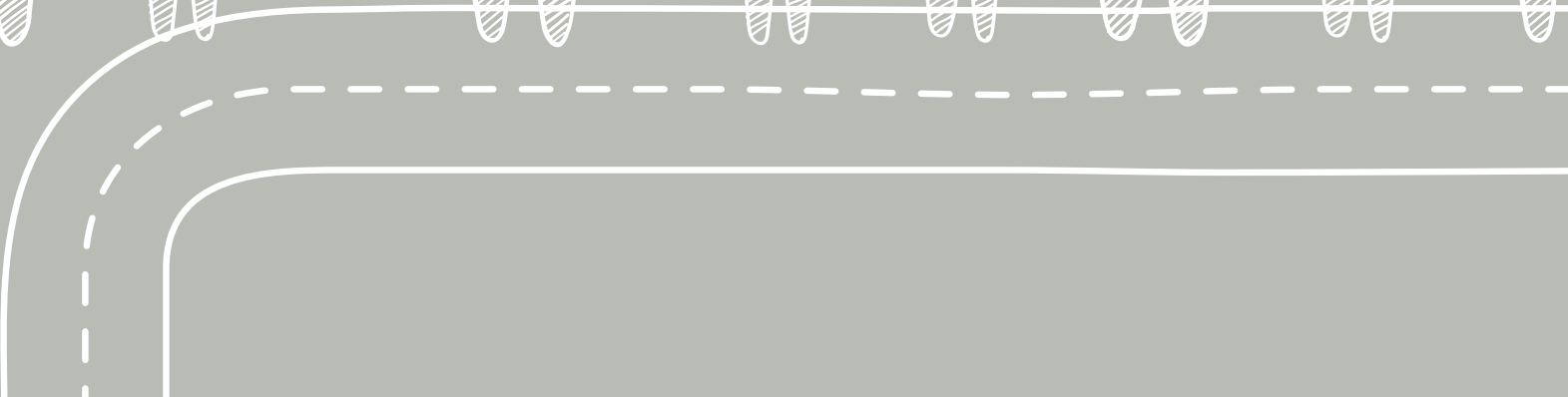
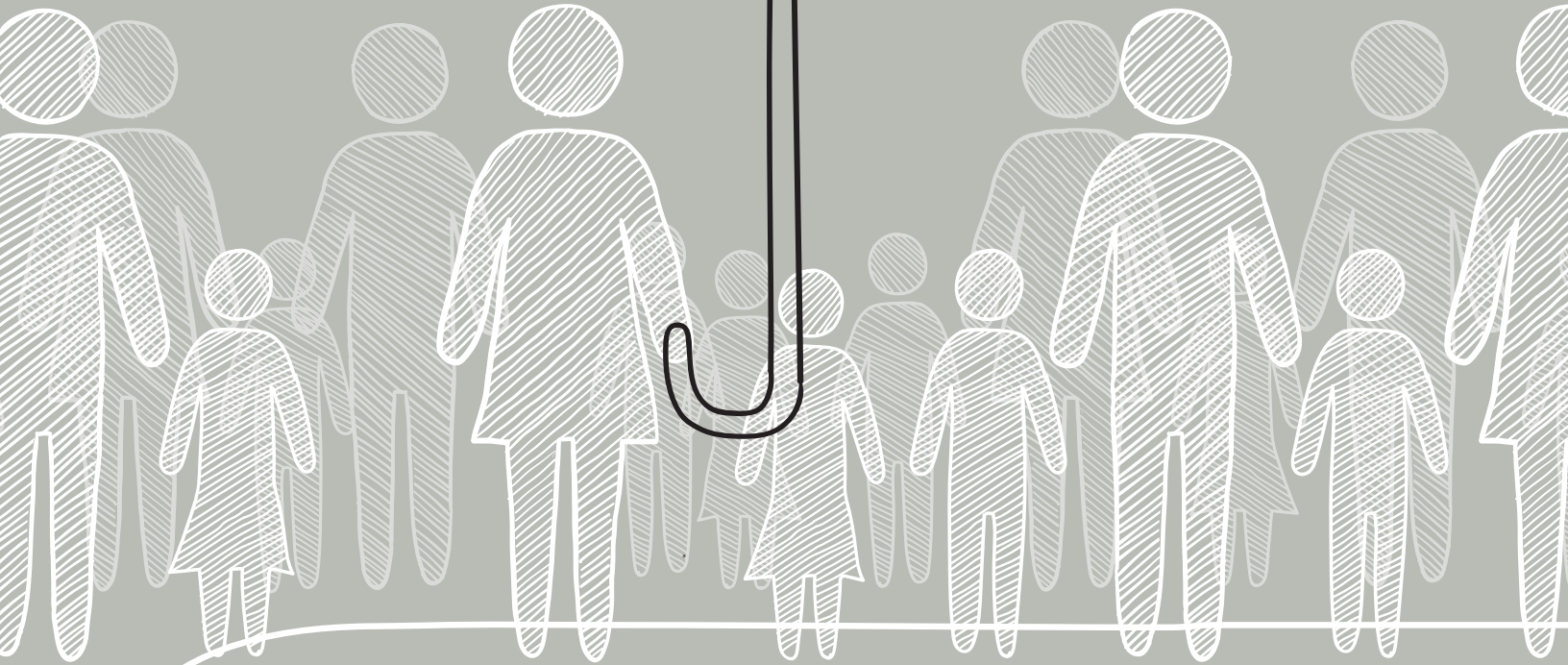
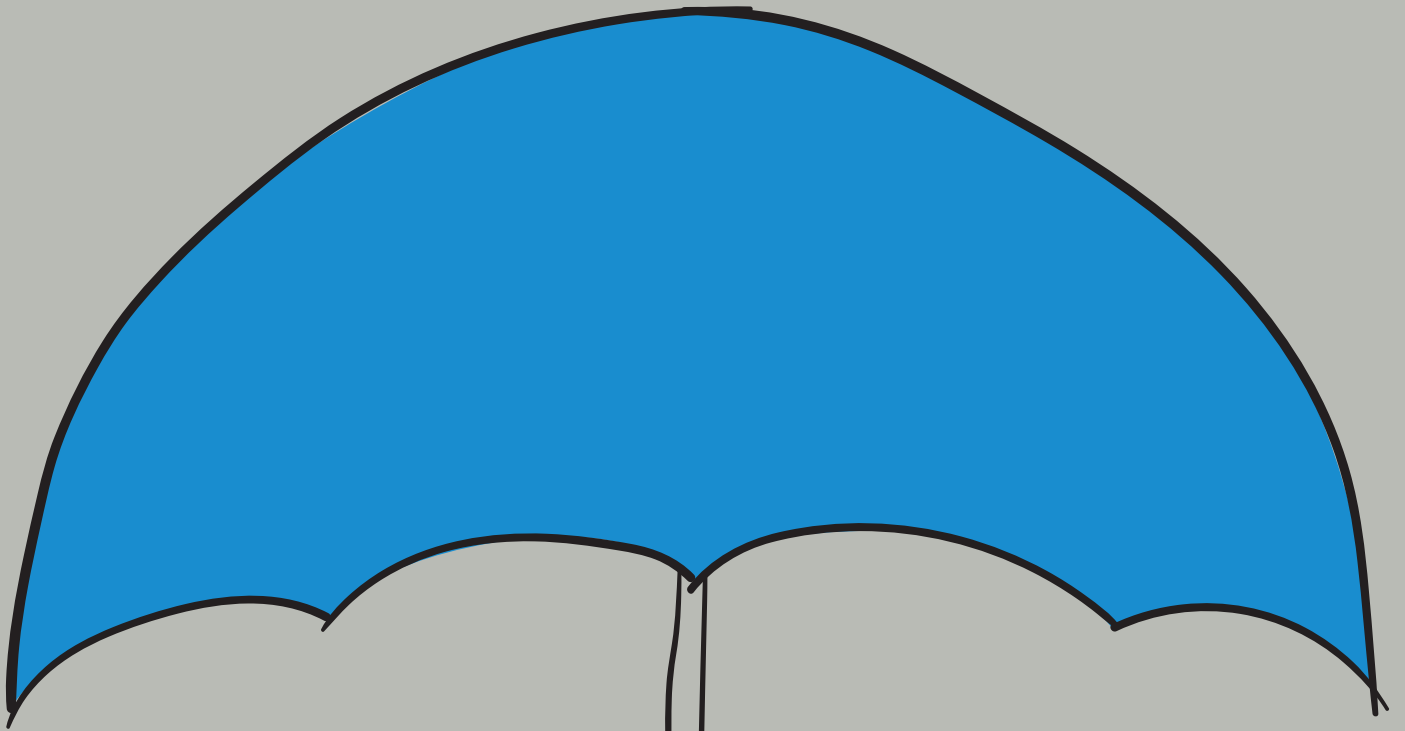




