Basel, 8 March 2019

MMI input to UHC2030 “Key Asks” survey

Dear Madam/Sir,

We will focus initial input by the MMI Network to the preparatory process of the UN High Level Meeting on UHC on the following:

1. **Development cooperation and UHC**
   The issue of development assistance for health (DAH) risks to be neglected in the mainstream discourse on UHC – see our joint workshop at the PHC Conference in Astana. Countries still relying on development cooperation have difficulties to play their expected role, and there is no debate on how development cooperation itself supports or hinders countries in achieving UHC.
2. **Structural critique of the UHC pathways**
   Issues such as Comprehensive Primary Health Care as core of every health system or financial issues around UHC have been addressed by MMI and its members and civil society partners over many years. They are not sufficiently considered in the preparatory process so far.
3. **The preparatory process itself and related legitimacy issues (representation, deliberation)**
   We refer to the blog of the MMI Executive Secretary Thomas Schwarz “Universal Health Coverage: It’s up to you, New York, New York…” published last week as editorial of the MMI Network News and as G2H2 blog.

Overall, and this is also expressed in that blog, the outline of the current consultation on “UHC2030 key asks” is disappointing: The survey includes, in its background information, a long and detailed list of previous commitments or declarations they considered in the drafting of these “key asks”. These references should also be respected in the contributions to the consultation.

However, if adoption or improvement of existing approaches and language is your ambition regarding the outcome of the High-Level meeting and the content of the Political Declaration, the case for “adding value” is already lost: The meeting and its declaration will mainly confirm the status quo and current minimal consensus and risk not to contribute to addressing and resolving some of the challenging realities and questions regarding UHC.

In this sense, we kindly ask you to consider our input drafted under time constraints: We do not limit ourselves to the current minimal consensus on UHC expressed in the “key asks”, but rather look at what should be stated in a new Political Declaration on UHC and what risks to be neglected.

As the survey form does not allow to provide substantial input, please accept that we add the current document to our specific inputs submitted under every question/ item. At this moment, we do not intend to be comprehensive. We see it as our contribution at the beginning of a conversation, and we will be one of many voices. But we hope that our messages are clear and make sense.

Thanks for your consideration, and we look forward to more substantial interactions in the continuation of the preparatory process.

Best regards,

Thomas Schwarz, MMI secretariat

Medicus Mundi International · Network Health for All · Murbacherstrasse 34 · CH-4056 Basel
Phone +41 61 383 18 11 · office@medicusmundi.org · www.medicusmundi.org
“Sharing knowhow and joining forces towards Health for All.”

Q3. Political Momentum: Uniting firmly behind our commitment to universal health coverage, starting with greater investment and action.

Our comments and suggestions related to the first item ("We must achieve UHC to promote physical and mental health and well-being, and to extend life expectancy for all"):

1. Rather use the agreed SDC language: "...to ensure healthy lives and promote well-being for all at all ages" instead of "to promote physical and mental health and well-being, and to extend life expectancy for all".

2. The formula that "we must achieve UHC to..." is misleading, such as the introduction to the survey ("mobilise the highest political support to package the health agenda together"). Achieving UHC is a necessary and highly relevant contribution of the health sector, but there are other fields beyond UHC and the health sector that need equal attention, in particular addressing the social, political, economic and environmental determinants of health, including gender inequity. The ambition of "packaging the health agenda together" under the umbrella of UHC is therefore wrong and, in addition, opens unnecessary disputes with actors highlighting e.g. the fight against diseases or the human rights and SDOH agenda.

Our comments and suggestions related to the second item ("Unite the international community and global health partners, as well as regional and national stakeholders, to support Member States in carrying out their primary responsibilities to accelerate the transition towards UHC"):

1. The formula "the international community and global health partners, as well as regional and national stakeholders" is too vague and confusing: The challenge is mainly with the governments of all UN members (they are the duty-bearers, and they adopted the SDGs). It is up to the countries to provide (intersectoral, coherent) guidance, leadership and, when/if necessary, regulation. To unite in order "to support Member States in carrying out their primary responsibilities to accelerate the transition towards UHC" is not ambitious enough and does not distinguish clearly between the diverse fields of action and responsibility/roles of governments and other actors. It is mainly up to the g***overnments*** to unite to (a) fulfil their primary responsibilities to accelerate the transition towards UHC in their own countries, and (b) to support each other in this task. This support must go beyond development cooperation and include action on political and economic determinants of health policies and financing, e.g. migration, intellectual property right or capital flight/tax evasion. All other actors are called to align, contribute, and respect regulation.

2. Still related to the same section: In view of supporting/accelerating and not undermining national health policies and systems based on comprehensive PHC and UHC,

the role of development cooperation / development assistance for health needs particular attention: the aid and development agenda is often not aligned with national policies but captured by powerful external players motivated by political gain, profit, ideological or religious values, or misconceptions of problems and solutions.

