ISSUE BRIEF
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UNIVERSAL HEALTH COVERAGE IN THE POST - 2015 DEVELOPMENT AGENDA

The goal of universal health coverage (UHC) is to ensure that all people obtain needed health services – promotive, preventive, curative and rehabilitative – without financial hardship. The central tenets of universality and affordability make UHC an important human rights and development issue. **However, fully realizing the promise of UHC requires additional measures that complement universally available and affordable health services. Action on the social determinants of health, including laws, policies, norms and governance mechanisms that influence risk and access to services, and specific measures to include the most marginalized and vulnerable in UHC are two such measures.** As articulated in UNDP's 'Strategy Note on HIV, Health and Development 2012-2013,' UNDP is uniquely well placed to support such efforts through its work on governance, human rights, poverty reduction, capacity development and gender, drawing from experience in HIV and health [1]. UNDP can work with partners to help ensure that better health systems are built on a foundation of UHC and that systems for health are built on the promise of reducing health inequities and ensuring healthy lives.

Universal health coverage: a human rights and development issue

Health is enshrined as a human right in several treaties and in a number of constitutions [5]. UHC is anchored in a human rights-based approach to health, as it aims for all people to have access to health services regardless of sex, class, religion, ethnicity, social origin or any other factor. Many health conditions – communicable diseases, such as HIV, and non-communicable diseases, such as diabetes and cardiovascular disease – affect those already most vulnerable and marginalized. UHC can benefit these groups in particular. For example, many of Thailand's poor and near-poor were without health coverage prior to 2001. To reach these groups, the Thai Government introduced the 'Universal Coverage Scheme' in 2001. By 2005, the scheme increased use of inpatient care[1] among the poor by 8-12 percent [6,7].

[1] Inpatient care is the care of patients who require admission to a hospital or health facility.

Box 1: UHC in global policy

The '2011 UN Political Declaration on Non-communicable Diseases' (NCDs) recognized the importance of UHC as part of broader efforts to strengthen national policies and systems to address NCDs. The Declaration drew attention to primary health care, social protection and access to health services for everyone, especially the poor. In June 2012, the 'UN Conference on Sustainable Development (Rio+20)' emphasized UHC's role in enhancing not just health but also social cohesion, economic growth and development. The UN General Assembly highlighted UHC in a December 2012 resolution on global health and foreign policy, recommending that UHC be included in discussions on the post-2015 development agenda. Within the UN Development Group's (UNDG) consultation process on the post-2015 agenda, UHC has featured prominently in the global thematic consultation on health, alongside other related objectives such as reducing health inequities, addressing NCDs and safeguarding hard-won gains on the health Millennium Development Goals (MDGs). UHC is also highlighted in the reports of two other advisory processes to the UN Secretary General on the post-2015 agenda: the 'High Level Panel of Eminent Persons' [2] and the 'UN Sustainable Development Solutions Network' [3]. In his July 2013 report to the General Assembly, the UN Secretary General identified several transformative actions for all countries to realize a post-2015 vision. Improving health is one of those actions, with UHC highlighted as one component [4].

UHC contributes to better health outcomes. Apart from being important in its own right, health is an indicator and driver of development [8]. Three of the eight MDGs are explicitly about health. By expanding access to needed health services, UHC improves the well-being and productivity of people, households, communities and nations. In Mexico, for example, expansion of health coverage increased access to prenatal and childbirth care and contributed to significant declines in maternal and child

mortality.[2] Mexico is projected to reach MDG 4 on reducing child mortality prior to the 2015 target [9].

UHC can strengthen the resilience of households and communities in the face of health shocks, helping them to prevent and escape poverty. Poor health is a major driver of poverty. It reduces productivity and introduces costs associated with seeking care. Each year up to 100 million people, many already vulnerable, are driven into poverty by direct payments for health care [10]. Financial protection is a cornerstone of UHC, helping people access health services while protecting their savings, assets and livelihoods. Seen in this way, UHC can be more than a health intervention; it can also be a poverty reduction measure. For example, Mexico's national health insurance programme reduced out-of-pocket spending significantly and increased financial protection, especially for the poorest households[3] [9,11].

