Universal health coverage: political courage to leave no one behind

Thanks to the leadership of Angela Merkel and Shinzo Abe, universal health coverage (UHC) is on the agenda of the G7 Summit. The achievement of UHC will contribute to increased global health security by tackling much of the world’s ill health and associated poverty. As the G7 Summit approaches, it is time to consider what it will take to get to UHC by 2030.

In our increasingly globalised world, the fabric of global health security rests on resilient communities. Everywhere, whether in remote villages or crowded cities, resilient communities are ultimately made up of people who enjoy their basic human rights: to live in dignity, free from fear and free from want. UHC is a cornerstone of these rights and the right to health, with protection against financial hardship at its heart. This is why UHC must be more than a technical exercise. UHC is, and must be, about realising rights and redistributing opportunity. And, as such, it is inherently political—it is about addressing entrenched power structures and tackling disempowerment, marginalisation, and exclusion.

The backbone of our achievements in the AIDS response has been our commitment to maintain the focus on the rights of every individual. We chose not to look the other way as we were told to, whether in the name of sovereignty or culture, or because of powerful private-sector interests. We must do the same for UHC: remain grounded in the paradigm shift at the end of World War 2 that brought the Universal Declaration of Human Rights and the right to health. This commitment to cover everyone, including those outside of the salaried workforce and the very poor, began a new era of increased reliance on government revenue to finance UHC (eg, Japan in 1961 and the UK in 1948).

Five bold actions are now required to make UHC a reality for everyone worldwide. First, we need dynamic systems for health with people at the centre—ie, devising innovative ways to reinforce the interface between service providers and communities. Community health workers provide a crucial, integral, and cost-effective link to the formal health system. As we have known since the early days of AIDS, and as was recently shown in the Ebola epidemic, in many countries, community-based organisations are the only ones able to access the populations that are the most difficult to reach.

Second, we need to bring those being left behind to the forefront. Too often, we take the easy route as we move quickly to implement programmes, which inadvertently worsens inequality. It is only when we try to reach the last mile of the journey that we realise that we ignored the most fragile members of our communities—undocumented migrants hiding in the back streets for fear of being deported or the 700 million people living in remote rural areas.

Third, I urge that we go upstream and address the day-to-day causes of vulnerability—discrimination, injustice, inequality, and lack of access to justice and social protection. Addressing such issues will require new forms of partnerships, working across sectors, and reforming laws, policies, and practices.

Fourth, we must ensure that user fees are not replaced by health insurance schemes that rely on collecting premiums from people who are already struggling to make ends meet. Everyone should play their part, starting with taxes. Countries such as Brazil, Malaysia, Mexico, and Thailand have shown how building home-grown health financing systems can be done by prioritising general government spending for health. By raising government revenue, along with innovative financing, international aid, and other sources, we can, and must, fully fund UHC.

Fifth, to achieve UHC we need to better engage other sectors, craft regulations, and ensure more inclusive governance. This echoes my call for transforming our existing health architecture so that it, above all, serves people. The health architecture must be simplified and streamlined, and must engage civil society. At every step of the way, from designing and delivering integrated systems for health to being advocates, watch-dogs, and whistle-blowers, civil society will help us to maintain focus if we—the UN, governments, and other actors in the global health community—start back-sliding on our commitment to UHC.

I urge attendees at the G7 Summit to muster the political courage to embrace UHC as a human rights
enterprise. A rights-based approach to UHC means building systems for health, putting those being left behind at the very forefront, tackling the social determinants of health, fully financing UHC, and renewing our health architecture. Only if we muster the political courage to do so will we succeed in achieving UHC for everyone by 2030.

Michel Sidibé
UNAIDS, Geneva 1211, Switzerland
sidibem@unaids.org

I am Executive Director of UNAIDS. I declare no competing interests.

Copyright © Sidibé. Open Access article distributed under the terms of CC BY.

1 Abe S. Japan’s vision for a peaceful and healthier world. Lancet 2015; 386: 2367–69.