led to the steepest reductions in child and maternal mortality ever recorded.

The key was an approach that put individuals and communities at the centre of care. In choosing this path,

17m

Shortfall in Africa's health economy workforce

25%

Of the global health workforce is unpaid labour by women

90%

Of Rwandans are enrolled in health insurance today

Rwanda learned from others who preceded us in the community-based approach, such as Ethiopia. We also benefited greatly from advice and support from the World Health Organization and other partners.

Integrating digital applications and new technologies into our health system has also made a difference. An example is the use of drone aircraft to quickly deliver blood and medical supplies to rural hospitals.

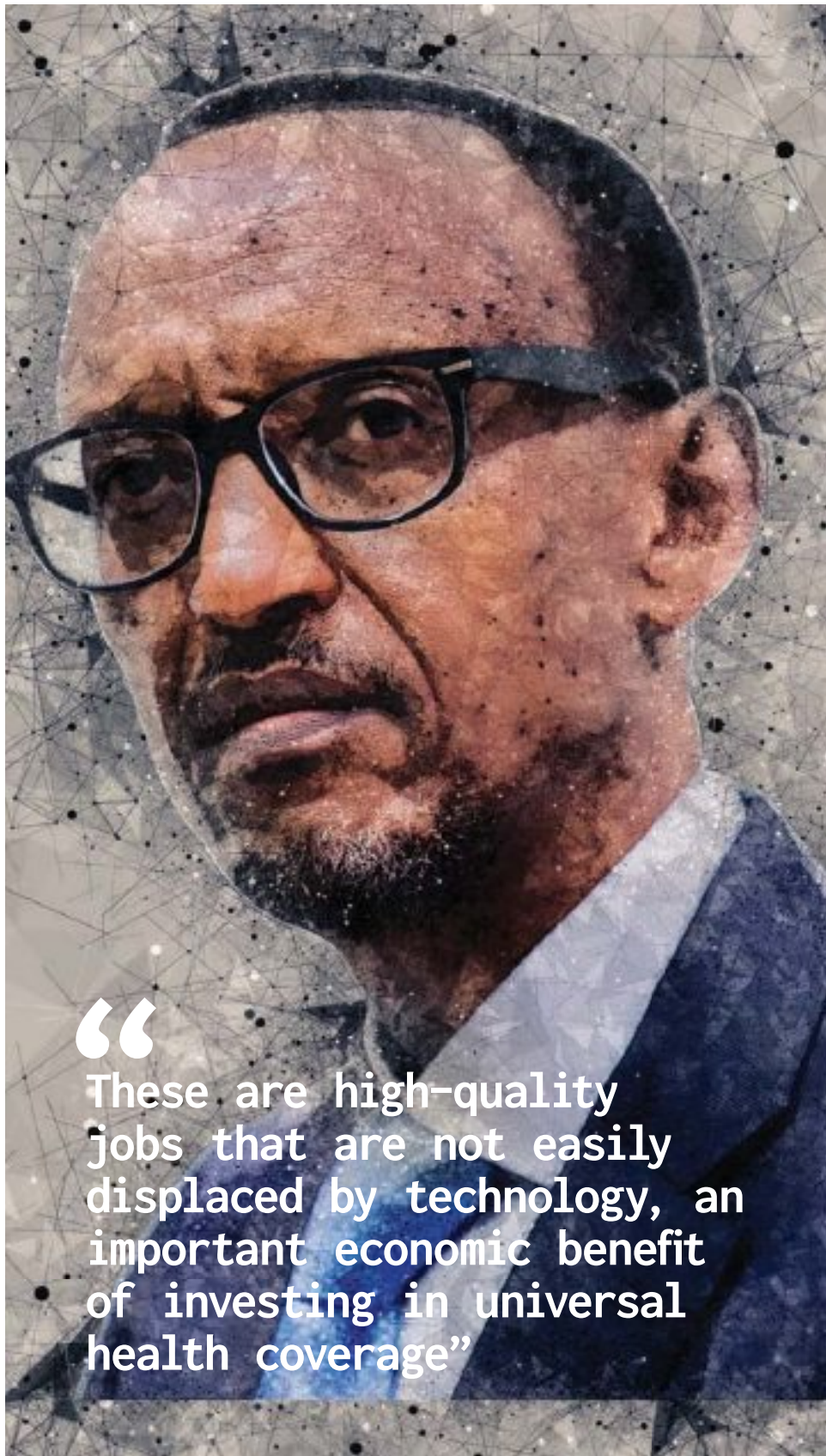
More than 90% of Rwandans are enrolled in health insurance today, and two-thirds of the costs are covered by contributions from beneficiaries, with government subsidising the remaining one-third.

At the same time, we continue to expand our network of volunteer community health workers, who are present in every village and serve as an essential link between the population and health facilities.

Universal health coverage is affordable for countries at every income level, as examples from all over Africa show. Ghana, Kenya, Morocco and Senegal all offer a subsidy to insurance. Ethiopia is a pioneer in the use of community health workers as the frontline of primary health care, and Ghana is also deploying them with success. In Tunisia, we have seen an effective example of the importance of involving citizens in the planning and evaluation of health provision. ▶

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Universal health coverage is affordable for countries at every income level, as examples from all over Africa show. Ghana, Kenya, Morocco and Senegal all offer a subsidy to insurance”



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These are high-quality
jobs that are not easily
displaced by technology, an
important economic benefit
of investing in universal
health coverage”

In many cases, these programmes can be scaled up using national resources, even as direct partner funding addresses other important health needs.

An added benefit is the attitudes of future-mindedness and entrepreneurship that universal health coverage helps to unlock. People are more free to plan for the future with confidence. For example, families can invest the savings in businesses and in better-quality education for their children.

The International Labour Organization estimates that Africa’s health economy workforce has a shortage of almost 17 million workers in both health and non-health occupations. Under universal health coverage, the number of unfilled jobs is projected to increase by another nine million by 2030. Half of the funding needed to achieve universal health coverage by 2030 will go to training and employing workers in the health sector.

These are high-quality jobs that are not easily displaced by technology, an important economic benefit of investing in universal health coverage.

Building the health workforce of the future can also radically transform women’s lives, with benefits for all. One-quarter of the health workforce globally consists of unpaid labour by women, particularly long-term care. But this labour is not really free. It comes with tremendous opportunity costs, as tens of millions of women forego employment.

Resources undoubtedly matter and the world has come together to do the right things. That includes government donors, and also transformational philanthropies, such as the Bill and Melinda Gates Foundation, as well as fellow organisations such as the Global Fund, and Gavi, the Vaccine Alliance, and the World Health Organization, which is as essential as ever.

The G20 also has a useful role to play in keeping universal health coverage high on the global development agenda and advocating for continued investment.

After all, universal health coverage is an opportunity, not a burden, in every respect. ■

TOP ECONOMISTS SPEAK OUT FOR UHC

4

CHAPTER

4.1

Financing UHC in low-income countries

By Jeffrey D. Sachs, director of the Center for Sustainable Development at Columbia University

p44

4.3

The economics of universal health

An interview with Lawrence Summers president emeritus of Harvard University

p48

4.2

Financing universal health coverage

By Peter Sands, executive director, Global Fund to Fight AIDS, Tuberculosis and Malaria

p46

4.4

The crises in US health care

An interview with Robert Fauver, president of Fauver Associates

p50

4.5

In numbers

Financing global health and UHC

p52



Financing universal health coverage in low-income countries

Through simple mathematics, it's possible to calculate the global investment required to achieve universal health coverage

By Jeffrey D. Sachs

Financing universal health coverage in low-income countries runs up against the stark reality of poverty. Health care must be publicly financed in order to achieve universal health coverage and decent health care for the poor. Universal health coverage is a matter of practicality to control epidemic diseases, a matter of priority investment for economic development and a matter of basic human rights. Yet governments in the low-income countries cannot afford universal health coverage on their own. The rich countries and the richest people around the world need to be taxed sufficiently to enable the low-income countries to be able to finance universal health coverage.

The basic financing calculations are straightforward. According to the World Bank, in 2018 there were around 732 million people in 34 low-income countries with a combined gross domestic product of \$576.9 billion. Hence, the average per capita GDP is \$788. Countries in this income range (below roughly \$1,000 per person per year) collect on average 20% of GDP in government revenues. These countries are called upon to devote at least 15% of the budget to health care, and can plausibly achieve up to 20% of the budget for health care.

That, in short, means healthcare spending on the order of 4% of GDP per capita (20% of 20% of GDP), which is

roughly \$32 per person per year, which equals 4% multiplied by \$788.

Yet the evidence shows that even a basic healthcare system requires around \$100 per person per year to cover essential services. The third edition of the Disease Control Priorities Project, for example, found that essential universal health coverage would cost \$76 per person (at 2012 prices) to achieve 80% coverage. This translates into around \$105 per capita (at 2018 prices) for 100% coverage.

Clearly, \$105 per person is far beyond the government's financing capacity of roughly \$32 per person.

The financing gap is around \$73 per person (= \$105 - \$32). For 732 million people, the total financing gap comes to approximately \$50 billion every year.

The gap of \$50 billion per year seems daunting, but looks are deceiving in this case. The high-income donor countries have a combined gross national income of around \$50 trillion. Therefore, the financing gap for universal health coverage in low-income countries comes to just 0.1% of the GNI of the donor countries. Moreover, the United Nations has long called on donor countries to reach the target of 0.7% of GDP in official development assistance. But ODA is stagnant at around 0.3% of GDP, less than half of the global ODA target. If the developed countries therefore raise ODA by another 0.1% of GNI - to roughly 0.4% of GNI - and devote the incremental proceeds to universal health coverage, they would cover the needed \$50 billion and would still be far below the UN target of 0.7% of GNI for ODA.

The conclusion is simple and stark. Because of a shortfall in ODA of mere 0.1% of GDP of the rich countries, millions of

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Because of a shortfall in ODA of mere 0.1% of GDP of the rich countries, millions of people die unnecessarily and tragically in the low-income countries”

people die unnecessarily and tragically in the low-income countries. Universal health coverage is a choice, but not one that can be achieved by the low-income countries alone. Universal health coverage must be a matter of global solidarity between the rich and the poor.

Here is a simple way to close the financing gap. There are currently around 2,200 billionaires in the world with a combined net worth of some \$10 trillion. Just these 2,200 individuals could cover the financing gap in universal health coverage with little real effort. Consider this. Suppose that governments around the world levied a modest wealth tax on billionaires of 1% of net worth. This would raise around \$100 billion per year (= \$10 trillion x 1%), which is roughly twice the financing gap for universal health coverage in the low-income countries. Indeed, the estimated global financing gap to enable all children to attend school up to the completion of secondary school is roughly \$40 billion per year. A 1% net worth tax on billionaires could in principle fund both universal health coverage and universal education access in the low-income countries.

There are other ways forward as well. Consider the fact that the United States spends \$700 billion per year on the military and squandered trillions of dollars on wars of choice in the Middle East.

The world as a whole spends around \$1.5 trillion per year on the military. Even a small transfer of funding from the military to health care in low-income countries would close the financing gap for universal health coverage.

Development assistance for health works well, as the success of the Global Fund to Fight AIDS, Tuberculosis and Malaria attests. Universal health coverage is within reach if the low-income and high-income countries work together to achieve practical financing solutions for universal health coverage.

Investing in health for human decency, for human rights and for economic development is one of the world's best investments to achieve a healthier, fairer, more productive and peaceful world. ■

\$100

The cost per person per year to fund basic access to health care

2,200

Billionaires in the world who could, with modest taxation, fund UHC

\$1.5tr

The combined annual spend of all countries on the military



JEFFREY D. SACHS

Jeffrey D. Sachs is a professor and director of the Center for Sustainable Development at Columbia University, where he directed the Earth Institute from 2002 until 2016. He is also director of the United Nations Sustainable Development Solutions Network and a commissioner of the UN Broadband Commission for Development. He has been advisor to three United Nations secretaries general, and currently serves as a Sustainable Development Goal advocate under secretary-general António Guterres. He spent more than 20 years as a professor at Harvard University, where he received his BA, MA and PhD degrees. His most recent book is *A New Foreign Policy: Beyond American Exceptionalism* (2018). Sachs was twice named in *Time* magazine's 100 most influential world leaders, and was ranked by *The Economist* among the top three most influential living economists.

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of AIDS, tuberculosis and malaria – are tantalisingly within reach, but not yet firmly in our grasp. Delivering on these goals is undoubtedly a political choice.

History tells us that these infectious diseases can be defeated, and that the path to success involves building strong, inclusive and resilient health systems. For example, in Japan tuberculosis was the biggest killer in the 1950s. The government launched a massive campaign against tuberculosis, which proved highly successful and became the platform for Japan's system of universal health coverage. We now salute Japan for leading efforts to promote universal health coverage everywhere.

At the Global Fund we see our role as enabling countries to defeat the three epidemics and accelerate their journey towards universal health coverage. Alongside disease-specific investments, such as anti-retroviral drugs and mosquito nets, we invest more than \$1 billion a year in health systems, making the Global Fund the largest multilateral provider of grants for health systems. Through our co-financing requirements, typically amounting to 15 – 30% of the grant amount, we catalyse increased domestic investment in health.

Many countries are stepping up admirably to the challenge of increasing investment in health. Domestic finance commitments in our current three-year grant cycle are 41% higher than in the previous period. However, there are huge variations among countries and overall levels of investment in health remain too low. Of 55 countries in Africa, 52 fail to meet the Abuja Declaration's target of dedicating 15% of public spending to health. Significant funding gaps mean far too many people are still dying of diseases that are fully preventable.

To fund the next phase of the fight against AIDS, tuberculosis and malaria, and to support countries as they build their health systems, the Global Fund is looking to donors to provide at least \$14 billion for the sixth replenishment, a 15% increase on the last replenishment. But we are calling for an even bigger number from domestic resources – \$46 billion, a 48% increase on the previous three-year period.

PETER SANDS

Peter Sands became the executive director of the Global Fund in March 2018. A former chief executive officer of Standard Chartered PLC, one of the world's leading international banks, Sands has been a research fellow at Harvard University since 2015, dividing his time between the Mossavar-Rahmani Center for Business and Government at Harvard Kennedy School and the Harvard Global Health Institute, working on a range of research projects in financial markets and regulation, fintech and global health.

[@PeterASands](https://twitter.com/PeterASands) www.globalfund.org



Delivering this scale of increased domestic resource mobilisation will entail addressing fundamental weaknesses in tax design and collection, and building resilient and inclusive health insurance systems. Just as important are improvements in financial management, tracking and reporting tools to ensure every dollar is spent wisely.

Innovative financing tools can help tap new sources of finance and, even more, be used to maximise the impact of existing resources by aligning incentives and allocating risks efficiently. As a former banker, I constantly remind everyone I work with in the health sector that innovative finance does not mean money can grow on trees. But smartly deployed innovative financing tools can make a significant difference.

To achieve the SDG of greater health and well-being for all, we must step up the fight against disease, and step up the pace of building inclusive and resilient health systems. We must embrace and not shy away from the tough political decisions needed to make this happen. Health is undoubtedly a political choice, and political leadership is the key to unlocking the resources to deliver better health for all. ■

41%

Increase in domestic finance commitments in the current three-year grant cycle

\$14bn

Must be raised by donors to support the Global Fund in its sixth replenishment

11

Years until the deadline for attainment of the Sustainable Development Goals

A portrait of Lawrence Summers, a middle-aged man with short, graying hair and a slight smile, wearing a dark suit jacket over a light-colored, striped shirt. The background is a complex network of thin black lines connecting various sized black and white dots, set against a dark purple and blue gradient.

The economics of universal health coverage

Lawrence Summers, president emeritus of Harvard University, talks to John Kirton, director of the G20 Research Group, about the economic growth and extended tax frameworks that could fund UHC

The Lancet Commission on Investing in Health, which you co-chaired in 2014, came to four conclusions: an enormous payoff comes from investing in health; a grand convergence on health is achievable in our lifetime; fiscal policies can curb non-communicable diseases and injuries; progressive universalism as a pathway to universal health coverage is an efficient way to achieve health and financial protection. Would you revise these conclusions now?

The conclusions all look pretty good, in particular the idea that there's an enormous payoff to further investments in global health. We may not be quite on track to hit the goals for a grand convergence, because sufficient

efforts haven't been made in both domestic and international resource mobilisation. But the broad objective is there, and is attainable for this generation. The case for public goods has been strengthened by what we've seen in terms of the consequences of global climate change and the smaller things we've seen on epidemics, which emphasise the importance of preparation for the low likelihood but high consequential risks of an influenza pandemic. The idea of moving towards progressive universalism remains an important beacon, although we are generations away from having achieved that in a meaningful sense.

How important is universal health coverage in the case you make now for investing in health?

I know universal health coverage is a shibboleth of the global health community, but realistically when you've got many countries that have \$5 a year, if that, to spend on individuals' health care, you're not going to provide those individuals with anything like universal health coverage as it is understood in the industrial world. The more appropriate focus is towards the gradual expansion of the quality and quantity of services for more and more people designed in ways that will maximise saving life and reducing pain and suffering. That's the way healthcare resource policy allocations should be made. I don't find the rhetoric of high-quality care available for all at no cost to them to be consonant with reality on the ground.

Your report suggested two pathways to achieve universal health coverage by 2030: rapid movement towards publicly financed coverage of the entire population for a defined set of interventions, and a larger set of interventions that may require patients to pay premiums or co-payments, with exemptions for the poor.

I think that's the right way but I think it's going to take a long time to get there. The trick is one has to respect budgets in defining what's going to be in the package that's going to be provided universally at no cost. If one is realistic about the size of budgets, then one will have to be very severe in the set of benefits that are provided at zero cost, focusing on vaccinations and the like. There is a strong tendency to assert everything's available for free, which just leads to more arbitrary choices as to who is going to get access to the things that are 'made available' but not made available in sufficient quantity for everybody.

Where will the money come from for universal health coverage?

The lion's share of basic universal health coverage in the vast majority of countries –



It would take only a quite limited fraction of the increases in their tax revenues to finance universal health coverage”

not the very poorest, but certainly in middle- and lower-income countries – is going to have to come from their own resources. And it can. Because of economic growth, their tax bases are going to expand by trillions of dollars in the aggregate over the next two decades. It would take only a quite limited fraction of the increases in their tax revenues to finance universal health coverage.

What would the impact of that money be on human health and on the economy as a whole?

Years of life expectancy, meaningful increments to economic growth, the further emancipation of women, greater ability of children to learn, and more modern and happy and well-functioning societies.

How can we make the needed monies flow?

It's heavily a matter of the choices that countries make. Those of us with backgrounds in economics and health have an obligation to pound the drum and make the case for how high the return on these investments can often be. ■

LAWRENCE H. SUMMERS

Lawrence H. Summers is the Charles W Eliot University professor and president emeritus at Harvard University, and the Weil Director of the Mossavar-Rahmani Center for Business and Government at Harvard Kennedy School. In 2012, he co-chaired the Lancet Commission on Investing in Health, an independent group of 25 leading economists and global health experts from around the world. He has also served in several senior policy positions in Washington DC, including treasury secretary for President Bill Clinton, director of the National Economic Council for President Barack Obama and the World Bank's vice president of development economics and chief economist.

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The crises in US health care

The United States spends vast sums on its health care, but the system is riddled with issues from access to opioid prescriptions. Robert Fauver, president of Fauver Associates, tells founder and co-director of the Global Governance Project, John Kirton, where the issues lie

To what extent are healthcare costs an economic burden in the United States?

Many older people are facing more health issues. If they come to the United States for treatment, they benefit from the large US expenditures on public health. It is a double-edged sword. On the one hand, the United States spends more money per capita, or as a share of gross national product on health than any other industrial country. In many respects it has some of the best and most accessible high-quality health

care of any country in the Organisation for Economic Co-operation and Development. Wait times are shorter in the United States.

If the United States puts export controls on drugs, the rest of the world would be in sad shape as it looks for new drugs and the benefits of modern drug technology. At some point, the United States will find a problem with drug pricing around the world. I can buy US-made drugs more cheaply in Canada than in the United States. Canada has controls on the pricing of drugs and has done deals with drug manufacturers so that they will price low to maintain market access. At some point, the American consumer will say 'wait, why should we be subsidising this through our export of drug technology and drug development?' Other countries in the OECD do the same thing. Why should the US taxpayer pay for access to cheaper drugs around the world? There is a real potential problem as more and more focus shifts to the United States as having a higher share of costs related to



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If the United States puts export controls on drugs, the rest of the world would be in sad shape as it looks for new drugs and the benefits of modern drug technology”

medical issues than any other country in the OECD. We have good health care in the United States, but we pay for it. We have huge inefficiencies in our system, yet we provide quicker access to all comers than other countries in the OECD do, especially for high-tech surgery and technology.

Do you see the thrust of health-related policy going in a desirable direction?
The debate in the Congress is so political at the moment, and will be

until the elections in 2020, that the odds of anything significant being done are close to zero. In the states, there is much focus on trying to reduce spending on Medicare and Medicaid. States are now asking “how are we going to pay for that, what does it mean for the rest of our budget?” There is not a consistent approach across states.

On the opioid addiction crisis in the United States, at the 2018 G20 Buenos Aires Summit President Trump asked China’s President Xi Jinping to outlaw their shipment to the United States. Is this a serious health problem in the United States that has social and economic impacts?
It is a very significant, very serious problem in the United States. The opioid crisis has grown exponentially. It has

spread to all income sectors. It is not the heroin or crack cocaine problem, which was centred in inner cities. It involves athletes in high school who became addicted because they had a muscle pull and the doctor overprescribed opioids, and mothers of five kids at home who have a sprained back muscle and had opioids overprescribed. There is addiction up and down the income scale, across gender and race. It is widespread. It is apparently such a significant addictive drug that no matter how many times you go back through treatment programmes, you can be in a treatment programme for three months, locked up and completely withdrawn and completely clean, and within a week or two back in freedom, you’ve gone back on the drug and the tendency to overdose. It is so widespread a problem that we often give a drug called nalaxone to first responders and parents of addicts so they can give this life-saving injection to overturn the effects of an overdose. It is a very serious problem. The source of opioids is not just China but also Latin America.

But a large part of the crisis is prescription based. There are certain pharmacies in West Virginia that sell more opioids in a year than there are people in the three surrounding states. So clearly, there is an illegal black market for prescription use of opioids. ■

ROBERT FAUVER

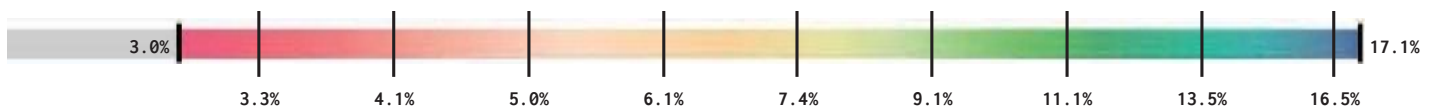
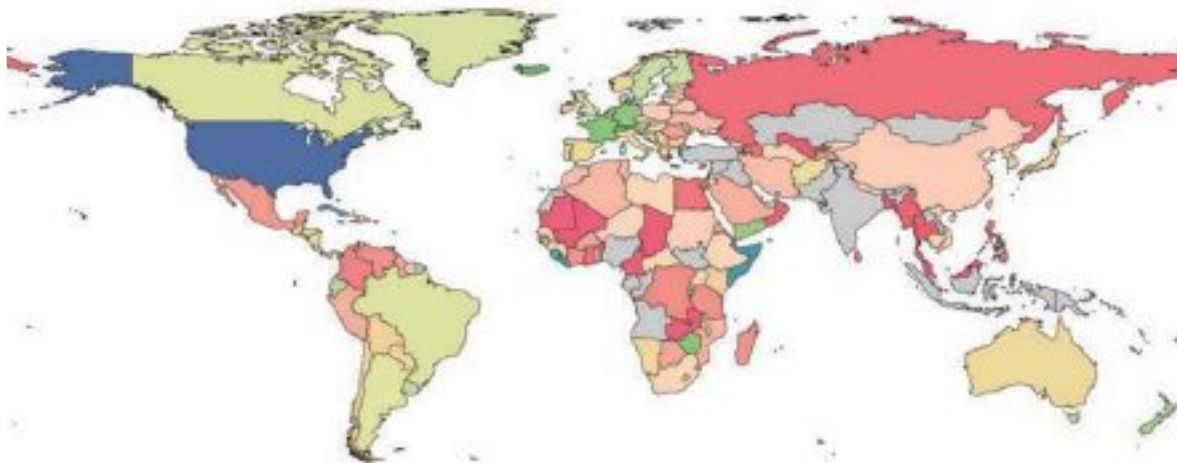
Robert Fauver is president of Fauver Associates, LLC. He spent 32 years as a career public servant in the United States working in the Treasury, State Department, White House and National Intelligence Council. He specialised in international economic issues, especially trade and finance. He negotiated a variety of path-breaking deals with Canada and Japan and was one of the founders of the Asia-Pacific Economic Cooperation forum in 1989. He has been a private consultant on world economic and finance issues since retiring from the US government.



