Health for All Now!
People's Health Movement

WHO WATCH UPDATER

Universal health coverage stalls while financial protection goes backwards: Economic inequities contributing to UHC shortfalls ignored by WHO

Under Item 13.1, at this week's World Health Assembly, the delegates will review the report (in A76/6) on progress regarding the implementation of 'universal health coverage' and will also review four draft resolutions proposed by the Executive Board (EB152), in Jan and Feb earlier this year, including the draft resolution in EB152(5) which would provide guidance to the Secretariat and Member States preparing for the high level meeting on UHC at the UN General Assembly in September 2023.

A76/6 provides an assessment of the progress towards UHC at the half way point of the term of the SDGs (2015 to 2030) focusing specifically on target 3.8 on universal health coverage. The report notes that by one indicator, 3.8.1, there has been an increase in coverage from 45 to 67 percent in the period from 2000 to 2019 but that this has slowed down since 2019. (This service coverage indicator is extremely basic and is qualified as 'indicative only' whatever that means.) Indicator 3.8.2, which relates to financial protection measured by the proportion of population experiencing catastrophic healthcare expenditure (CHE), shows a sharp worsening. (The report comments that there is no indicator in place to measure care foregone and needs not met and that this would be required for the full picture of progress (or not) towards UHC.) There has been a similar lack of progress in most of the disease specific targets of SDG 3 as well. Further disaggregating the data across countries shows that much of the improvement has been experienced in HICs. Within countries, those who are poorer, have less education or are living in more under-serviced habitats did worse. Taken together these data present a very disappointing picture.

The report affirms that the shortfalls in relation to UHC (and other SDGs) are in part a consequence of the COVID-19 pandemic including the lack of international solidarity which was manifest during and after the pandemic. Inequities in access to COVID-19 vaccines are stark, with 22% of the population fully vaccinated in lower-income economies compared to 75% in high-income economies, as at 19 December 2022 (para13). Likewise the impact of the pandemic in many countries was exacerbated by social division and lack of trust. A76/6 does not explore the origins and impact of the shortfalls in international solidarity during Covid in relation to health systems development, nor the fundamental political, economic, and cultural drivers of this failure of solidarity. Understanding these drivers would throw valuable light on the stalled UHC project. The report also highlights the barriers to UHC which arise from the intersecting crises of climate change and natural disaster, regional conflicts, economic recession and income inequality, spiralling inflation rates, public and private debt, and growing energy and cost-of-living challenges.

Notwithstanding the recognition of these dynamics in the first part of A76/6, the later sections of the report and the commitments in the proposed draft resolution (EB152(5)) are largely cast within the familiar health policy boundaries with little of substance directed to more fundamental barriers to UHC. This myopia is expressed clearly in para 43 which suggests that, in discussing this item, the Assembly focus on how to:

- strengthen their national plans and increase government financing towards the progressive realization of universal health coverage, supported by evidence-based prioritization;
- reorient their national health systems to primary health care as a foundation for universal health coverage, health security and better health; and
- promote equity and accountability informed by national, regional and global evidence, data and multistakeholder engagement to ensure that no one is left behind in the progressive realization of universal health coverage and Health for All?

Clearly WHO's unique expertise resides within the technical specifics of health and wellness. However, WHO could be contributing more effectively to the intersectoral project by addressing the relationships between political and economic variables and health outcomes. This could include: tracing the trends and patterns in sovereign debt and fiscal capacity; analysing the impact on health care of structural adjustment packages imposed by the IMF; tracing the links between the flow of international assistance for climate change and the incidence of hunger and forced migration; or tracing the relations between tax avoidance and health.

Even within the institutional boundaries of 'health' this report and the associated resolution fail to engage with the basic controversy over the role of subsidised insurance markets and private providers versus public health care delivery.

The international financial institutions and big philanthropies have sought to limit the government role to provision of a very selective package of services (delivered by public and private providers) with beyond-the-package-services funded entirely through user pays in the private market, or partially underwritten through health insurance. This model has not worked. Primary healthcare must be organized as a global public good and a basic human right, rather than a marketable commodity. Market based approaches have not worked for primary healthcare. Primary health care must be universal and comprehensive, where ‘comprehensive’ means that all essential health services are covered.

The shortfalls in UHC are partly a function of limited budgets but they also reflect a design failure in treating 'coverage' as resource distribution through market forces and service delivery through private practitioners. This is a model which has been forced on WHO by the World Bank and the US, urged on by the big US philanthropies.

The cause of universal access to comprehensive health care will be further set back if this same model is further endorsed by the UN General Assembly in September.

