Aktionsbündnis gegen AIDS e.V.
Rungestr. 19
10179 Berlin
Tel. 030 / 536799844
info@aids-kampagne.de

Aktionsbündnis gegen Aids e.V.
Rungestr. 19 • 10179 Berlin • Germany

Berlin, September 2019

Critical Statement on the Political Declaration to be adopted by the High-level Meeting on Universal Health Coverage

Overview and Summary

Even though the political and financial support to realize the Millennium Development Goals (MDG) remained partial and fragmentary, between 2000 and 2015 the international community made great strides to reduce some of the most disastrous consequences of worldwide inequality, in particular in the field of health. The most important progress can be observed in the improvement of survival chances of the most disadvantaged countries and populations. The reduction of child and maternal mortality, the fight against HIV, TB, Malaria and other epidemics combined with the strengthening of health systems led to a significant reduction of premature mortality. Especially in low-income countries the probability of surviving between birth and age 60 increased from 50 to 68 percent, reversing the previous trend of a widening gap in relation to better-off nations.

The 2030 Agenda for Sustainable Development (SDG) was meant to build on these positive results and devise a consequent path forward to overcome the persisting disadvantages regarding health and development chances. Indeed, the agreed document contains ambitious principles, goals and targets for ending avoidable deaths caused by communicable, maternal and perinatal conditions as well as reducing mortality related to other threats. In addition, achieving universal health coverage (UHC) was established as an overarching commitment that encompasses and enables the specifically emphasized health targets, while going beyond to extend services for dealing with other health risks. When it comes to the necessary redistribution of resources and power, however, the respective stipulations fall behind the required level of ambition, and even water down longstanding obligations, most importantly the UN-agreed target for developed nations to contribute at least 0.7 per cent of their Gross National Income (GNI) for social welfare and economic advancement of developing countries. Thus, the agreement suffers from an inherent ambivalence setting far-reaching aspirations to eradicate extreme poverty in all its forms and dimensions on the one hand, while denying the formulation of the necessary measures for overcoming the excessively unequal distribution of assets and incomes between countries and individuals on the other hand.

Bearing in mind this fundamental contradiction between human connectedness and narrow minded selfishness, it is sad to state that the agreed UN Declaration on UHC to be adopted at the High-Level Meeting on the 23rd of September is mostly congruent with the latter stance. Exactly in this area of vital importance the representatives of member states evidently succumb to the destructive

positions of those governments that put the economic interest of the privileged few before the lives of the many disadvantaged people. This is the only reasonable explanation for the fact that the document suppresses all indications, which point to the still abysmal differences between and within countries regarding health outcomes and its underlying causes. For instance, there is no reference to the utterly insufficient resources and the life-threatening living conditions calling for concrete financial and political efforts in the spirit of global solidarity, justice and responsibility. Even the data and statements referring to the large health gaps and necessities that still can be found in earlier versions were totally erased in the final Declaration. Excessive generalization and arbitrarily selected references are used to obscure the harsh reality of disadvantaged countries and populations regarding the extremely low level of public finances for health, the high mortality due to treatable conditions and the predominating causes of premature deaths. Across nearly all paragraphs the prevailing perspective reflects the situation of the economically more advanced nations and, conversely, ignores the conditions of low-income countries that not only face the lowest health spending but also the highest disease burden. Furthermore, the document avoids any concrete commitments by economically privileged states to support and enable better health services and outcomes in the more disadvantaged countries and populations. This is true for both main areas of collaboration, raising the financial contributions to close the resource gaps and preclude the detrimental health impacts resulting from unsustainable economic and political practices. Thereby, the Declaration tends to reduce the concept of UHC to a variable bundle of interventions that will be determined by the extremely different economic capacities of single countries instead of a worldwide common effort to realize the health targets of the 2030 Agenda. This increases the risk that the unacceptable disparities of survival chances will widen again, making a mockery of the principle to leave no one behind. In the following, we can only outline the most important distortions and deficiencies.

