PIH's Universal Health Care (UHC) Messages

Message #	1st Level (basic message)	2nd Level (message contains some detail)	3rd Level (message contains more detail/nuance)	Supporting Evidence
1 Everyone everywhere has the right to high quality, comprehensive health care.	Health is a human right. The global community must be held accountable for fulfilling the right to health for all.	UHC will not be achieved without significant and sustained external funding, and in an era of globalization, there needs to be an increasingly globalized notion (beyond the member state) for who bears responsibility for protecting and fulfilling the right to health.	As enshrined in the International Covenant of Economic, Social and Cultural Rights (ICESCR), achieving the right to health for all requires the collective commitment and action of global duty bearers where it is beyond the ability of the state to create an environment conducive for its realization, via international assistance and cooperation. Yet the status quo of international assistance and cooperation ignores these obligations. We need a new notion of human rights. For centuries, massive amounts of resources – natural and human – have been extracted from the Global South. We must take action to address the structural violence and inequalities that are the legacy of the dehumanizing history of colonization and imperialism. The Political Declaration of the High-level Meeting on Universal Health Coverage completely ignores this history, denying both its legacy on health inequities globally and the obligations of nations to redress this harm – in even a very small way. The global community must be held accountable as duty bearers – in addition to Member States – for fulfilling the right to health for all.	International Covenant on Economic, Social and Cultural Rights
2 UHC must meet the full health needs of all people to achieve this right.	UHC should be linked explicitly to the right to health and should meet the entirety of the burden of disease for every person (i.e. both the full continuum of care and meeting the full	UHC must not become synonymous with increased access to health insurance alone, and must include investments in the human resources, medication and equipment, health facilities, operations and social support systems needed to ensure high quality care delivery is	Direct investments must be made simultaneously at community, primary and secondary levels to ensure one uniform, functioning referral pathway. A primary health care only approach will only go so far if these ideals aren't also central to a more comprehensive approach to UHC reflective of the whole health system. Some conditions - and often those with the most severe and catastrophic health & financial consequences for the most vulnerable families - can't be treated at health center level. These conditions include most severe NCDs, cancer, mental illness, surgically-amenable conditions, emergency obstetric care etc. Reinforcing district hospital based care with strong linkages for referral and mentorship to primary care level services at community & health center level is required to ensure UHC is achieved.	Practical Strategies for the Progressive Realization of the Right to Health

	needs for every person – medical and biosocial).	available, leaving no one behind.	Achieving these goals requires the promotion of decentralized and integrated delivery strategies that are comprehensive and encompass the full extent of medical and surgical needs across the health system, ensuring that care reaches the poorest and most vulnerable communities. Progressive realization of UHC must also be based on practical, country-led, and adequately financed plans that account for sufficient human resources for health, medicines and supplies, medical equipment, dignified spaces for care, and social support that is timely, accessible and affordable at high quality to all.	
3a The global North must significantly increase funding, with far fewer strings attached, to realize UHC in the global South. 3b The status quo of global health funding is woefully inadequate. 3c Tax evasion, dodgy trade agreements, and interest on loans sucks resources from the global South. For every $1 of aid the global North gives to the global South, $24 flows in the other direction—a monumental injustice that few people talk about.	Wealthy countries need to meet their global responsibilities by significantly increasing their funding to global health (i.e. pay their fair share).	To achieve the right to health for all, significant and sustained external global health financing (provided by high-income countries [HICs] to low and middle-income countries [LMICs]) is required – in addition to what countries can mobilize domestically. The global UHC discourse has completely ignored this fundamental point. UHC first and foremost must prioritize the needs of LMICs.	The achievement of health for all requires HICs and other global duty bearers committing global resources to close the gap between what LMICs countries can mobilize domestically and what is required for high-quality health for care for all. The Political Declaration fails to address this need to transfer resources from the Global North to the Global South for the achievement of the right to health for all. The status quo of global health funding is woefully inadequate. An estimated additional $371 billion will be needed each year for LMICs to reach the health-related SDG targets, of which at least $54 billion will need to come from official development assistance (ODA), i.e. external financing. Current ODA for health globally is only $24 billion. At a minimum, all donor countries must provide 0.7% of their GDP to ODA, while all governments must reach the domestic government expenditure target on health of 5% of GDP. Not only is it important that the quantity of global health funding is significantly increased, the quality of funding also needs to be improved. How aid is provided impacts its results, and currently progress is regularly impeded by poor practices (including 'tied aid'; excessive administrative and reporting burdens; promotion of parallel/vertical systems rather than strengthening the public health system).	Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries https://www.cgdev.org/commitment-development-index-

