Six Years To UHC 2030: Time to Unite and Mobilize Global Health Actors

Center for Indonesia's Strategic Development Initiatives
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Speakers	Notes
Opening Remarks - Katri Bertram	• Dire situation in regards UHC as the figures are really shocking with half of the global population lacking access to essential services and financial coverage. • We see political commitment being made but very little is translated into action. For example, only 11% of countries have actual plan and strategy, so we are very far from the goals of UHC by 2030. • The World Bank and IMF meeting have just announced ambitious goals to reach an additional 1.5 billion people, a good momentum for the financing side of UHC which has been a challenge. • Different global health actors see the global health agenda differently [depending on their own perspective, position and interest].
	Panel Session I
Rob Yates	**6 years from 2030, should we give up on UHC or should we remain optimistic?** - I am an optimist, so if we see, in the last 10 years, yes it looked bleak, but if we see the history then we have been progressing. Even as we see right now our health system is recovering following the pandemic, but **we are progressing to UHC 2030**. In short, it is going in the right direction. Even now there are many great things that countries have done. For example, South Africa has signed the (NIH) bill into law. The South African election is next week so it is political. - **UHC is a political choice,** to socialize the health financing system and for the healthy wealth to pay for services. **For UHC, the financing will come from public domestic financing** and it will take time. - **Historically, crises after crises from economic crises,**

	health emergencies and more will make the governments find funding for health, saying "enough of this" to socialize the health system. We see the pandemic exposed the frailties of financing and **countries of all income levels tried to find the money**. - **In countries of all income levels and areas, we see a definite trend of politicians coming in to provide a universal type of publicly financed system.** No more means testing to define the groups of rich or poor.
Moderator - Katri Bertram	There is a really interesting debate if we look at the political situation from LIC to HIC and whether that political commitment is there. You pointed out the South Africa example and there is an article that says this NIH bill is catastrophic and would make the candidate lose the election.
Rob Yates	**So on political support, across parties, whether we should expect less support for UHC as the world shifts to the right?** - There is a vested interest to maintain the health system. In my country there is opposition between the conservatives and the labor party, so it is the same issue between the right and the left. - Therefore, for politicians to stay in power, we have something to offer to keep them in power. So, the trick is to sell UHC to politicians, we have got to be involved in politics.
Stephanie Dagron	**Looking at the political support, is this a driver why we are lacking progress in UHC? Or what are the other variables?** - Implementing UHC within the law system, we are not only talking about the realization of UHC in *some* countries, but **we should consolidate UHC in *all* countries as there are which remain excluded**. - In the last 2 years of the negotiation of the pandemic treaty, member states recognized strengthening the health system, health coverage and social protection. However, **social protection disappeared from the last text pandemic treaty**. While health systems and coverage are mentioned, there are **no mechanisms that have been developed by member states so far.**

	- **UHC and social protection are complex issues**, up to 10 years ago, this is the domain where states fought access to health care in their countries. However, **competencies are quite limited**, there is a paradox from the pandemic which shows lack of inclusivity of vulnerable populations and financing support. **Obstacle is that it is very national**. - **The issue is also the interconnectedness between UHC, social security and economics** as "*you have to first be wealthy before you can be healthy*". - We need to compel states to report about the system, look into the legal mechanism and implementation. **It's not sufficient to have [legal] acts, you have to really implement it**. - "***Social security systems and health care systems are based on solidarity, we all have to contribute to a collective fund***." It is a collective effort to ensure states are able to deliver based on the budget and technical support.
Moderator - Katri Bertram	- So many points which complement what Rob says. We often look at UHC and think of it as political. However, **we very rarely look at the legal implications and how it's embedded into national frameworks.** - On social protection, it is rare to be discussed in the context of UHC. UHC is about solidarity, distributing resources and ensuring there is no financial hardship, for certain populations, we need that support. - Many advocate for UHC says it is a health issue and does not want others to take our turf, yet the **concept of UHC has to have that element of social protection at the central**. - You touched upon concept of sovereignty. Yes, it should happen at the national level and we want it to be driven by domestic public finance and to have a national sustainable model. On the other hand, for global air and financing support from other countries, UHC is often missing and only comprises a small share of it. **There is advocacy at the global level but it is not really translating to financial support**. - On the legal obligations, the SDG and high level meetings on UHC last year are not legally binding treaties in the way the PA is supposed to be. They are merely political commitments and so how do we translate that in the national level that is legally binding and covers all population? "***How do we ensure that those legal***