**Together on the  
road to universal  
health coverage**  
A CALL TO ACTION



**World Health  
Organization**



**CONFERENCE EDITION**



# Together on the road to universal health coverage

## A CALL TO ACTION

### **Universal health coverage is needed for people's health and sustainable development**

**ACTION:** All countries must make universal health coverage a political priority.

### **Universal health coverage is possible and affordable for all countries**

**ACTION:** Each country should use available evidence and tools to determine its own path towards universal health coverage.

### **Universal health coverage is people-centred and politically smart**

**ACTION:** Countries should ensure that universal health coverage meets the needs and aspiration of its people, with their participation.

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# Together on the road to universal health coverage

**A CALL TO ACTION**





## **Together on the road to universal health coverage**

As I wrote on my election as WHO Director-General in May, ensuring universal health coverage is our top priority at WHO. For me, the key question is an ethical one. Do we want our fellow citizens to die because they are poor? Or millions of families to become impoverished by catastrophic health expenditures because they lack financial risk protection? Of course not, because universal health coverage is a human right.



**A**chieving universal health coverage will be my top priority, because I believe it is the best overall investment in health we can make. Where health systems are strong, we are better able to prevent, monitor, detect and respond to health emergencies, At the same time, universal health coverage delivers disease prevention, health promotion, and treatment for communicable and noncommunicable diseases alike, while ensuring that individuals are not driven into poverty because of high costs.

At least 400 million people have no access to basic health services, and 40% of the world's people lack social protection. Think about some of the human realities behind these numbers. About the young mother who dies in childbirth because she lacks access to health care. About the young child dropping out of school due to impoverishing health expenses. About the adult living in the inner city of a middle- or high-income country suffering from chronic non-communicable diseases and not getting treatment or rehabilitation. About the sheep herders who will have to kill all of their livestock when a health system is unable to detect or respond with a new animal to human pathogen. And about adolescents and adults not receiving HIV/AIDS messages or getting protection from

exposure to tobacco-smoking so that they might take control of their health. Universal health coverage provides a forward-looking framework for countries to put people at the centre of their health systems.

I know from personal experience that it is possible for all countries to achieve universal health coverage. Even with low national incomes, countries can make substantial progress. Many countries have achieved universal health coverage at different levels of economic development, so this is more a political than an economic challenge.

The world has agreed that health coverage should be universal. SDG Goal 3.8 sets the following target for 2030: *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.* WHO will do everything in its power to help countries achieve that goal.