Financing Global Health and UHC

World Maps: global health spend against gross domestic product in 2016

Chart 1: COUNTRIES THAT SPENT 3% OR MORE OF THEIR GDP ON HEALTHCARE DELIVERY IN 2016



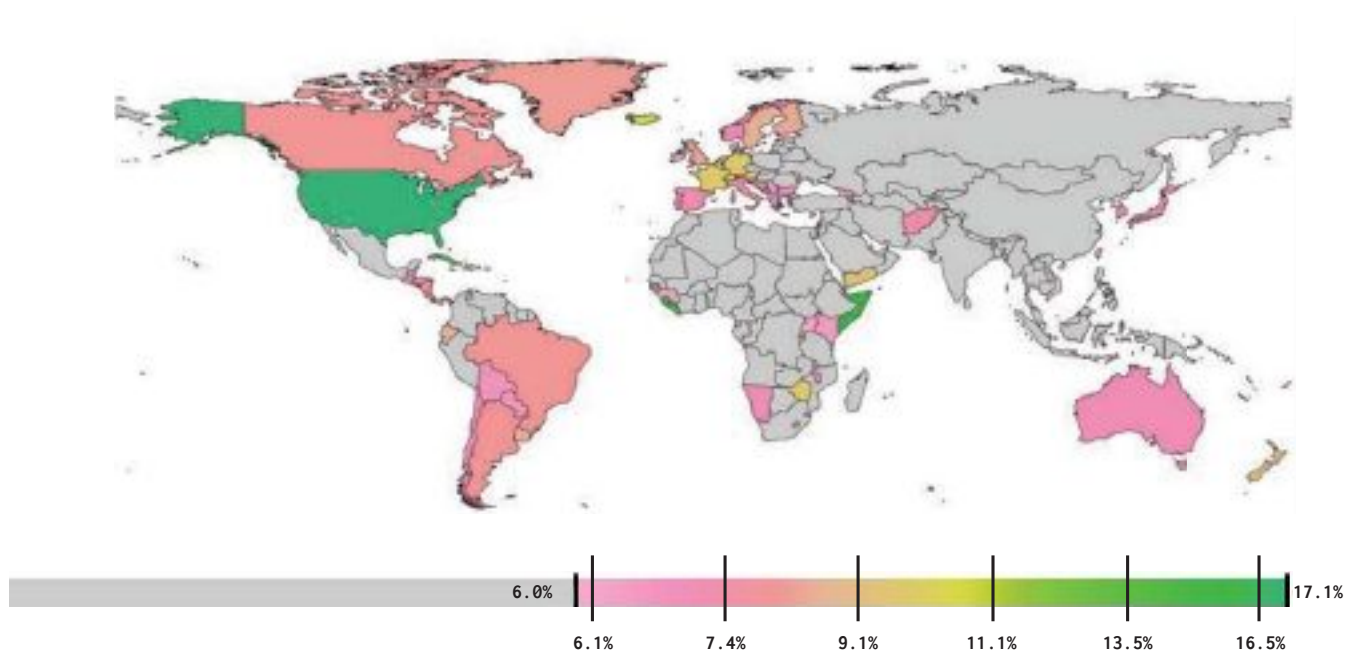
Funding sources include government, out-of-pocket, prepaid/private and and development assistance for health.

*Source: Institute for Health Metrics and Evaluation. *Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda*. Seattle, WA. IHME, 2018. <http://bit.ly/fgh2017>



Chart 2:

COUNTRIES THAT SPENT 6% OR MORE OF THEIR GDP ON HEALTHCARE DELIVERY IN 2016



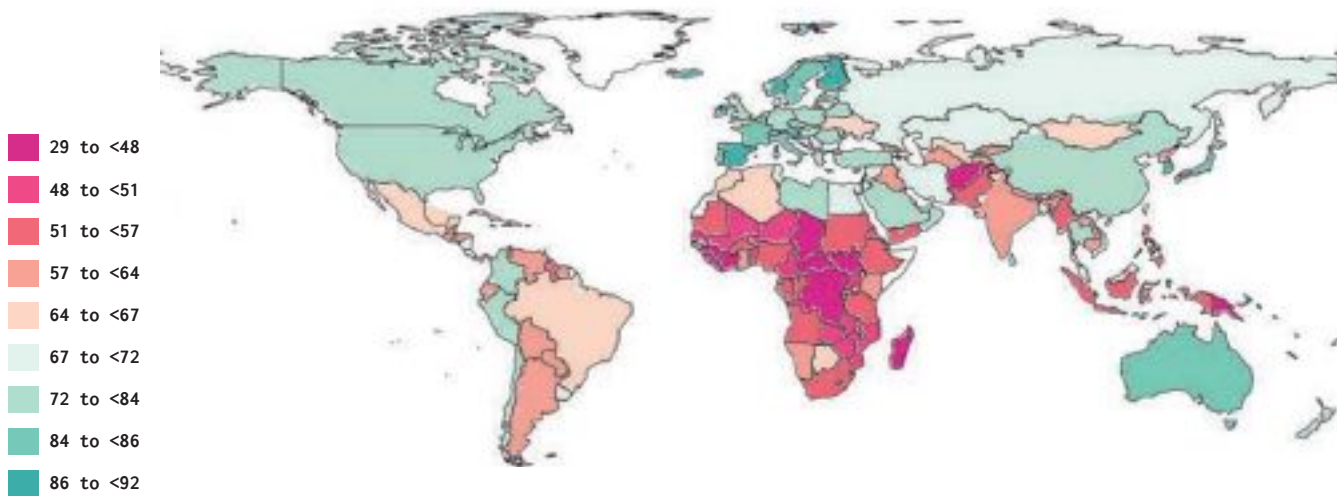
Funding sources include government, out-of-pocket, prepaid/private and development assistance for health.

* Source: Institute for Health Metrics and Evaluation. *Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda*. Seattle, WA. IHME, 2018. <http://bit.ly/fgh2017>



Chart 3:

UNIVERSAL HEALTH COVERAGE IN 2030



Funding sources include government, out-of-pocket, prepaid/private and development assistance for health.

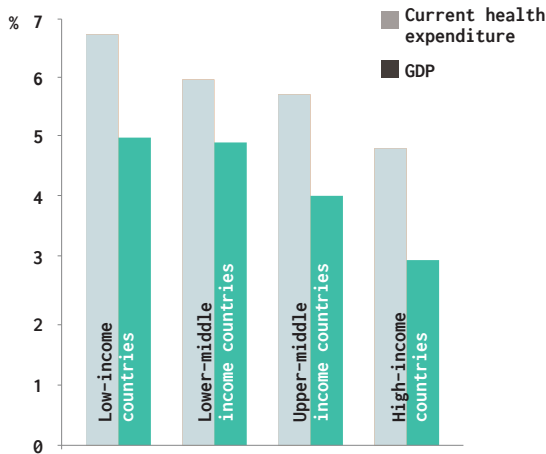
*Source: Institute for Health Metrics and Evaluation. *Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda*. Seattle, WA.

The universal health coverage index – developed as part of the Global Burden of Diseases, Injuries, and Risk Factors Study 2016 – is a summary measure of essential health service coverage based on the coverage of nine interventions and risk-standardised death rates from 32 causes amenable to health care. The index is measured on a scale of 0 (lowest coverage) to 100 (highest coverage).

Trends in uhc spending

Chart 1:
HEALTH SPENDING IS GROWING FASTEST IN LOW- AND MIDDLE-INCOME COUNTRIES

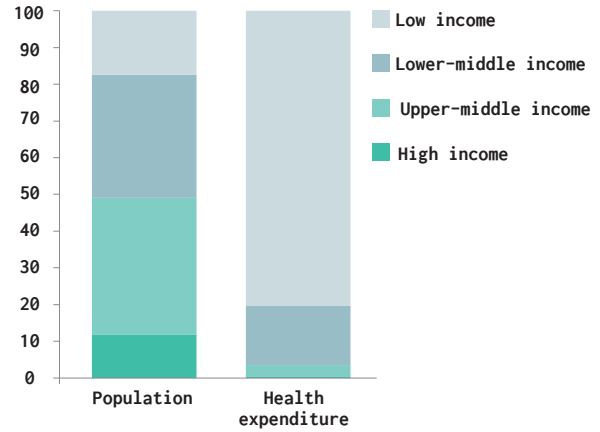
Average real growth rate by country income group, 2000–2016



*Source: World Health Organization. *Global Report: Public Spending on Health: A Closer Look at Global Trends*. 2018.

Chart 2:
MORE THAN 80% OF THE WORLD'S POPULATION LIVE IN LOW- AND MIDDLE-INCOME COUNTRIES BUT ACCOUNT FOR ONLY 20% OF GLOBAL HEALTH SPENDING

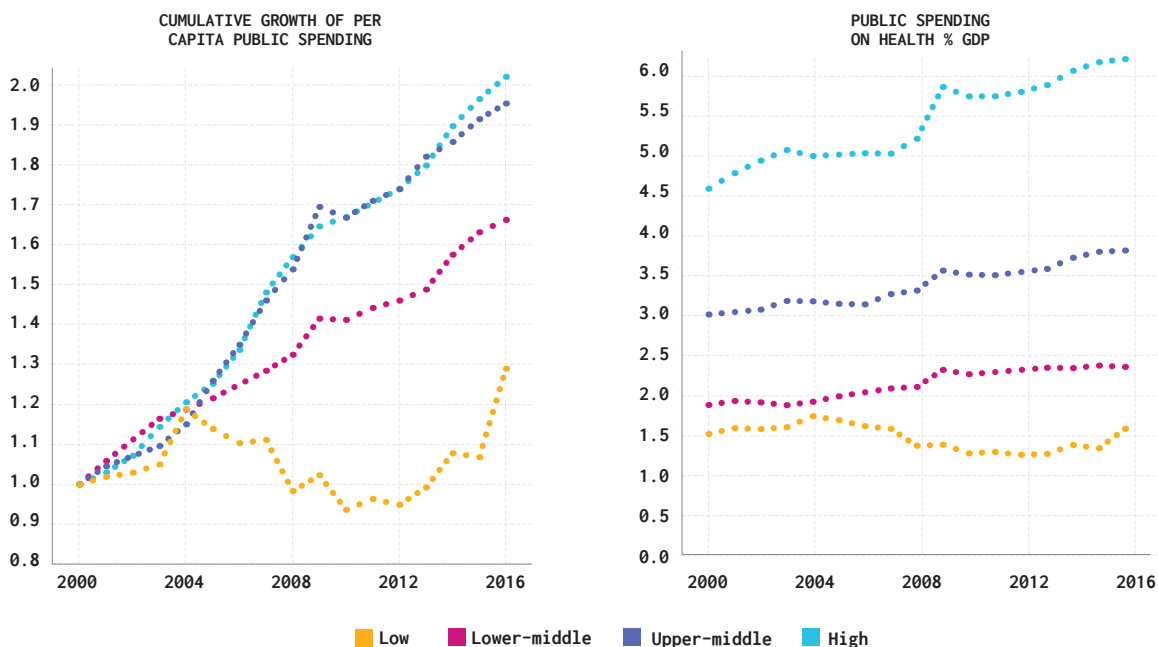
Global population and health expenditure distributed by country income group, 2016



- Total health spending is growing faster than gross domestic product, increasing more rapidly in low- and middle-income countries (close to 6% on average) than in high-income countries (4%).
- Health system resources are coming less from households paying out of pocket and more through pooled funds, in particular from domestic government sources.
- External funding (aid) represents less than 1% of global health expenditure and is a small and declining proportion of health spending in middle-income countries, but it is increasing in low-income countries.

Chart 3:
PUBLIC PER CAPITA SPENDING ON HEALTH IS INCREASING, EXCEPT IN LOW-INCOME COUNTRIES

Trends in public on health per capita (left) and as a share of gross domestic product (right)



- Globally, public spending on health increased as country income grew, but low-income countries lagged behind.
- In middle-income countries, average per capita public spending on health has doubled since 2000, as these countries progress in their transition to domestic funding.
- Governments in high-income countries increased their allocations to health, even after the economic crisis of 2008–2009.

Note: Public spending on health is central to universal health coverage, but there is no clear trend of increased government priority for health

* Source: World Health Organisation. *Global Report: Public Spending on Health: A Closer Look at Global Trends*. 2018.

WHAT TO EXPECT FROM THE UN HIGH LEVEL MEETING ON UHC

5

CHAPTER

5.1

Local action driving universal achievements

By Githinji Gitahi, CEO of Amref Health Africa

p56

5.2

Youth as an accelerator to achieve universal health coverage

By Batool Alwahdani and Marian Sedlak

p58

5.3

The political choice for patient-centric and compassionate universal health coverage

By Kawaldip Sehmi

p60

5.4

Protecting reproductive rights

By Suzanne Ehlers, president and CEO of PAI

p62

Local action driving universal achievements

Every member of the international community has a role to play in building a healthier world

By Githinji Gitahi, MD, MBS

The world has never been as aligned on a common global health priority as it is now on universal health coverage. It is a global imperative for cohesive societies and economic prosperity.

A consensus has existed since 1948 that health is a human right, and the call for health for all has been a lingering voice since 1978 at Alma-Ata. But there has never been such high advocacy as there is today with the current call for universal health coverage with access to essential services for all without financial hardship.

The United Nations High Level Meeting on 23 September 2019 in New York may be the climax of this building advocacy.

Despite this celebratory moment, there remains a real fear that the political endorsements, high fives, dinners and numerous side events, will bring little change for half of the world's population, living in Malawi, Vietnam, Somalia and other countries. This includes large numbers of people living in developed countries such as the United States who still do not have full coverage for essential health services.

As the world converges in New York this September, many issues will need to be prioritised. The UHC2030 movement, through its various multi-stakeholder constituencies and wide-ranging consultations, has identified six key areas of focus. They start with political leadership beyond health and commitment to health as a social contract.

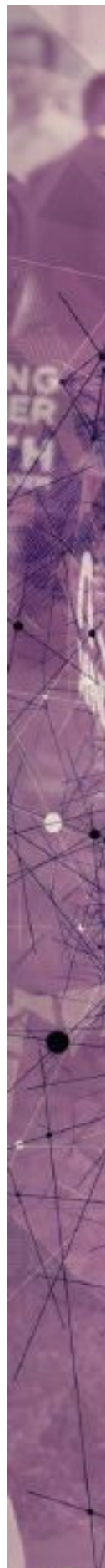
Health is the foundation for people, communities and economies to reach their full potential – and the achievement of universal health coverage

is primarily the responsibility of governments. Governments ensure that people's health is a social contract, noting that achieving universal health coverage is essential for inclusive development, prosperity and fairness. It requires political decisions that go beyond the health sector.

Second, half the world's population is left behind. That includes the poor, migrants, criminalised populations and women. Health is enshrined as a fundamental right of every human being. Universal health coverage is key to reducing poverty and promoting equity and social cohesion. Extending geographic coverage and reaching the most marginalised and hard-to-reach populations are essential to achieving positive health outcomes. For real action in all communities, governments must commit to report disaggregated data for the official statistics compiled on the Sustainable Development Goals in order to capture the full spectrum of the equity dimensions of universal health coverage.

The third priority is to ensure that governments create a strong, enabling, regulatory and legal environment that responds to people's needs and builds institutional capacity, so the rights of people and their needs are met. There is no debating the fact that governments bear this primary duty under the International Covenant on Economic, Social and Cultural Rights.

The fourth call is to uphold the quality of care by building health systems that people and communities trust. That starts with primary health care as the backbone of universal health coverage. It is best achieved through creating confidence in public health systems that respond





to people's needs and deliver desired outcomes. Where private health services are required, leadership should come from the public sector.

The fifth call is for leadership through public financing and efficiency by investing more and investing better through sustainable public financing and by harmonising health investments from all players including development assistance and the private sector. Governments must adopt ambitious investment goals for universal health coverage and make progress in mobilising domestic pooled funding towards existing targets, such as 5% of gross domestic product or the African Union's Abuja Declaration of 15% of government expenditure. This funding should be equitable and driven by the need to reduce impoverishing and catastrophic out-of-pocket expenditures for communities.

Furthermore, development assistance for health should reduce fragmentation and strengthen national capacities for health financing.

Finally, and in line with SDG 17 on the need for partnerships – and in recognition of the fact that health can only be achieved by a whole-of-society approach – countries should take active steps to engage non-state actors more meaningfully. In providing clear direction from the public sector, civil society and the private sector, they too can shape the universal health coverage agenda.

As in many other sectors, there is no one-size-fits-all answer. Solutions for each country must be tailored to that country's particular context and population needs. The international community and global health partners should unite to support all countries to build a healthier world.

The UN High Level Meeting in September must therefore reach high enough to mobilise political leadership but local enough to drive meaningful country action. ■

GITHINJI GITAH

Githinji Gitahi joined Amref Health Africa as the group chief executive officer in June 2015. He is also a member of the Private Sector Advisory Board of Africa CDC, the Global Health Investment Advisory Board, and of the World Health Organization's Community Health Worker Hub. Gitahi is co-chair of the UHC2030 Steering Committee, a global World Bank and World Health Organization initiative for universal health coverage. Gitahi has a doctor of medicine degree from the University of Nairobi and a master's in business administration from United States International University.



🐦 @daktari1 🌐 amref.org



Here are two numbers that represent both a threat and a hope to the universal health coverage movement: 18 million and 1.8 billion. How can we translate 18 million healthcare workers and 1.8 billion youth into actions that would accelerate universal health coverage to be achieved by 2030?

The right to health, gender equality, health equity, the financial hardship of health care, marginalised groups – these and many other factors influencing universal health coverage are rarely part of educating and training future health workers. In a survey of medical students from 80 countries, 65.5% answered they did not learn about universal health coverage in medical school. With almost no content on global health issues, dental students are slowly starting to explore their roles in developing an interprofessional global dental health community.

These alarming examples and many others reflect the fact that today's educational systems are not prepared to produce a generation of health workers with all the competencies to deliver health for all.

How do we ensure that health workers have all the necessary skills, knowledge and values to drive universal health coverage? And why do we underestimate the crucial role

Youth as an accelerator to achieve universal health coverage

By **Batool Alwahdani**, president, and **Marián Sedlák**, vice president for external affairs, **International Federation of Medical Students' Associations**

65.5%

Of medical students from 80 countries had not heard of universal health coverage

10.3%

Of global wealth is represented in the health and social sectors



of socially accountable education and proper training for future generations of healthcare providers? These questions are not usually included in high-level political dialogues and decision making, and it is natural for political choices to be driven by financial figures and seen through the lenses of the economy and immediate impact. Investing in the education and training of future healthcare providers is an investment in building an accessible, capable, skilled and robust health workforce, able to deliver the care needed in their communities.

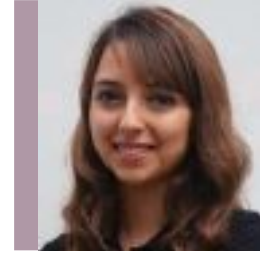
Working for Health and Growth: Investing in the Health Workforce, the 2016 report of the United Nations High Level Commission on Health Employment and Economic Growth, projected a global shortage of 18 million health workers by 2030, primarily in low- and lower-middle income countries. Growth in the health and social sectors has outpaced most other sectors and now represents 10.3% of global wealth. Therefore, investing in the health labour sector – by creating new decent jobs with safe working environments, free of bias, violence and discrimination – will have positive

socio-economic impacts, and will fill the estimated shortfall in healthcare providers by 2030. Political leaders need to keep in mind that universal health coverage is not attainable without investments in the employment and education of healthcare providers.

Today's generation of 1.8 billion young people, which is the largest that we have ever had – with 90% living in developing countries – are undoubtedly important agents of positive change. Using that human capital can accelerate achieving universal health coverage by 2030. We cannot ignore the fact that we live in a time when youth play an active role in health advocacy at local, regional and global levels. Youth and health students' organisations represent, advocate and speak on behalf of millions of future providers and recipients of services.

Therefore, we need to foster partnerships with youth and ensure they are recognised, acknowledged and supported to play a transformative role. Innovation, grassroots movements, ambitious actions and creative solutions – young people naturally possess these unique skills, which are rarely fully utilised. But youth and early career healthcare professionals cannot be engaged through token actions, such as simply offering them speaking opportunities and inviting them to meetings. States must implement meaningful youth participation by granting them equal opportunities to be involved in decision making and explicitly include them in the political declaration of the High Level Meeting on Universal Health Coverage in September 2019.

Two important norms can thus change today's norms and flip the coin in the universal health coverage movement: the shortfall of 18 million health workers and the 1.8 billion young people around the world, a hope we must utilise. ■



BATOOL ALWAHDANI

Batool Alwahdani is the current president of the International Federation of Medical Students' Associations, which represents 1.3 million medical students from 123 countries. She has represented medical students in many international events, including the International Advisory Group on Primary Health Care for universal healthcare. She represented youth in the launch of the United Nations Youth Strategy: Youth 2030, and spoke on behalf of youth in the opening of the World Health Summit 2017. Batool has led student campaigns in her country, Jordan, focused on supporting refugees and spreading awareness about important health issues.

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MARIÁN SEDLÁK

Marian Sedlak is the vice president for external affairs and the past liaison officer for human rights and peace issues in the International Federation of Medical Students' Associations. His main focus areas include universal health coverage, meaningful youth participation in global health and attacks on healthcare services. Through his engagement and advocacy in several United Nations processes, he has involved and lifted up the voice of thousands of future health professionals in opportunities related to global health decision making.

🐦 @majkosedlak 🌐 ifmsa.org

The political choice for patient-centric and compassionate universal health coverage

By Kawaldip Sehmi, CEO,
International Alliance of
Patients' Organizations

In 1948, Britain's health minister Aneurin Bevan, made the bold move to set up the National Health Service in a war-ruined and nearly bankrupt United Kingdom. In doing so, he appreciated the value of universal health coverage for society, viewing it as an investment and not a cost. Today the NHS is a much-loved national institution that has helped shape the United Kingdom's economic, social and cultural life over seven decades.

In a most prophetic moment, Bevan had said that in his new NHS, "if a patient bedpan is dropped in a hospital corridor in Tredegar, the reverberations

Since its inception in a post-war United Kingdom, the National Health Service has demonstrated that it is possible to care for all, without cost at the point of access



should echo around Whitehall, London". Indeed, health became a political choice for every generation in the United Kingdom.

The patient and carer voice and perspective have considerable influence on the country's politics. Elections in the United Kingdom are now won and lost on the basis of which political party's manifesto promises greater investment in the NHS. Waiting lists at hospitals can translate into voter lists during elections.

Globally, patient advocates want health ministers gathering for the United Nations High Level Meeting on Universal Health Coverage in September 2019 to learn from Bevan's example. Patients want their health ministers to make the bold decision to invest in universal health coverage in their own countries. The United Nations has appreciated that the third Sustainable Development Goal, on health, will have an impact on every other SDG.

The World Health Organization has been right to push for health in all policies. The NHS was a major driving force behind the post-war United Kingdom's economic development. It has in fact 'hot housed' the entire industry involved in innovative health technologies and innovative medicines via various satellite company spin-offs and collaborative centres.

Patients want to ensure that each UN member promotes, respects and protects patient participation and involvement within the universal healthcare institutional framework, which spans law, policy, and practice and standards. Today many 'expert-patients', who because of the chronic nature of their diseases, have navigated most of their healthcare pathways, advocate that the patient voice and perspective must be the firm foundation upon which universal health coverage is established globally.

For our health finance to produce the best value for money, patient-centric universal health coverage must be the cornerstone of all healthcare systems. Learning from other consumer-focused industries, where consumers are encouraged to participate in and contribute towards the development of the products and services, our universal health coverage must be shaped by the patients and

“

Patients want their health ministers to make the bold decision to invest in universal health coverage in their own countries”



KAWALDIP SEHMI

Kawaldip Sehmi is chief executive officer of IAPO, having previously held the positions of CEO at Richmond Psycho-social Foundation International and managing director of Coram Children's Legal Centre. He has European and international public health experience as director of the Global Health Inequalities Programme and as chair of the European Network of Quilines.

🐦 IAPOvoice 🌐 iapo.org.uk

their communities. Other industries know that this participation not only improves the consumer experience of their products and services, but also improves the safety, quality, efficiency and effectiveness of the industry – this affects the bottom line.

Another expectation from the High Level Meeting was adequately expressed by *Global Action on Patient Safety*, the report by WHO director-general and the resolution adopted by the WHO Executive Board in January 2019. As universal health coverage covers more people, offers new services and reduces the out-of-pocket expenditure for many, the benefits of increased access to health care may be undermined by service structures, culture and behaviour that inadvertently harm patients and may lead to fatal consequences.

Patients want safe and good-quality universal health coverage that will reassure them and their communities that they can trust healthcare systems to keep them and their families safe.

Bevan and other healthcare policymakers in the 1950s did not face the current healthcare landscape, with its fast-changing health systems and a workforce operating in increasingly complex environments. Rapidly evolving treatments, technologies and care models, despite improving clinical effectiveness and efficiency, can in themselves become a threat to safe health care.

Patient safety is now becoming a big and growing global public health challenge. Countries, while improving access to health care, must also encourage expert-patient participation and engagement to assure that in planning and resourcing their vision of universal health coverage, they are not presiding over flawed and wasteful models of care.

Lastly, we must not forget that medicine retains its societal roots, no matter how complex its structures. Patients want to see universal health coverage that positively encourages compassion in health care. Health ministers must humanise health care and ensure that staff, vulnerable patients, families and communities are well supported and that their participation and welfare become the other cornerstone of patient-centric universal health coverage. ■

By Suzanne Ehlers, President and CEO of PAI

As PAI's CEO, I am often asked why we do this work. Of all the avenues to advance human prosperity and development, why sexual and reproductive health and rights? Why when it seems that in too many countries – the United States included – the political climate is at worst hostile and at best indifferent, to the needs and perspectives of women and girls?

Our answer is always that we believe that when women and girls can make their own choices about when and if to become pregnant, they can transform their lives and their communities.

We believe that the best way to catalyse that transformation is through deep partnership and engagement with civil society and communities who best understand the needs of the people they serve and who are both drivers of accountability and sources of technical expertise.

It is our mission to remove the barriers that stand between women and girls and their sexual and reproductive health and rights, because we understand that at its core, the right to health is about the right

Although often overlooked, sexual and reproductive rights must also be upheld through universal health coverage

Protecting reproductive rights



SUZANNE EHLERS

President and CEO of PAI

Suzanne Ehlers has led PAI since 2009. Ehlers often serves on the US delegation to the United Nations Commission on Population and Development, and has been a board member for the US Global Leadership Coalition and Ibis Reproductive Health. She has been involved in Rachel's Network, the Global Health Council, the Janelia Family Foundation, The Biodiversity Project and the Asia Pacific Alliance. For two years, she co-led the Rights and Empowerment working group of FP2020. Prior to joining PAI, Ehlers was a grantmaker at the Wallace Global Fund.

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to self-determination. That is why the promise of universal health coverage based on a primary healthcare approach is so powerful. Its mandate of health for all, that all people have the promotive, preventive, curative, rehabilitative and palliative health services they need – without exposure to financial hardship – represents the highest political and financial commitment to the fulfilment of health as a human right.