	mechanisms are not used against populations which can see in many countries at the moment where certain population groups are being denied care because of their population characteristics. "
Diah Saminarsih	**Moving to more of a national level, what are your experiences from Indonesia as to the main gap resulting in slow progress of UHC at the national level?** - Even before the pandemic, the conception of UHC at national level was that the government **focused only on enrollment**. - Notwithstanding the high number of enrollment in Indonesia, **UHC nonetheless requires political commitment and as social participation** and these have lessened gradually. - Burden of UHC is at national level, but we do not have more resources, especially after the pandemic. With **limited resources and the political dynamic, the government has pushed for more privatization.** - **Privatization results in Primary Health Care and social participation to become less and less of a priority**. Therefore, the public also receives less of a quality of care. - With the new President Elect for Indonesia, **we need stronger commitment so that UHC also becomes stronger for Indonesia**. While it is concerning to see this happening in Indonesia, it is unfortunately an issue also happening elsewhere in the world.
Moderator - Katri Bertram	Thank you for highlighting the importance of social participation and civil society in the civic space play in UHC. It really is a bottom up demand, as Rob says, it is a good election platform for politicians for that reason.
Esther Nasikye	**What are Uganda's experiences at the national level, particularly on the role of social participation, civil society and change of civic space over the last years?** - Uganda does not have a UHC yet. We have always had agendas and commitments for UHC for the last 20 years, "**but commitments need to be translated into something tangible, such as financing**." - During the pandemic, the government had to find more

	resources which shows an increase from 7-8% to 10% for our health expenditure. This shows that **when we have a strong commitment, we can find the resources**. - Uganda has a young population, but **our out-of-pocket spending for health is almost 40% and this shows low prioritization and less of a commitment from the government**. If we are going at this rate, I'm not sure we can achieve the SDGs in the next 6 years. - Other than commitment, **accountability of our resources and commitment made are also important**. We need to appropriately invest in health and business to achieve UHC. All global businesses, the president, ministers and the government shall have accountability in making their promises and commitments. - We know that Community Health Workers (CHW) are the main resources and workforce that are reaching people that have challenges to access health care, **yet we are not investing in CHW and regard their work as voluntary**. So it is also imperative to ensure that we talk about **social accountability**, so that the people who are accessing the services and those who have challenges in accessing such services, can hold the relevant actors accountable. - Additionally, coalition between CSOs have been happening but most importantly **how could CSO engage with the government to improve accountability**. - In different countries such as the UK / US, opposition parties can discuss issues for the next election, but in other geographies as Uganda, this does not happen. So we need to look at **innovative ways for CSOs to engage with the government to hold them accountable, ensure advocacy and better allocation of resources to the health sector.**
Moderator - Katri Bertram	- Again, a highlight on the need or CSOs participation and civic space. - Now moving into the financing side, there are questions revolving around how do you do UHC with limited resources? Or in HIC with an aging population, or in Global South where most of the population is old and cannot contribute to the social security system.
Kimberly Green	**Can you share your insights on the global investments on UHC and PHC?**

	UHC: - First, we need to balance the optimism and how do we balance where we are headed and the ongoing crisis. We have various issues at the moment, including inflation, struggling to pay off debt, climate change, aging population, shifting priorities, essential medicines, and lack of significant investment. ***"So if there is a crisis, NOW is the crisis, it's a plural crisis. Given the multifactorial challenges being experienced by various countries, maybe this is the tipping point."*** - For UHC, we should not only look at the number of enrollment. **While enrollment is a good indicator, this is not the only figure to look at** as catastrophic OOP expenditures remain high and allocation of GDP expenditure for health remain lacking especially in LICs. **PHC:** - PHC is the approach to achieve UHC2030, unfortunately **investment for PHC is not where they need to be within the overall framework.** - ***"The Success of the Pandemic Accord will strongly rely on the scaffolding and foundation of a strong and healthy PHC as learnings from Ebola and COVID show, including to respond to climate resiliency".*** With the complicated climate catastrophe and environment we are moving into, **our PHC system is not ready even in HIC**. - UHC is a priority for a lot of countries although the financing is not there yet, but we are in progress. ***"We need to work better with ministers of finance, not only talk about return on investments, but also look at the multifactorial benefits that PHC offers to the stability of countries beyond having good health outcomes which in itself is essential."*** - **UHC is really a tale of 2 financial systems**; governments thinking how to use resources to finance the primary health system overall and that global health mechanisms are catching up. World Bank, Gavi, Global Fund have made commitments and amazing impacts. - DRC has made it into law that future investments and donors shall be made into their overall health plan, which is great. **It is important to have a legal approach that enforces and reinforces that public health mechanism,**