Universal health coverage requires complementary measures to realize its promise

Complementary measures are needed alongside UHC in order to maximize health outcomes, reduce health inequities and accelerate progress on broader development objectives.

Action on the social determinants of health is needed to realize the potential of UHC. Health services are only one factor among many determinants of health and health inequities. Health inequities persist in richer countries with decades of experience in UHC, even where health services are largely free of charge [12-15]. These persistent inequities are driven by underlying social determinants, such as levels and distribution of income, education, housing, nutrition and safety. These factors are themselves rooted in underlying social norms, inequities, laws, policies and governance arrangements.

Social determinants impact health by directly influencing risk behaviours, such as sexual networks, diet, physical activity, and use of tobacco and alcohol. They also prevent people, especially those already vulnerable and marginalized, from accessing health services. Stigma, discrimination and certain punitive laws, for example, continue to prevent certain groups[4] from accessing HIV treatment, despite remarkable progress in scaling up[5] [16].

[2] Maternal mortality declined in Mexico from 90.4 per 100,000 live births in 1990 to 51.5 in 2010. Mortality in children under five fell from 47.1 per 1,000 live births in 1990 to 16.7 in 2010 [9].

[3] Over the 10-month assessment period, Mexico's national programme, *Seguro Popular*, reduced by 23 percent the proportion of all respondents (29,897 households) experiencing catastrophic expenditures [11].

[4] Examples include people living with HIV, men-who-have-sex-with-men, transgender people, sex workers, people who use drugs etc.

[5] At the end of 2012, 9.7 million people in low– and middle-income countries were on HIV treatment, representing an increase of 1.6 million people from the year prior [16].

The importance of universal access, as well as universal health coverage, is reflected in the UN Secretary General's report to the General Assembly on the post-2015 agenda.

Action outside the health sector can positively influence behaviours, remove barriers to health services and ultimately improve health outcomes. Improvements in social conditions, housing and nutrition drove dramatic declines in tuberculosis in higher-income countries prior to the advent of effective anti-tuberculosis medicines [17-19]. Taxes on tobacco and laws on smoke-free places – both of which require coordinated multisectoral action – are key weapons in the fight against tobacco [20,21]. Cash transfers are another promising area for multisectoral action on the social determinants of health. They can increase access to and uptake of health services, influence risk behaviours and improve health outcomes [22,23]. Studies have shown that cash transfers can increase treatment adherence and retrieval of HIV test results [24,25]. Recent studies in sub-Saharan Africa have demonstrated how cash transfers can change HIV-related risk behaviours, resulting in significant declines in HIV prevalence or proxies for risk of HIV [25-28].

Social and legal protection measures are also important complementary measures. People affected by poor health or at high risk of poor health may face difficulties in securing or maintaining suitable employment or housing. Pension schemes and various forms of insurance may be out of reach, especially where they exclude people considered to be high risk or where they do not provide adequate benefits in the face of early illness or death. In South Africa, for example, many people living with HIV (PLHIV) have historically found it difficult or impossible to obtain life insurance. AllLife, a for-profit life insurance company, used innovations like continuous underwriting and active engagement in clients' health to become the first insurer of PLHIV. AllLife later expanded its offering to diabetics, who faced similar difficulties in obtaining affordable life insurance. In addition to providing financial protection, AllLife's life insurance model has improved clients' health, reduced HIV-related stigma, encouraged entrepreneurship and enabled access to finance. AllLife's initial coverage target is 50,000 PLHIV and diabetics; it estimates a total potential market size of over one million [29].