Ultimately a political choice, UHC is the responsibility of every country and national government to pursue it. Countries have unique and competing needs, and tailored political negotiations will determine domestic resource mobilization. WHO will catalyse engagement and advocacy with global, regional, and national stakeholders, including heads of state and members of parliaments, make UHC a top priority.

Countries will also need to know where they stand on UHC. What is measured can be managed – so data matter. Based on the evidence, WHO will track progress on how the world is meeting the health-related Sustainable Development Goal indicators, using a measurement system to help countries benchmark their attainment of universal health coverage.

Among the greatest contributions WHO can make is to help countries learn best practices from their peers, especially those with similar political or economic contexts. Achieving universal health coverage requires political leadership, national investment, health system strengthening and innovation. Evidence-based interventions can guide coverage decisions for promotion, prevention, care, and rehabilitation,



as each country develops according to its socio-economic, demographic and epidemiological situation.

Universal health coverage is not an end in itself: its goal is to improve the chances of every person attaining the highest level of health and well-being and contributing to socioeconomic and sustainable development. Attaining UHC is thus essential to every nation's economic productivity, health security, social stability – and

to every individual's well-being, security, and productivity.

We have a historic opportunity to transform world health. Let's take the opportunity at the UN General Assembly in September 2017 to make universal health coverage a reality for many more people.

**Tedros Adhanom Ghebreyesus**

Director-General, WHO







**1**

## **Universal health coverage is good for sustainable development**

Universal health coverage (UHC) means that all individuals and communities have access to quality services without financial hardship.

**U**HC is central to achieving better health and well-being for all people at all ages – as emphasized in Sustainable Development Goal 3.<sup>1</sup>

### UHC produces high returns across the life course

UHC can produce high returns, particularly when targeting those most often left behind – women, children, adolescents and older people in the poorest communities. Health has intrinsic value for individuals and their families, and also contributes significantly to social and economic development.

For example:

- The Lancet Commission on Investing in Health suggests a return of about US\$ 10 for each dollar invested in health services across the life course.<sup>2</sup>
- A comprehensive package of family planning, quality care in pregnancy and childcare, and preventing and managing childhood illness would yield US\$ 9 in economic and social benefits in low- and middle-income countries for every dollar spent.<sup>3</sup>
- Adolescent health investments can yield more than US\$ 10 in health, social and economic benefits for every dollar spent.<sup>4,5</sup>
- Integrated health investments in older age can reduce health care costs and burdens on caregivers – and promote independent functioning and social participation.<sup>6</sup>

### UHC contributes to broader development goals

#### Health services drive employment and economic growth

The broader benefits of health systems are underappreciated across government and society, with the health system commonly viewed as a “cost,” and health spending as a drag on productivity and public budgets. Since the health sector relies heavily on health workers, some economic theorists believe that the health sector cannot keep pace with productivity growth in the rest of the economy. That may be so in developed countries but not in low- and lower middle-income countries.<sup>7,8</sup>

If the health sector is efficient, its growth promotes broader economic growth. In developed economies, evidence suggests that each dollar (US\$) spent in the health sector can contribute as much as US\$ 1.77 to economic output.<sup>9</sup> In low-income and lower middle-income countries, health systems are much less developed than in richer countries, so health system improvements can have a much greater impact.

The economic co-benefits of a health system produce positive economic outcomes for a country through employing staff; purchasing equipment, supplies and services; investing in buildings and related facilities; developing communications, logistics and supply networks; and investing in human capital, such as training and education.

Globally, the health sector is a significant economic force, likely more than US\$ 8 trillion a year.<sup>10</sup> The combined health sectors of just the 34 Organisation for Economic Co-operation and Development member countries are larger than the economic output of any country except the United States and possibly China. The U.S. health sector alone is larger than the entire economy of France, making it the world’s sixth-largest “economy.” To this, we can add the value of goods and services related to the nutritional, sports and fitness industries, receipts from over-the-counter



## Life or death choices

Robert was 55 and thought he had his life ahead of him. A great job, a lovely wife, three great kids, healthy and doing well at school. But he started losing weight and had to shorten his morning run. He was so tired suddenly. And what was that strange pain? His world suddenly collapsed when he was diagnosed with a rare form of cancer, and told that without treatment he would probably not live longer than a year. In panic and despair, his family looked for second and more opinions.

There was an alternative treatment, an experimental one. But it was expensive, and doctors said

it might give him only one more year of life. The treatment was so expensive it would consume all the family savings, the money saved for college for the children and for rainy days. And if the treatment would not work, what would happen to his family? What about his children's education? What about the financial safety his wife enjoyed? After long and agonizing nights, Robert decided he would forgo the experimental treatment. He would keep his family financially secure. A little more than a year later he passed away. The children are in college now.

medicines, and expenditures on home care services. These bring the contribution of health services to the broader global health economy to US\$ 10.7 trillion.<sup>11</sup>

The global health sector is growing faster than the world economy, and this is unlikely to change.<sup>12,13</sup> Rising incomes increase demand for health-related services and products, and technologies create new opportunities to improve health. Ageing populations and age-related health problems can also increase demand for health-related goods and services. As a result, the health sector is growing faster than GDP in most economies, particularly in high-income countries.<sup>14</sup>

## Beyond the economic benefits, UHC contributes to well-being, social stability and health security

### GOOD FOR SOCIAL PROTECTION

Central to UHC is the need to protect persons from financial hardship due to health expenditures.