				2018#CDI_AID
4a Governments must provide health care to the public in order to achieve health equity. 4b Instead the status quo pushes the global South to privatize its health care systems, which only increases health inequities. .	The public provision of health care is a requirement of achieving health equity. Yet the dominant UHC discourse promotes the commodification of health through the privatization of health care and health insurance (i.e. health insurance coverage NOT health care)	UHC is now the dominant discourse in global health. The use of the term 'coverage' rather than 'care' clearly embodies the focus on health financing over health care. UHC as it is represented in the finalized Political Declaration, is a clear product of and serves to replicate the dominant neoliberal paradigm, promoting the division of health financing and health care delivery, to increasingly move countries away from public systems and toward privatization.	Equity and quality, key stated objectives of UHC, requires the strong public provision of care. Privately provided care is only comparable to the public provision of care in terms of financial protection. Pro-poor financing, including the elimination of out-of-pocket expenditure, is required to achieve equity. Study after study has shown that any fees or copayments increase inequity. Despite its ubiquitous use, the meaning of UHC remains contested. UHC has been used to refer to everything from realizing equitable, high-quality health for all via public financing and public provision of care, through to simply meaning financial protection alone. This tension about what UHC represents has never been resolved and instead, key institutions and Member States who hold power in framing UHC have papered over these fundamental differences about what UHC should mean, to give the appearance of a united front. The result is a Political Declaration which seeks to promote the commodification of care (and replicate the dominant neoliberal paradigm) by concealing and containing three fundamental debates: 1) The requirement of the redistribution of accumulated global capital to achieve health for all as fundamental human rights imperative. 2) The value of integrated comprehensive public provision of care vs privatized/verticalized/stratified service delivery; and 3) The value of public financing (where it can be mobilized through progressive taxation) vs health insurance markets;	Morgan, R, Ensor, T & Waters, H. (2016) Performance of private sector health care: implications for universal health coverage, The Lancet, vol. 388,no. 10044, pp. 606–12. World Health Report 2010
5 The public's perspectives are tokenized and they don't have a genuine seat at the decision-making table.	'Nothing About Us Without Us!' End users – community members, patients, the most vulnerable, civil	The political declaration obscures and removes the key asks of civil society and other non-state actors in the multi-stakeholder process (despite this process being set up to inform the declaration).	The "Key Asks from the UHC Movement" presented by the UHC2030 at the Multi-stakeholder hearing in April 2019 to inform the Political Declaration, contained a number of critical components that have been either removed, obscured or not included in the Political Declaration, including: clear and strong references to public systems; language on the need for a paradigm shift; the importance of progressive tax systems; government responsibility and ensuring health as a social contract; social accountability mechanisms; importance of CHWs; policy on	

