Input by Thomas Schwarz, MMI Network

Well, I will not represent here the “unified voice of civil society”. My structural role on this panel is rather to disturb the party. So let us go for it.

I will speak about:

- UHC as an umbrella?
- UHC2030 as a movement?
- Multistakeholderism
- Health care as a social contract

UHC as an umbrella?

Let me quote the UHC2030 “Key Asks” document: “The UN High-Level Meeting (UN HLM) on UHC is a major opportunity to mobilise the highest political support for uniting other health agendas under a common theme.” I could also quote many statements by WHO DG Tedros.

I kindly disagree.

The good news of the current focus on UHC is that the health system and the politics and economics of health are back at the center stage of the international debate on access to health, after too many years of working in vertical silos to fight against diseases or promote the health of particular groups. I could not be happier.

And I love the surprisingly strong political and public health language of the “Key asks” paper. This document will be longer on my desk than the outcome statement of the High-Level meeting. But that’s no good news...

And yes, if properly designed and well implemented, UHC is the key contribution of the health system to achieving universal access to health.

However, the definition and iconography of UHC as an umbrella to unite all health agendas is intellectually, politically and strategically wrong.

Even WHO does not go that far. Its 13th General Programme of work includes three strategic priorities. UHC is just one of them, the other being the promotion of healthier populations (diseases, determinants) and health emergencies. (in italics: sections not read out).

The health systems “umbrella” hides in particular the free sight on the social determinants of health: “The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.” (quoting the WHO).
Everything is UHC now. UHC is #healthforall. This does not allow a sound conversation of the core of health systems and public health issues related to access to health care but leads to an overloaded and distorted discourse. Ask the Russian delegate at the New York hearing...

A UHC movement?

We talk today about a paper entitled “Moving Together to Build a Healthier World. Key Asks from the UHC Movement”.

When Medicus Mundi International joined UHC2030 two years ago, and later on its Civil Society Engagement Mechanism, we were quite explicit that we rejected their “movement” narrative, and we still do.

I have been engaged in social and mainly political movements all over my life. What I learnt is that, in being part of a movement, there is even a big difference between being existentially affected or just being in solidarity.

Last autumn, I attended the People’s Health Assembly in Dhaka, and listened to the stories of anger, oppression and pain, to the calls for mobilization and for a united struggle for social justice by representatives of social movements for health from all parts of the world. And I was touched by this existential core of the PHM movement. All that I – and other NGO people and academics attending the Assembly - could offer was our solidarity, and our contributions to their struggle at the place where we live and work.

What I know for sure: A social movement for health must be a people’s health movement. A movement for health cannot be organized top-down, with a secretariat hosted by WHO and the World Bank, and with interactive multi-stakeholder consultations and a civil society engagement mechanism.

So call UHC2030 as you like, but not a movement. And yes, let us talk to each other what we can contribute at all levels to achieving strong and people owned health systems. Let us learn from each other, get better organized at a global level.

And yes, let us work together where it makes sense, particularly in the production of global public goods (data, governance, regulation etc).

Of multi-stakeholder platforms and mechanisms

So UHC2030 is a “multi-stakeholder platform” and promotes “multi-stakeholder mechanisms”.

Last week, I participated in an “interactive multi-stakeholder hearing” in view of the HLM. I realized once more that some people do not even hear anymore how weird “stakeholder” and “multi-stakeholder” sounds.

When I was, at the end of the 1990s, invited for a first – and last – time to a stakeholder dialogue by Novartis on access to medicines, I first had to look up the word “stakeholder”, because I did not know it. Now we all have taken over the stakeholder narrative and paradigm from industry, we have become used to it, as we are used to talking about partnership and inclusiveness. I do not see much good in this.
Multi-stakeholderism is mainly an instrument of manipulation and co-optation. Pretending that we can achieve access to health, if we do it together in partnership blurs fundamental differences in positions, roles and responsibilities, power and interests of the different actors.

At the end of the Astana PHC conference, I walked out of the room, when the crowd started singing “We are the world”.