PEOPLE-CENTRED SOLUTIONS

At PAI, we also see in universal health coverage an integrated, people-centred expression of many of the solutions we seek as a reproductive rights organisation:

- Meeting the unmet needs of the 214 million women globally who do not want to become pregnant but are not using contraception;
- Providing respectful, confidential, culturally appropriate – and integrated – care for all people but especially women and girls, young people and other vulnerable populations;
- Increasing the availability, affordability and quality of sexual and reproductive health services and supplies, including improving the range and availability of contraceptive methods; and
- Reducing reliance on donor funds for health and increasing country ownership of family planning.

It is clear: the achievement of universal health coverage and the fulfilment of sexual and reproductive health and rights are part of the same equation.

Within that equation, we see primary health care as a critical entry point. As the foundation of the healthcare system, strong primary healthcare systems can ensure

equitable coverage, increase access and improve the quality of services that citizens receive. Additionally, a primary healthcare approach includes awareness and address of the social, economic and environmental determinants of health, which are drivers of inequity affecting the health and well-being of women and girls.

Unsurprisingly then, primary healthcare systems are instrumental in meeting the needs of women and girls. Contraceptive services, antenatal and postnatal care, vaccines and nutrition support for infants can all be provided at the primary healthcare level in a high-performing system – helping to accelerate the achievement of the Sustainable Development Goals.

GAPS IN THE SYSTEM

Unfortunately, according to the *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, “at least half the world’s population still lacks access to essential health services. Furthermore, some 800 million people spend more than 10% of their household budget on health care, and almost 100 million people are pushed into extreme poverty each year because of out-of-pocket health expenses.”

As a whole, the health sector remains donor-dependent, underfunded and under-prioritised in most countries. The challenges of ►



STRATEGIES
PURSUED BY PAI

- Improving primary health care at the country level by strengthening health systems to deliver integrated essential health services, including sexual and reproductive health: The Primary Health Care Strategy Group convenes civil society health advocates from around the world to improve global and domestic financing and policy for primary healthcare systems.
- Increasing government accountability for sexual and reproductive health through budget advocacy: This includes supporting civil society engagement in health financing policy reforms, including national health insurance schemes and essential health service benefits packages. The goal is to ensure that governments incorporate sexual and reproductive health information and services including contraceptives, safe abortion and post-abortion care into these mechanisms.
- Improving the quality of sexual and reproductive health services and supplies by addressing the structural determinants of quality.



For perhaps the first time in human history, a truly inclusive approach to delivering health care – including sexual and reproductive health – is within reach”

mobilising governments, civil society, communities and other stakeholders can seem daunting. But progress is possible – as in Peru where 19 different ministries came together to develop a multisectoral adolescent pregnancy prevention strategy and in Ghana where efforts to increase both access to health services and financial protection are ongoing.

Replicating – and sustaining – these successes requires collaboration across sectors by both governments and civil society. It must also be rooted in accessible and actionable data, and it requires financial and technical support for civil society engagement at the global and local levels. Our approach is therefore guided by the core principles of access, equity and quality, which undergird primary health care and universal health

coverage. In close collaboration with our global network of partners, we have pursued a number of strategies (see left).

For perhaps the first time in human history, a truly inclusive approach to delivering health care – including sexual and reproductive health – is within reach. Thankfully, sustaining momentum for universal health coverage, improving primary health care, and ensuring a just and equitable future for women and girls are all part of the same endeavour.

Our progress towards that goal will only be possible through the ingenuity of our partnerships among civil society, governments, donors and the private sector, fostering accountability and increased country ownership – and an unwavering commitment to upholding the right to health for all. ■

WHY WE SHOULD BE OPTIMISTIC

6

CHAPTER

6.1

Lessons from Turkey's achievements in UHC

By Recep Akdağ, Former Minister of Health, Turkey

p66

6.2

Strengthening systems for equality

By Agnès Buzyn, Minister of Solidarity and Health, France

p68

6.3

Political choices that transcend borders

By Shinichi Kitaoka, president of the Japan International Cooperation Agency

p70

6.4

Achieving the impossible with vaccines

By Dr Seth Berkley, CEO of Gavi, the Vaccine Alliance

p72

6.5

The technology transforming the future of healthcare

By Houlin Zhao, ITU secretary-general

p74

6.6

UHC in small island developing states

By T. Alafia Samuels, Caribbean Institute for Health Research, University of the West Indies

p76

6.7

Disruptive innovation and multi-stakeholder alliances

By Hiromi Murakami and Kiyoshi Kurokawa

p78

Lessons from Turkey's achievements in universal health coverage

By Recep Akdağ,
Former Minister
of Health,
Turkey

In February 2013, I received a letter from Julio Frenk, who was the dean of Harvard T.H. Chan School of Public Health. At that time, my duties as the minister of health of Turkey since 2002 had just ended. Turkey's Health Transformation Programme, which we carried out during that period, had achieved great success. In an article in *The Lancet*, Rifat Atun and his colleagues put this achievement into words: "After 30 years of slow progress, since 2003 Turkey has been able to design and implement wide-ranging health system reforms to achieve universal health coverage that substantially reduced inequities in health financing, health service access, and outcomes".

Julio's letter included an invitation to lead an eight-week seminar for post-graduate students, in addition to my existing responsibilities for the Ministerial Leadership in Health programme at Harvard University. I gladly

With political will, Turkey achieved universal health coverage in a decade, improving life expectancy, maternal mortality and citizen satisfaction

accepted the invitation and decided to present a section from the movie *John Q* in my first seminar. This movie is about the story of a father who, for financial reasons, was not able to get treatment for his son who needed a heart transplant. *John Q* makes us realise the profundity of the concept of health for all or, in more recent terms, universal health coverage. I would like to highlight that, with its focus on humanity and equity, providing universal health coverage is much more than just having health insurance.

We achieved universal health coverage in Turkey in 10 years, not only by increasing the insurance coverage to 99% but also by ensuring quick access to high-quality services without financial hardship.

Through the HTP, citizen satisfaction rates increased from 39% to 75%, life expectancy at birth improved from 72 to 78 years, the maternal mortality ratio was reduced from 64 to 14 per 100,000 births, and households with catastrophic health expenditure decreased from 81 to 14 per 10,000 households.

To maintain these figures, we spend only \$500 per capita in a year, out of which \$400 comes from public funding.

Nevertheless, the stagnation in these indicators from the end of the HTP until 2019 implies that we need a second phase of transformation in Turkey. I strongly believe that it is necessary to simultaneously focus on the final

RECEP AKDAĞ

Recep Akdağ is a paediatrician, a professor of paediatrics and a member of the Turkish parliament who served as Turkey's minister of health between 2002 and 2013 and between 2016 and 2017. As minister, he led the Health Transformation Programme, which strengthened the country's health system through introducing a single-payer national health insurance system, incorporating public hospitals, implementing a family medicine system, providing better access to healthcare services and pharmaceuticals, and increasing the efficiency and quality of healthcare services. He also served as Turkey's deputy prime minister in 2017 and 2018, and is currently in his fifth term as a member of the Grand National Assembly of Turkey.

🐦 @DrRecepAkdag





With its focus on humanity and equity, providing universal health coverage is much more than just having health insurance”

goals of a health system (namely health status, satisfaction, financial protection and sustainability) and the regenerative logic of the policy cycle.

THE IMPORTANCE OF POLITICAL WILL FOR EQUITY

John Q has a happy ending. However, in most regions of the world, including many rich countries – such as the subject of the movie, the United States – patients do not always end up in such happy scenarios.

There are hundreds of millions of people who cannot access their most basic healthcare needs, which I believe is a fundamental human right. Unfortunately, catastrophic and impoverishing healthcare expenditures are ruining families around the world.

So, what should we do? Of course, there are numerous technical solutions to the problem, such as establishing single-payer insurance with an equitable benefit package, restructuring primary care, strengthening health literacy and promotion, switching

to pay-for-performance, employing public-private partnership models, and other measures. These kinds of solutions were embedded in the health reforms of Turkey.

We also implemented more politically difficult interventions, such as ending dual practice. In most countries, policy makers ignore or hesitate to solve this problem. However, dual practice not only makes patients suffer, but also significantly reduces the efficiency of public healthcare facilities. Another politically difficult action we took was to challenge the *laissez-faire* approach to providing health care and regulate the role of the private sector. It is crucial to have a balanced allocation of human resources between public and private healthcare sectors, and a strong public capacity, in order to procure services from the private sector without causing harmful consequences.

Whether easy or difficult to implement, healthcare reforms always require political support from both the public and head of state. I suggest

a two-pronged approach to obtain these types of support: harvesting the low-hanging fruit to gain power for more time-consuming reform initiatives. On the other hand, to convince ministers of finance, we should be very patient and always use the relevant literature to establish legitimacy. Furthermore, the role of international organisations, such as the World Health Organization, is invaluable for the ability to empower actors of transformation.

I would like to conclude with a request from the politicians of rich countries: let us unite in helping the poor countries. Turkey has fulfilled this duty with utmost sincerity for many years, including its charitable work for asylum seekers that made Turkey the most charitable country in the world in terms of official development aid as a percentage of its gross domestic product in 2017.

All of us can do it. Let us make universal health coverage more than just a dream. ■

Strengthening systems for equality

By Agnès Buzyn, Minister of Solidarity and Health, France

Strong health systems can only be achieved with better access to high-quality health services for all, without financial hardship or risk of impoverishment. That is the aim of achieving universal health coverage, a sustainable solution that takes full account of the economic and social aspects of reinforcing health systems and that contributes to their resilience when faced with pandemics and health crises.

Significant inequalities persist worldwide between countries, as well as between populations, depending on gender and geographical, social, environmental and health conditions. In many developing countries, a fragile healthcare system is one of the main obstacles to accessing vital treatment. Furthermore, in some developed countries, even today, a large section of the population has no guaranteed access to health care.

Given ageing populations and the growing burden of chronic diseases – and also the rise in health spending, shortages in the healthcare workforce and the persistence of health inequalities – policies to achieve universal health coverage need to become more multifaceted and widespread throughout health systems. They need to target inpatient and outpatient care, leverage new digital technology opportunities, and involve patients and service users. Implementing transversal and cross-sectorial action is now a priority for policymakers at the national level, as well as for the international community, including civil society, at the global level.

Since 1945, France has made the choice of promoting solidarity and equality as core values of its French social model, basing provision of health care on a compulsory social insurance system funded by social contributions, co-administered by workers' and employers' organisations under state national regulation, and driven by redistributive financial transfers.

Currently more than 95% of the population is covered by national health insurance. Out-of-pocket fees – around

As an established advocate for universal health coverage, France has implemented several leading initiatives to increase health provisions, while minimising costs

7% – are among the lowest among the countries in the Organisation for Economic Co-operation and Development.

Nonetheless, sustainable performance improvements remain a concern for successive French governments. Through the current policy reform *Ma Santé 2022*, which I have been leading along with President Emmanuel Macron since September 2018, priority is now given to shaping new synergies among all professionals whether they practice within hospitals or medico-social systems or outside of those systems. The model of financing is also revised, especially through 100% Health Reform, which aims to reduce out-of-pocket payments.

Innovative measures have also been implemented for guaranteeing better prevention and access to quality health care for all, developing multisectoral prevention policies (targeting non-communicable diseases, as well as risk factors and social and environmental determinants of health), and strengthening the primary healthcare system. *Ma Santé 2022* proposes the creation of a real healthcare project in each territory that brings together all hospital, non-hospital and medico-social health professionals. Doctors, pharmacists, nurses and physiotherapists must pool their skills and resources to serve the health of patients within their territory

AGNÈS BUZYN

Agnès Buzyn was appointed France's Minister of Solidarity and Health in 2017. Previously she was appointed chair of the independent French National Authority for Health and, from 2011 to 2016, president of the National Cancer Institute. As a haematologist and clinician, she has supervised a haematology intensive care and bone marrow transplant unit, and directed research studies on tumour immunology at the National Institute of Health and Medical Research.

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and create a healthcare collective at the service of patients.

At the international level, France has been advocating universal health coverage for years to all international organisations, especially the World Health Organization. This commitment culminated in September 2015 with the adoption by the international community of universal health coverage as one of the targets of the Sustainable Development Goals. Moreover, France has made it a guiding principle of its Global Health Strategy 2017–2021. In particular, France is supporting joint initiatives for developing countries, particularly in Africa, to implement universal health coverage, notably for vulnerable populations, such as for improving maternal and child health.

More recently, under the 2019 French presidency, the G7 has recognised that

progress was still needed globally in reinforcing primary health care to combat health inequalities. Indeed, health promotion, prevention, treatment, immunisation and nutrition, as well as health literacy, can lead to significant advances in health, stability and socio-economic development.

Furthermore, ending the three epidemics of AIDS, tuberculosis and malaria, achieving universal health coverage and the SDGs related to health by 2030, and improving global health security, will not be possible without a mix of financing sources. That is why the G7 has committed to support the success of the Sixth Replenishment Conference of the Global Fund, which France will host in Lyon on 10 October 2019.

Forty years after the global commitment of Alma-Aty, in October 2018 the new declaration of Astana

renewed the political commitment to primary health care of governments, non-governmental organisations, professional organisations, academics, and global health and development organisations. Today, this approach deserves to be fully implemented. In particular, there is now momentum to improve coordination of knowledge on primary health care, facilitate its use by policymakers and share experiences on primary healthcare implementation.

France is leading the G7 Primary Health Care Universal Knowledge Initiative to explore options for a web-based knowledge-sharing platform. It will allow gathering and coordinating existing expertise, and encouraging cross-country learning on primary health systems among interested countries for mutual benefits. The WHO, OECD, World Bank Group, Global Fund and Gavi, the Vaccine Alliance, will work together for improving coordination towards achieving SDG 3 for good health and well-being, notably under the framework of the Global Action Plan for Healthy Lives and Well-being for All. ■

95%

Of the population is covered by national health insurance

7%

Is the typical out-of-pocket fee, one of the lowest

Political choices that transcend borders



By Shinichi Kitaoka,
president of the
Japan International
Cooperation Agency

As Japan has demonstrated, universal health coverage starts with a political choice and requires unwavering commitment

Universal health coverage is a fundamental and significant political choice that every country should make.

No one should be denied quality health care because of the cost or unavailability of services. Japan made that choice early in its economic development and achieved universal health insurance coverage in 1961.

Japan continues nevertheless to make policy choices even today to sustain universal health coverage amid growing healthcare expenses due to population ageing and technological innovation, against the backdrop of sluggish economic growth.

Japan in the 1950s enjoyed a rapid economic recovery from the devastation

of World War Two. But it was challenged by remaining poverty that left 10 million people barely above

the level of needing state welfare. About 30 million people were excluded from existing health insurance plans. It was evident that poor welfare conditions could create serious social instability. The 1958 Citizen's Health Insurance Act mandated local governments to enrol all people not covered by other plans. It was no coincidence that the idea of universal coverage was conceived and promoted at a time of increasing political challenges from the socialist party, reflecting the socio-economic landscape at the time.

FEATURES OF THE SYSTEM

One prominent feature of Japan's universal health insurance system is the combination of employment-based and residence-based health insurance. It can be broken down into four tiers. The oldest two tiers belong to employment-based insurance, the origin of which can be traced back to 1922 when the Health Insurance Act was enacted. The employees of big corporations and civil servants are covered by health insurance associations, while those in small to medium-sized enterprises are covered by a single association managed by the government.

Reflecting Japan's pre-war demographic profile, when many people resided in rural areas without formal

employment, the Citizen's Health Insurance Act was enacted in 1938 as the third tier. It was the predecessor of the 1958 act. The fourth and latest addition is the Late Elders' Health Insurance established in 2008 to provide mandatory coverage for people aged 75 and older. A fairly complex system operated by more than 3,000 insurers, it resulted from political choices to accelerate the achievement of universal coverage.

If the political choices made in the 1950s were instrumental for achieving universal health coverage in Japan, the ones made in the 1980s were pivotal in containing costs and enhancing sustainability. Political rivalry, fuelled by demands from people increasingly dissatisfied by the gap between the national economic achievement and their own welfare, created the impetus for policy choices to expand the depth of the coverage. In 1973, the government introduced a reimbursement scheme for catastrophic medical expenses exceeding a certain threshold.

Co-payments by people who were 70 years and older were removed. Unfortunately, the economic recession resulting from the oil shock that same year – and rapid increases in medical expenses due to the generous package – created a significant financial burden on the system. The government enacted the Elderly Health Act in 1982 (later transformed into the Late Elders' Health Insurance), which reintroduced co-payments and created cross-subsidy transfers among the insurance plans with different demographic profiles. Together with the revision of the Health Insurance Act in 1984, it signified a turning point in Japan's welfare policy.

LEARNING FROM EXPERIENCE

As Japan's experience indicates, universal health coverage is only achieved and sustained by continuous political choices. The choices made in 2006 that resulted in the late elders' health insurance in Japan included several measures to control medical expenditures. In 2018, to improve financial viability, financial responsibility for managing citizen's health insurance was transferred from municipalities and villages (the third tier of local governance) to



If the political choices made in the 1950s were instrumental for achieving universal health coverage in Japan, the ones made in the 1980s were pivotal in containing costs and enhancing sustainability”

prefectures (the second tier). With the share of people over 65 years expected to rise from the current 28% to 30% in 2025 and the increasing availability of effective yet expensive medical technologies, further political choices are inevitable.

Despite the challenges Japan faces, its experiences and lessons are shared with our partner countries to encourage and facilitate their informed policy

choices. In Kenya, for example, where we extended policy support through technical advisers and a \$36 million loan to accelerate reforms related to universal health coverage, President Uhuru Kenyatta made universal health coverage one of the four pillars of his national development agenda.

Health insurance coverage for the poor increased from 17,000 households in 2015 to 182,000 in 2017, through the concerted efforts of the government and various partners. In Senegal, where we provided a similar package with a \$78 million loan, the percentage of remote health facilities staffed with a nurse and a midwife increased from 41% in 2015 to 92% in 2018, and health insurance coverage for the poor increased from 186,000 in 2015 to 1,342,000 in 2018, under the strong leadership of President Macky Sall.

It is my sincere hope that many other countries will join hands through this new platform in making such choices, so universal health coverage can be achieved collectively by 2030.

Japan has made many choices in the past, and still makes them today. Some were good and some were bad. We are more than willing to share our experiences with our partner countries and global communities so that people can learn from our experience. ■



SHINICHI KITAOKA

President, Japan International Co-operation Agency

Shinichi Kitaoka is president of JICA. Previously, he was president of the International University of Japan. His career includes being a professor at the National Graduate Institute for Policy Studies and at the Graduate Schools for Law and Politics at the University of Tokyo, and serving as ambassador extraordinary and plenipotentiary and deputy permanent representative of Japan to the United Nations.

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Achieving the impossible with vaccines

As India's eradication of polio proves, the impossible is often in closer reach than it appears

By Dr. Seth Berkley, CEO of Gavi, the Vaccine Alliance

When the Government of India announced in 2014 that it had successfully eliminated polio from the country, Dr Margaret Chan, who was director-general of the World Health Organization at the time, said that "India has shown the world that there is no such thing as impossible". And indeed, looking at the statistics from 2009, just five years prior, that is exactly how this goal would have looked – impossible. India was a country of 1.3 billion people carrying 60% of the global disease burden, with millions living in extreme poverty with poor sanitation. Yet they did it. India has not seen a single case of wild polio virus since 2011.

This story is a reassuring one to keep in mind as the global health community reaches for another seemingly impossible goal: universal health coverage, where good-quality and affordable health care is available to every person, everywhere, no matter what their income. It illustrates what can be done with strong political commitment, with community engagement and with strong surveillance systems. But it also illustrates the power of a very simple, almost ubiquitous public health intervention: vaccines.

In 2011 alone, 900 million doses of oral polio vaccine were administered in India. This was made possible by a team of 2.3 million vaccinators, the support of religious leaders and thousands of community mobilisers, and heavy investment from the Government of India in surveillance. To achieve elimination, vaccinators needed to reach communities that had been chronically neglected by public health services. They needed supply chains, cold storage, community outreach, and meticulous healthcare records and planning. Through this effort, the Government of India, the World Health Organization and partners did not just eliminate polio: they created a vast infrastructure that is now proving invaluable in

delivering other essential health services. Because of this, the polio elimination effort is now helping to deliver a range of other vaccines, as well as vitamin A supplements, zinc, oral rehydration salts and reproductive health services.

In other words, the impact of vaccines goes far beyond their ability to protect against specific deadly infectious diseases. Routine immunisation reaches more people worldwide than any other health intervention, including those living in some of the hardest-to-reach communities on the planet. It is the only intervention that brings the majority of children and their families into contact with primary health services five or more times during the first year of a child's life. In 2017 alone, vaccines created 550 million touchpoints in countries supported by Gavi, the Vaccine Alliance. This makes immunisation an ideal platform to improve access to primary health care and ultimately work towards universal health coverage.

The contribution that vaccines make towards improving health for all goes further than just logistics. Prevention is not only better than the cure: it is also cheaper. Vaccines offer a better return on investment than any other public health intervention: for every \$1 invested in immunisation, \$16 is saved in healthcare costs and lost productivity. This rises to \$44 when taking into account the broader benefits of people living longer, healthier lives. Part of this return on investment is thanks to the role vaccines play in protecting families from medical impoverishment. According to research published in *Health Affairs* in 2018, vaccines administered between 2016 and 2020 will prevent more than 21 million people from slipping into poverty in 41 of the world's poorest countries. With finite resources to draw from and conflicting priorities, efficiency will be key to achieving universal health coverage. Governments can be confident that when they put money into vaccines, that money has been well spent.



DR. SETH BERKLEY

A medical doctor and epidemiologist, Seth Berkley joined Gavi, the Vaccine Alliance as CEO in 2011. Under his leadership, Gavi has reached more than half a billion children in the 73 poorest countries in its 15 years of existence. Prior to Gavi, he founded the International AIDS Vaccine Initiative in 1996, where he served as president and CEO for 15 years. He has worked for the Rockefeller Foundation, the Center for Infectious Diseases of the US Centers for Disease Control and Prevention, the Massachusetts Department of Public Health and for the Carter Center, where he was assigned to the Ministry of Health in Uganda.

🐦 @GaviSeth 🌐 www.gavi.org



Gavi – the organisation I head – is working to reach every child in the world’s poorest countries with these lifesavers. It is a huge challenge: rapid urbanisation, population growth and human migration mean we are chasing a moving target. Each year we start afresh with a new and larger cohort of children born, so that even maintaining the progress in coverage already achieved cannot be a given. To reach more children, we are increasingly harnessing the latest technology from drones to biometrics, and constantly looking at where we can collaborate with other organisations to reach our common goals. By doing so, we are laying the groundwork for the provision of broader health services. There are also lessons to be learned here when it comes to reaching universal health coverage: it will require a concerted global effort from a huge range of partners, making the most of 21st century technology.

Gavi is also investing money and expertise in strengthening health systems, working to reach unreached communities and identifying best practices to integrate other health services into immunisation programmes. The benefit of this goes both ways: expanding immunisation systems can improve access to primary health care, and stronger primary healthcare systems can boost vaccine delivery.

There is no doubt that universal health coverage is an ambitious goal. But if the enormity of the task had put India off tackling polio, that one country might still be seeing as many as 200,000 cases a year – as it did in the 1970s – rather than zero. India took on a seemingly impossible goal and, with vaccines, made it possible. Now let’s do the same for universal health coverage. ■



The technology transforming the future of healthcare

Digital technologies and access to the internet are both critical to the promotion of universal health coverage, and ensuring treatment is within reach

By Houlin Zhao, ITU secretary-general

How can digital transformation help foster universal health coverage? Without digital technologies, we cannot achieve universal health coverage.

Digital technologies and services can help accelerate momentum towards all 17 Sustainable Development Goals, including target 3.8, to achieve universal health coverage.

Widely and wisely used, digital technologies can improve the quality of health care, from promotion, prevention and care to rehabilitation. Furthermore, digital financial services help mitigate drifting into poverty when using health services. They give people the ability to save, access health insurance and make healthcare payments; they help governments ensure that social security payments reach their intended recipients.

WHICH CHALLENGES LIE AHEAD?

For the first time in history, at the end of 2018, 51.2% of the global population was using the internet.

However, to ensure that health services become accessible for all, we need to ensure that digital transformation leaves no one offline.

HOW IS ITU WORKING TO ADVANCE HEALTH?

ITU has a long and productive history of collaboration with the World Health Organization. A few examples follow:

- Since 2012, ITU has been helping countries develop national eHealth strategies. The WHO-ITU National eHealth Strategy Toolkit provides a comprehensive roadmap for governments to develop a digital health strategy, from leadership, strategy and investment, to infrastructure, legislation and policy, and workforce capacity.
- Digital technologies and artificial intelligence will be essential tools in achieving universal health coverage. In July 2018, ITU, together with WHO, established the Focus Group on Artificial Intelligence for Health. It seeks to create a framework for benchmarking AI-based health solutions that will provide a common ground for national and regional medicine regulators in their certification processes.
- Earlier this year, ITU and WHO launched a new global standard for safe listening devices to help young people lower the risk of early onset of hearing loss due to excessive exposure to loud sounds. ITU and WHO also developed a toolkit for assisting governments, industry and civil society to foster faster adoption of the standard.
- A year ago, ITU launched the Regional Digital Health initiative to accelerate achievement of the SDGs in Africa, together with WHO Regional Office for Africa. We joined forces to train the next generation of tech-savvy leaders, software developers and digitally literate healthcare workers in Africa.
- Since 2013, ITU and WHO have been working on the BeHe@lthy, BeMobile initiative in 11 countries, using mobile technologies for preventing and controlling non-communicable diseases.

11

Countries globally are engaged with the BeHe@lthy, BeMobile initiative, which uses tech to advance healthcare access

51%

Of people around the world were using the internet in 2018, the highest rate of connection yet

85%

Of people in the Republic of Niger will receive internet connection to support their access to health care, education and other services

WHAT SHOULD THE PRIORITIES BE FOR THE GLOBAL COMMUNITY NOW?