Out-of-pocket health spending drives more than 100 million people into poverty every year.<sup>15</sup> And individuals purchase too few necessary health services when they involve high out-of-pocket costs, possibly spreading transmissible disease.<sup>16</sup> High costs of care, such as treating multidrug-resistant TB, seriously hampers people's access to health services.<sup>17,18</sup>

Out-of-pocket health spending also reduces opportunities for purchasing food and basic amenities.<sup>19</sup> And by diverting resources from other purchases or resulting in the underuse of essential health services, it creates persistent, intergenerational inequalities.<sup>20,21</sup>

In addition, spending on health means jobs, and when these are decent jobs offering a range of social protection benefits by providing





income or consumption transfers, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalised, the social protection of the population benefits thereby.<sup>22,23</sup>

### GOOD FOR SOCIAL COHESION

Fiscal policies to promote health coverage are good not only for the health of people, for the economy, and for the social protection of vulnerable individuals – but also for basic social cohesion. Health employment also offers the possibility of jobs to members of social groups traditionally unemployed or underemployed, such as women and youths, as well as to populations in remote, rural or underserved communities.<sup>24,25,26</sup>

Exceptionally, the second half of the 20th century showed a sustained trend towards more equal shares of incomes between labour and capital in many countries.<sup>27</sup> In recent years, however, the trend has reversed towards greater concentration of wealth in the hands of a few. In this light, fiscal policy has become more prominent in promoting equality, and thus economic growth.<sup>28</sup> More equal societies are more economically productive in part simply because they have higher political and social stability.

Political stability is essential for sustaining economic growth. That's obvious. Less obvious is that the uprisings of 2011's "Arab Spring" were to a degree motivated by the desire for decent jobs and economic opportunities by parts of the population that had yet to see concrete benefits from post-colonial independence.<sup>29,30,31</sup> Persistent socioeconomic inequalities sparked massive political instability that in turn caused catastrophic hardships, economic and otherwise, for substantial populations, as well as causing significant negative knock-on effects for neighbouring and regional governments and societies. And greater spending on health by reducing inequality and increasing social cohesion can help maintain political stability

### GOOD FOR ECONOMIC DIVERSIFICATION AND INNOVATION

The economic benefits of diversification and innovation extend beyond their direct



### Chronic kidney disease hugely complicated by shortages of specialist care

Gaps in health service coverage add greatly to the misery of illness for such children as 10-year-old Seham, who has suffered from chronic kidney disease since the age of six. She and her family were forced to travel hundreds of kilometres in search of diagnosis and treatment because there were no dialysis facilities near her home in the north of Yemen.

Seham was already in a coma when she started her first dialysis session in Sana'a, in the country's west. This stabilized her condition, but the family could not afford the cost of living in Sana'a and had to move closer to home. They rented a one-room apartment near the hospital in Sa'ada City.

It is not only the kidney pain and gradual loss of vision that make Seham's life challenging. "Because of this disease, I had to stop going to school," she said. "All I want is to be free from this disease and to go back again to my studies."

Seham's plight illustrates what happens when a country like Yemen – the poorest in the Middle East – is unable to provide UHC due to lack of resources and the effects of conflict. Treatment for kidney disease – and noncommunicable diseases in general – are only available in about 20% of health facilities. And, in the midst of an economic crisis, many patients can barely afford the cost of transportation to get treatment.

Noncommunicable diseases are now killing more people than bullets or bombs, accounting for 39% of all mortality in Yemen.

**If the health economy were a national economy,  
it would be the world's second largest**

contribution to national income and to human health.

Novel medicines can provide substantial health benefits.<sup>32</sup> Often, but not exclusively, the private sector responds to the demands for better health through innovation in technology, medicine and vaccines, equipment, information systems, and processes. The health sector's development is thus beneficial for economic diversification. For economies dependent on mining or tourism, an additional benefit of a strong health sector is that health sector employment tends to be countercyclical. Health employment can continue to grow even when other sectors are shrinking, or it shrinks less than other sectors in response to economic shocks.<sup>33,34,35</sup>

#### **GOOD FOR CONTAINING PANDEMICS**

The health system provides health security beyond improving health, being on the front-line to preparedness for epidemic surveillance and response. The Ebola epidemic is estimated to have reduced economic output in the three hardest hit countries by US\$ 3–4 billion, of a prior output of about US\$ 50 billion,<sup>36,37</sup> a result of the disruptions in trade, commerce and population movement.<sup>38,39</sup> Tourism and travel bookings in African countries far removed from the epidemic were also affected. Food production fell, and food security was adversely affected for upwards of 1 million people.<sup>40</sup> Human capital and other assets were in some cases directly affected (for example through the death of health workers). And essential refurbishments to or investments in manufactured capital were also postponed or cancelled as a result of the epidemic's generalized social disruptions.

But health emergencies do not have to incur such impacts on the economy. By investing in health emergency preparedness, a key





## The power of UHC in the fight against childhood pneumonia

Without the timely intervention of a skilled community health worker and a health facility – two cornerstones of UHC – two-month-old Tarunish from Ethiopia would almost certainly have died.

Her mother brought her to a community health day near her village, where she was seen by Mayasa – a community health worker trained in the diagnosis and treatment of common illnesses. His training told him she had all the symptoms of severe pneumonia: laboured breathing, inability to breast feed, and a blue-grey hue to her skin from lack of oxygen. Often children get sick and die before they are seen by a health professional, because health facilities are a long way from the family home, particularly in rural areas.

Mayasa gave Tarunish a first dose of antibiotics and told her mother to take her to the nearest health centre, two hours' walk away. Tarunish's mother did not rest and took Tarunish to the health centre immediately. When Mayasa checked a few days later, Tarunish was already fit and well.