	and the need to find the flexibility for that.
Moderator - Katri Bertram	- UHC is so often interconnected to these other dimensions, because it is primarily at the national level, connected with national budgets and populations, it is really difficult to disconnect in practice. - **We think of [UHC] as its own silos and that it is disconnected from global health security**. We can see from the PA negotiation in the last two years - we cannot do health security without addressing your health systems , equity, financing. There has been incredible fragmentation and you took it even further to consider climate and conflict which makes it even more complex and funders do not like complexity.
Justin Koonin	**What are the roles of global actors and partnership? Do we have a unified partnership for UHC? What is mobilization?** - Increasingly the question is whether global partnership / multilateralism is the way to go? None of the local partnerships are disconnected. From 2019 with the high level meeting, it has been a momentous milestone yet we didn't go forward. In fact, we are going backwards as **UHC becomes a very deeply political situation**. - We are working with a system that needs to be there, but the limitations include **the need to ensure the agenda remains there with heads of states. We also need an action oriented, concrete and implementable system** which we have not had so far. - **Global partnership is needed but also need to develop appraisal if this is the way to go forward**, whether we are actually going to make progress this way. **It seems that from the bottom up, the picture looks a lot easier**.
	Panel Session II
Moderator - Katri Bertram	**We have identified the challenges from the earlier discussion and many people are seeking solutions, so what are the recommendations / guidance or how can countries be more strategic in achieving UHC?**
Rob Yates	**What do you want to see changing in terms of collaboration, in particular, financial support at the global level or should it be**

	more at the country level? - **We need to be more strategic by using aid** for who needs it most starting from the poorest countries in the world. This aid includes humanitarian support and global public goods. - There are instances where domestic public financing is the issue. However, countries in South Asia and some Sub-Saharan Africa cannot break away independently from the use of aid to build their own universal health system. So we need to work collectively with the new generation of UHC and better link from the global and businesses.
Moderator - Katri Bertram	- Fantastic topic and a lot of people are engaged in the discussion of **do we need aid or do we want to give countries ownership and responsibility.** - Stephanie, your earlier remarks touch on **groups of people are being legally excluded from services and this puts, particularly vulnerable groups including LGBTQI, refugees and migrants at a jeopardy.**
Stephanie Dagron	**What kind of pressure can countries that do not have any financial connection institute? How can we make states take more responsibility to ensure these populations are covered?** - Subject of UHC is extremely complex. While HICs have a social protection system that has been present for decades, we do not see community engagement in HIC. UHC in HIC is declining and countries are now at different stages when it comes to UHC. - "***We should use different instruments we have at our disposal, such as human rights instruments to put pressure on countries***". For example to tell Russia to comply with their obligations. We can also use global health security instruments to tell countries to improve step by step and what direction they need to go. - We see that **global partnership is working in silos.** WHO, ILO, Human Rights institutions, different countries all have different objectives according to their own situations. Therefore, coordination between all of these actors are required so there is something that should be done here.
Esther Nasikye	**Moving back to a bit more on the national level, what are your**