The delivery of services using digital technologies needs to be engrained in societies' DNA. We need to continuously adopt digital technologies to fundamentally change the way health and other vital services are conceived, planned, designed, deployed and operated. In smart societies, digital services are driven by demand and are citizen-centric. Transformation is social, driven by technology.

We recommend three transformation pillars: whole-of-government strategic thinking, universal telecommunication service coverage and standards.

WHOLE-OF-GOVERNMENT STRATEGIC THINKING

For this digital transformation, we need a whole-of-government approach to digital vision, strategy, policy and investment, to identify which technologies matter most in achieving universal health coverage, and to maximise economies of scale and return on investment. Leadership at the highest level is needed to bring together and coordinate across governments, donors, technology solution vendors and other actors from information and communications technologies, health, and other sectors.

UNIVERSAL TELECOMMUNICATION SERVICE COVERAGE

For universal health coverage, we need universal telecommunication service coverage. This means we still need to connect the other half of the world's people to the internet and the benefits it brings.

It can be done. For example, the Republic of Niger is collaborating with ITU, WHO and others to connect more than 85% of its population, mostly rural, to the internet for health care, agriculture, education, financial, government and other services through the Niger 2.0 Smart Villages project.

STANDARDS

ITU welcomes public and private sector players, from developed and developing countries, to join its standards-setting process. International standards can ensure interoperability, open up global markets, help protect investments, promote knowledge sharing, and spur innovation and growth. ITU's Bridging the Standardization Gap programme facilitates the participation of developing countries in the standards-setting process.

We need to continue to work together to make sure that digital technologies and services are everywhere for all, for good, for our future. ■

HOULIN ZHAO

Houlin Zhao was re-elected ITU secretary-general at the 20th Plenipotentiary Conference in Dubai, United Arab Emirates, in November 2018. An information and communication technology engineer born in Jiangsu, China, he served eight years as deputy secretary-general before his first election to secretary-general, in 2014. Under his leadership, ITU has opened up its membership to the academic community, moved to a near-paperless work environment and increased the use of remote participation systems. He has focused on extending ITU's commitment to accessibility, multilingualism, and broad multistakeholder participation.

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UHC in small island developing states

Small island developing states have many vulnerabilities, not least in their supply chains. From the food that is consumed to the resources required to keep 65 million people healthy, the challenges are truly unique

Among the 30 small island developing states in the Caribbean and 21 in the Pacific, population size varies from 11.5 million in Cuba to 1,500 in Niue. The 58 SIDS globally have a combined population of 65 million; 38 are independent member states of the United Nations, and 20 are still colonies. Two-thirds are high or upper middle income states.

Despite their wide geographic spread, SIDS face similar challenges regardless of their income status. They are vulnerable to global economic shocks and to natural disasters and are on the front line of the impact of climate change. Their small, vulnerable economies, dependent on a few industries such as tourism, struggle with a limited and unstable tax base and a disproportionate burden of the public administration required for an independent nation-state. Their remote locations mean high costs for communications, energy and transportation, and economies that are not diversified means dependence on imports. St Kitts and Nevis import 95% of what they eat.

BURDEN IN SIDS

As a group, SIDS have a disproportionate burden of non-communicable diseases – risk factors, morbidity, mortality and, most important, premature mortality. In both Guyana and Fiji, 31% of those aged 30 will die from an NCD before their 70th birthday, compared to Canada at

10%. The top 10 most obese countries in the world are all Pacific Islands. While the global prevalence of diabetes is 8%, in SIDS the diabetes prevalence is around 20% and diabetes-related mortality is three times higher than the global rate.

HEALTH SYSTEMS RESPONSE

SIDS health systems are under-resourced and struggling to transition to a chronic care model to reflect the epidemiological transition from communicable to non-communicable diseases.

Small markets, high transport costs and lack of economies of scale for negotiating better deals for drugs and medical technology result in high, variable prices. The price of Simvastatin to treat high cholesterol varies tenfold between Nauru and the Cook Islands. Universal health coverage is ideal and appropriate funding arrangements need to be put in place, most obviously in the form of national health insurance schemes.

In the Caribbean, both primary and hospital health services are mostly free at the point of delivery, but inadequate human, financial and organisational resources limit the quality and quantity of services delivered. Several Caribbean countries are actively considering introducing a national health insurance scheme, but in these small islands, several concerns need to be considered.

Population ageing in the Caribbean and the rapid increase of NCD risk factors mean that within 15 or 20 years, the demands for services will likely double.

Public expectations of the benefit package will be driven by the medical dramas and advertisements on North American cable television. US media penetration of the region is complete, since small populations cannot generate sufficient local content, and social media is ubiquitous.

Small populations can neither train nor generate sufficient demand for the full spectrum of sub-specialties, so that, for example, none of the

By T. Alafia Samuels, Caribbean Institute for Health Research, University of the West Indies

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The heads of government and ministers of health in the Caribbean are committed to enhancing their populations' access to quality care. The challenge is how to pay”

50%

Tax on sugar and sugar-sweetened beverages, recently introduced in Bermuda

10%

Tax on sugar and sugar-sweetened beverages, recently introduced in Barbados

4%

Reduction in consumption of sugar and sugary drinks, recorded in Barbados

smaller islands will have a paediatric orthopaedic oncologist. Such specialised care will need to be sought overseas and the national health insurance scheme will need to determine how much overseas care it can support.

Among health professionals on the islands, the brain drain is acute. Barbados, a country of fewer than 300,000 people, lost 51 registered nurses in January 2019 to recruiters from the United Kingdom.

Health information systems are weak, underdeveloped and fragmented. There is a history of systems being installed that cannot be queried and serve poorly the needs of NCD care.

Travel back and forth between SIDS and high-income settings is very common and has contributed to the 'westernisation' of the Caribbean diet. Marketing and sales by 'Big Food' and 'Big Drink' transnational companies have aggressively targeted those SIDS that have high disposable income – and the World Bank classifies 10 of the 20 countries in the Caribbean Community as high income.

Despite these challenges, some countries have already instituted specific initiatives to improve patient access to chronic disease care. Trinidad and Tobago's Chronic Disease Assistance Programme and the Jamaica Drugs for the Elderly Programme both provide extra support for purchase of a defined list of medications for chronic conditions. In Antigua and Barbuda, the Medical Benefits Scheme provides a suite of services to its members.

The heads of government and ministers of health in the Caribbean are committed to enhancing their populations' access to quality care. The challenge is how to pay for it. As one Jamaican prime minister famously declared, "It takes cash to care."

Bermuda recently introduced a 50% tax on sugar and sugar-sweetened beverages, concomitant with subsidies for healthy foods. In Barbados, a 10% tax on sugar and sugar-sweetened beverages has seen a 4% decline in consumption and 8% increase in the sale of water. Dominica's tax on sugar was to be evaluated, but then came island-wide devastation from Tropical Storm Erika in 2015, followed two years later by Category 5 Hurricane Maria. Other Caribbean islands are actively considering taxing sugar-sweetened beverages. Several countries in the Pacific have implemented such taxes, including Fiji, Tonga and Vanuatu.

This is a good solution. Taxes on sugar and sugar-sweetened beverages and on ultra-processed and unhealthy fast food can be framed as a health levy – prepayment on the cost of treating the diseases that will result from their consumption. These taxes will generate a steady stream of funds to support universal health coverage.

Jamaica already earmarks taxes from tobacco and alcohol for the National Health Fund.

In the face of free trade and aggressive marketing of ultra-processed food and sugar drinks, which are driving the change in food culture and the tsunami of premature mortality from NCDs, the options open to governments include fiscal, regulatory and legislative measures. Small islands have limited human resources to generate their own legislative measures and are often reluctant to adopt 'model legislation' from elsewhere. Earmarked taxes appear to be more feasible and effective in both reducing risk and as an easy source of funding for universal health coverage. ■

T. ALAFIA SAMUELS

Director of the George Alleyne Chronic Disease Research Centre

T. Alafia Samuels is the director of the George Alleyne Chronic Disease Research Centre at the Caribbean Institute for Health Research in the University of the West Indies in Barbados. She is a medical doctor, trained at UWI Mona, and holds a master's in public health and a PhD in chronic disease epidemiology. She is a member of the Barbados National NCD Commission and was the principal investigator for the formal evaluation of the CARICOM Heads of Government 2007 Port of Spain NCD Summit Declaration. She is a board member of Defeat NCDs and of NCD Child, and a commissioner for the global Lancet One Health Commission.



Disruptive innovation and multi-stakeholder alliances



Emerging societal dynamics in donor countries are altering the perception of aid and curving its impact. However, a new generation of donors can – and must – be supported in their ability to drive change



By Hiromi Murakami, adjunct fellow, Global Health Policy Center at the Center for Strategic and International Studies, and Kiyoshi Kurokawa, professor emeritus, National Graduate Institute of Policy Studies and the University of Tokyo

We are living in an uncertain era of a globalised world where leaders must think disruptively beyond the existing frameworks. The western world's model of donors assisting the unprivileged has been sustained for decades, chiefly due to a relatively stable global order, the middle classes electing 'sensible' leaders and the consciences of those leaders with apparently ambivalent feelings of guilt.

That creed of development assistance is now passé, as donor countries experience political polarisation and growing economic inequality, with middle class incomes dropping. It is increasingly difficult to attract political support from voters to pump cash unconditionally into international agencies, as ever-striving middle classes are also concerned about their own future. This situation foments anger and discontent, divides societies into radical movements, encourages xenophobia and increasingly gives rise to populist leaders. The more domestic politics are strangled, the less attention is paid to synergistic collaborative efforts to solve international problems. There is widespread apathy among national leaders to truly engage on common agendas, while those leaders are under extreme pressure to survive 'democracy' at home.

Since World War Two, the United Nations and the World Bank have not been consistently successful in improving the living standards of the poorest. Yet advances in digital technology and the wide distribution of mobile phone services have now made it easier to reach people in remote villages and for them to receive education and training at very low

cost. Still, the poor remain poor, and we witness mounting frustration and violence amplified by sheer despair. Development assistance has not functioned as intended, as aid money has often been dispersed before reaching those who need it. Access to basic socially supportive infrastructure, including health and income generation, has remained at a minimum. The reality we see today is far from what we had envisaged.

Dramatic strides were made when the private sector stepped into the global health realm. The Bill and Melinda Gates Foundation deserves recognition, with its clear goals of alleviating extreme poverty and health inequality. By using cost-benefit analyses and accelerating the development of novel technologies with an annual budget that exceeds the World Health Organisation's, it brought a dramatic shift in the mind-set of the development assistance community, swapping aid-based assistance for an outcome-based efficient model that



We continue to search for a new form of government - not an authoritarian one - to enable an allied framework of global multi-stakeholders who work together to build capacity among the poorest"

facilitated actual progress. This new perspective will lead to new models. The risk, however, is the sustainability of governance where power rests in the hand of only a few founders.

Wealth has been steadily accumulating in a small number of the super rich. Globalisation and the rise of digital technology have not created enough jobs. Millennials and the so-called Generation X will be deciding investment trends for years to come. In fact, almost half of American households with net assets of \$25 million or more are dominated by millennials. The encouraging news is that those individuals are keen to invest in and support environmental, social and governance issues, which should stream money flows into emerging enterprises and socially conscious businesses that may contribute to socio-economic equality. Therefore, it is gravely important to build a consensus among these 'haves', in particular with Google, Apple, Facebook and Amazon, to invest in environmental, social and governance issues and actively engage in tackling inequality in all its forms among the 'have nots'.

In 2005, the World Health Organization initiated a bold move to advocate a new concept of evaluating the social determinants of health from a broader perspective. With such a pioneering spirit, it could start by creating a new platform for cross-border and cross-stakeholder public-private alliances. Such a platform would accommodate various forms of contributions, not necessarily in financial form. Private corporations would be able to offer technology, products, supply chains, expertise and any other resources. Some endeavours already exist: the Global Health Innovation Technology ►

Fund promotes global health research and development and sheds light on dormant innovation efforts, through a public-private funding scheme. Since 2013, the fund has invested \$170 million in 80 projects to fight infectious diseases. The Coalition for Epidemic Preparedness Innovation has also initiated collaboration involving the governments of Japan, Norway, Germany and India as well as industries, philanthropy and civil society to finance, coordinate and accelerate development of vaccines against infectious diseases, especially critical ones such as Ebola, before they reach crisis levels. The coalition has committed over \$280 million, and has a unique risk-sharing scheme for R&D costs and benefits among vaccine developers when market incentives fail. The Hideyo Noguchi Africa Prize also provides individuals with an opportunity for initiating collaborative efforts. Using their honorariums, the inaugural laureates Brian Greenwood and Miriam Were respectively established the Africa London Nagasaki Fund to provide training and education opportunities for African doctors and expanded the public health programme in Kenya to train community health workers.

We continue to search for a new form of government – not an authoritarian one – to enable an allied framework of global multi-stakeholders who work together to build capacity among the poorest. Inequality has also become a central issue in developed countries, as fears of losing jobs to artificial intelligence rise. By reallocating resources and available technology, offering expertise and providing opportunities for education and training, we can harness the collective will to build capacity to allow each one of us to tackle the fundamental problem of inequality.

It is critical that international agencies, including the World Health Organization, continue to raise awareness and remind national leaders to engage in such vital challenges. With an outcome-oriented approach, delivering visible returns, with an innovative spirit and open mind, we welcome the fusion of ground-breaking experiences and develop novel, cost-effective solutions that must become accessible to all those who need them. ■

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Hiromi Murakami has spent many years working in public policy, and has been involved in various policy projects at the Center for Strategic and International Studies, the Health and Global Policy Institute, and the Economic Strategy Institute. She has taught at graduate schools in the United States and Japan. Murakami holds a PhD in international relations from the Paul H Nitze School of Advanced International Studies at Johns Hopkins University.



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Kiyoshi Kurokawa trained in internal medicine and nephrology and has taught in the faculties of medicine at the University of Tokyo, University of Pennsylvania, University of Southern California and served as the dean of Tokai University Medical School, among others. He has served as science advisor to prime ministers, and chaired the Fukushima Nuclear Accident Independent Investigation Commission of the National Diet. He has also served many national and international professional societies and organisations, including as World Health Organization commissioner, president of the Science Council of Japan, and on the boards of A*STAR (Singapore), KUSTAR (United Arab Emirates) and OIST (Okinawa). He is a member of the World Dementia Council.

7

CHAPTER

SUPPORTING THE VULNERABLE

7.1

Investing in equitable societies

By Gunilla Carlsson UNAIDS executive director, a.i.

p82

7.2

The role of agriculture, food and nutrition

By Laurette Dubé, Raphael Lencucha, and Nick Drager

p84

7.3

Protecting the brain

By Vladimir Hachinski, professor of neurology and epidemiology at Western University

p87

7.4

Game-changing priorities for UHC

By Françoise Girard, Katja Iversen, Roopa Dhatt, and Kim van Daalen

p90

7.5

Mental health is universal health

By Vikram Patel and Shekhat Saxena

p94

Investing in equitable societies

In Sweden, publicly-funded services are designed to respect privacy, dignity and quality of care. As a result, the country has one of the highest life expectancy rates in the world

Life expectancy in Sweden is among the highest in the world. The Swedish healthcare system is anchored in the values of human dignity and solidarity and is explicitly committed to ensure the health of all citizens. The system is designed to respect everyone's rights, regardless of their status. It is largely financed by taxes – about 80% of all health investments are public investments.

My siblings and I were raised to value and cherish a social contract based on equity and redistribution whereby part of our income would go to the state and, in exchange, the most underprivileged in society would access free, quality public services, including health care. One day, we might need it too. And that day, the system would take care of us. Such was our luck.

By **Gunilla Carlsson**
UNAIDS executive director, a.i.

Not everyone today is that lucky. Globally, every year, 100 million people fall into poverty because of healthcare-related expenditures. The risk of impoverishment is much higher in poorer countries and the most marginalised communities. That is also where fiscal space is most constrained and compulsory contributions into redistributive risk pools are virtually non-existent. There we see health inequities weakening society as a whole and leading to despair.

Universal access to high-quality, affordable health care is key to a healthy, prosperous and cohesive society. The economic case for universal health coverage is strong.



The Lancet Commission on Investing in Health found that 24% of income growth in developing countries between 2000 and 2011 resulted from health improvements. Access to care reduces workers' absenteeism and boosts productivity.

Expanding universal health coverage can also reduce overall inequalities and thereby bolster social and political stability. Greater health equity can narrow inequality in income, wealth and education through better school attendance, higher educational attainment, capital accumulation and use of family planning. These are the determinants of a person's ability to escape the poverty traps that can affect life chances for families across generations – and are particularly significant factors to create opportunities for women and girls.

GROUP DECLARATIONS

Recent declarations from the G7, the G20 and the United Nations General Assembly reiterate countries' commitment to universal health coverage. This is definitely the smart political choice – the right to health is a pillar of equitable development – a building block to enable all people to participate in the political, social and economic life of society as full-fledged citizens. Providing people-centred, rights-based, gender-equitable universal health coverage systems requires countries to develop new models of healthcare delivery and financing. Here are some of the essential elements to collectively chart the path towards universality, inclusion and keeping people healthy:

To leave no one behind, leaders need to understand the barriers to equitable health outcomes.

Service coverage without access will not lead to better health. Geography, cost, stigma, inequality or harmful laws can leave people behind. Implementing the principles of universality means eliminating all forms of discrimination against vulnerable and marginalised people. This demands, among other things, gender equality and eradicating gender-based violence as well as working across ministries to tackle the social and other determinants of health.

To deliver results, leaders need to encourage inclusive governance of universal health coverage.

Communities and civil society have historically fulfilled key and often unique roles to improve health equity. Doing so includes promoting and defending health as a rights and social justice issue, monitoring and tracking political health commitments, and addressing service gaps for people most excluded. Community organisations contribute as demand creators, agents of change, and implementers and demanders of accountability. Universal health coverage needs a whole-of-society approach, one that includes

80%

Of all healthcare investments in Sweden are derived from public funds

24%

Of income growth in developing countries over 11 years could be attributed to improved health

100m

People are pushed into extreme poverty every year after paying for medical treatment



GUNILLA CARLSSON

UNAIDS executive director, a.i.

Gunilla Carlsson was appointed UNAIDS executive director, a.i., in May 2019, having joined as the deputy executive director for management and governance in February 2018. She was previously a member of the Swedish Parliament (2002 – 2013) and served as the minister for international development cooperation (2006 – 2013). She was also elected member of the European Parliament (1995 – 2002). Carlsson has held various positions, including chair of the Commission on Climate Change and Development, member of a High Level Panel for Global Sustainability ahead of the 2012 United Nations Conference on Sustainable Development, and member of the UN High Level Panel on the Post-2015 Development Agenda.

the meaningful engagement of communities and civil society, from the clinic to the health policymaking table. By establishing inclusive monitoring mechanisms at all levels of health systems, everyone can play a role in holding governments accountable for universal health coverage.

To scale up from millions to billions, leaders need to support new delivery models.

Among the myriad of lessons learned from the AIDS response is that remarkable achievements would not have been possible without the contribution of communities to bringing testing, treatment, peer counselling and prevention to scale. Expanding health coverage must not mean lower quality. Community groups need more resources to deliver impactful results. Investments in community health workers will create new jobs and economic opportunities, which are key to promote gender equality and decent paid work. Overall, communities need to be better supported, equipped and recognised as the heart of primary health care.

At a time when humanity faces crises ranging from climate change to gross inequalities of opportunity and wealth, it is time to recognise the limits and pitfalls of political short-termism. A healthier future requires bold leadership. One place to start is to take the needed tough decisions to ensure that everyone realises their right to health and well-being. ■

The role of agriculture, food and nutrition



In health, economic policy only tells half a story – for universal coverage to include all health drivers, as well as the health of all people, consideration must be given to agriculture, food and nutrition

By Laurette Dubé, James McGill chair, Desautels Faculty of Management, Center for the Convergence of Health and Economics, McGill University

Raphael Lencucha, professor, School of Physical and Occupational Therapy, McGill University, and

Nick Drager, CEO of the TuBerculosis Vaccine Initiative

Achieving universal health coverage, a key target of the third Sustainable Development Goal to ensure healthy lives and promote universal well-being, cannot be accomplished by the health sector alone. Nor can other targets for the same goal, such as reducing premature mortality from non-communicable diseases by one-third through prevention and treatment or promoting mental health and well-being, or substantially reducing the number of deaths and illnesses from hazardous chemicals and polluted air, water and soil.

Pathways to these goals lead through the everyday lives of individuals, organisations, economies and societies. Solutions cross boundaries between industrial sectors (such as agriculture, food, transportation, education and health care) and societal sectors (for-profit, non-profit and government). Those solutions are needed to contain the contribution of the non-health sectors to the demand and costs for health care because of their impact on the social determinants of health.

A pragmatic approach is needed to achieve a healthy society where universal health coverage can be affordable, with government catalysing a convergence of health and economic policy. This approach contains reciprocal contributions by the health and non-health sectors with capacity-building strategies through transformative innovation. Agriculture, food and nutrition offer an illustrative case.

Government plays a critical role in shaping food environments through interventions that promote the economic performance and

competitiveness of the agri-food sector, public health interventions that control the nature and types of foods available to consumers, and interventions that seek to influence consumer food choice. There is an ongoing exploration of the most effective and appropriate role of government in building multisector strategies to control unhealthy foods and promote healthy food environments. Given that food environments are key health determinants, with the commercial sector – such as farmer markets, grocery stores and restaurants playing a major role – the relationship between government and the commercial sector is relevant. The principal controversy at the heart of this relationship pertains to the potential influence of commercial enterprises on public institutions. Navigating the tenuous relationship between government and the commercial sector is at the core of the whole-of-society approach underlying the United Nations recommendations to curb the progression of NCDs and associated risk factors.

TAKING THE LEAD

The regulatory and catalytic roles of government need to be distinguished in any consideration of the nature of the relationship between government and the commercial agriculture and food sectors. Controversies often centre on whether governments can develop sound policies with the public interest in mind, particularly as market regulators, while in partnership with the private sector. How can government regulate health-harming products and simultaneously promote transformation in the agriculture, food, nutrition and healthcare sectors so that

consumer environments make healthy food choices easy and accessible? Can government set the foundations for the public health/healthcare sector viewing itself, with other social and economic sectors, as generating demand for economically viable nutritious diets from sustainable food systems as a key path to universal health coverage? When consumers acquire most of their food through commercial channels, even in emerging economies, there can be major benefits for government to serve not only as regulators or norm setters, but also as catalysts for change in the consumer food environment. There are three forms this catalytic role can take.

Gathering, interpreting and sharing information

Governments are well situated to facilitate information generation and sharing. In an era of social media and big data, governments are a credible source that links consumer information to health-promoting commercial practice in the agriculture and food sectors while inspiring demand for healthy food and diets through professional and organisational practices in education, health and social sectors. They can also capitalise on the rapid rise in information and communication technologies to support consumers in making healthy choices in real time, more consistently and better adapted to their real-world conditions.

Hybrid forms of coordination

Governments can facilitate new institutional forms of coordination between public and private actors, and can also build synergy with ►



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🐦 @RLencucha

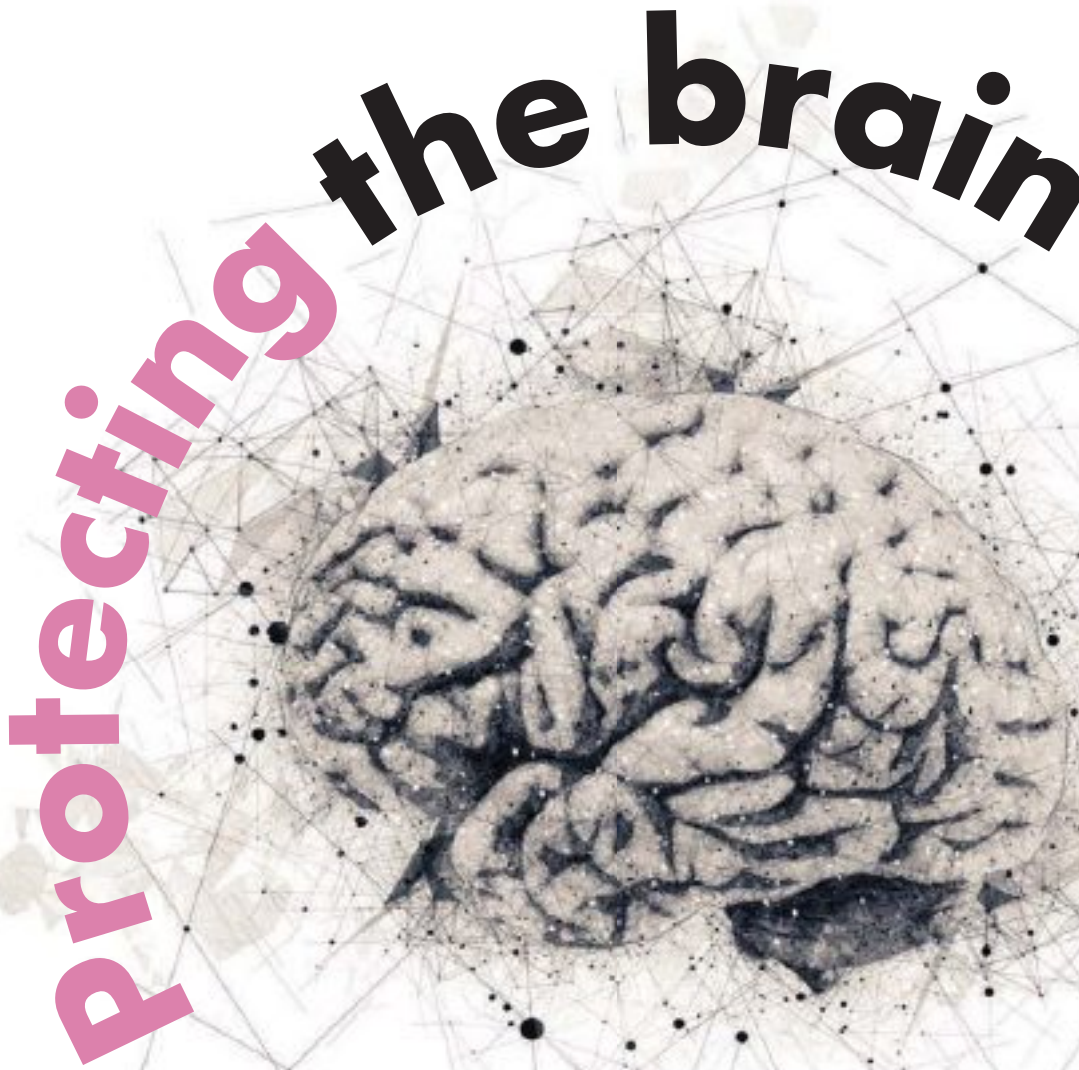
social innovators in non-government organisations. These community-based partnerships typically serve as brokers in connecting individuals and families with supportive programmes and socio-environmental transformation in agriculture, education, sports, transportation, media, health, industry, commerce and service. Part of the strategy is to use 'pull' mechanisms to foster results-based financial incentives that reward successful commercial and social innovations that address health and other social problems in person-centred and community-focused ways that are also financially sustainable and support economic development.