The case is testimony to the power of UHC. Around the world, more than 900 000 children under the age of 5 years died from pneumonia in 2015. But – as in the case of Tarunish – almost all could have been saved by UHC measures such as trained health workers and people using affordable services at health facilities that provide quality care.

component of UHC, pandemics and health epidemics can be at best prevented, and at least detected and responded to quickly, minimizing their health, and economic impact. The U.S. National Academy of Medicine notes that “the annualized expected loss from potential pandemics is more than US\$ 60 billion,” against costs of preparedness of around US\$ 4.5 billion.<sup>41</sup> The most critical component, that plays the biggest role in the front line of responding to emerging pandemic threats are human resources, including the associated training and salary costs, which are an integral part of resilient health systems.<sup>42,43</sup>







# 2

## **UHC is within reach – it is technically and financially possible**

Many countries have achieved and sustained UHC. A range of evidence-based, cost-effective interventions and health system strategies to provide financial protection can support countries on their paths towards UHC.

UHC is technically possible. The evidence-based health interventions, the means to set priorities in various country contexts, and the policy and planning options all exist. Countries can learn and apply lessons to their situation to promote UHC.

It is also financially possible. The services to reach the health-related SDGs through UHC have been estimated to require an additional US\$ 370 billion a year.<sup>44</sup> The vast majority of low- and middle-income countries will through additional domestic health spending be able to provide most of the public finances to cover these needs.<sup>45</sup>

### Designing benefit packages

At the core of UHC, countries and communities need to determine which health services, of sufficient quality, need to be covered, identifying potential barriers to access.

#### WHICH SERVICES FOR UHC?

The type of services included in UHC and the delivery methods chosen should be determined by country priorities and resources. But all countries can reach some level of universality by:

- Creating enabling and health-promoting environments for households and communities, through *community and cross-sectoral services*, information for behaviour change,

and regulations and appropriate health taxes (such as tobacco, alcohol and sugar taxes).

- Ensuring that all people benefit from life-saving prevention services, such as immunization, even when it requires establishing *periodic outreach services*.
- Ensuring *first-level health services* to respond to illnesses and health events.
- Building functional *referral services* that protect from health shocks (figure 1).

#### “BEST-BUYS” FOR UHC ARE ACHIEVABLE

With the broader scope and targets of UHC, the efficiency of health sector spending is under the microscope now more than ever before. Two main areas can ensure more efficient spending. First, the mix of health care interventions being delivered should provide the greatest possible value for money. Second, the services available should use the least expensive delivery method.<sup>46</sup>

Interventions that are effective (high impact), low cost (affordable), cost-effective (deliver good value for money) and easy to implement (feasible) are “best buys” for the health sector.<sup>47</sup>

A small number of interventions, can be implemented for less than US\$ 1 a person. Tobacco, alcohol and unhealthy food policies, voluntary medical male circumcision for HIV, insecticide treated bednets for malaria, prenatal care and preventive treatment for diseases are examples.<sup>48</sup> Other interventions have higher

FIGURE 1. EXAMPLES OF ESSENTIAL HEALTH SERVICES UNDER UHC

Community & cross-sectoral services	Periodic outreach services	First-level health care	Referral health care
<ul style="list-style-type: none"> <li>• Health promotion – community, family, individual and living, learning, work, leisure environments, including m-health solutions</li> <li>• Social mobilization and support for health</li> <li>• Health taxes and subsidies</li> <li>• Prevention and control of disease and hazards, including environmental</li> <li>• Risk management preparedness and resilience</li> </ul>	<ul style="list-style-type: none"> <li>• Immunization, large scale preventive treatment for NTDs, vitamin supplementation</li> <li>• Surveillance, screening and monitoring</li> <li>• Targeted discrete services, including follow up</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive health status assessment</li> <li>• Integrated case management including emergency services</li> <li>• Referral to health and social services</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive specialized health status assessment</li> <li>• Integrated, specialized case management including emergency and surgical services</li> <li>• Links across health and social services, including for long-term care</li> </ul>

**TABLE 1. PROJECTED INCREASES IN HEALTH AND WELL-BEING THAT WOULD RESULT FROM INVESTMENTS IN UHC**

Number of <b>healthy life years gained</b> , 2016–2030	<b>535 million</b>
<b>Average life expectancy gained</b> by 2030	<b>5 years</b>
<b>Unintended pregnancies averted</b> due to use of modern contraceptive methods for family planning, 2016–2030	<b>400 million</b>
<b>Child deaths averted</b> (0–4 years), 2016–2030	<b>41 million</b>
<b>Non-communicable disease:</b> Cardiovascular disease, diabetes, depression, epilepsy and cancer (deaths averted), 2016–2030	<b>20 million</b>
<b>HIV/AIDS infections averted</b> , 2016–2030	<b>21 million</b>
<b>Additional people with access to clean water</b> in 2030 (above 2015 baseline)	<b>226 million</b>
<b>Additional number of people accessing treatment for depression</b>	<b>94 million</b>

WHO modelled projections for 67 low-and middle income countries, 2016–2030

per capita costs but lead to long-term health outcomes, such as HPV vaccination to prevent cervical cancer through outreach services.<sup>49,50</sup>

Many of these interventions can even be delivered through low-cost cross-sectoral community services including m-health solutions or periodic outreach. As health systems become stronger, highly cost-effective interventions that rely on clinical health services – such as treating HIV, TB, malaria, cardiovascular disease, cancer, depression and other non-communicable disease – can be scaled up (table 1).<sup>51</sup>

### Strengthening health systems to ensure health security

A country cannot claim to provide health coverage for all its citizens if this right is only in some circumstances or for some health threats. UHC requires having health systems that are ready to take on the next type of health emergency, and continue to provide essential care under even the most challenging circumstances. With a health system leading inter-sectoral efforts for preparedness, a pandemic

### Investing in UHC is a smart investment

never becomes an epidemic, an outbreak does not become an epidemic, and outbreaks can possibly be prevented. A health system that has invested in preparedness works towards an aim of health security that means not just responding to a health emergency, but containing it or even preventing it.