	experiences through the interactions between CSOs and the north-south? Are they working in silos or in collaboration? - To paint a picture, when a woman needs a vaccine for her child, it is at a corner in a facility from GAVI. She also needs tests for malaria and others which are located elsewhere that comes from the Global Fund. That woman maybe pregnant again and needs antenatal care that needs Global Financing Facility at another facility. **This is just to show how uncoordinated efforts across global health actors** render the woman to queue and wait all day which sometimes they cannot afford. **We need global donors to work collectively on this one system**. - Even when governments try to collect resources, it is still not enough financing as we still spend high out-of-pockets even when covered by insurance and have been taxed. Government has to spend on their health and **there is a great need for additional financing along with their delivery mechanism**. - A woman [or community] needs to have a voice on what health services are provided and the quality thereof. The **[community] voices need to reach the decision making table**. This is not just at the national level, or regional level, but up until the World Health Assembly to make member states accountable for the commitments they are making and the resources.
Moderator - Katri Bertram	- A highlight on OOP, as we see from LIC and HIC, we are looking at reintroduction of OOP. **There are so many lessons for HICs from countries in Asia and Africa as to what happens to the access and quality of services from OOP increase.** - On integrated services, we see these challenges also happening in HIC. Cross-learning is not taking place as we assume HIC is progressing with their 100 year existing systems. In fact **we are seeing both progress and regress at HIC.**
Diah Saminarsih	**So how does it work in Indonesia? Does CSOs work in collaboration or isolation both at the national and regional level?** - CISDI work together with other CSO nationally and regionally. CSOs work together easier and work in

	solidarity as we share the same spirit and perspective for the same cause, i.e. CSO social participation which we hope to be included asa a resolution in this WHA. - After the WHA, if we get a resolution, we need to make sure it is implemented at the national level. **Resolution of the WHA relies on successful policy and regulation and can be a good foundation for similar policy at the national level.** - Governance is an issue. Question is how do we govern CSOs' interactions? Whether CSO should only work with other CSO, but it should also include **how should CSOs reach out to other counterparts, such as the government to push for public finance for example**? While it is a challenge, this is also an opportunity. - There are fragmented policies at national and subnational level. Therefore there is a need for coordination between government, CSOs and other partners. - In Indonesia, we have COVID19 Task Force which cuts different sectors and actors which were successful in performing their duties during the pandemic. This shows that **it just takes commitment for multi actors and multi sectors to work together** as well as ensuring that the commitment to work together does not immediately end once the crisis is averted. So COVID has 2 sides of the same coin; it is devastating, but it also proves that **when we want to put the work together, we can**.
Moderator - Katri Bertram	Coalition of CSOs are easier. However, there remains fragmentation as to the funding for UHC coalition and work. While GAVI, Global Fund, GFF have a lot of financing for very strong civil society coordination and advocacy at the ground, we need to reflect on what would be needed to enable that willingness into practice.
Kimberly Green	**How can we provide more strategic guidance to have high quality public health financing?** - There are phenomenal initiatives happening across the world from LIC to HIC to achieve UHC2030 in different ways. We need to be generating resources from global health actors. - We can learn from South Africa to the DRC. DRC has put forward a vision to reform PHC gets delivered to reach the

	UHC 2030, including to set up different pilots, structure the system, finance, equip CHW, supervision, family doctors and placing them in the community with nurses, which is a very interesting track. **We need to systematize CHW and how to finance as well as support them as the existing mechanisms have been fragmented**. - **Countries are different and we need to be learning from different localities noting the diversity in population and geographies**. We also need to observe and understand the learning from multiple countries. Despite the differences, there will be commonalities. We can look at the different social insurance system versus the investments which have been made in different countries. - There is also **a lack of social engagement** and therefore there are lots to learn.
Moderator - Katri Bertram	- I totally agree as much of the global health architecture is still searching for a very simple silver bullet solution. - **There are a lot of arrogance and lack of patience on the learning and listening**. We hope to see the transition as UHC is a fabulous concept but it does not have a single solution. - **UHC needs to consider the specific community and country**, we need to cater and implement them for different populations in contact.
Justin Koonin	**Are we being strategic or are we rabbit-holing to UHC 2030?** - It's a very tough question but simply **we just need to get the narrative a bit simpler** although there is no simple solution when it comes to UHC and its financing. - **We need coordination between global health initiatives. We need to present a case for UHC which is simpler and reach the high level committee.** - There is ongoing funding for the CSO coalition and advocacy. For example, the SPHERE project (Social Participation for Health, Engagement and Research Empowerment) in Kenya, Argentina, Vietnam and Tunisia. Funding is to be expanded so we can develop in other countries to advance social participation. We still have a lot of work to do.
Q&A Session I	