Financial resources provision and mobilisation

Government can serve as a catalyst through providing or mobilising funds for cross-sector partnerships at the juncture of agriculture, food, nutrition, education, health and healthcare systems. In some cases, state agencies can serve as members of networks or partnerships, or participate in structuring or managing networks. Governments can

serve as orchestrators to facilitate movement towards a joint governance goal. A more integrated approach to providing and mobilising individual and collective financial resources for crucial actors in key sectors may be an essential step towards health and economic policy convergence.

In summary, health and economic convergence is needed to achieve solutions at scale to achieve universal health coverage and other components of SDG 3. Political leaders on both sides of the prevailing health and economic divide must reach a common view of the nature of the problem and the solution, and acknowledge that the current policy and its goals, instruments and governance institutions are failing to reach sufficient scale. Governments must invest in innovative solutions to break down the health and economic silos and create environments conducive to human health. The challenge facing governments is to identify legitimate non-state actors that can contribute to the economic well-being of a society that is rooted in genuine care and commitment for the health and well-being of individuals. ■



Protecting the brain

From strokes to dementia, diseases of the nervous system are the leading cause of disability-adjusted life years. This calls for strong preventive strategies to be incorporated into universal health coverage

Diseases of the nervous system represent the leading cause of disability-adjusted life years, with stroke and dementia accounting for more than half of the total, at 42% and 10%, respectively.

Strokes result from a sudden blockage or rupture of a brain artery. The extent of the

By **Vladimir Hachinski**, professor of neurology and epidemiology at Western University

damage varies, depending partly on the cause: atherosclerosis, hardened arteries, high blood pressure or blood clots from the heart that block brain arteries.

Dementia means severe impairment of thinking, memory and other abilities, resulting in dependency. Two pathologies account for the majority of cases of ►

dementia: Alzheimer pathology, characterised by senile plaques and neurofibrillary tangles and cerebrovascular (blood vessel) pathology. The main types result from:

- Large arteries, where abnormal depositions of fats and other materials (atherosclerosis) narrow the walls of the larger arteries and become breeding grounds for blood clots that can occlude blood vessels either locally or downstream;
- Small arteries, where the walls are thickened and weakened, usually due to high blood pressure, leading to closure and producing death of the tissue supplied by the artery (ischemic infarct) or rupture (brain haemorrhage); or
- Heart abnormalities, which can also lead to clot formation that can be washed into the brain circulation and cause brain infarcts.

Atrial fibrillation (an irregular heart beat) represents the leading cause of stroke and a risk factor for dementia. In some low- and middle-income countries, rheumatic heart disease also contributes to the risk of stroke. The mainstay treatment of both atrial fibrillation and rheumatic heart disease is anticoagulation – thinning the blood enough to prevent clot formation but not enough to cause bleeding. Anticoagulation requires close supervision, only possible at the population level by a universal health coverage system.

The older the person, the more likely both pathologies contribute to the dementia. So far, vascular pathology is the only treatable and preventable one. This forms the scientific basis for preventing stroke and dementia together.

A stroke doubles the chances of developing dementia, but fortunately, stroke is 90% preventable and dementia is preventable by at least one third (see table 1). In addition to exercise

and a healthy diet, patients require control of risk factors such as high blood pressure, cholesterol and atrial fibrillation that involve medication and continuing health care. Universal health coverage represents the essential framework for delivering such care.

Air pollution has been known to impair the lungs, hurt the heart and predispose to stroke. More recently, it also has been shown to increase the risk of dementia (see table 2).

The closer people live to a major highway the higher the risk of developing dementia.

Air pollution represents a vital example of the importance of a healthy environment for overall health, particularly brain health. Without it, the World Health Organization’s definition of health – a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity – cannot be fulfilled.

Table 2:
Air pollution and dementia

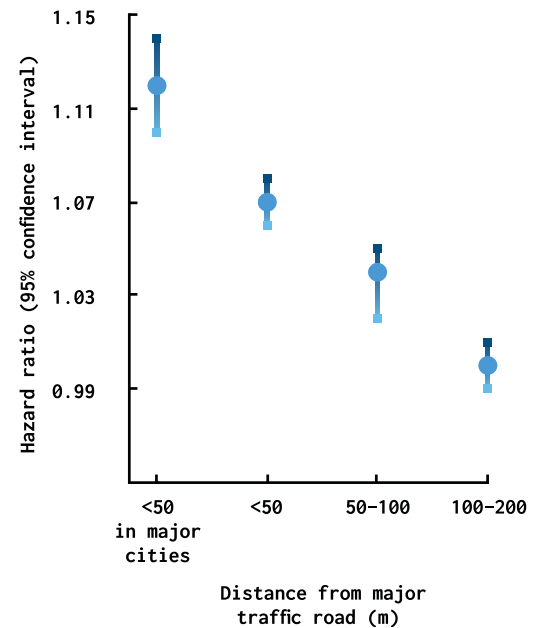
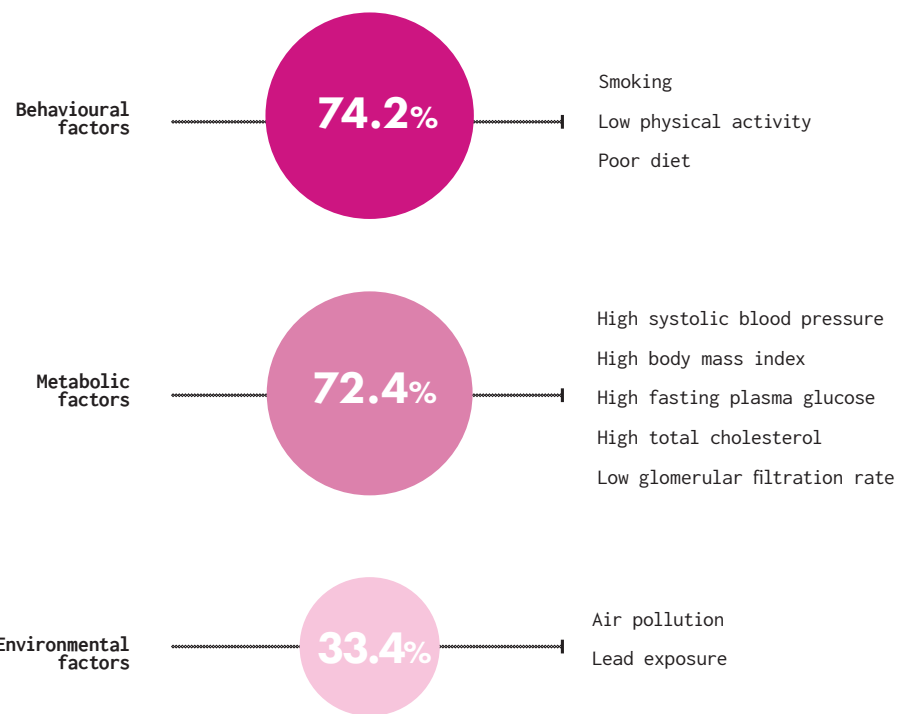


Table 1:
Stroke burden attributable to modifiable risk factors



Source: Table 1 - Adapted from VL Feigin et al., 'Global burden of stroke and risk factors in 188 countries, during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013', *The Lancet Neurology*, August 2016.
Table 2 source: Adapted from H Chen et al., 'Living near major roads and the incidence of dementia, Parkinson's disease, and multiple sclerosis: a population-based cohort study', *The Lancet*, February 2017.



With a population of 14 million, the Canadian province of Ontario illustrates what is possible when universal care coverage is available”

VLADIMIR HACHINSKI

Distinguished university professor, Western University

Vladimir Hachinski is a professor of neurology and epidemiology and distinguished university professor at Western University. He introduced a clinical diagnostic tool, the Hachinski Ischemic Score for identifying the treatable components of dementia. He founded, with John W. Norris, the world’s first successful acute stroke unit. He was the president of the World Federation of Neurology. In 2017 he received the Prince Mahidol Award in Public Health and in 2018 was inducted in the Canadian Medical Hall of Fame.



At the individual level, prevention strategies have emphasised information. These are an essential first step. However, motivation and implementation also play crucial roles. Without universal health coverage, implementation becomes very difficult.

With a population of 14 million, the Canadian province of Ontario illustrates what is possible when universal care coverage is available. In 2000 the province introduced a strategy of building stroke units, stroke prevention clinics and carrying out public campaigns on risk factor controls. These strategies aided in reducing the incidence of stroke by 32% and decreasing the incidence of dementia by 7%.

Based on such evidence, the World Stroke Organization updated its World Stroke Day Proclamation calling for the joint prevention of stroke and potentially treatable dementias.

It has been endorsed by all the major international organisations

dealing with the brain, the heart, stroke and dementia (see table 3).

The World Health Summit has featured this approach in the past two years. The 2018 summit was preceded by a one-day symposium on preventing dementia by preventing stroke. This yielded the Berlin Manifesto on the joint prevention of stroke and dementia, available for use by the public and policymakers.

We are undertaking a Canada-wide detailed survey of dementia and stroke focusing on the environment, economic, social, psychological and individual predisposing and protective risk factors.

We plan to develop cost-effective modules that could be implemented in low-, middle- and high-income settings.

The bad news, however, is that diseases of the nervous system have become the leading cause of disability-adjusted life years. The good news is that more than half the incidence of stroke and dementia is potentially preventable. ■

Table 3:
Organisations endorsing the joint prevention of stroke and dementia

- Alzheimer Society Canada
- Alzheimer’s Association
- Alzheimer’s Disease International
- Alzheimer’s Society
- American Academy of Neurology
- American Stroke Association
- European Academy of Neurology
- European Society of Hypertension
- European Stroke Organisation
- Heart and Stroke Foundation
- Hypertension Canada
- International Brain Research Organization
- Public Health England
- Stroke Association
- VasCog: International Society of Vascular Behavioural and Cognitive Disorders
- World Federation of Neurology
- World Federation of Neuro-Rehabilitation
- World Federation of Neurosurgical Societies
- World Heart Federation
- World Stroke Organization

Game-changing priorities for UHC

Universal health coverage can be a global game changer for economics, equality and inclusion, but only when gender equality and women's rights are prioritised

By Françoise Girard, president of the International Women's Health Coalition

Katja Iversen, president and CEO of Women Deliver

Roopa Dhatt, executive director and co-founder of Women in Global Health, and

Kim van Daalen, Women in Global Health

Health is a human right. Universal health coverage is the potential catalyst to help realise the right to health for all.

But to ensure universal health coverage is actually universal, the design, decision making and implementation must prioritise gender equality and girls and women's health and rights, including in the health workforce. This will not happen without strong political leadership.

Since the Sustainable Development Goals were adopted in 2015, political movements globally have amplified opposition to girls and women's health and rights – not least to their sexual and reproductive rights. This is a significant impediment to health for all.

To galvanise political will to withstand these challenges, the International Women's Health Coalition, Women Deliver and Women

in Global Health, have co-convened the Alliance for Gender Equality and UHC. The alliance is calling on governments to prioritise gender equality and girls' and women's health and human rights during September's landmark United Nations High Level Meeting of Heads of State and Government on Universal Health Coverage – and beyond. Together, our 35 member organisations from 24 countries are using our



collective voice to ensure universal health coverage responds to girls' and women's specific health needs and truly leaves no one behind.

The alliance has proposed that UHC2030 mainstream gender in its six key asks from the UHC movement. We are also advancing a seventh ask: urging governments to commit to gender equality and women's rights in universal health coverage. ▶

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We are urging governments and health decision makers to take five critical actions in designing and delivering universal health coverage”

CALL ON GOVERNMENTS

We are urging governments and health decision makers to take five critical actions in designing and delivering universal health coverage.

First, put human rights and gender equality at the centre of universal health coverage, and take a gender-responsive approach to health that promotes and upholds equality and equity. Women are diverse: leaving no one behind requires recognising how multiple and intersecting forms

of discrimination based on race, ethnicity, age, ability, migrant status, sexual orientation, gender identity or expression, indigeneity, health condition, class and caste, influence access to services and health results.

Second, address the needs of girls, women, adolescents and marginalised groups throughout the life course – including but not limited to their sexual and reproductive health and rights. This requires incorporating comprehensive

sexual and reproductive services in universal health coverage, including contraceptives, abortion, comprehensive maternity care, diagnosis and treatment of sexually transmissible infections, reproductive cancers and infertility, as well as services to prevent and respond to gender-based violence.

It also requires fully recognising and responding to the specific barriers, risk factors and health needs experienced by girls and women.



FRANÇOISE GIRARD

President, International Women’s Health Coalition

Françoise Girard is president of the International Women’s Health Coalition. A lawyer by training, she is a long-time advocate and expert on women’s health, human rights, sexuality and HIV/AIDS. She has held a variety of positions, including senior programme officer for international policy at IWHC; consultant for the International Planned Parenthood Federation and DAWN, a network of women’s rights activists from the global South; and director of the public health programme at Open Society Foundations.

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 🌐 iwhc.org



KATJA IVERSEN

President and CEO, Women Deliver

Katja Iversen is president and CEO of Women Deliver, a leading global advocate for investment in gender equality and the health and rights of girls and women, with a specific focus on maternal, sexual and reproductive health and rights. She has more than 25 years of experience working in non-governmental organisations, corporations and United Nation agencies. She is a member of President Emmanuel Macron’s G7 Gender Equality Advisory Council, the Unilever Sustainability Advisory Council, the MIT Women & Technology Solve Leadership Group, and an international gender champion.

🐦 @Katja_Iversen
 🌐 Womendeliver.org



ROOPA DHATT

Executive director and co-founder,
Women in Global Health

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Third, address health workforce dynamics that affect how women can leverage their role in health delivery, leadership and decision making, including the predominance of women in unpaid and informal health care. This includes ensuring decent work that protects fundamental rights, a fair income and a safe work environment, as well as integrating women's unpaid health and social care labour into the formal sector. It includes an enabling environment with leadership pathways and accountability for discriminatory labour practices to equitably engage women from diverse groups in the health workforce, achieving parity in universal health coverage design, decision making and monitoring at all levels.

Fourth, develop and implement health financing mechanisms that reduce gender and other inequalities. This includes gender-responsive public finance, budgeting, programming, monitoring and evaluation, and auditing. It should ensure that all women, including those in the informal sector, can access and benefit from insurance programmes and financial risk protection, and minimise the greater burden of out-of-pocket payments faced by women over their life course for all healthcare needs – especially for comprehensive sexual and reproductive healthcare services and non-communicable diseases.

Fifth, commit to data collection, systematisation, analysis and dissemination that promote equity

35

Member organisations from

24

Countries around the world, are calling for...

6

Key asks from the UHC movement



KIM VAN DAALEN

Women in Global Health

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in health service design, delivery and access, while upholding the privacy and confidentiality of all. This includes mandating and funding data disaggregated by gender, age, sex, caste, ethnicity, geographical location and income level to ensure inclusive, appropriate health service delivery and to promote accountability.

In committing to the SDGs, world leaders made the political decision to achieve universal health coverage by 2030. To do so, they must safeguard the rights of girls and women everywhere, particularly their sexual and reproductive rights. The High Level Meeting can be a powerful political moment to advance health for all and gender equality. Governments must make it one. ■



Mental health is universal health

Healthy bodies cannot exist without healthy minds and, as such, the architecture for universal health coverage must be designed around the mental, as well as the physical

Universal health coverage is a focus at this year's G7 and G20 summits and the United Nations General Assembly in September. Therefore it is important to remind all those participating: there can be no universal health coverage without mental health. Mental health is not only an intrinsic part of a truly universal health system but universal health coverage is critical for significant improvement in mental health outcomes.

Long before the Sustainable

By Vikram Patel,
Pershing Square
professor of global
health at Harvard
Medical School, and
Shekhat Saxena,
visiting professor
at Harvard T H Chan
School of Public
Health

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For individuals, mental health may have the highest treatment gaps for any health condition in all countries. For countries, when it comes to mental health every country is a developing country”

Development Goals and the renewed push towards universal health coverage, the United Nations in 1966, declared that “the right of every human being to the enjoyment of the highest attainable standard of physical and mental health”. Yet health systems development and resources for health have never matched the parity mental and physical health were given in international law.

The world left mental health behind.

The impact of omitting mental health from health policies and budgets is stark (see bullet points) and the statistics demonstrate the immense burden of untreated mental disorders on individuals, families, communities and economies. For individuals, mental health may have the highest treatment gaps for any health condition in all countries. For countries, when it comes to mental health every country is a developing country.

Moreover, mental and physical health cannot be separated. Individuals with unsupported mental health conditions, such as depression, anxiety and substance use disorders, are less likely to seek testing for HIV, and less likely to follow advice following their test result. Mental health conditions adversely affect medication adherence for HIV, tuberculosis and TB/HIV co-infection, and are significant risk factors for developing drug resistance, loss to follow up and death. It is hard to see

how the global HIV target of 90-90-90 will be reached without investment in mental health services. Replenishment for the Global Fund this year falls on World Mental Health Day – an appropriate moment to demonstrate the importance of integrating mental health to help achieve global HIV targets.

In the 2018 report of the Lancet Commission on global mental health and sustainable development, we argued that mental health must be reframed within the sustainable development framework and that mental health care is an essential component of universal health coverage.

Successfully incorporating mental health is core to the three principles of universal health coverage.

1. EQUITY

Universal health coverage is a rights-based approach to health. An equity approach will significantly improve mental health outcomes for sub-groups in populations – often the poorest and those most marginalised such as refugees or sexual minorities – who disproportionately experience mental health conditions. Yet health system reform to achieve universal health coverage too often omits mental health services. These population groups are also less likely to use digital technology and more likely to experience discrimination, isolation and premature mortality, and so specific sensitive planning must be undertaken. Universal health coverage must include equitable access to mental health services. ►

- Mental disorders are leading contributors to the global burden of years lived with disability.
- Only 1% of the global health workforce works in mental health, leaving 45% of the world’s population living in a country with fewer than one psychiatrist per 100,000 people.
- Less than 1% of health budgets in low-income countries is spent on mental health (less than \$2 per capita) and less than 3% of health budgets on average across all countries worldwide.
- The global cost of mental illness in 2010 was nearly \$2.5 trillion (two-thirds in indirect costs), projected to exceed \$6 trillion by 2030.
- High-income countries on average have a treatment gap for the most common conditions that often exceeds 50%, while in low-income countries this is as high as 90%.

VIKRAM PATEL

Pershing Square professor of global health and Wellcome Trust principal research fellow, Harvard Medical School

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Community-based services centred in primary healthcare systems provide the best opportunity to cover entire populations including those hardest to reach. This requires diversifying from the currently high proportion of spending on mental health institutions and other tertiary-level care. Without full integration, universal health coverage can never truly be achieved.

2. QUALITY

Universal health coverage means delivering an essential service package of adequate quality that meets the needs of the population. If mental health services are not included, this cannot be achieved. An essential package must include the full range of mental disorders, particularly severely disabling conditions such as schizophrenia, alcohol dependence and dementia, while responding to the disease burden of the population. Integration must also emphasise quality of care both for the mental disorder – in particular to abolish the use of coercive, harmful and abusive practices – as well as for co-existing physical health conditions, for these are common and significant contributors to premature mortality.

3. FINANCE

Not having the ability to pay should never be a barrier for accessing treatment. The vast majority of mental health services are low cost

with a high return on investment – depression services alone return \$5.3 for every \$1 invested. Universal health coverage will not be achieved unless national health budgets increase so that health systems are almost entirely financed by progressive, domestic funds. However, mental health is so far behind that in many countries, international strategic financial stimulus is needed to kick start systemic change. Simply, \$1 billion of global aid per year is needed, for 5% of health budgets allocated to mental health in low- and middle-income countries and 10% in high-income countries.

MOVING FORWARD

Ultimately, universal health coverage depends upon political will. So too does the inclusion of mental health. Much political will is attained, demonstrated and acted upon at global moments and 2019 is a significant year for universal health coverage – and therefore mental health. The High Level Meeting on UHC in September is a key moment for national and international commitments to accelerate political and financial support for mental health as part of universal health coverage, as are the G7 and G20 meetings and the replenishment of the Global Fund. This year can change the course for mental health if world leaders recognise the importance of good mental health and act to achieve parity of physical and mental health, starting with universal health coverage. ■

KEEPING THE WORLD SAFE

8.1

Addressing the humanitarian challenge

By Peter Maurer, International Committee of the Red Cross

p98

8.2

An agenda to tackle the politics of real problems and real people

By Mit Philips, Kerstin Åkerfeldt and Caroline Voûte

p100

8.3

Reaching the missing millions

By Elhadj As Sy, secretary-general, International Federation of Red Cross and Red Crescent Societies

p102

8

CHAPTER



Addressing the humanitarian challenge

The International Committee of the Red Cross works to bring UHC to victims of conflict, but meaningful political action is also needed

Delivering health services to victims of conflict without distinction or discrimination is an increasingly complex challenge in contemporary conflicts. A political environment in which professional and ethical solutions can flourish is vital so that health care is not tainted by political or military considerations, and the sanctity of health care is upheld.

The International Committee of the Red Cross has observed over many years the devastating impacts when health care is politicised, used as a tactic of war or directed to control populations, resulting in large sections of communities cut off from

help. These tactics also impede the achievement of universal health coverage, which relies on full access, quality and impartial service delivery to all segments of the population, and health facilities and personnel protected from attack.

People's health outcomes depend on other systems, such as sanitation, infrastructure, food, education and security. A breakdown of water and sanitation infrastructure is often the origin of water-borne diseases; food insecurity heightens the risk of mortality for the most vulnerable; and low education levels often present a roadblock for effective public health measures.

The international community, states and local actors cannot take their eyes off the achievement of universal health coverage. A crucial first step is ensuring full access to, and the protection of health care in, areas affected by conflict and violence.

Access is an encompassing concept: it means healthcare workers can access communities and that patients can freely access services.

Attention should focus on reaching those who face particular challenges in accessing health care and making the invisible visible. This may include

By Peter Maurer,
International Committee of the Red Cross

women, children, the elderly, survivors of sexual violence, persons with disabilities, those dealing with mental health conditions and detainees. They all require specific approaches from trained and skilled health workers.

APPROACHING THE ISSUES

The ICRC has a unique needs-based approach in its humanitarian delivery, which allows for several health determinants to be addressed at once. For example, the multidisciplinary programme for survivors of sexual violence involves clinical care, mental health and psychosocial support as well as economic security support and protection measures.

Another example is ICRC's training of community health workers in primary health care to identify signs of high-risk pregnancies. Improving pregnancy outcomes might involve antenatal consultations and vaccinations at the primary healthcare level, training and essential supplies packages for traditional birth attendants or negotiations with fighting factions to allow for the rapid referral of women requiring hospital care.

Anchored in our field experience, these programmes highlight the reality that health care is as much of an urgent short-term need as a long-term investment. It would be futile to design treatment for persons with mental health issues if there is no continuum of care, or if there is no system in place with an adequately trained health force. It is also impossible to conceive of the proper management of non-communicable diseases in fragile settings in the absence of evidence-based research of what works in these settings.

These activities take time and should prompt governments, donors and agencies to consider health care in humanitarian settings as a part of a long-term investment to providing a continuum of care for people affected by conflict (in all of its phases) and violence.

Finally, another crucial step towards achieving universal health coverage is the common effort in preventing the total collapse of healthcare systems amid crisis.

In this regard, the ICRC works to support and safeguard key health system pillars in conflict areas where other agencies have restricted access, to keep them functioning even when other systems seem to be collapsing. This effort, however, should be shared with governments and other actors, who must take all feasible measures to limit the destruction of health.

The protection of health in armed conflicts is a political choice – choices that determine humanitarian realities, that affect people, communities and systems. The ICRC, as a neutral, impartial and independent humanitarian organisation, does not exist to help authorities further their political objectives, but it works to help



PETER MAURER

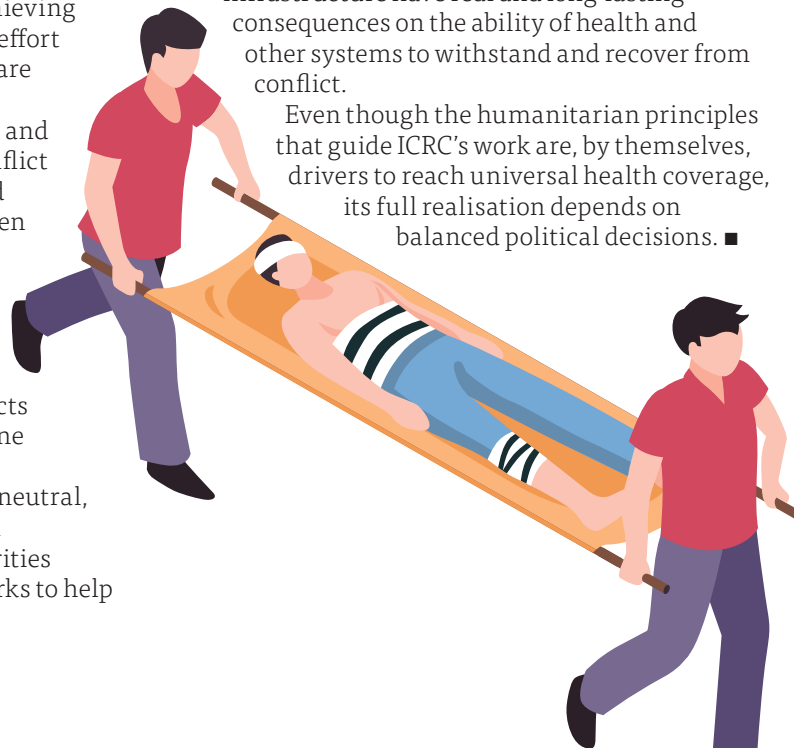
Peter Maurer has been president of the ICRC since 2012. He was appointed secretary of state for foreign affairs in Switzerland in 2010. In 2009, the UN General Assembly elected him to chair the Fifth Committee in charge of administrative and budgetary affairs, and he was also elected chair of the Burundi configuration of the UN Peacebuilding Commission. He previously served as Switzerland's ambassador and permanent representative to the United Nations in New York, and head of the human security division in the political directorate of the Swiss Department of Foreign Affairs, among other posts.