Since the health and economic impacts of public health emergencies increase with the scale of their spread, investments in preparedness far outweighed the cost of responding to a health emergency that is not prevented, not detected quickly, not contained, and for which the health system, and the populace, are not prepared.

### UHC is affordable – the resources are there

Higher spending does not always improve health, but making the right investments at the right time can. Up to an additional

## Many countries – across the socioeconomic spectrum – have attained UHC or made major strides

US\$ 370 billion a year is required to reach UHC, including the SDG health system targets in 67 low- and middle-income countries, the equivalent of an average additional US\$ 58 per person per year until 2030.<sup>52</sup> These investments would boost health spending across a range of low- and middle-income countries from an average of 5.6% of GDP to 7.5%. (The global average for health spending is 9.9% of GDP.)

Realizing these outcomes, however, depends on increasing resources for health. Most middle-income countries and some low-income countries are capable of mobilizing the needed resources. Domestic resources can supply 85% of the aggregate investments needed in low- and middle-income countries.<sup>53</sup> But this requires making the health sector a higher priority in many countries.

Some of the world's poorest countries are projected to continue facing a financing gap and will continue to need external assistance. A financing gap of US\$ 17–35 billion a year is projected for low income countries, and US\$ 3–4 billion for conflict-affected countries.<sup>54</sup>

Even so, all countries, can reach some level of universality. In settings where clinical services are still underdeveloped and health workforce

density is low, there is still potential for rapidly moving towards full coverage with some key essential health services.

All countries could afford government funded universal access to the range of public health services delivered through cross-sectoral community services and periodic outreach delivery platforms. Examples include public health taxes on goods harmful to health, such as tobacco, alcohol and sugar, and delivering vaccines and medicines for neglected tropical diseases.<sup>55</sup>

Not every country can achieve a “full UHC package” at the same speed. But every country can make substantial progress over the next 15 years by looking at their resources, their priorities, and their health systems. UHC embodies progressive realization and a focus on those worst off. Each country should use available evidence and tools to define the package of benefits, and determine its own path towards UHC.

### **MORE RELIANCE ON (BETTER) PUBLIC SPENDING**

In most low- and middle-income countries, sustaining progress towards UHC requires both







more public funding (revenues) and more effective public spending (efficiency).

Countries need to move towards a predominant reliance on public funding sources to sustain progress towards UHC. Both theory and practice demonstrate that at best, voluntary private sources can only play a complementary role, and high levels of such spending tend to be associated with both inequity and inefficiency.<sup>56</sup>

Income growth does not automatically translate into greater public finance. Therefore, strengthening tax administration is a high priority, not only for health, but to enable all social expenditure, particularly as governments transition away from external aid.

Creating special taxes for UHC, or earmarking an existing tax, may be a politically useful way to “sell” a new tax. But in response to earmarks, governments sometimes adjust discretionary revenues away from health over time, so that the effect of earmarking on the share of

public spending devoted to UHC tends to “wash out” over time.<sup>57</sup>

#### **MORE EFFICIENT PUBLIC SPENDING**

Countries cannot simply spend their way to UHC. More effective use of available resources is essential. Within health financing, a key principle to support greater efficiency is to reduce fragmentation in how funds are pooled and flow.<sup>58</sup>

Up to 40% of resources in the health system are used inefficiently.<sup>59,60</sup> Countries could potentially achieve significantly greater health system performance, including improved health outcomes, at current levels of health spending. But a lot of the resources are largely fixed, such as salaries for health personnel, and not easily reallocated to new uses. Making health personnel work more effectively might in fact require paying them more. But other strategies are quick-wins, such as using provider payment mechanisms that create incentives for the use of generic drugs that have lower prices.

On average, where governments spend more on health, countries achieve better results in both service coverage and financial protection.

**Evidence-based interventions support country efforts to design UHC benefits**



## Treating HIV to avoid mother-to-child transmission

Love Saidi is happy she's healthy. She is also happy her husband can continue working. The young couple, who live in Ndirande, on the outskirts of Blantyre, Malawi's commercial capital, faced first-hand the struggles of living with HIV.

Love came to the Ndirande Health Centre with her husband in January 2015, when she was 3 months pregnant, to start antenatal care. She quickly learned that she and her husband were both HIV positive. Ndirande is one of the largest townships in Africa. Hundreds of thousands of its people struggle to access basic health and social services.

The Ndirande Health Centre delivers early antiretroviral therapy to more than 6000 people living with HIV. The clinic operates efficiently, with a few doctors training and mobilizing community health workers using a "task-shifting" approach to serve the needs of thousands of people like Love. At the clinic, Love took antiretroviral medicines to prevent mother-to-child transmission of HIV. Her daughter, Patience, was born without HIV later in 2015. And Love and her husband can continually access the free therapy and counselling at the clinic.

But for any given health expenditure, there is substantial variation in coverage outcomes.<sup>61</sup> This confirms the importance of developing context-specific efficient strategies for UHC.

In low and lower middle-income countries, substantial resources often flow through defined "public health programs," such as for HIV. Even if such programs are well run and effective, they may each have their own information system, procurement arrangements and even separate staff and facilities. Countries should explore the potential to streamline underlying subsystems while ensuring – even strengthening – accountability for results.<sup>62</sup>







# 3

## UHC is people-centred and politically smart



The broad and ambitious goal of UHC by 2030 calls for the mobilization of a broad range of stakeholders, first and foremost citizens, but also civil society organizations, service providers, the private sector and political leaders. Orienting a health system towards UHC puts people at the centre of decision-making. Popular views, perceptions and opinions are pivotal in shaping a UHC-oriented health system. Political leaders have a central role in constructing a health system that ensures the needs, opinions and rights of the people they represent.