Yes, let us talk and negotiate with the private sector, where it is adequate, and where the process can be controlled and, if necessary contained. There would be much to say about hearings....

And yes, for many civil society colleagues, the temptation to follow and promote a “multi-stakeholder” and “partnership” narrative is just too big, as they think that it will help them to be heard...

The same happened with the WHO. But that’s a different story.

“Ensure people’s health as a social contract”

This is the single expression I like most in the entire “Key asks” document.

At the New York hearing last week, the WEF representative said that countries could learn a lot from the private sector, for example by seeing patients as customers.

Still in New York, civil society colleagues promoted the idea of asking the global health initiatives such as GAVI or the Global Fund to facilitate and convene dialogues between national governments and civil society and to make good practices of engaging with civil society a condition for getting “aid”.

And, preparing for today’s meeting, I saw the announcement of an event at the Institute with the title “Is Democracy Good for Health?”

It is high time to stop this nonsense.

The fulfilment of the right to health cannot be imposed to a country, nor can access to health care be organized as a customer relation. People are not customers, and not beneficiaries. They are the people, they are sometimes individuals, sometimes patients, sometimes organized in many forms. They are the right-holders. And the state is the duty-bearer, a role that goes beyond regulation and stewardship of the health sector. Under international law, and in most of the constitutions, States and governments assume obligations and duties to respect, to protect and to fulfil the right to health.

But a well governed, responsive and caring State does not come easy, and neither does universal access to health care. They are the result of tough societal negotiations, or call it a struggle for the right to health, and too often this struggle is lost. Just the fact that countries signing the Global Compact of the UHC2030 movement or a political statement of a High-Level meeting will not change this.

Please read Richard Horton’s remarkable Lancet “offline” editorial last week!
“There are few indicators of a civilised society more telling than the presence of a strong health system. The morality of a health system surely cannot be separated from the morality of the wider society it inhabits. The political economy of a nation determines the way that country and its people envision a health system. Health systems are not Lego-like ‘building blocks’ of component parts. Health systems are a set of moral principles. The values of a health system are shaped by the values of a nation’s political economy. The idea that a health system can be separated from the history, politics, and economics of a country is a conceit that seems to have distorted advocacy for universal health coverage.”

Let me end with quoting my friend Amit Sengupta who passed away last year: “The struggle for health is a struggle for a more caring world.”

Thank you.

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“Sharing knowhow and joining forces towards Health for All.”

The struggle for health is a struggle for more caring world

Annual memorial lecture in memory of Amit Sengupta

Universal health care: Making it public, making it a reality

Chair- Sarojini N
Speakers -
David Sanders
T Sundararaman
Kajal Bharadwaj

Closing words- Amitava Guha

May 5th
6-9 pm

Multipurpose Hall
India International Centre
New Delhi
Moving Forward Together:
Key Asks from the UHC Movement for the UN HLM

Monday, 6 May 2019 | 12:30 - 14:00
Auditorium Ivan Pictet, Maison de la paix

This event aims to inform all stakeholders - in and outside of global health – about the Universal Health Coverage (UHC) Key Asks and results of the Multistakeholder Hearing for the UN High-Level Meeting on UHC held on 29 April 2019 at the UN HQ in New York. It seeks to provide a momentum for UHC in the context of the upcoming World Health Assembly (WHA), stimulating multistakeholder dialogues in health, and to look already ahead towards the UN HLM on UHC.

Speakers

- Ranieri Guerra, Assistant Director-General, Lead for UN High-Level Meeting on UHC, World Health Organization
- Jemilah Mahmood, Under Secretary-General, Partnerships, International Federation of Red Cross and Red Crescent Societies
- Uwe Petry, Head, Economic Affairs Division, Permanent Mission of the Federal Republic of Germany in Geneva
- Dessislava Dimitrova, Lead, Health Systems and Joint Ventures, World Economic Forum
- Thomas Schwarz, Executive Secretary, Medicus Mundi International

Moderator

- Ilona Kickbusch, Director, Global Health Centre, the Graduate Institute

Organised jointly with uhc2030