The implications of universal health coverage

Universal health coverage and the post-2015 development agenda

The framing of health in the post-2015 development agenda is crucial not just for achieving the right to health but also for achieving other development objectives, such as poverty reduction. The global thematic consultation on health in the post-2015 development agenda and the Secretary General's High Level Panel have proposed that health might best be framed in the post-2015 development agenda in terms of a goal to 'ensure healthy lives,' with outcome targets and indicators related to life expectancy or

premature mortality, among other options. This proposed overall goal and its associated indicators could be supplemented by specific targets for expanding UHC, promoting multisectoral action on the social determinants of health and reducing the burden of specific diseases, such as NCDs. A post-2015 development agenda anchored in such an approach to health would be transformative. The focus would be on the ultimate objective of maximizing health overall while allowing countries the flexibility to achieve that objective based on their unique contexts and priorities, all while ensuring a rights-based, equitable approach to health.

UNDP's role

UNDP can contribute to realizing the potential of UHC by working with partners in three areas: (1) positioning UHC as a human rights and development issue; (2) supporting multisectoral action for health and (3) strengthening UHC governance, design and financing.

1. Positioning UHC as a human rights and development issue

UNDP has significant experience in supporting governments to mainstream the health MDGs and gender into national development planning. On HIV, UNDP implemented a joint programme with the World Bank and UNAIDS to mainstream HIV into national development planning processes [30,31]. More recently, UNDP has engaged in developing guidance for integrating HIV and gender into environmental impact assessments of large capital projects in east and southern Africa [32]. The importance of protection from health shocks, including through UHC, can also be mainstreamed in UNDP's work on poverty reduction and building resilience. UNDP has already spearheaded analytical work in several countries that underscores the multidimensional impacts of poor health, especially on vulnerable groups [33,34].

2. Supporting multisectoral action for health

UNDP can support multisectoral action for health through its core areas of work. Health services can be delivered through non-health sectors to enhance service reach and effectiveness. In Namibia, for example, UNDP has supported the integration of HIV-related prevention services into the environmental sector. The project uses national parks as delivery platforms to extend services to remote populations, helping to fill gaps in the formal health sector and supporting steps toward UHC [35]. In India, UNDP has supported the National AIDS Control Organisation in integrating HIV service provision into other sectors. The Ministry of Shipping, for example, has committed to extending HIV promotion, prevention and biomedical services to port workers and communities around major ports [36].

UNDP can support multisectoral action on social determinants, addressing conditions that give rise to poor health and ensuring that people can access health services even when services are available and affordable. UNDP can support countries to implement the recommendations of the Global Commission on HIV and the Law as a way of addressing legal and human rights barriers to accessing HIV and health services for those affected by HIV [37]. In the Pacific, UNDP is working with WHO and other partners to help countries understand the intersection between trade, diets and NCDs and develop 'health-sensitive' trade policy that involves dialogue across trade, health and finance ministries [38]. In addition, UNDP has worked with academia to develop methods for cross-sectoral financing of action on social determinants [39-41]. The approach helps different sectors determine their financial contributions to multisectoral action that has benefits across sectors.

UNDP can play a role in ensuring that other social and legal protections complement the financial protection afforded by UHC and in strengthening links between social and health services, especially for vulnerable groups (see Box 2).

Box 2: HIV-sensitive social protection in India

HIV-sensitive social protection involves tailoring existing social protection measures such that positive impacts on HIV are maximized and negative ones are minimized [42]. A 2006 UNDP study in India found that the most visible impact of HIV at household level is the financial burden on HIV-affected families. In these households, PLHIV are often unable to work, families liquidate assets and/or accumulate debt to pay medical fees and children drop out of school to care for sick parents. Women and girls are particularly affected [43]. In response, UNDP has supported networks of PLHIV to better articulate their needs, understand social protection options and demand inclusion [44]. UNDP has also advocated for and provided technical support to relevant state and central ministries and civil society to expand the scope and inclusion criteria of India's existing social protection schemes, including by linking these schemes to PLHIV and those most vulnerable. For example, pension schemes have been amended to include women widowed by AIDS, while free road transport, legal assistance and nutrition have been provided to PLHIV [45].