UHC inevitably requires an immense amount of investment in health systems. But decision-making needs to bring together technical knowledge and population preferences underpinned by equity and human rights.<sup>63</sup> UHC is a social contract – an ambitious agenda contributing to peaceful and inclusive societies that provide equal access to justice based on respect for human rights, effective rule of law, good governance, and transparent, effective and accountable institutions (SDG 16).<sup>64</sup> Only health systems built on these principles are likely to achieve UHC.

### UHC is people-centred

In each country, UHC should reflect the health needs and aspirations of the whole population. UHC reforms must have people at its centre, with participation and dialogue as underlying principles. Bringing in citizen input into the way a health system is shaped also ensures

population ownership and buy-in to difficult reforms.<sup>65</sup>

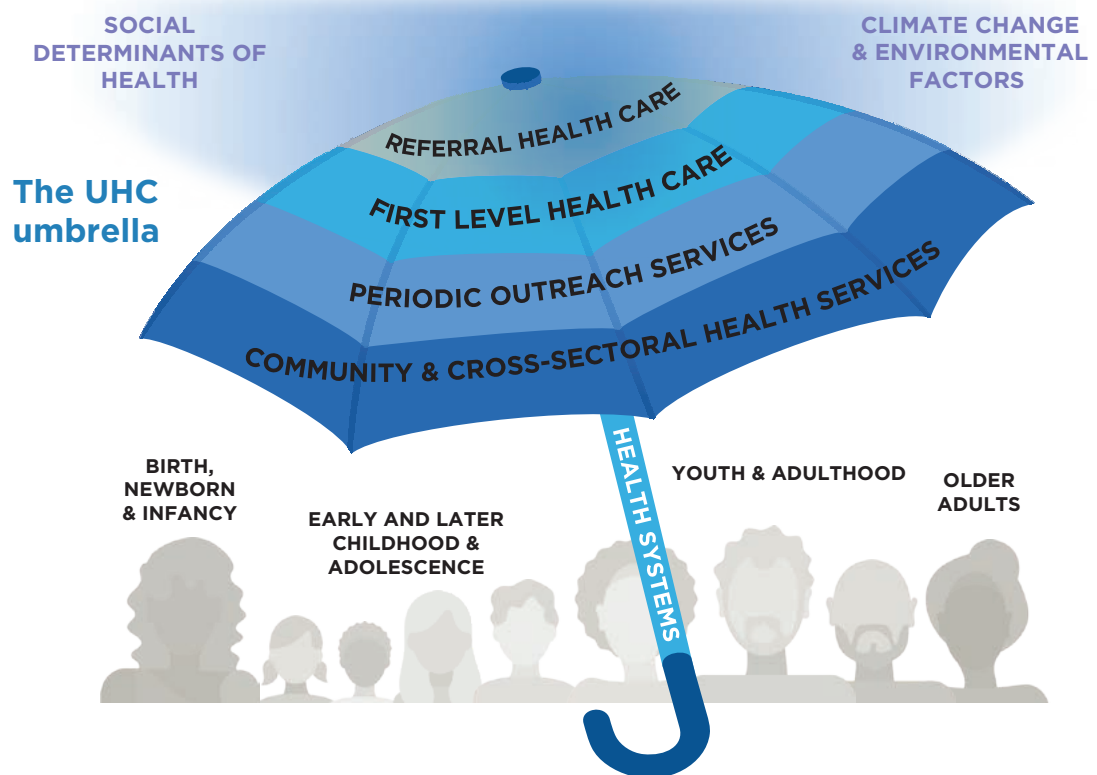
UHC is not an end in itself. It is a tool countries can use on the road to achieving the highest possible standards of health and well-being for all their people. In this way, UHC will best support the highest attainable standard of health and well-being at every stage of life.<sup>66</sup> And it will help people achieve their full potential as self-fulfilled and productive citizens.

An umbrella that protects the health of all citizens is a useful metaphor (figure 2). But the umbrella is more than a shield. It represents a proactive and people-centred approach to health that is as much about the demand for health services – and the political choices required to deliver them – as it is about service provision.

### INVESTING IN HEALTH SYSTEMS FOR UHC

Health systems are the backbone on which UHC is built. Interventions expanding population coverage, combined with interventions

FIGURE 2. A PEOPLE-CENTRED APPROACH: THE UHC UMBRELLA



## A new cure for hepatitis

More than 10 years ago, Parascovia Dogot from the Republic of Moldova tested positive for chronic hepatitis C infection. At the time, hepatitis C was rarely discussed on the world stage, despite being one of the deadliest infectious diseases.

In 2014, an effective curative therapy for hepatitis C was approved and recommended for global use by WHO. This decision shed light on the struggles of more than 70 million people who needed the cure.

Today, an increasing number of countries are delivering access to hepatitis C therapy. In Moldova, 3000 people, including Parascovia, have been cured. WHO supported the country in procuring generic hepatitis C medicines, which can cure chronic infections in 95% of patients within three months.

But 7% of all people living with chronic hepatitis C have access to treatment. Expanding access to hepatitis C curative therapy could be a key strategy to eliminate the disease.

focused on poverty alleviation, clearly contribute to advancing UHC.<sup>67</sup> Strong health systems are also essential to ensure both individual and global public health security.

Health systems should be *fit for people*, *fit for context* and *fit for purpose*. Countries can develop health systems and services to progressively meet the needs of their populations as health systems mature, building foundations, strengthening institutions and fostering transformations.