Q4. Leave No One Behind: Reaching every person and community with comprehensive, quality health services and people-centered care, putting the poorest and most marginalized first.

Our comments and suggestions related to the first item ("Achieve UHC based on a resilient and responsive health system that provides comprehensive primary health care, with extensive geographical coverage, including in remote and rural areas, and with a special emphasis on access to populations most in need."):

1. We miss two important elements: the people-centeredness of the health systems, and the notion of equal access to health care for all. Universality means "for all" and can therefore be left unspecified, or, if it needs to be "translated", this needs to be as comprehensive as possible.

2. In the same sense, the "special emphasis on access to populations most in need" should be replaced by "equal rights" or "equal access" of all people within a health system, and this needs to be achieved by a public national health system that cares for both the provision and regulation of the sector and the redistribution needed to achieve fairness and equality, based on the right to health. In this sense special emphasis is needed to integrate all people/populations whose particular vulnerability is defined as being, for various reasons, outside any health care system and without any attributed or recognized rights, such as children without a birth certificate or displaced persons and refugees that often have no legal status.

3. It goes without saying that poor countries cannot be left alone in this task, but regulation and redistribution are challenges for global solidarity within and beyond Development Cooperation – and related instruments. The ultimate ambition of universality should reach beyond the national borders and limitations.

Our comments and suggestions related to the second item ("Incorporate the health needs of vulnerable populations in fragile settings in national and local health care policies and plans, by strengthening capacities for service provision, facilitating affordable and non-discriminatory access, reducing communication barriers, and training health-care providers on culturally sensitive service delivery"):

In particular in fragile settings or in the absence of a functional state / government, the challenge and responsibility to achieve universal access to health is with the international community, both in providing access for the entire population (regarding vulnerable populations: see above, comments on first item) and by undertaking all efforts to overcome the crisis. This cannot be left up to national and local health care policies and plans.

Q5. Sustainable Financing & Health Investment Harmonization: Mobilizing and using resources equitably and efficiently — including by aligning funds across diverse issue areas — to ensure everyone can get the health care they need without fear of financial hardship.

Our comments and suggestions related to the first item ("Commit to set nationally appropriate spending targets for quality investments in health, consistent with national sustainable development strategies, while improving the use of pooled funds more efficiently"):

This section is framed for a LMIC setting and should be adapted to make it relevant for all countries: Health financing and budgeting should correspond with (democratically) agreed health national policies and strategies. The responsibility to generate and pool the resources needed is with the respective health authority (at all levels).

Related to second item ("Optimise country investments by the development of country investment cases using standardised methodologies, and shift emphasis the highly cost-effective frontline health systems, building on existing services.") and including a section of the first one:

The language here is misleading and unclear: The rational and (cost-)effective use of resources and the focus on Primary Health Care are key elements in any sound national health policy and strategy, resulting from a democratic political process and not from an "investment case". National policies need to be supported and respected by international / external actors.

Our comments and suggestions related to the third item ("Encourage a better alignment between GHIs, and encourage them to improve their contribution to strengthening health systems."):

Global Health Initatives, but more generally all actors engaged in global health programmes and development assistance for health are requested to critically assess their roles and contributions, in order to strengthen and not weaken national health policies and systems. Instruments such as the Paris/Dacca Declarations or the IHP+ "seven behaviors" or the new Global Action Plan should be further developed or revised in a process involving those who are expected to benefit from them (or are rather affected by them), in particular the governments and people of the countries in the Global South.

Our comments and suggestions related to the fourth item ("Enhance international coordination and enabling environments at all levels to strengthen national health systems and achieve UHC, building on the Statement on sustainability and transition from external funding (i.e. develop policies on transition from external funds in the context of UHC; direct efforts towards sustaining or increasing effective coverage of quality priority interventions.)":

The focus on transition is misleading: Transition is just one setting that needs greater attention and coordination, the other two being ongoing need for external support and fragility.

Our comments and suggestions related to the fifth item ("Encourage consideration of how existing international financing mechanisms might be replicated to address broader development needs."):

One should not only mention how international financing mechanisms being replicated, but also pay attention to the debt burden (Sovereign debt crisis) of least developed countries. This requires urgent attention as policies to overcome this challenge (debt relief/restructuring) would free the much-needed resources required for many countries to advance towards UHC.

Reference: *"We acknowledge that debt sustainability challenges facing many least developed countries and small island developing States require urgent solutions, and the importance of ensuring debt sustainability to the smooth transition of countries that have graduated from least developed country status."* ([ref. A/RES/69/313 para 93)]

Unfortunately, the sovereign debt crisis has only deepened since 2015 – see https://csoforffd.files.wordpress.com/2018/09/joint-cso-submission-to-unctad-ffd-ige.pdf:

"Debt financing has been used too often in recent years, both by sovereigns and by private sector actors. In consequence, debt levels have surged to record highs. Four out of five low-income countries are at high or moderate risk of debt distress (according to the IMF methodology) or are already in default.