3. *Strengthening UHC governance, design and financing*

UNDP can work with WHO and other specialist health partners on UHC governance, planning and design, including in areas such as inclusive governance and

human rights, which draw from UNDP core competencies. The greater involvement of people living with HIV principle

(GIPA)[6] can be a starting point for strengthening participation of vulnerable groups in health policymaking, including that related to UHC. Without specific measures and concerted advocacy to include those most vulnerable in UHC, these groups can be excluded from the benefits of expanded health coverage. This, in turn, increases their risk and vulnerability. Even when UHC does not formally exclude specific groups or health conditions, barriers within the health sector can exist and should be addressed. These barriers include, among others: enrolling and maintaining enrolment in health insurance schemes; health facility locations and hours of operation; suitability of health service packages; and stigma and discrimination by health providers. UNDP can promote participatory governance structures to help vulnerable groups raise these concerns and devise solutions. Having specialized health system entry points, including services delivered by civil society organizations, for different marginalized groups can be important, especially where stigma and discrimination are powerful deterrents to health-seeking behaviour. Integration and referral between health and other social services can also be beneficial in reaching vulnerable groups (see Box 3).

Box 3. Governance and design of local AIDS responses

UNDP has worked with 25 municipalities since 2011 to support the development and implementation of innovative, multisectoral municipal HIV strategies for key populations, such as men-who-have-sex-with-men, sex workers, injecting drug users and transgender people. In Lagos, UNDP convened health care providers, policemen, civil society organizations and representatives of the Ministry of Justice, to identify institutional and social and behavioural factors that influence access to health care for key populations, understand the impacts of stigma and to build trust and relationships among different stakeholders. Action plans were developed to improve stigma-free delivery of health services for key populations, including policy discussions about proposed legislation that would prohibit same-sex marriages and the development of a partnership network to document and report human rights abuses against key populations. This work is set to continue and expand in scope, for example in Indonesia, East Timor and Malaysia, with the support of UNDP and WHO.

[6] The GIPA principle was declared at the Paris AIDS Summit in 1994. It affirms that PLHIV should be fully involved in HIV policy development.

UNDP can also work with WHO and other specialist health partners on sustainable financing and coordination of development assistance for UHC, especially in contexts where broader governance reforms, such as decentralization, affect health system financing and delivery. UNDP supports countries to identify innovative financing mechanisms. In Uganda, UNDP worked with UNFPA and the Ministries of Health and Finance to implement the MDG Acceleration Framework on maternal health. Among priority actions identified was the creation of an MDG Acceleration Fund, a ring-fenced financing arrangement that multiple sectors could tap for MDG-related activities.

Increasing the affordability and availability of essential medicines is also critical to UHC and its sustainability. UNDP provides policy and technical support to countries to incorporate and utilize, when required, public health-related TRIPS[7] flexibilities, to lower the cost of essential medicines. For instance, when the government of India issued a compulsory license for a medicine used to treat cancer in March 2012, it used guidelines developed by UNDP to calculate the royalties due to the patent holder. The resulting compulsory license reduced the cost of the cancer medicine in India by 97 percent [46].

UNDP's role in a number of countries as interim Principal Recipient (PR) for the Global Fund to Fight AIDS, TB and Malaria focuses on health systems strengthening as a means for maximizing the impact of core investments in HIV, TB and malaria programmes [47]. In Zimbabwe, UNDP is interim PR for an HIV grant that, among other objectives, aims to retain the health workforce, strengthen community health systems and scale-up community programmes [48]. Progress has been achieved on a range of health systems-related indicators, such as the percentage of doctors in authorized posts as well as the completeness and timeliness of health information management system reports, especially from rural sentinel sites [49]. These experiences contribute to the overall aim of developing efficient financing modalities for UHC.

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5. See Universal Declaration of Human Rights: http://www.un.org/en/documents/udhr/. Article 25 provides that, “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.” See also the International Covenant on Economic, Social and Cultural Rights, Article 12. For a detailed interpretation, see the right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), General Comment No. 14, E/C12/2000/4. Geneva, UN Committee on Economic, Social and Cultural Rights, 2000. http://www2.ohchr.org/english/bodies/cescr/comments.htm.
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