- *Foundations*: The foundations of a health system reside in well-functioning sub-systems, the health system building blocks, including human resources, medicines, information, service delivery and financing systems.<sup>68,69</sup>
- *Institutions*: Setting a coherent institutional frame, creating interconnectedness through legislative and legal frameworks, citizens'

voice mechanisms and the building of the technical capacity of policy, regulatory, management and training organizations.

- *Transformations*: Developing collective intelligence, helping health systems to evolve to respond to emerging challenges, embracing continuous adaptation and learning, and adopting knowledge as one source of social transformation.

Long-term planning, which may extend over several decades, can ensure that the design of UHC systems is sufficiently flexible to allow for growth and changing priorities.

In most countries, the private sector is a key provider of health services, sometimes the predominant provider. Changes in the burden of diseases and disease patterns, aging populations, rapid technology innovations, and restrictions of the public fiscal space all put pressures on governments. Governments should engage with the private sector with the aim of increasing investments for UHC, while deploying effective governance and regulatory arrangements.

### PEOPLE'S PARTICIPATION IS CRITICAL

People most in need of health services are often not reached.<sup>70,71</sup> Many factors – wealth, environment, gender, education, geography, culture and other structural determinants – affect health services uptake, and indirectly through relationships and behaviours outside the clinical setting. Addressing these factors requires different actors, including citizens, communities, civil society organizations, service providers and governments.<sup>72,73,74,75</sup>

Citizens' voices are important to build equitable health systems and to provide quality health services, particularly in settings with poor governance.<sup>76</sup> Members of the community need to recognize their entitlement to health but also understand the constraints of health systems.

**UHC is people-centred, and people's participation in decision-making is key**

## Strategies based on human rights, equity and gender equality are required to ensure that no one is left behind

This enables them to play an integral role in planning, implementing, monitoring and evaluating policies and services – and in identifying workable solutions.<sup>77,78</sup> Leveraging UHC laws and legal frameworks can enable wider and more active citizen participation in the new governance mode of health planning, policy-making and service delivery.

### UHC REQUIRES POLITICAL VISION AND WILL

UHC is achievable and affordable, even in challenging settings. A common factor in success is political vision and will in convening and leading a broad stakeholder base to help decide and implement the best form for UHC in each country. Strong political leaders will be able to listen to and manage differing views and conflicts of interest to broker a consensus leading to the most appropriate road towards UHC, including organizing and applying the resources to see the process through.

UHC is thus as much a political process as a strategic or technical one. World leaders have committed to the SDGs, including ensuring UHC. They now need to make the political and policy choices to make this a reality.

Political and economic frameworks determine how health budgets are set and where investments are made. This is a central consideration for UHC, and political leaders have a key role in deciding priorities for investments in health and ensuring they are carried out.

### UHC IS A RIGHT NOT A PRIVILEGE

UHC is about universal human rights and equity. The idea of UHC is rooted in the right to health, set out in the International Covenant on Economic, Social, and Cultural Rights.<sup>79</sup> Six legal principles underpin UHC based on the right to health: minimum core obligation, progressive realization, cost-effectiveness, shared responsibility, participatory decision making, and prioritizing vulnerable or marginalized groups.<sup>80</sup>

Countries need to ensure that every person in every section of the population knows which health services they are entitled to and how to claim them, without impediment. In turn, citizens should claim or – where necessary – demand their rights. In some cases this will require a revolutionary new approach to health care, placing people at the centre of policy, planning and service delivery.

UHC can be universal only if it applies equally to all people, so equity is central. The SDG principle of No One Left Behind should guide countries to put people first when designing their UHC systems – people who are marginalised, underserved and face discrimination. This will require approaches and investments that are based on human rights, equity and gender equality.

### Many roads to a common objective

UHC can enable citizens to enjoy their full health potential at every age by using health services that are appropriate to them. The 2030 Agenda connects the right of every person to the highest attainable standard of health to







the broader idea that this right should apply at every stage of life, from infancy to older age.

Choosing the right road to UHC will differ according to country priorities and resources, but the principles underlying UHC suggest a common starting point – to decide what form UHC should take, whom it should serve and how it should be delivered.

Each country should begin with the question: “What is our vision for the health of our people?” Answering will require extensive consultation, so UHC should be people-centred from the outset. A national needs assessment should consider all relevant health data. It should actively seek the views of people from all elements of the population, including marginalized and hard-to-reach groups.

### Bringing depression out of the shadows in Uganda

Bikutwala lives with his wife and four young children in a small village near the Pager River in the Kitgum district of northern Uganda. He experienced frequent headaches and lost his appetite and interest in the things he used to enjoy. He was struggling to provide for his family. He did not know what was wrong with him and felt guilty for not being able to support his family. At one point he felt so hopeless that he thought about drowning himself and his four children in the river to end his misery.

Neither his wife and family nor anyone in the village could help him. Until the health team from the district headquarters conducted an awareness talk. Bikutwala was treated successfully. In his own words: “the intervention by the district health team saved my life and my children! It has made such a big difference; it’s much better than someone giving me money!”

Countries need to take the pathway of “progressive universalism,” as articulated by The Lancet Commission on Investing in Health.<sup>81,82</sup> Countries, when designing UHC systems, should target inequities from the outset.

Whichever the road chosen, countries should always aim to increase the equitable delivery of health services.



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A group of people, likely healthcare workers, are shown from the chest down, wearing blue scrubs. They are gathered around, holding out their hands, some holding white pills and others holding clear plastic cups filled with water. The scene is set outdoors on a grassy area. The text is overlaid on the image in white, bold font.

**All countries must make universal health coverage a political priority.**

**Each country should use available evidence and tools to determine its own path towards universal health coverage.**

**Countries should ensure that universal health coverage meets the needs and aspiration of its people, with their participation.**