In most low and middle income countries publicly funded insurance schemes have been introduced, mostly for hospital care, but these have failed to provide effective financial protection. These insurance schemes are not like the social insurance frameworks of Germany or Japan or Australia. In LMICs these subsidised insurance programs route public financing through private markets so as to allow private markets to grow, and in this they have been successful, although at great cost. However they do not provide significant financial protection. For primary healthcare, the push has been for purchasing through contracts, packaged and promoted as “strategic purchasing of primary healthcare”. There is no record of success in this approach.

While there are problems with public service delivery,they remain the mainstay for public health goals. Public services, without user fees, deal with health interventions as public goods. Clearly when the funding and administrative capacity are inadequate there will be major gaps but to lock in inequitable and inefficient health care markets is not a solution. A further problem is the persistence of vertical global interventions, with very poor integration into a general health systems strengthening and universal primary health care. This model is being replicated where NCD interventions are conceptualised as discrete commodities to be purchased/implemented without reference to the rest of the health system. The alternative would be the integration of NCD programs within comprehensive PHC.

The forthcoming high-level meeting on UHC is most welcome, but if the Political Declaration fails to engage with the fundamental barriers to the proper funding of health care and if it fails to engage with the issues of health system architecture it will be a lost opportunity. PHM calls on member states and civil society to actively engage in the shaping of the Political Declaration between now and September.

PHM appreciates:

- the recognition by WHO of the need to include indicators of foregone care and unmet needs and quality of care as important indicators of progress towards UHC;
- the call for more fine grained measurement and disaggregated reporting of these indicators so that inequities in access are measured and addressed;
- the recognition by WHO of the need to improve civil registration and vital statistics systems (current estimates which are often based on crude extrapolations from very scarce or absent country data);
- the call for increased financial investment in the healthcare workforce, employed on fair terms of employment which meet labour standards;

- the call for including public health actions in primary health care (while noting that the technical support provided in this area is inadequate);
- the recognition of social determinants in the resolution, but the political declaration must ensure that progress on all the SDGs related to the social determinants of health are followed and the accountability of global bodies on trade, environment and human rights in these areas is made clear.

However, PHM calls for redoubled efforts to ensure that the UN political declaration also include calls for:

- Closer attention (analysis and policy) to the structural roots of fiscal limitations. WHO must be mandated to work with the relevant UN agencies to identify and ameliorate the structural barriers to domestic funding capacity for healthcare in LMICs;
- Central role for public sector service delivery. Primary health care encompasses preventive, promotive care and of public health interventions, all of which are known areas of market failure. Accordingly, they require public service delivery (or publicly administered programs even when services are contracted from private sector providers).
- Caution about marketising health care. Clinical decision making on care should not be shaped by personal financial incentives. Insurance schemes, 'pay for performance', and fee-for-service approaches all tend to shift care provision to those services and customers that are most profitable for the private provider and thereby undermine equitable access to quality healthcare.
- Affordable access to all essential health commodities. Countries or regions must have the capacity to obtain at affordable prices all the essential health commodities required for all primary health care services. This would necessarily require greater capacity in domestic manufacture, price controls, and public procurement. For example, in most LMICs, universal access to diabetes care will not be possible until human insulin and insulin delivery systems become much more affordable.
- New technology innovation for public priorities on non-commercial terms. This requires a different approach to product innovation, one that is less based on restrictive patent regimes and more dependent on public financing and cooperation between academia, industry and governments in the global South.
- Cost-effectiveness studies for choice of technology not for rationing access. We see an important role for cost-effectiveness studies in determining what are the best technologies for addressing health needs and whether sophisticated new technologies are value for money. In a comprehensive primary healthcare approach, the principle must be that all basic services that are effective and cost effective must be included. Only exclusions need to be specified. Interventions that can be provided by existing categories of health workers and require health

commodities are already on existing lists of essential medicines and diagnostics would cover 90% of primary care needs.

- Reducing the role of separated vertical programs. As primary health care networks are strengthened with human resources and essential commodities and skills and support, separate vertical programs need to be integrated into coherent healthcare provision, except where needed for technical support, research and innovation, and action on specific social and commercial determinants.

The full PHM commentary on this item provides more detail and references. See also Tracker links to previous discussions of UHC.

See Tracker page for this WHA76 session (here). To ensure that you receive Update Alerts ensure you are subscribed to the Updater.

The WHO Tracker and PHM item commentaries are produced as part of WHO Watch which is a project of the People's Health Movement in association with Medicus Mundi International, Third World Network and a number of other civil society networks. WHO Watch aims to contribute to democratising global health governance, through new alliances, new information flows and by broadening the policy discourse.

You can support WHO Watch by publicising the Tracker; by inviting others to subscribe to the Updater; and by following us on Twitter via @PHMglobal and @WorldHealthWatch.

To provide feedback on this newsletter please write to editor@phmovement.org.

Our mailing address is:

WHO Tracker / People's Health Movement
PHM c/- Viva Salud
Chaussee de Haecht 53
Brussels B-1210
Belgium
Add us to your address book