	society all need to have a seat at the decision-making table – and not be tokenized. The genuine input of civil society, especially those from the Global South is critical, yet the declaration and discourse on UHC ignoes key recommendations form civil society.		intellectual property; understanding and regularly evaluating who is left behind; government as duty bearers including when there is private provision; international legislations on tobacco, labor laws, humanitarian responsive and international human rights law; and prioritizing debt restructuring to address debt sustainability issues. All global advocacy efforts pertaining to UHC must ensure that people living with a diverse set of conditions, their families and care providers, particularly among the world's poorest communities are given a voice and meaningfully included in decision-making processes and civil society efforts advocating for health for all. Meaningful inclusion prioritizes and amplifies the voice of the most vulnerable communities to participate in every aspect of policy and program planning from design, to implementation to evaluation. This must also include participation and attendance at global conferences and meetings, with a priority for global advocacy and policy discussions and decision-making forums to not be hosted in the global north.	
6 At best, the declaration represents an empty promise for achieving the right to health. At worst, it advances the privatization of health care and advocates for different, selective "sets" of health services for different people. It disregard the hegemony, racism, and structural violence that created, sustain, and continue to increase global inequities.	The version of UHC presented in the declaration represents selective "sets" of services. i.e. equating to 'some (low level of) health care for all' rather than meeting the health needs of all, equitably.		The Political Declaration clarifies the meaning of UHC as nationally determined "sets" of health services. This serves to undermine the meaning of health as a right as it promotes limited/selective sets of interventions consisting of marketable commodities and leaves much of the health needs to private markets. UHC meaning a few select services for everyone while the rest left to the market does not serve to promote equity. It also exaggerates the agency of countries to "nationally determine" these selective "sets" of services when resources are not available to do so. LMICs lack agency both in setting the global agenda for UHC and in their ability to reach the health needs of their populations. The seminal 1978 Declaration of Alma Ata called for the achievement of health for all by the year 2000, making clear that a "new international economic order" was required. However, the establishment of a sustainable and equitable economic order was not advanced by signatories, rather global capitalism increased national	

			and global inequities, with the policies of neoliberalism managing its inherit instabilities and crises, represented in global health by the promotion of Selective Primary Health Care. This turned the idea of *health for all* into *some health for some*. Rather than renewing the goal of health for all (i.e. high quality, equitable health) the dominant UHC discourse appear to represent *some health for all*.	
7 Powerful countries are only paying lip service to the idea of fairness and equity.	To achieve health equity there must be an explicit equity focus including measuring the progress for the lowest wealth quintiles, and for the most, marginalized, vulnerable, rural and hard to reach populations.			
9 In order to achieve UHC, we also must address the social, economic, and environmental factors that determine people's health.	Achieving health equity requires addressing the social determinants of health beyond the provision of health care services.	Addressing the social determinants of health requires comprehensive primary health care, which cannot be delivered by the private sector as it goes much beyond first contact care.		https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31831-8/fulltext#
10a Again, it doesn't have to be this way. Join us in pushing for a future in which	Summary messages		• PIH's conception of truly transformative UHC: ▪ Is a deliver strategy for achieving the right to health for all;	

billions of people live healthy, vibrant lives. 10b As a global community, we can realize the right to health for all through truly transformative UHC, but doing so will require vision, commitment, solidarity, and a rejection of the status quo. 10c Climate change hurts vulnerable and marginalized people the most. Health equity requires climate action.			▪ Is an integrated approach encompassing primary, secondary, and tertiary care; ▪ Meets the health needs of the whole population with high-quality care; ▪ Includes social support and addressing the social determinants of health; ▪ Promotes not just equity of access to services but equitable health outcomes, prioritizing the most vulnerable; ▪ Requires the public provision of care, in order to achieve equity, quality and clinical governance objectives; ▪ Preferences progressive tax-based funding over health insurance; ▪ Includes professionalized community health worker cadres of properly trained, equipped, compensated, and supervised community members serving as a bridge to care; ▪ Requires pro-poor financing, including the elimination of out-of-pocket expenditure, is required to achieve equity; ▪ Requires that governments allocate at least 5% of GDP to support the public health system; ▪ Requires that donor nations increase global health funding to close the financing gap of at least $77B annually (this number is an estimate from Jeffery Sachs and just for 'essential services'; WHO referred to $54B), between what LMICs can mobilize domestically, what is required to achieve health-related SDGs (Global ODA is currently $149B but would be $340B if donor countries met commitment of 0.7% GNI by 2015) ▪ Requires not just more but <u>better</u> quality aid: how aid is provided impacts its results, and currently progress is impeded poor practices (including 'tied aid'; excessive administrative and reporting burdens; promotion of parallel/vertical systems rather than strengthening the public health system), which is rarely ever discussed; ▪ Requires more egalitarian terms for non-aid related international cooperation which is equity/rights-oriented (for every $1 of aid that LMICs receive, they lose $24 in net outflows. This is mainly due to interest outstanding debt, illicit capital, and trade misinvoicing - this does not even	

			include the economic externalities due to environmental degradation and climate breakdown which are mostly felt in LMICs);	