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them live up to their obligations under international humanitarian law. Modern international humanitarian law in fact originated from the idea that enhancing the protection of the medical mission was an essential step to better assist and protect victims of armed conflict.

The ways in which parties to conflict comply – or not – with their obligations under international humanitarian law to protect civilians and civilian infrastructure have real and long-lasting consequences on the ability of health and other systems to withstand and recover from conflict.

Even though the humanitarian principles that guide ICRC's work are, by themselves, drivers to reach universal health coverage, its full realisation depends on balanced political decisions. ■



An agenda to tackle the politics of real problems and real people

Implementation of universal health coverage requires the efforts of multiple agencies, sectors and leaders... and a new way of talking about health

By **Mit Philips**, health policy advisor, Analysis Department, MSF in Brussels, Belgium

Caroline VouÛte, health policy advisor, Programmes Unit, MSF in London, United Kingdom, and

Kerstin Åkerfeldt, health policy and advocacy advisor, Analysis department, MSF in Brussels, Belgium

Across the world, every day, patients are denied access to health care. People are stigmatised, marginalised, neglected, denied their rights by society, state or the international community. Health care is often hardest to obtain for the poor, and for people affected by crisis or forced from their homes. If the stated ambition of universal health coverage ‘to leave no one behind’ is to be made reality, people – including the most vulnerable – must be at its heart.

The universal health coverage agenda cannot be delivered by the health sector alone. It must be a collective effort, and one that focuses on the needs of patients and communities. Without real political determination, inequity and precariousness will remain unchallenged – official policies will continue to make people ill.

Yet the current political discourse on global health is not encouraging. It echoes the precipitous economic models of the 1990s, once again making health investments dependent on countries’ potential economic capacity to pay or pay back. Countries with disproportionate health burdens struggle to make universal health ambitions fit within restricted budgetary and fiscal spaces. International solidarity seems to be increasingly limited to those health issues fitting the global security agenda, migration deterrence policies or trade interests. ‘Innovative’ funding, loans, bonds, private and blended financing, all promise to compensate for dwindling health grants. However, for universal health coverage to deliver, saving lives and reducing the suffering caused by disease must always take precedence over considerations of return on investment.

Ambition cannot be limited to administrative coverage models that take years to translate into concrete access to health care. It should start to

make a difference for patients in the real world, right now. We must focus on what those in need are struggling with today: patients forced to pay for essential care, insufficient frontline workers, scarce or interrupted stocks of key medicines.

When vulnerable people are forced to pay for care, a negative chain of events is triggered. User fees lead to reduced quality services, increased financial distress, and delays or exclusion from care. Médecins sans Frontières has repeatedly documented how user fees lead to substandard or incomplete treatment, delayed care seeking and exclusion from care. How can we speak about universal health coverage when children with malaria are unable to afford a full course of treatment? When pregnant women asked to pay for HIV screening tests fail to protect their unborn child? When patients are detained in hospital until families find the money for medical bills?

These are far from anecdotal or innocent events. Recent MSF survey findings from Bili, a rural area in the Democratic Republic of Congo with a high malaria burden, show that in a quarter of cases of illness leading to death, no medical care was sought – with a lack of money cited as one of the major reasons. The subsequent impact on communities can be devastating. The delay in seeking care leads to slower detection of epidemics and outbreaks. Data show that even small fees deter people who need care from seeking it, with the poorest or marginalised most affected.

For those deemed non-resident or without the correct papers, such as asylum seekers, migrants, refugees and displaced people, accessing health care is particularly difficult. National plans for universal health coverage tend to focus on their citizens, often excluding people on the move or without the right documents. Just as Europe’s migration strategy harms the health of those it deters and detains, the lack of adapted mechanisms to realise universal health coverage for people living outside their home communities continues to reduce



access to health care. Migrants moving through Greece struggle to receive vaccinations via the public system; in Jordan and Lebanon, refugees with non-communicable diseases are forced to interrupt treatment because it is unaffordable.

For universal health coverage to succeed, the vital role of frontline health workers must be recognised, with decent pay and recruitment according to health needs. Pay and recruitment are restricted in many countries now by wage bill ceilings and salary freezes. Continued access to affordable quality drugs must also be given greater attention and viewed as a crucial part of the universal health coverage jigsaw. The mobilisation of more domestic financing for health makes little sense if it is offset by the high price of medicines and vaccines.

In today's narrative, the potential progress to achieving universal health coverage is often merely measured by a country's intent of providing increased domestic resources for health, without much attention given to whether those commitments are sufficient or focus on the right interventions. Yet many governments lack the resources or the capacity to deliver medical services at the scale or pace that is being proposed. Pressure on countries to mobilise more domestic resources for health may translate into pressure on patients; faced with shortfalls in national health budgets and waning international funding, countries such as Afghanistan, Mozambique and Malawi are already considering increasing patient payments for essential care.

Without realistic assessments of countries' economic potential and careful consideration of restrictions and risks to health, cutting back international support might jeopardise previous achievements and delay progress towards universal health coverage. In several countries, simultaneous donor transitions away from aid have led to competing priorities and rationing. The aid sector – including global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria



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CAROLINE VOÛTE

Caroline Voûte has a background in social justice and a master's in public health. She has been working in medico-humanitarian contexts and emergencies with MSF, the World Health Organization, the US Centers for Disease Control and the UN's High Commissioner for Refugees across 16 countries since 2008. She joined MSF in 2010 and has spent her years in the field as a health promotion specialist and emergency coordinator/head of mission. From 2017 to 2018 she served as health operations team lead and health cluster coordinator with WHO's Health in Emergencies programme. She returned to MSF as a health policy advisor with the programmes unit in the UK. Caroline's recent work has focused on the Ebola outbreak in the Democratic Republic of Congo, changing global health architecture and donors, anti-microbial drug resistance, climate change and vaccine policy. She is the current coordinator of the MSF Global Health Actors Network.

and Gavi, the Vaccine Alliance – now seems to focus on increasing the leverage of domestic financing as a priority, including in low-income and crisis contexts. Discussions urgently need to (re-)engage the subject of international political will and its direct contribution to people's health.

The agreed goal of universal health coverage by 2030 will remain a distant dream if those most in need are deprived from even the most basic of care because they cannot afford it. If it is to succeed, those people must be kept at the centre of political commitments, smart policies and equitable resource allocations. ■





Reaching the missing millions

Collective failures in humanitarian and emergency settings, are holding back the achievement of universal health coverage. But action can be taken

“

Global policy and global agreements may give us the International Health Regulations and the Global Health Security Agenda, but national health systems are still deficient in delivering on them”

By Elhadj As Sy, secretary-general, International Federation of Red Cross and Red Crescent Societies

Governments the world over have agreed to try to achieve universal health coverage by 2030, as an integral indicator not just of the third Sustainable Development Goal of good health and well-being for all, but also of just, inclusive, empowered, peaceful and economically productive societies. Universal health coverage is therefore more than an aspiration; it is an imperative, a political choice, as the title of this publication clearly states.

For all the clear global health progress made in the last generation – with numbers of maternal and infant mortalities cut by half – we still live in a world where half of people on the planet cannot access essential health services. Where in principle they can, often the quality of the services is unacceptably low or the price too high.

The situation is even more critical in humanitarian settings, and deserves particular attention. Health should be addressed in two ways in humanitarian and emergency settings. First, health is a major component of the response to every shock and crisis, like cholera following a flood in Mozambique, or measles and diarrhoea in the refugee camps of Cox's Bazar in Bangladesh. Second, health can be an emergency and a humanitarian crisis of its own, like Ebola now in the Democratic Republic of Congo, or Zika across Southern and Central America.

Global policy and global agreements on universal health coverage must be supported by strong local action to have a meaningful impact. In daily non-emergency situations – just as in emergencies – no country can meet the health needs of its people without well-financed, functioning, equipped and adequately staffed health systems.

Global policy and global agreement may give us the International Health Regulations and the Global Health

Security Agenda, but national health systems are still deficient in delivering on them.

RESOURCES FOR CHANGE

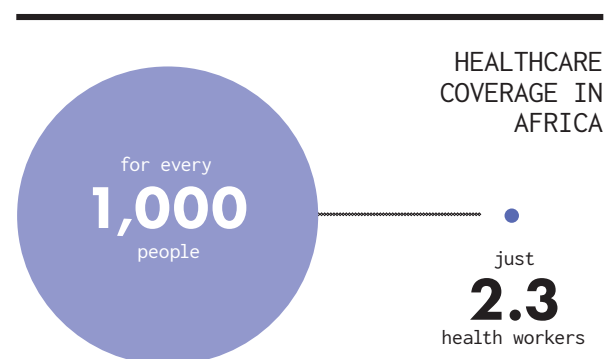
The World Health Organization confirms that the world is short of 18 million health workers if we are to meet the ideal of the universal health coverage agenda. Africa feels this the worst, with just 2.3 health workers for every 1,000 people.

Health is ultimately a community matter. Sickness, disease and even pandemics start in communities and will end in communities; they are detected in advance by communities, and – long after they are contained – there are communities that prepare

against the next outbreak.

It is of paramount importance to be there all the time on the side of communities, to accompany them in withstanding shocks, hazards and disease outbreaks. That way, we build the much-needed trust and the enabling environment to address the difficult issues that are revealed by health crises. Humanitarians like the Red Cross and Red Crescent volunteers are companions on that journey. Our 14 million volunteers worldwide are part of the communities they serve, and many play the roles of community health worker.

So the IFRC, for instance, runs an Epidemic and Pandemic Preparedness Programme now unfolding in seven ►





ELHADJ AS SY

Secretary-general, International Federation of Red Cross and Red Crescent Societies

Elhadj As Sy was appointed secretary general of the IFRC in 2014. Before joining the IFRC, he was UNICEF’s director of partnerships and resource development, regional director for Eastern and Southern Africa, and global emergency coordinator for the Horn of Africa. From 2005 to 2008, Sy was director of the HIV/AIDS practice with the United Nations Development Programme. He served as Africa regional director and director of operational partnerships and country support with the Global Fund to Fight AIDS, Tuberculosis and Malaria. Sy has also represented UNAIDS in New York and was director of its New York Liaison Office. From 1988 to 1997, he served as director of health and development programmes with Environment and Development Action in the Third World, in Senegal.

🐦 @As_SyIFRC 🌐 ifrc.org

18m

Health workers will be needed to meet the global demand created by UHC

MISSING MILESTONES

Our collective failure to reach those people is holding us back from achieving universal health coverage. We call them the missing millions, and our *World Disaster Report* of last year – on leaving no one behind in situations of humanitarian need – put the figure at more than 100 million people. Many of these are in pockets of humanitarian need, of fragility, and of protracted crisis and conflict. These are the people on the margins of formal health systems, often where there is no doctor, no school and even no government.

The world may see these millions as ‘the last mile’ and the hardest to reach – but for humanitarians, they are our first priority, our first mile of response.

Let’s go beyond slogans and keep our promises. In 1978 in Alma-Aty, the world adopted a visionary ‘Health for All’ agenda that rightly prioritised primary health care, but that, over time, has not fully reached local communities. Let’s make the empowerment and funding of local actors our priority in the provision of local health. Red Cross and Red Crescent National Societies, together with other local humanitarians in the form of millions of volunteers and community health workers, are everywhere for everyone. We are ready to partner. ■

African countries, bringing national coordination down to the community level. And our community-based health and first aid programmes have already reached 20 million people in 150 countries. The essence of all this education and empowerment is that communities act for themselves and take responsibility for their health just as for their livelihoods.

Local humanitarian health workers and volunteers are in the vanguard of health provision and good water and sanitation. They often build the bridge between national health systems and communities. They help reach the hardest to reach and most vulnerable, with health promotion and immunisation campaigns.

9

CHAPTER

9.1

Health and social justice

By Guy Ryder, director-general of the ILO

p106

9.2

Health and care: more than a family

By Joachim Breuer, president of the ISSA

p108

9.3

Nature is the ultimate healthcare system

By Inger Andersen, UN Environment Programme

p110

ADDRESSING THE INTER-SECTORAL CHALLENGE OF THE SDGS

9.4

Biodiversity: the foundation of human health

By Cristiana Paşca Palmer, executive secretary, UN Biodiversity p112

9.5

Leaders in health

By C. James Hospedales, executive director of CPHA

p114

9.6

In numbers

Progress and challenges in the health-related SDGs

p116

9.7

Pollution 5.0

By Rolph Payet, executive secretary of the Basel, Rotterdam and Stockholm Conventions p118

9.8

Asia's healthcare evolution

By Woochong Um, Asian Development Bank

p120

9.9

Performance and progress

By Brittany Warren, Global Governance Project

p122

9.10

Three steps to universal health coverage

By Michel Sidibe, Minister of health and social affairs of the Republic of Mali p127

Health and social justice

More than half of all people have little to no access to essential health services, posing a whole new challenge for universal coverage

By Guy Ryder, director-general of the International Labour Organization

The majority of the world's population is being left behind because people cannot afford quality health care and have no income security if they fall ill. Tackling this issue must be a priority, so that everyone can enjoy a healthy and dignified life – a condition for achieving sustainable development and social justice.

The figures are stark. More than half the world's population have virtually no access to essential health services, despite significant progress in extending health coverage. More than half the population is not covered by at least one social protection benefit, and every year, millions of people end up in poverty after paying for health care out of their own pockets.

A person living in poverty is far more likely to be in poor health, whether because of infectious or non-communicable diseases.

The world can break this vicious circle by stepping up efforts to reach universal health coverage (Sustainable Development Goal 3.8) and building universal social protection systems, including floors (SDG 1.3).

SOCIAL PROTECTION SYSTEMS

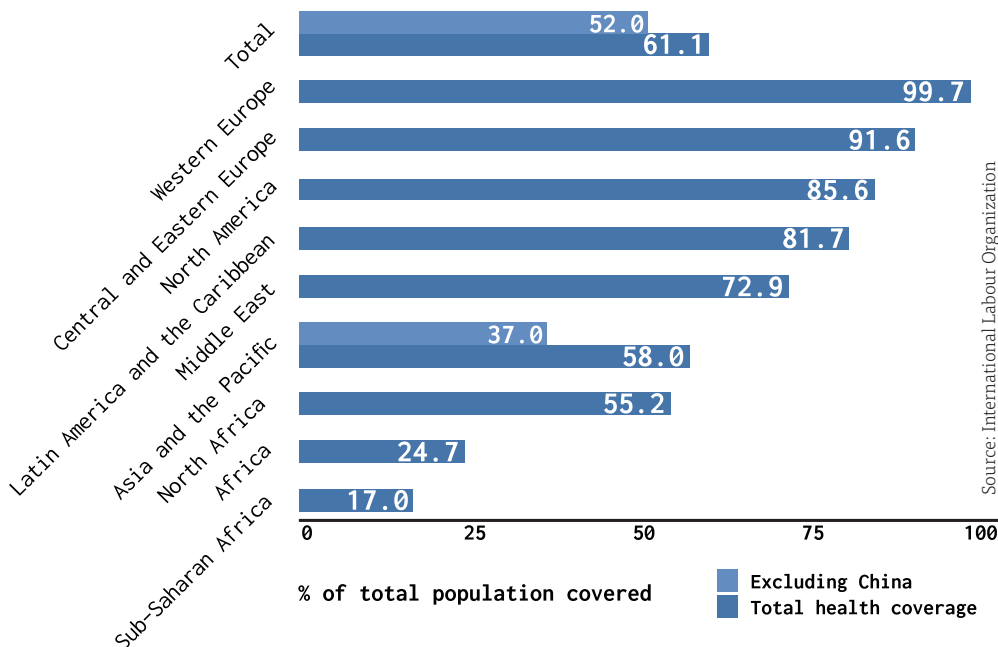
Universal health coverage is a key objective of social protection systems and achieving universal health coverage is essential if the right to health and social security is to become a reality. That is why it is an imperative for the International Labour Organization.

The United Nations General Assembly Resolution on Global Health and Foreign Policy, adopted in 2012, underlines “the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, including nationally determined social protection floors.” Further, it acknowledges that the ILO Social Protection Floors Recommendation is an important step forward.

This recommendation calls for effective access to at least essential health care for all, including maternity care, as the first guarantee of nationally defined social protection floors. The recommendation complements standards adopted earlier on effective access to quality healthcare and financial protection in case of sickness.

The global partnerships UHC2030 and USP2030 are important platforms to mobilise political support for universal health coverage and universal social protection, helping accelerate the achievement of the 2030 Agenda for Sustainable Development.

Health coverage by region based on the percentage of the population affiliated to national health services, social, private or micro insurance schemes



Source: International Labour Organization



GUY RYDER

Director-general of the International Labour Organization

Guy Ryder has been director-general of the International Labour Organization since 2012, having held various senior positions in the ILO from 1999 to 2002 and again since 2010. Ryder leads action to promote job-rich growth and make decent work for all a keystone of strategies for sustainable development. He has a background in the trade union movement and is the former general secretary of the International Trade Union Confederation.

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ACHIEVING SDG 8

If we are to achieve SDG 8 on productivity and employment, then ill health and the inability to seek care – for financial, geographical or social reasons – must be considered as a factor affecting productivity in the workforce. Households lacking financial protection often find themselves unable to invest in productive assets and create or maintain enterprises in case of sickness, eventually falling into poverty.

The realisation of SDG 8, and specifically targets on growth (8.1), productivity (8.2) and job creation (8.3), is closely linked to the availability of a healthy workforce able to engage fully in productive economic activities.

Additionally, achieving universal health coverage requires the development of the health sector, which is an important source of employment. Investments in the care economy to achieve the SDGs could mean some 475 million jobs by 2030, to a large extent for women, according to ILO projections. The High Level

Commission on Health Employment and Economic Growth believes the global economy could create 40 million new health sector jobs by 2030.

SUSTAINED POLITICAL AND FINANCIAL COMMITMENT

This is indispensable. Securing effective access to health care as an entitlement for all within universal social protection systems is a priority. Governments need to finance universal protection in a fiscally, economically and socially sustainable fashion, through a combination of taxes and contributions, reflecting the principles of risk sharing, equity and solidarity.

Many countries around the world have made rapid progress towards universal health coverage by combining social insurance schemes with non-contributory or subsidised schemes, with a view to accelerating coverage of the poor and vulnerable, as well as workers in informal employment and their families (see graph). However, public expenditure

on health and social protection is often under threat of curtailments, which undermine essential benefits and services, even though experience shows there are generally alternatives to expenditure cuts, even during adjustment periods and in the poorest countries. Through social dialogue and multisectoral engagement, it is imperative that governments explore all possible alternatives to safeguard and sustainably expand fiscal space in order to attain universal health coverage and social protection for all. ■

475_m **40_m** **50%**

Jobs could be created by 2030 in the care economy

New health sector jobs could be created by 2030

Of all people have virtually no access to health services

Very often, it is argued that only countries with a certain level of economic development are able to achieve universal health coverage. However, recent data from the International Social Security Association shows that economies at different levels of development can achieve universal models of health services by combining mandatory contributory programmes with subsidised programmes for certain groups of society and voluntary programmes. In 2016, the People's Republic of China received the ISSA's Award for Outstanding Achievement in Social Security for its unprecedented extension of coverage. In addition to extending pensions and other forms of social protection,

By **Joachim Breuer**,
president of the
**International
Social Security
Association**

China increased its national health insurance coverage

from 317 million people in 2005 to more than 1.3 billion people in 2015, reaching more than 95% of the population.

The example of China and other ISSA members shows that providing adequate and comprehensive universal health coverage is a complex challenge: improved access must be matched to healthcare services with predictable quality, delivered by a suitably qualified and sufficiently staffed workforce.

An important part of China's solution was to make use of new technologies in order to improve the performance of social security administrations through streamlined workloads. Coincidentally, this helped lower administrative costs. Platforms for information and communications technologies and mobile technologies helped reduce errors, identify fraud and improve benefit adequacy by supporting contribution collection

Ageing populations will force all countries to examine long-term care and forge a new societal infrastructure

Health and care more than a family affair



and the calculation and delivery of benefits. Smartcard solutions or mobile front-office applications improved access to services and bridged remaining coverage gaps, especially for rural and informal economy workers. In order to make the services sustainable, the Chinese government installed preventive measures and rehabilitation programmes aimed at reducing absence at work and at ensuring high productivity throughout all age groups.

The investments necessary for establishing and maintaining such a system must not be underestimated. It is crucial to offer universal access to medical services in order to cushion the impact of demographic change, which will – sooner or later – challenge the financial sustainability of numerous economies. Population ageing will force us to also focus on long-term care. Compared to achieving ‘standard’ healthcare solutions, establishing a coherent and comprehensive infrastructure for long-term care is more like the vast underwater mass of an iceberg than the small part that is visible above the water’s surface.

The World Health Organization predicts that the number of people aged over 80 years will triple between 2000 and 2050. Even if they are healthier, the expenses for pensions and care will rise with the number of people who depend on the benefits.

Long-term care is not only costly in terms of finances. It also requires the human resources necessary for providing adequate services for a significant number of people – many of whom will require assistance for decades. For most of human history, it has been customary to organise this assistance within families but changes in the nature of career paths, family structures and caring responsibilities have considerably affected the number of family carers. A growing number of elderly people live alone and rely on the support of caring institutions. Yet ISSA studies inform us that only a handful of



JOACHIM BREUER

President of the International Social Security Association

Joachim Breuer was elected president of ISSA in 2016. He is also director-general of German Social Accident Insurance (DGUV). He began his career at Germany’s Federal Ministry for Food, Agriculture and Forestry and in 1990 joined the Federation of German Accident Insurance Institutions (HVBG). He became director-general of the Institution for Statutory Accident Insurance and Prevention in the mining industry in 1995. In 2002 he became director-general of the German Federation of Institutions for Accident Insurance and Prevention. Breuer also co-chairs the International Disability Management Standards Council. From 2008 to 2016, he was vice president of Rehabilitation International for the European Region.

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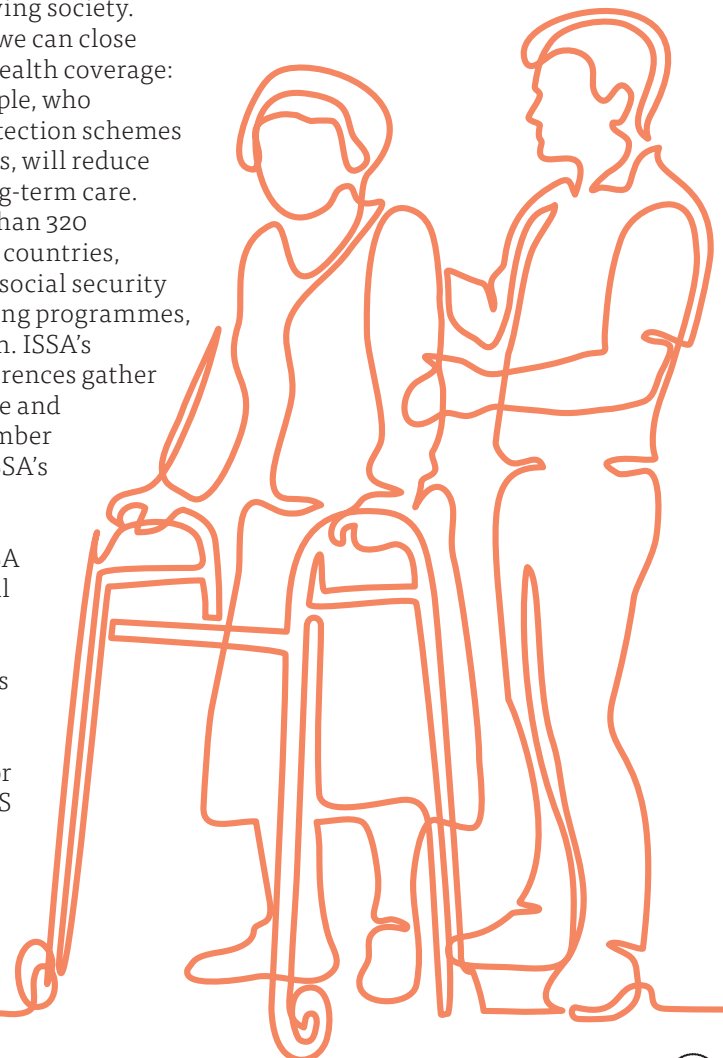
countries offer long-term care financed by social insurance contributions.


This development jeopardises the financial stability of countries. It also affects social peace, as masses of people who have worked and contributed to the prosperity of their country, discover they do not have adequate access to financial or medical benefits at the age of retirement. Such prospects serve the expectations of neither the older nor younger generation.

We need to find ways to balance the extra expenses of a greying society. This is the point where we can close the circle to universal health coverage: more and healthier people, who contribute to social protection schemes during their active years, will reduce the burden of costly long-term care.