Q1: How can we leverage other opportunities to achieve UHC, such as digital health, to become a part of health system and not in silos to close the equity gaps?	**Rob:** - I think we should work together not only with the governments for political situations, but also other sectors such as education and transport. - But to advance UHC, it is also important for other UN agencies to be more bold and brave, to work under the radar in opposition with authoritarian leaders in the pursuit of good health. **Kim**: - Digitalization is critical and essential for equity. It enables integration into the health system. We see how data is collected and used, how efficient it is for PHC, good quality management and view at other levels to provide a 360 view, what is happening at the populace overall. - We need to develop a strong back end system to enable the full integration of the health system. - It is critical, but it is also important to ensure that it is done in a way that is equitable and protected. **Stephanie**: - Digitalisation of health is not magic. It should just be used more efficiently and not fragmented. - We need to change the narrative. While access to health services and medicine are essential, it cannot be independent from the social protection aspect. - The way we talk is important, for example talking to the Ministry of Health and Ministry of Social Affairs. It is not sufficient to talk just about UHC and the health system.
Q2: So hould we focus more on the aspects of UHC (work taskforce, equity), rather than, UHC of in itself at declarations and see it as incremental and progress?	**Arush Lal:** - For the last 4 years, I have been studying the integration of international health security, the intense political moment we are finding in the global health community. The rise of authoritarianism makes it increasingly hard for health and human rights work. - We are better at working with economic institutions such as the WTO, but less so with defence institutions. - Fragmentation occurs not only between institutions, but also within institutions. Even WHOs have fragmentation on UHC.

Q3: 1. **UHC is nothing and everything at the same time, how could we simplify so that it can be achievable?** 2. **Should we engage with the private sector more, what is their role?** 3. **Global and country level collaboration, how do we encourage finance when there is barrier at the national level when implementing it?**	**Diah - A3.2**: - In Indonesia, in densely populated area they are heavily relying on the private sector. In the context of UHC, quality of health delivery, capacity building of health workers and others, private and public sectors work together hand in hand. - This ties to the need for innovative financing. Since UHC rely on domestic resources, it needs private sector involvement and government to formulate together to think what is best, as different countries have different needs, big homework for national policy makers. **Esther - A3.3**: - Different countries have different mechanisms, in reporting and resources. So how we do things are differently. - We need a unified agenda from the global level and the integration at the country level will follow.
Q&A Session II	
Q1: Recognizing CSO as part of decision making, looking at social participation inclusion, how do we mobilize that other member states apply those process locally?	**Justin**: - Unfortunately, lack of social participation for these agreements are lacking. However, for example multilateral institutions have these mechanisms, such as WHO CSO Commission and other bodies have to govern this. So it's a good place to start. - Member states need to ensure that they incorporate best practices into the negotiations process - it is a long work.. **Diah**: - Prior to coming here to mobilize CSO participation into GH processes, we wanted to be informed so we held CSO FGD through our network, and we formulated input to the government. This coalition provided assurance that we have the same voices. - There are several recommendations that specifically

	highlighted the importance of meaningful participation of civil society in global health, not limited to consultation process, but also the implementation, particularly on the monitoring and evaluation process in the community level. - We are hoping to push more at global level, including UHC2030 governing board, CSO in the Pandemic Fund and WHO CSO Commission to complete the end-to-end perspective. **Stephanie** - Note that not only CSOs are disappointed with the negotiation of the Pandemic Agreement, but even member states are just as disappointed.
Q2: 5% of rare disease has medical treatment. 95% people with rare disease in the world do not have a feet in UHC. So, how do we include them in the system (UHC) in a more holistic approach? **Q3: We are working with a system that is 50 years and we are seeing limitations. After 2030, what are you hoping for and what is reasonable for goal setting in terms of UHC?**	**Stephanie**: - We have key concept that have been accepted, such as equity, health system, UHC, social protection. However, we need to simplify when we talk about UHC. - We need champions, lead of countries and CSOs that take UHC as important issues and to advocate at the global level. - The system from Costa Rica and the UK show the goodness of having free access to healthcare. However, we are seeing a decline. - Agenda of UHC2030 should not be seen in silos. UHC is strongly connected with other objectives combating poverty, social security system and etc.
Conclusion	We are clearly not giving up on UHC and taking on the optimism. This discussion unlocks the key issue of equity, which is absolutely linked to issues such as human rights. How to integrate the services needed and to galvanize the political support as well as to keep the momentum. It is Universal Health Coverage, not Universal Health Care, it needs to be broader than care or services. We need to address

	poverty and access issues, and we need to be more vocal about this. If not, then we will be going to 2030 without UHC.