Debt service costs have surged massively in the wake of the borrowing boom. Debt service is competing with investment and social spending, posing a severe risk to the implementation of Sustainable Development Goals(SDGs)."

A 2018 EURODAD report (https://eurodad.org/press-unhealthy-conditions) concludes:

"The most damaging measures are those mandating budget cuts and public sector employment reductions. The prioritisation of debt servicing in countries with IMF programmes competes with health spending, in a way that rapidly growing debt service costs threaten to crowd out health spending" with the recommendation:

Creating fiscal space through debt restructuring must be the first option when countries face a protracted debt problem, instead of lending with conditionality."

It is of the utmost relevance and a requirement in the "UHC asks" to refer to and call for international Debt restructuring mechanisms in Low-income countries and debt sustainability/ reduction in Middle-Income countries.

Related to (development) finance advancing UHC, there is also the need to refer to some systemic issues: We quote some key sections of https://undocs.org/A/RES/69/313 part F:

"105. We commit to pursuing sound macroeconomic policies that contribute to global stability, equitable and sustainable growth and sustainable development, while

strengthening our financial systems and economic institutions. When dealing with risks from large and volatile capital flows, necessary macroeconomic policy adjustment could be supported by macroprudential and, as appropriate, capital flow management measures.

106. We recommit to broadening and strengthening the voice and participation of developing countries in international economic decision-making and norm-setting and global economic governance. We recognize the importance of overcoming obstacles to planned resource increases and governance reforms at IMF.

107. Consistent with its mandate, we call upon IMF to provide adequate levels of financial support to developing countries pursuing sustainable development to assist them in managing any associated pressures on the national balance of payments. We stress the importance of ensuring that international agreements, rules and standards are consistent with each other and with progress towards the sustainable development goals. We encourage development finance institutions to align their business practices with the post-2015 development agenda.

113. Building on the vision of the Monterrey Consensus, we resolve to strengthen the coherence and consistency of multilateral financial, investment, trade and development policy and environment institutions and platforms and increase cooperation between major international institutions, while respecting mandates and governance structures. We commit to taking better advantage of relevant United Nations forums for promoting universal and holistic coherence and international commitments to sustainable development."

Q6. Monitoring & Accountability: Improving monitoring and feedback mechanisms to hold leaders accountable to promises of Health For All and progress toward stronger, more equitable health systems for UHC.

Our comments and suggestions related to the third item ("Commit to produce data for SDG 3.8.1 and 3.8.2 indicators and ensure access to and freedom of use of data for accountability purposes").

We are confident that this item will be the focus of many civil society inputs. Generally speaking, to really achieve accountability (of the duty-bearers to the right-holders, and mutual accountability among duty-bearers), it is not enough with monitoring two standard indicators. In addition, we might need to adapt the tools and policies over the years. We would need to assure periodic evaluations of the implementation of the policies, considering if the means, the theoretical framework of this policies and the intermediate goals and results are still well oriented towards the final goal of UHC in the broader framework of Comprehensive Primary Health Care and universal access to health.

Q7. Foster Multi-Stakeholder Actions: Ensuring that all people, regardless of race, gender, age, citizenship or ability, are represented in the movement for UHC.

Our comments and suggestions related to the third item ("Strengthen multi-stakeholder dialogue with civil society, academia, private sector to maximize their efforts in implementing health goals. Also, promote and strengthen dialogue with other stakeholders to maximize engagement in and contribution to the implementation of health goals and targets through an intersectoral and multi-stakeholder approach, while at the same time safeguarding public health interests through the promotion of policy coherence.")

We clearly reject the currently dominating, but misleading and blurring "multi-stakeholder" narrative. There are different roles for governments, civil society and other actors. Governments, as main duty-bearers, are expected to lead health policies and their implementation in a democratic and responsive way and therefore in a structured dialogue with their people / civil society. Other actors are called to align, contribute, and respect regulation. People and their organizations shall be supported in any way to claim and defend their health related rights within and beyond the health sector. In any dialogue among those actors, the role must be clearly defined.

Our comments and suggestions related to the fourth item ("Strengthen collaboration between humanitarian and development actors for joint analysis, implementation of an essential package of health services, and monitoring, with more flexible funding modalities to facilitate long-term outcomes.")

The notion of an "essential package" of health services to be agreed and implemented by humanitarian and development actors is misleading and does not correspond with universal access to health services that need to be defined by the countries and people themselves. The notion of an "essential package" itself needs to be challenged, as it risks fragmenting and undermining the right to health and the universality of access to health care by restricting this right and universality to a minimal set of services provided to the poorest, increasing therefore inequity rather than overcoming it.

...and a final remark regarding your request to provide "authoritative" references: Our input is based on a critical assessment of global health policies in political and scientific publications. Detailed references can be provided; as a general reference, please refer to Global Health Watch, the alternative world health report published by PHM et al., and its sections on the global political and economic architecture and on Health systems. Global Health Watch 5: https://phmovement.org/download-full-contents-of-ghw5/