The ISSA, with more than 320 members from over 150 countries, promotes excellence in social security schemes through training programmes, research and innovation. ISSA’s commissions and conferences gather the technical knowledge and experience of a vast number of experts working in ISSA’s member institutions.

This unique pool of expertise allows the ISSA to detect trends in social protection and provide best practice examples for supporting members in coping with their challenges. The ISSA shares this expertise, for instance at G20 or BRICS meetings. ■





Nature is the ultimate healthcare system

From the mountains to the ocean,
healthcare solutions are all
around us

By Inger Andersen,
executive director,
UN Environment
Programme

You do not need to be a doctor to understand the links between a healthy environment and healthy people. Simply walk out into nature, breathe the fresh air, listen to the sounds of birds chirping or the rustle of leaves, and feel the stress drain away.

In such moments, we know instinctively that nature is good for us. Yet we have built our increasingly urban world on an economic model that erodes the natural environment and its biodiversity.

The full health benefits of the natural world are too extensive to list. Nature gives us breathable air, drinkable water and productive soil. It is the source of many medicines, traditional and new. Research shows that time spent in

nature improves health outcomes: from children's brains becoming better wired to deal with anxiety and hyperactivity, to our bodies producing the same de-stress chemicals that are prescribed to patients in pill form.

The environment can, of course, also cause poor health. Every year, diarrhoea and malaria claim the lives of hundreds of thousands of children under five in developing countries, and infringing on nature can increase the incidence of diseases such as Ebola and avian influenza.

Degradation of the natural world is driving up healthcare costs, disproportionately affecting the poorest and most vulnerable people. To have any chance of achieving universal health coverage, we need to prioritise policies and actions that protect and restore ecosystems, so we can take full advantage of the health benefits and minimise the negative impacts.

THE CURRENT SITUATION

Unfortunately, we are still far from achieving this balance. The World Health Organization tells us that almost a quarter of deaths globally are due to unhealthy environments that expose people to risks such as air, water and soil pollution.

Indoor and outdoor air pollution alone claims seven million lives and causes a host of other problems annually. The World Bank estimates that air pollution costs the welfare system more than \$5 trillion every year.

Then there is the damage we are doing to biodiversity. In early May, the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services reported damning research that showed nature is declining at unprecedented rates. Humanity has significantly altered three-quarters of the land-based environment and two-thirds of the marine environment. The decline in biodiversity harms our ability to provide diverse and nutritious diets and research new medicines – both obvious determinants of health.

There is, however, hope. We are increasingly facing up to global challenges that are closely linked to health, as is the case with air pollution, climate change and biodiversity loss – all priorities for the UN Environment Programme. The huge growth in rewilding movements demonstrates growing recognition of the importance of nature. Crucially, young people around the world are now demanding we protect their future, as personified by the emergence of young climate activists such as Greta Thunberg.

It is now time for us to make the right political choices and investments, both immediate and long term, to build on this momentum, while understanding that approaches and challenges vary in developed and developing countries.

An obvious and urgent task is to embrace the idea of putting a value on nature. Gross domestic product is an outdated indicator that encourages perpetual growth without acknowledging the erosion of the natural capital that supports our economies, livelihoods and health.

Our planet has limits. We need to acknowledge this in our economic models.

We can do much to preserve biodiversity by moving to less impactful forms of agriculture – ones that do not convert huge swathes of land for monocrops or livestock, and pump chemicals into the land and water. Encouraging people to move to more plant-based diets can play a key role, too.

By prioritising actions that have multiple benefits, we can maximise our time and resources. For example, policies that promote clean transport – such as incentivising hybrid or electric vehicles – cut greenhouse gas emissions, improve air quality and reduce health costs. Such triple action can more than recoup the costs of retooling our economies. According

to the sixth Global Environmental Outlook, achieving the Paris Agreement's climate mitigation targets would cost about \$22 trillion, but bring an additional \$54 trillion in health benefits from reduced air pollution.

These are only a few examples of what we can do. There are hundreds of ways we can conserve nature. By using them we can improve our health, save valuable resources and open up the possibility of universal health coverage across the globe. Governments need to demonstrate real political will, corporations need to work within the limits of nature and citizens need to keep the pressure on.

Nature is the ultimate healthcare system. It is time we started treating it that way. ■

INGER ANDERSEN

Executive director of the United Nations
Environment Programme

Inger Andersen is the executive director of the United Nations Environment Programme. Between January 2015 and May 2019, she was the director-general of the International Union for the Conservation of Nature. Andersen has more than 30 years of experience in international development economics, environmental sustainability and policy making, and has held various leadership roles at the World Bank and United Nations.

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It is now time for us to make the right political choices and investments, both immediate and long term, to build on this momentum”

Biodiversity: The foundation of human health

From economics to pollution, human activity is creating new health challenges, but the protection of biodiversity may provide the answer

By **Cristiana Paşca Palmer**
executive secretary, UN
Biodiversity

We often neglect the intimate links between ourselves and nature, yet to a large extent our health and well-being depend on the environment in which we live.

Biodiversity – at the genetic, species and ecosystem levels – is central to human survival. Without it, our immune systems would falter, local livelihoods and economic development would suffer, life-sustaining ecological functions would be hindered, social and ecological resilience would be compromised, and we would lose

the health benefits and cultural values afforded by our landscapes, seascapes and the life that shares our ecosystems.

Biodiversity and healthy ecosystems are key determinants of human health. They sustain essential ecological processes and functions, such as soil formation, nutrient cycling and carbon sequestration, essential to all life on earth. They also regulate the quantity and quality of freshwater, pollinate our crops; protect against floods, storm surges, pests and disease; and increase resilience in the face of climate change and disaster risk.

Biodiversity is also the source of essential nutrients, vaccines, energy, shelter, livelihoods, cultural heritage and spiritual enrichment. It provides the basis for both biomedical discovery and traditional medicine. As non-communicable diseases such as diabetes and obesity continue to escalate across rapidly urbanising landscapes, the conservation and restoration of our ecosystems can also provide an essential lifeline for healthy lifestyles. Nature filters the air we breathe, supports key immunoregulatory functions of our gut microbiota, and provides green spaces to support physical and mental health.

Biodiversity is not a luxury, but a fundamental prerequisite of well-being. The aggregate value of ecosystem services provided by nature has been estimated at \$125 trillion annually. We cannot afford to overlook nature's contribution to people as the bedrock of equitable and resilient health systems and societies.

Working toward twin goals: biodiversity conservation and universal health coverage

The recently released United Nations Global Assessment on Biodiversity and Ecosystem Services provided us with an alarmingly clear picture of the magnitude of the ongoing damage inflicted on our life support systems. As our natural infrastructure erodes, it weakens the social safeguards that universal health coverage ultimately seeks to extend, namely that people and communities everywhere have access to essential, high-quality health care, without fear of financial hardship. These twin challenges can, and must, be approached together.



Public health policy must consider the root causes of ill health, including its upstream environmental and economic drivers. According to the World Health Organization, approximately 12.6 million deaths were attributable to modifiable environmental factors in 2012. The stark proportion of environmentally mediated mortality is even higher among children under five years and the elderly, in low- and middle-income countries. Ecosystem degradation and climate change are also increasing overall healthcare costs, making universal health coverage a more daunting political, economic and social challenge.

To help bridge these challenges, the Convention on Biological Diversity and WHO have doubled their efforts across multiple stakeholder groups since establishing their joint work programme in 2012. Regional and subregional capacity-building workshops, sustained cross-sectoral dialogues, efforts to support education and awareness raising, and a comprehensive review of the state of knowledge have supported evidence-based policy making. All this has led to the establishment of a dedicated interagency liaison group, fostered new diplomatic overtures and generated international policy guidance.

These efforts provided the basis for bold commitments on biodiversity and health agreed by 196 countries at the 2018 UN Biodiversity Conference. Here governments endorsed the comprehensive biodiversity-inclusive One Health guidance to strengthen the capacity for prevention, early warning, risk reduction, and the management of national and global health risks exacerbated by degraded ecosystems, land-use change, pollution, anti-microbial resistance and unhealthy environments. Countries also called on the CBD, WHO and other stakeholders to develop a global plan of action on biodiversity and health, to ensure common drivers of degradation and ill health are taken up in a coordinated and purposeful manner, coherent with the common goals of the 2030 Agenda for Sustainable Development.

These developments reflect the recognition that health is not solely the responsibility of the health sector. Strong and resilient public health systems demand much more than just financing and services. Addressing the multisectoral nature of health

determinants and root causes of ill health requires holistic, whole-of-government, whole-of-society approaches. It also requires bold political, economic and social commitment to prevent and create health-promoting environments.

The task ahead: integrating biodiversity conservation and universal health coverage for all

Inequity remains a central challenge to global health and sustainable development. Those with the least access to social protection mechanisms and health care are also disproportionately affected by the steadfast degradation of our natural world. Indeed, the right to health is our most basic human right. Yet more than half of the world's population does not have access to essential health services, especially in low- and middle-income countries.

At the same time, the pressures of prevailing economic structures and anthropogenic activity on planetary processes are giving rise to a new set of global health and development challenges. Meeting these requires bold transformative actions that effectively reconcile the three pillars of sustainable development. Governments are already starting to develop an ambitious post-2020 global framework for biodiversity that is transformational, achievable and closely aligned with the aims of the Sustainable Development Goals. The engagement of all stakeholders will be central to its successful implementation.

To ensure that pursuing SDG 3 (ensuring healthy lives and promoting well-being for all, at all ages) and SDGs 14 and 15 (life under water and life on land) will truly leave no one behind, we need concerted, inclusive, cross-sectoral engagement, commitment and action.

Universal health coverage can be truly universal only if it jointly considers the health of people and the health of our planet and if it galvanises the political will to advance an agenda based on equity and sustainability.

Healthy ecosystems will reduce the costs of public health provision, making universal health coverage more affordable across developed and developing states. There will be a unique opportunity at the 2019 G20 Osaka Summit in Japan and again at the 2019 G7 Biarritz Summit in France to advance policy options that can reflect these essential relationships. ■

12.6m

The number of deaths attributable to modifiable environmental factors



CRISTIANA PAȘCA PALMER

Executive secretary, UN Biodiversity

Cristiana Pașca Palmer was appointed executive secretary of the Secretariat of the Convention on Biological Diversity in March 2017. Previously she served as Romania's minister for environment, waters and forests, and headed the Romanian delegation at the 2015 Paris Climate Conference, 2016 Marrakech Climate Change Conference and 2016 UN Biodiversity Conference in Cancun. She served as head of the Climate Change, Environment and Natural Resources Unit within the European Commission's Directorate-General for International Cooperation and Development. She was also one of two appointed EU negotiators on behalf of the European Commission for the Rio+20 Summit in 2012.

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Leaders in health

By C. James Hospedales,
executive director of the
Caribbean Public Health Agency

Leaders in health can come from all walks of life – public, private or civil society. In the Caribbean, the leader who has made the largest contribution to global or regional health of relevance to universal health coverage is the Honourable Patrick Manning, who was prime minister of Trinidad and Tobago from 1990 to 1995 and again from 2001 to 2010. This leadership led to the recognition of the twin-island republic and the Caribbean as the birthplace of the global movement on non-communicable diseases.

Shortly after his death, at their 2016 conference, the Caribbean Community heads of government stated, “Mr Manning displayed the finest qualities of regionalism and had an unswerving commitment to building his country and the wider CARICOM. His progressive ideas for strengthening the regional integration movement led to many initiatives which redounded to the enhancement of the sense and spirit of community among our Member States.”

At that same meeting, the secretary-general of CARICOM, Irwin Larocque, said, “Mr Manning led the way in recognising the dangers, highlighted by the region’s experts, that non-communicable diseases posed to our community, and hosted the groundbreaking Special Summit of CARICOM Heads of Government on NCDs in September 2007. This recognition led to the initiation of a United Nations High Level Meeting on combatting NCDs.”

LEADING THE CHARGE ON NCDs NATIONALLY AND REGIONALLY

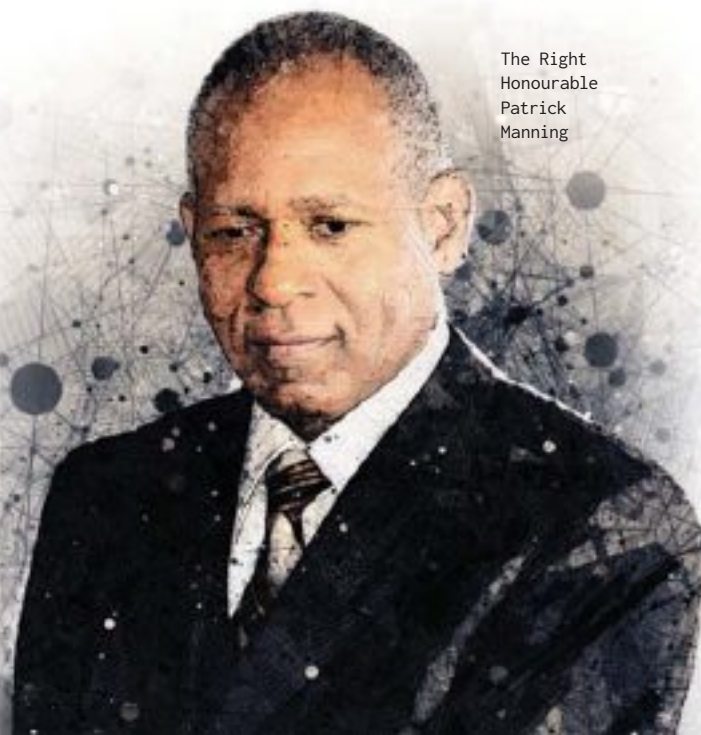
Under Prime Minister Manning’s leadership, Trinidad and Tobago launched the National Chronic Disease Action Programme in 2003 to respond to the growing NCD epidemic. The CDAP provides free medicines for people living with chronic diseases, such as hypertension, diabetes, hyperlipidaemia, asthma and glaucoma. This programme has been shown to increase access to

The former prime minister of Trinidad and Tobago, the Right Honourable Patrick Manning, transformed how non-communicable diseases are tackled in the Caribbean, and the progress he led became central to his legacy

essential medicines for people with NCDs, and has had a positive impact in reducing mortality from cardiovascular disease, with the effect growing over time.

This bold national step was a herald to far-reaching leadership in 2007 and 2009. In 2007 in Port-of-Spain, Prime Minister Manning hosted the historic special summit of CARICOM leaders on NCDs, which issued the *Declaration of Port-of-Spain: Uniting to Stop the Epidemic of Chronic NCDs*, a 15-point mandate with 27 commitments.

The commitments included building the capacity of national and regional institutions; establishing national NCD commissions; legislating tobacco control; establishing care and treatment plans to achieve 80% coverage for persons living with NCDs; educating the public; promoting physical activity and healthy diets; and carrying out surveillance and research. It



The Right
Honourable
Patrick
Manning



C. JAMES HOSPEDALES

Executive director, Caribbean Public Health Agency

C. James Hospedales was appointed the inaugural executive director of the Caribbean Public Health Agency in 2013. He was previously the coordinator of the Prevention and Control of Chronic Diseases at the Pan American Health Organization. From 1998 to 2006, he was director of the Caribbean Epidemiology Centre. Hospedales was a member of the Caribbean Commission on Health and Development, which made policy recommendations to the heads of government and named chronic diseases as a super-priority for the region.

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also led to establishing the Caribbean Wellness Day every September, which has stimulated the Pan American Health Organization/World Health Organization to establish the Wellness Week. Annual monitoring was initiated by the University of the West Indies in 2008, tracking 26 progress indicators and producing a colour-coded performance grid, with annual reports to the health ministers. The monitoring grid was shown to be useful for cost-effectively documenting progress on those indicators.

A comprehensive evaluation of the *Port-of-Spain Declaration* at 10 years was conducted by a consortium of institutions led by the UWI George Alleyne Chronic Disease Research Centre and funded by the International Development Research Centre, with a set of papers published in a special edition of the *Pan American Journal of Public Health*.

THE GLOBAL IMPACT OF THE CARICOM NCD SUMMIT

The CARICOM summit galvanised several global events leading to the United Nations High Level Meeting on NCDs in 2011:

- **April 2009:** The Summit of the Americas in Port-of-Spain, hosted by Prime Minister Manning, included 14 CARICOM member states and endorsed CARICOM and PAHO/WHO policies and plans to prevent and control NCDs.
- **July 2009:** The 30th Conference of CARICOM Heads of Government in Guyana decided to advocate for a UN General Assembly special session on NCDs.



Regionally, his leadership contributed to the Caribbean's increasing attention to and investment in preventing and controlling non-communicable diseases"

- **November 2009:** The Commonwealth Heads of Government Meeting in Trinidad and Tobago, hosted by Prime Minister Manning, underlined the threat of NCDs, committed Commonwealth countries to prioritise NCDs, and called for a UN meeting on NCDs.
- **May 2010:** The UN General Assembly decided to hold a high-level meeting on NCDs in September 2011.
- **December 2010:** The scope and modalities of the HLM were agreed for 19 – 20 September 2011.

The CARICOM summit in 2007 in Trinidad and Tobago was historic. It was the first time that heads of government anywhere in the world sat down to look seriously at the issue of NCDs and what can be done to prevent and control these problems. At this summit, together they made the highest-level political choice.

CONCLUSION

Under Prime Minister Manning's leadership, the national capacity of Trinidad and Tobago was strengthened to benefit people living with NCDs. Regionally, his leadership contributed to the Caribbean's increasing attention to and investment in preventing and controlling NCDs. The CARICOM summit he hosted in 2007 had a traceable global impact, leading to the UN HLM on NCDs in 2011, through to the Summit of the Americas and Commonwealth meetings of 2009 in Trinidad and Tobago. The Port-of-Spain Summit also clearly signalled the need for a multisector all-of-society approach to NCDs. Since NCDs have a relationship to climate change – industrialised agriculture and motorised transport contribute to unhealthy diets and physical inactivity – the prime minister's leadership was also a stimulus to addressing the existential threat of a changing climate. ■

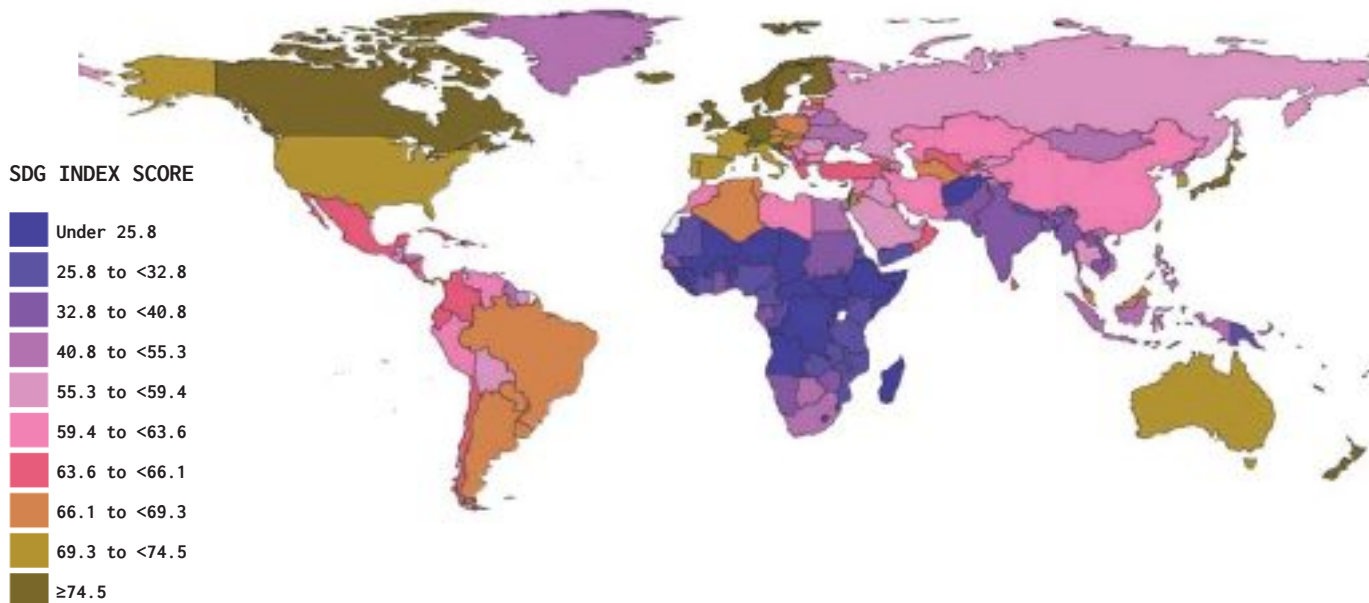
Progress and challenges in pursuing the health-related Sustainable Development Goals

Measuring progress from 1990 to 2017 and projecting attainment to 2030 of the health-related Sustainable Development Goals for 195 countries and territories: a systematic analysis for the *Global Burden of Disease Study 2017* includes an updated and improved analysis of progress towards the SDGs.

It produces estimates for 41 of the 52 health-related SDG indicators, including an estimation of four additional indicators compared to the 2016 study. It also includes subnational analyses of SDG progress for a subset of countries and analysis of trends by sex for select indicators. The study also uses revised methods to project progress between 2017 and 2030.



FIGURE 1: PROGRESS AND CHALLENGES IN PURSUING THE HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS



The SDG index is a composite measure, ranging from 0 to 100, of overall progress toward meeting the SDGs. It takes into account 40 of the 41 performance indicators for the health-related SDGs. Population census coverage.

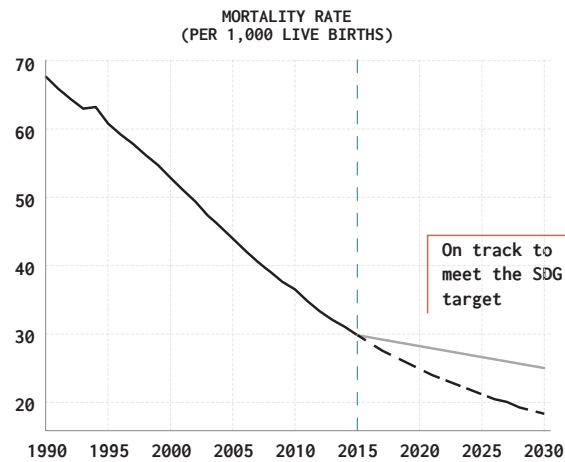
- Based on past trends, most countries' SDG index* scores are projected to rise between 2017 and 2030.

- By 2030, the under-five mortality, neonatal mortality, maternal mortality ratio and malaria indicators had the most countries likely to attain their targets.

*The Institute for Health Metrics and Evaluation (IHME) at UW Medicine, University of Washington.



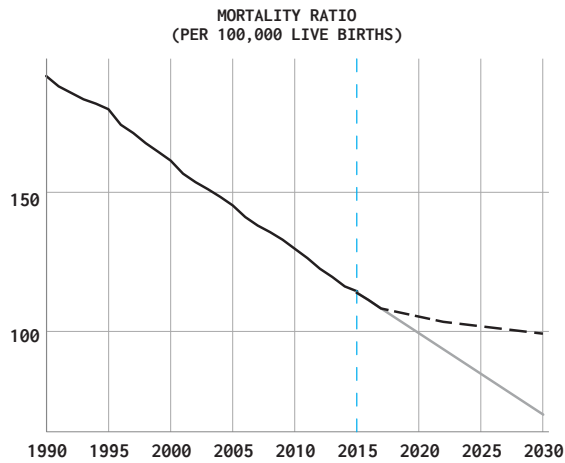
**Chart 1:
GLOBAL UNDER-5
MORTALITY RATE,
1990-2030**



SDG target: Reduce under-five mortality to 25 per 1,000 live births or below by 2030



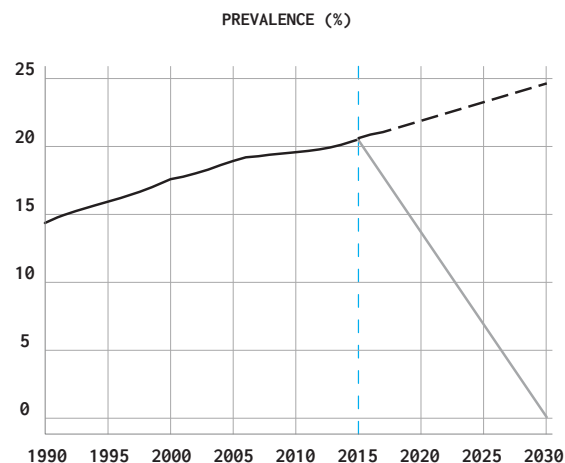
**Chart 2:
GLOBAL MATERNAL
MORTALITY RATIO,
1990-2030**



SDG target: Reduce maternal mortality ratio to 70 per 100,000 live births or below by 2030



**Chart 3:
GLOBAL
PREVALENCE OF
OVERWEIGHT IN
CHILDREN AGED 2
TO 4, 1990-2030**



SDG target: Eliminate child overweight by 2030

KEY

- Past trend
- Anticipated future trend
- Future trend needed to meet SDG target

*The Institute for Health Metrics and Evaluation (IHME) at UW Medicine, University

Source: Global Burden of Disease 2017 SDG Collaborators 'Measuring progress from 1990 to 2017 and projecting attainment to 2030 of the health-related Sustainable Development Goals for 195 countries and territories: a systematic analysis for the Global Burden of Disease Study 2017'. *The Lancet*. 8 November 2018: 392.



Pollution 5.0

In 2015, diseases arising from pollution caused three times more deaths than AIDS, tuberculosis and malaria combined. As the problem evolves and grows, global governance must address the causes head on

By Rolph Payet

Pollution, to be understood in its historical context, refers to contamination by something foreign. But with the expansion of human development we have seen that interpretation evolve to a much broader perspective, including health, and thus become a primary challenge of environmental law. Since pollution knows no borders, can accumulate, does not readily disintegrate, and can have visible and invisible impacts on the environment as well as human health and well-being, many international conventions today seek to tackle pollution at source with a life-cycle approach, through prevention and exposure, and through economic policies and legal instruments.

However, with intense pressure on resources for development, against a backdrop of increasing population growth and consumption, pollution levels are now well beyond the planetary boundary with serious health consequences such as acute respiratory and toxic accumulation in human tissue, to graver effects such as

several types of cancers, reproductive and neuro developmental disorders, and disruption of our hormone (endocrine) system. As estimated by the

Lancet Commission on Pollution and Health, more than nine million premature deaths in 2015 were caused by diseases arising from pollution. This is three times more deaths than from AIDS, tuberculosis and malaria combined and 15 times more than from all wars and other forms of violence. Assuming that this figure is only the tip of the iceberg, and we consider the impact from a social and economic perspective, then we need to account for the billions of dollars that would be spent or lost in health treatment, loss of jobs, loss of economic development potential, and the increased disease burden in children and the elderly.

REGULATING POLLUTION

On that basis, global governance mechanisms involving governments and industry are critical in reversing these alarming trends. There are many cases where effective

“

It is now time for us to make the right political choices and investments, both immediate and long term, to build on this momentum”

action through sound government policies has led to measurable progress in addressing pollution. The successful implementation of the Montreal Protocol on the depletion of the ozone layer shows that skin cancers arising from exposure to UV will reduce by 14% per year by 2030. Body burden tests under the Stockholm Convention have seen a reduction in DDT, a toxic chemical used in agriculture.

The Basel, Rotterdam and Stockholm Conventions are three key, global, legally binding agreements that have in their preamble the common objective of protecting human health and the environment from hazardous chemicals and wastes at all stages of their life cycle, from production to disposal. They remain relevant in addressing present and emerging issues, such as plastic waste and its impact on human health and biodiversity.

The Plastic Waste Amendment under the Basel Convention, adopted in May 2019, aims to clarify and strengthen entries for plastic waste, bringing many types of plastics into the prior informed consent procedure and therefore ensuring a more transparent, traceable and enforceable set of measures concerning imports and exports of such waste between countries. To complement these amendments, the parties also adopted a comprehensive package of decisions to address the management of plastics and plastic waste through a partnership involving all relevant stakeholders and numerous activities to support countries in implementing the measures.

Besides international treaties, other high-profile global and political processes such as the G7, G20, the United Nations General Assembly and the World Economic Forum are required to effectively address pollution and its health impacts at the highest policy and industry levels.

Sustainable Development Goal 12 of the 2030 Agenda calls on states to achieve the environmentally sound management of chemicals and all waste throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimise their adverse impacts on human health and the environment by 2030. Tackling pollution from this integrated and wider framework is seen as the most effective approach to meeting those goals in the next 10 years with respect to pollution and health.

Those global processes provide the political motivation, context and framework to address those complex issues. But the onus remains on national governments to translate those expectations, targets and plans and to implement those measures. Lack of political will and consumer awareness

as well as poor capacity and governance frameworks are all challenges for achieving the 2030 target and successful implementation of the international environmental conventions. In many cases the political discourse is unilaterally driven by popular needs focused on jobs and economic growth, rather than the associated costs to health and environmental well-being. In countries that lack the most sound management of chemicals and waste, pollution-related disease is responsible for more than one death in four. In 2018, the World Health Organization estimated the disease burden preventable through sound management and reduction of chemicals in the environment at around 1.6 million lives and around 45 million disability adjusted life years in 2016. It is therefore also critical that industry make proactive decisions and stimulate innovation towards greener jobs and products. According to McKinsey, companies that manage sustainability, and indeed mitigate pollution, through their value chains have better prospects at value growth and long-term competitiveness.

Coupled with drivers of change, such as increased consumer awareness and availability of safer alternatives, health and environmental well-being are becoming the political choice in many countries of the world, but their efforts will have limited effect unless the entire planet and its leadership make health their political choice. Concrete steps should start with the most advanced countries, such as those in the G7 and the G20, and create an enabling political ‘afterburner’ within the UN General Assembly and the United Nations, to ensure clear commitment to the targets established through the SDGs and legally binding international instruments. ■

1.6m

Lives could be changed through reduction of chemicals in the environmental

14%

Annual reduction in skin cancer caused by UV exposure, following Montreal Protocol

ROLPH PAYET

Executive secretary of the Basel, Rotterdam and Stockholm Conventions



Rolph Payet, former minister for environment and energy for the Seychelles, has been the executive secretary of the Basel, Rotterdam and Stockholm Conventions since 2014. He has served in many international global forums including the Intergovernmental Panel on Climate Change and the Global Forum on Oceans, Coasts and Islands, and was interim coordinator of the Nairobi Convention UNEP Regional Seas Programme from 1999 to 2008. He also holds an associate professorship at the University of Linnaeus in Sweden.

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Asia's healthcare evolution

Investment in universal health coverage can boost GDP by up to 4%, which means that in Asia, health expenditure is money well spent

In the last 50 years, the Asia Pacific region has made tremendous strides in poverty reduction, economic growth and better health outcomes. Life expectancy is increasing and infant and maternal mortality is declining in many countries. The quality of health systems is improving, and health insurance coverage is gaining traction.

However, much work remains to be done to ensure everyone in the region has access to essential healthcare services. The increasing prevalence of non-communicable diseases such as diabetes, hypertension, cancer and mental illnesses – combined with increasingly open borders, rapid ageing, urbanisation, income inequality and climate change – is breeding a host of new health system threats that have not been fully addressed.

With many antibiotic and antiviral drugs becoming ineffective against infections due to anti-microbial resistance, and with other health security threats creeping up on Asia in recent years, the risk of new outbreaks similar to the severe acute respiratory syndrome and avian influenza outbreaks is increasing.



By Woochong Um,
 director-general, Asian
 Development Bank's
 Sustainable Development and
 Climate Change Departments

Moreover, adequate health care to safeguard against these threats remains expensive for many people in developing Asia. Out-of-pocket spending still accounts for nearly half of total health expenditures in lower-middle- and low-income countries in the region. Health financing and service delivery systems need further reform to withstand the strains placed on them by ageing populations and the rising tide of NCDs.

Combating these vulnerabilities requires difficult political decisions implemented through joint actions by finance and health ministries.

However, governments are not spending enough on health systems, with average domestic general public health expenditure as a percentage of gross domestic product at 2.7% for the Asian Development Bank's developing member countries in East Asia, Southeast Asia and the Pacific, and 0.9% for member countries in South Asia. This compares to the average 10% share of the members of the Organisation for Economic Co-operation and Development.

ACTION ON INVESTMENT

Helping countries make and persevere with these difficult choices is an increasingly important part of ADB's role. *Under Strategy 2030: Achieving a Prosperous, Inclusive, Resilient Sustainable Asia and the Pacific*, ADB's first operational priority includes



Health financing and service delivery systems need further reform to withstand the strains placed on them by ageing populations and the rising tide of NCDs”

supporting countries to enhance their human capital and the health, education and social protection of their people. ADB commits to help countries invest in health, maximise the health benefits of transport, urban, energy and other non-health sector interventions, and pursue universal health coverage.

It is a lofty ambition: the aim of universal health coverage is to ensure that everyone has access to quality essential healthcare services without financial hardship.

ADB has a strong track record in promoting better health in the region. We support efforts to strengthen urban health service delivery in Bangladesh and India, the upgrading of hospitals and health facilities in Papua New Guinea, Tajikistan and Uzbekistan, and the introduction of new vaccines in Pacific countries. Other ADB operations support health financing reforms that are expanding health insurance coverage in Laos and Mongolia, and the coverage of essential medicines in Bhutan. In China and Vietnam, we are helping improve the quality of elderly care and primary care health workers.

As funding universal health coverage is a major hurdle for many developing countries, ADB is focused on providing predictable and substantial long-term financing. Another priority is to help member countries build knowledge and capacities, mobilise partnerships

and leverage health benefits from cross-sectoral projects.

Under its G20 presidency, Japan’s priority for universal health coverage is to help countries focus on sustainable health financing and highlight the importance of collaboration between the ministries of health and finance, exemplified by the G20 joint ministerial meeting on the sidelines of the G20 Summit in Osaka in June. It is creating a valuable opportunity to inform and expand region-wide and country-level policy dialogues on this important challenge.

It is a chance to highlight how G20 members have reaped socio-economic benefits from sustained government investment in health. Investments in better health outcomes contribute to improved productivity and educational performance and sustained inclusive economic growth. The World Health Organization estimates that low- and middle-income countries can achieve additional GDP growth of at least 2% to 4% when they invest in universal health coverage.

Clearly, investing in health is money well spent. But obtaining the required levels of investment will not be easy. Success requires strong political commitment, as well as collaboration among multiple stakeholders including governments, domestic agencies within countries, physicians and

other healthcare providers, the private sector, civil society and international development organisations.

It is decision time on health for countries in Asia and the Pacific. By committing to universal health coverage, the region can ensure its tremendous economic progress is matched by the robust good health of its people and communities. ■



WOCHONG UM

Director-general, Asian Development Bank’s Sustainable Development and Climate Change Departments

Woochong Um leads ADB-wide knowledge management and innovation in various thematic and sector operation areas. He is responsible for developing sector and thematic policies, strategies, frameworks and operational plans, encouraging vibrant sector and thematic communities of practice, and developing new business ideas. Previously, he served as the Secretary of ADB, deputy director general of the Sustainable Development and Climate Change Department, and director of the Sustainable Infrastructure Division.

adb.org

2.7%

Average share of GDP spent on healthcare by ADB’s developing member countries

10%

Share of GDP spent on health care by OECD member countries, on average

4%

Projected GDP growth that can be achieved through implementation of UHC

Performance and Progress

The G20 and G7 may be aligned in their prioritisation of health and well-being, but globalisation means that health and its related issues cannot be viewed in a silo



By **Brittaney Warren**, Global Governance Project

On 28–29 June 2019, Japan will host the G20 summit for the first time. One key issue on the agenda is universal health coverage. The World Health Organization defines universal health coverage as ensuring access to quality and affordable health care for all across the full spectrum of healthcare provision —

prevention, promotion, treatment, rehabilitation and palliation. Universal health coverage is at the centre of the 2030 Agenda’s Sustainable Development Goal 3 on health, to reduce poverty and inequality worldwide. The G7 and G20 have steadily expanded their governance of universal health coverage since addressing it directly for the first time in 2016.

G7 performance on universal health coverage, 1975–2018

G7 LEADERS' HEALTH CONCLUSIONS

Since 1979 G7 leaders have dedicated more than 48,000 words to health in their communiqués, starting with malnutrition, drug addiction and HIV/AIDS. Throughout the 1990s, the agenda expanded to include ageing populations, thus addressing the palliative component of universal health coverage, and also child and maternal mortality and the environment-health link. The groundwork was laid for universal health coverage with references to healthcare funding and prevention, education, treatment and rehabilitation for specific diseases, namely HIV/AIDS.

Throughout the early 2000s more specialised subjects appeared, on micronutrients and food safety systems, active ageing, debt relief, AIDS orphans, healthcare technologies and workers. This decade ushered in globalisation and the Millennium Development Goals, and with them a broader view of health care as a system of services that should be equally accessible to all. This view included providing health care and responding in cases of emergency, particularly to natural and human-made disasters.

Thus strengthening healthcare systems acquired a greater place in the G7's communiqué-recorded public deliberations since the mid-2000s. This started with a regional focus on systems strengthening for Africa, then expanded at the 2008 Hokkaido-Toyako Summit to a more global focus. However, the term 'universal' was still

only used at that time to refer to health care for HIV/AIDS patients and to women's reproductive health (introduced at the 2010 Muskoka Summit), a key health target of the MDGs.

The G7 first publicly used the term universal health coverage at its 2016 Ise-Shima Summit. Of the 164 paragraphs on health at Ise-Shima, 18 (11%) referenced universal health coverage. Other paragraphs discussed the global health architecture, global health security and the new SDGs, in particular on women's health. The multisectoral One Health approach for the emerging anti-microbial resistance threat also appeared.

Yet at the subsequent 2017 Taormina Summit and the 2018 Charlevoix Summit, the term universal health coverage was not used, although health systems strengthening and access to health care were.

G7 HEALTH MINISTERS' CONCLUSIONS

The G7 health ministers were ahead of their leaders, first referring to universal health coverage at their 2015 Berlin meeting. At their 2016 Kobe meeting, universal health coverage appeared in the preamble to the communiqué and received a stand-alone section. Although the leaders focused on the important gender aspect of health and universal health coverage, the ministers took an even more holistic approach, linking health with other targeted or neglected demographics, including the elderly, refugees and immigrants. They also linked the SDGs with water-borne illnesses and with digitisation. At the 2019 Paris meeting, universal health coverage and the health-related SDGs were again referenced in the preamble. The 2019 United Nations High Level Meeting on UHC was mentioned in the following paragraph. Thus, while universal health coverage somewhat fell off the leaders' agenda in 2017 and 2018, the health ministers maintained some momentum for 2019.

G7 LEADERS' COMMITMENTS

Since 1975, the G7 leaders have made 410 health commitments. As with their public deliberations, throughout the first two decades of the G7's existence, commitments referred to some underlying concepts but not universal health coverage as a whole. Throughout the 1980s and '90s, concepts related to universal health coverage were disease-specific and sought to prevent and treat diseases such as HIV/AIDS. At the 2000 Okinawa Summit, the G7 committed to develop equitable and effective health systems. The 2002 Kananaskis Summit made 10 commitments focused on sustainable health systems for Africa. Access to health care for the poorest arose at the 2003 Evian Summit.

At the 2006 St Petersburg Summit the overall number of health commitments rose sharply to 60. Some of these were on health systems strengthening, including implementing WHO's International Health Regulations, and on funding, but none referenced universal health coverage. At the 2007 Heiligendamm Summit the G7 made commitments on primary and

11%

Of 164 paragraphs at the G7 Ise-Shima Summit referenced universal health coverage

410

Health commitments made by G7 leaders since 1975

\$60bn

In funding was committed in 2008, for the coming five years

universal health coverage for HIV/AIDS patients, and on increasing affordability and accessibility to healthcare services in Africa. The MDG-health link was made at the 2008 Hokkaido-Toyako Summit, taking the G7 health agenda from a regional to a global focus, while adding a funding commitment of \$60 billion over five years. At Muskoka in 2010, the G7 made three commitments referencing universal health coverage concepts: universal health coverage for HIV/AIDS patients, strengthening healthcare systems for HIV/AIDS patients, and making progress on MDGs 4 and 5 regarding child and maternal health.

At the 2014 Brussels Summit the G7 put WHO at the centre, committing to support its Global Health Security Agenda and International Health Regulations. The 2015 Elmau Summit committed to put health promotion at “the centre of [their] growth agenda” and to base national action plans on the multisectoral One Health approach for AMR.

Of the 85 health commitments made at the 2016 Ise-Shima Summit, 20 (24%) referenced universal health coverage. The leaders also committed to implement the health-related SDGs, to achieve universal health coverage for women and girls, to promote the One Health approach for AMR and to support health systems strengthening.

Yet this progress was not sustained at the 2017 Taormina or 2018 Charlevoix summits, where health systems strengthening, access and affordability were committed to, but universal health coverage as a whole was not.

G7 HEALTH MINISTERS' COMMITMENTS

The G7 health ministers have made 205 commitments at the five meetings they have held. The first meeting was in St Petersburg in 2006, with 14 commitments made. Two of these referenced the IHR, but none referenced universal health coverage. The next meeting was held in Berlin in 2015, with 36 commitments made. These included strengthening health systems and applying the One Health approach for AMR, but again no commitment on universal health coverage was made.

At Kobe in 2016, eight (21%) of the 38 commitments were on universal health coverage, including one that referenced the SDGs. Eleven other commitments



Since 1975, the G7 leaders have made 410 health commitments. As with their public deliberations, throughout the first two decades of the G7's existence, commitments referred to some underlying concepts but not universal health coverage as a whole”

were made on the global health architecture for public health emergencies, and there were commitments on ageing. No universal health coverage commitments were made at the 2017 Milan or 2019 Paris meetings, although other advances were made including on the environment-health and gender-health links.

G7 COMPLIANCE

The G7 Research Group has assessed 70 of the 410 leaders' health commitments for compliance and found an average of 76%. Seventeen of these assessments referenced an aspect of universal health coverage and one referenced universal health coverage directly, for average compliance of 70%.

Three commitments, all on preventing and treating HIV/AIDS, were assessed from the 1998 Birmingham Summit. They averaged 68% compliance. Two, both on promoting affordable medicine in Africa, were assessed from the 2002 Kananaskis Summit, with 85% compliance. The one assessed from the 2003 Evian Summit, also on affordable medicine for the poorest, had 57% compliance. The two assessed from the 2005 Gleneagles Summit, on preventing and treating HIV/AIDS and on improving health systems in Africa, averaged compliance of 82%. The one on improving healthcare systems for disasters had low compliance at 56%. Another three commitments on HIV/AIDS prevention and treatment in Africa were assessed from the 2007 Heiligendamm Summit with average compliance of 83%.

Three commitments were assessed from the 2008 Hokkaido-Toyako Summit: on access to basic healthcare services for children in Africa, on mobilising \$60 billion to “strengthen health”, and on neglected tropical diseases, including a reference to universal health coverage. These averaged compliance of 56%. One commitment on universal access for HIV/AIDS health care was assessed from the 2010 Muskoka Summit, with 61% compliance.

Two commitments were assessed from the 2016 Ise-Shima Summit, one on the IHR and the Global Health Security Agenda for Ebola and Zika, and one on the One Health approach for AMR. They averaged compliance of 69%.



All the presidents of the G20 are seen during the G20 meeting. 30 November, 2018. Capital Federal, Buenos Aires, Argentina

G20 performance on universal health coverage, 2008–2018

G20 LEADERS' HEALTH CONCLUSIONS

Since 2008, G20 leaders have dedicated 5,810 words to health in their communiqués. This attention began with general references to implementing the health-focused MDGs, expanding at the 2010 Seoul Summit to include non-communicable diseases and the jobs-health link. The first time an aspect of universal health coverage appeared was a reference to access to health care at the 2011 Cannes Summit. At the 2013 St Petersburg Summit health insurance and preventive healthcare arose. At the 2014 Brisbane Summit references to strengthening health systems and to the IHR appeared. At the 2015 Antalya and 2016 Hangzhou summits, the emerging threat of AMR was included, but there was no reference to any aspect of universal health coverage.

The 2017 Hamburg Summit saw the first reference to universal health coverage in the G20's deliberations, as well as references to the multisectoral One Health approach for AMR, SDG 3 and the digital-health systems link.

The 2018 Buenos Aires Summit kept universal health coverage and the health-related aspects of the SDGs on the agenda.

G20 HEALTH MINISTERS' CONCLUSIONS

The first G20 health ministers' meeting was held in Berlin in 2017. Implementing the health-related SDGs was referenced in the preamble to the communiqué. Universal health coverage was explicitly referenced in five paragraphs within a stand-alone section on health systems strengthening. At the 2018 Mar del Plata meeting, universal health coverage was referenced in two paragraphs, including a reference to the 2019 UN High Level Meeting on UHC.

G20 LEADERS' COMMITMENTS

G20 leaders made their first 33 core health commitments at the 2014 Brisbane Summit. Of these, five committed to strengthen health systems globally, with a focus on Ebola. At the following two summits the G20 ►



G20 leaders have dedicated 5,810 words to health in their communiqués. This attention began with general references to implementing the health-focused MDGs, expanding at the 2010 Seoul Summit to include non-communicable diseases and the jobs-health link”

leaders made commitments on AMR but none on universal health coverage or any of its parts. At the 2017 Hamburg Summit, 17 commitments were made on health systems strengthening and three referenced SDG 3. The G20 leaders' first and only commitment referencing universal health coverage was made at the 2018 Buenos Aires Summit.

G20 HEALTH MINISTERS' COMMITMENTS

The G20 health ministers have made 120 commitments in all. Of the 51 commitments made at the 2017 Berlin meeting, one was on the health-related SDGs, seven were on global health crisis management, and five were on health systems strengthening. At the 2018 Mar del Plata meeting one commitment was on universal health coverage. It appeared in a stand-alone section

containing 15 commitments on health systems strengthening.

G20 COMPLIANCE

The G20 Research Group has assessed eight of the 61 core health commitments for compliance by G20 members. It found they averaged compliance of 71%. One of the assessed commitments was on strengthening health systems worldwide. It tied for the highest compliance with another commitment on AMR at 98%, and all members except Mexico fully complied. Of the four assessed health commitments from the 2014 Brisbane Summit, the three on Ebola averaged compliance of 63% and the one on AMR averaged 98%. The two AMR commitments assessed from the 2015 Antalya Summit averaged 65%. The AMR commitment from the 2016 Hangzhou Summit averaged 30%.

Conclusion

There is thus a strong relationship between the health goals of both the G7 and the G20 and the UN's SDGs.

The G7 has governed health always in the context of development, basing its health discussions on the MDGs and later making concrete commitments to implement the health-related aspects of the SDGs. The G20 has done the same on the SDGs, leaving the G7 and UN to lead in the early days of health governance by the three bodies.

As with many other issues, globalisation has made health a global issue that cannot be viewed in a silo. Thus both the G7 and G20 have begun linking sustainable development and health, including linking the environment, gender and digitalisation. Most recently they have introduced universal health coverage to their agendas, although not yet as a permanent feature and appearing only when an interested host chooses to champion it. Yet with this year's G20 summit and UN HLM highlighting universal health coverage and the G7 emphasising inequality, universal health coverage could find the convergence it needs to endure on the G7 and G20's agendas and effectively advance health for all. ■



BRITTANEY WARREN

Director of compliance, Global Governance Program

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Three steps to universal health coverage

By Michel Sidibé, minister of health and social affairs of the Republic of Mali

Healthy citizens and community-led responses will form the strongest foundations for universal health coverage

The G20 is to be commended for its leadership and commitment to the 2030 Agenda for Sustainable Development. But it is time to ask: are we on track? World leaders committed to leaving no one behind, yet are they? The call of United Nations secretary-general António Guterres to “inject a sense of urgency” in implementing the 2030 Agenda for Sustainable Development confirms what we all fear – we are lagging in realising our ambitious plans for people and planet. I am convinced that the fastest route is to start with healthy citizens.

In recent years, G20 and G7 summits have elevated health as a political issue, a central plank of health diplomacy and a critical element to foster human capital. The first-ever meeting of G20 ministers of health in Berlin in 2017 underscored the G20’s commitment to health with calls for greater investments in human resources as well as addressing anti-microbial resistance and emergency preparedness.

As 100 million people fall below the poverty line every year due to catastrophic health expenditures, the global community is rallying behind universal health coverage – as a means for all people to access high-quality and affordable services. I commend the G20 for leading this charge. Let’s go a few steps further at the Osaka Summit.

Japan, and in particular Prime Minister Shinzo Abe, has long been a champion of universal health coverage, at home, in partner countries as well as through its health diplomacy efforts. Further to its central role in the adoption of the universal health coverage target in 2030 Agenda, Japan hosted the UHC Forum in 2017 and pledged \$2.9 billion to universal health coverage in developing countries. I salute the resolve of Prime Minister Abe to shift the G20 discourse on health – rightly seeing it as a global public good that is essential to inclusive growth. ►

Nonetheless, ambitious words may turn into empty promises if not accompanied by measurable targets focused on results for people. One of the lessons from the Millennium Development Goals is that targets provide a driving force to galvanise action, build political ownership, bring partners together and guide service providers. Ultimately, targets lay the foundations of national and global accountability. As executive director of UNAIDS, I saw this firsthand with the power of the 90-90-90 treatment targets. And as newly appointed minister of health for Mali, I will take a results-oriented approach.

If we are serious about eliminating health disparities, it behooves the G20 and the G7 to set clear, equity-focused targets across universal health coverage, along with robust accountability mechanisms that include independent monitoring. Japan already kicked us off in 2017, when calling for one billion more people to enjoy access to basic health services by 2023. Yet to achieve a universal health coverage system that truly leaves no one behind, I urge the G20 and G7 to adopt people-centred, rights-based and gender-transformative approaches in implementing universal health coverage. I see three ways the G20 and its partners can do so.

Community-led responses must be the foundation of universal health coverage

As we move from millions to billions, we need to support new models of community service delivery. We know from the AIDS response the essential role played by communities in delivering services that deliver health outcomes. I call on the G20 and the G7 to strengthen the capacity and professionalisation of community health workers and to do so in the context of promoting gender equality and decent paid work.



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MICHEL SIDIBÉ

Minister of health and social affairs of the Republic of Mali

Michel Sidibé is the former executive director of UNAIDS, the Joint United Nations Programme on HIV/AIDS, which he joined in 2001, and former under secretary-general of the United Nations. Prior to joining UNAIDS, he spent more than 25 years in public service, working for Terre des Hommes and later for UNICEF. Sidibé holds a master’s degree in economics and diplomas in social planning and demography as well as in development and political economy.

Inclusive governance for universal health coverage must be defended and advanced

When building the organisational arrangements of a universal health coverage system, we need to ensure multi-stakeholder stewardship. I call on the G20 and the G7 to promote inclusive governance with meaningful engagement of communities and civil society as demand creators, campaigners, innovators, experts, implementers and auditors, from the clinic to the highest policymaking table.

Human rights and gender-equality must be at the heart of universal health coverage

I believe universal health coverage provides a unique opportunity to ensure equitable access to health for all, but only if health facilities are free of stigma and discrimination and services are free at the point of care. I call on G20 leaders to do more to foster legal and policy environments that unleash the potential of civil society to contribute to universal health coverage.

This generation of G20 and G7 leaders has demonstrated their forward-looking thinking by raising the salience of investing in human capital. Their combined influence and resources, if channelled towards measurable, people-centred outcomes, hold the key to democratising the life chances of billions of people around the globe, from vulnerable and marginalised communities to ageing populations. I encourage both the G20 and the G7 to seize this opportunity. ■

2023

Japan’s deadline for one billion more people to enjoy universal health coverage

90%

Of all people diagnosed with AIDS will receive anti-retroviral therapy by 2020 under 90-90-90

\$2.9bn

Pledged by Japan to developing countries for universal health coverage



Health:

A political

choice

Delivering
Universal

Health

Coverage

2030

GLOBAL
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PROGRAM

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