Ignoring the Real Facts and Trends of Global Health

The Declaration focuses exclusively on general descriptions of the worldwide health situation evading the necessary differentiation in order to identify the critical disparities along economic and social categories that produce vulnerability and exclusion, such as income levels, regions, age groups and populations affected by marginalization and discrimination. Thus, it fails to adequately analyse the real trends and conditions of health, suppresses the evidence of still existing extreme disadvantage regarding the survival chances of impoverished countries and vulnerable populations, and ignores the essential lesson of the MDG period that enhanced international cooperation was instrumental for reducing the worst health gaps. Important indications on health inequities like differences in life expectancy of over 30 years between better-off and disadvantaged countries or 8 million lives lost each year in low and middle income countries due to treatable conditions were erased in the final text. The most revealing indicator, however, constitutes the probability of surviving until a certain age because it better reflects potentially high premature mortality of disadvantaged populations within countries. In low-income countries the percentage of new-borns that can expect to survive until the age of 60 years stagnated around 50% in the period 1985-2000 but thanks to the additional efforts spurred by the MDGs this crucial indicator has meanwhile increased to 68%. In Sub-Saharan Africa the probability to survive until the sixtieth birthday even fell below 50% in the first period but rose to over 62% at the end of the MDG era. Therefore, the world community succeeded in reducing the gap by a significant extent, but has a long way to go to overcome the still massive disadvantage, considering that in many parts of Europe roughly 93% of

babies born in 2015 can expect to reach age 60. In line with the principle of leaving no one behind, countries and populations facing the lowest survival chances should receive the highest attention.

In its only statement that refers to age-specific mortality, the Declaration focuses instead on the bracket of 30-69 years for overstressing the impact of non-communicable diseases (P. 11). Concentrating exclusively on the middle age group and ignoring mortality in children and young people contravenes the ethically sound assessment of health conditions and is highly misleading for setting the right priorities for health promotion. Looking at deaths occurring before 50 years of age gives a completely different picture, observing that communicable, maternal, perinatal and nutritional conditions accounted for nearly half of this premature mortality worldwide and for over two-thirds in low-income countries in 2016. While individual countries with high or middle income need to cover a broad range of health services, the international support for the poorest countries and regions may not lose its momentum in coping with devastating epidemics as well as child and maternal health. Instead, the Declaration contains weakened wording on the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases as well as child mortality and deaths and injuries from road traffic accidents, when compared with the corresponding SDG 3 targets. Hence, it obscures and ignores the needs of the most disadvantaged countries, both with regard to the immense magnitude of the avoidable risk of premature death and the main causes of these tragic effects of ill health.

Negating the Necessary Redistribution of Resources

The final draft completely omits the most significant fact regarding the inability to achieve UHC and the accomplishment of SDG 3 and its targets in many nations: All low-income countries and some middle-income countries simply lack the economic capacities to finance UHC for their populations on their own due to very low levels of Gross Domestic Product (GDP) per capita. Moreover, inadequate GDP rates of government revenue as well as insufficient health shares of public expenditure additionally exacerbate the funding gap to reach UHC. That is why the declaration should include measures on both sides, aiming at the improvement of domestic resource mobilization and, in addition, emphasizing the shared international responsibility to allocate enough financial resources to those countries that evidently miss the economic capacity to realize UHC.

However, in terms of domestic resource mobilization, the final draft neglects to mention an adequate commitment which focuses on reaching an ambitious but realistic level of domestic resources for health through appropriate fiscal policies, in particular efforts to increase revenue from taxes and social contributions, and prioritize health spending within budget allocation to no less than 15 percent as agreed in the Abuja Declaration. At the same time, the negative effects of tax evasion and tax avoidance on government revenues have to be taken into account in the Declaration because of their detrimental implications for public health financing. What is more, the dependence of low-income countries on development aid for health is in fact considerably higher than the 30% stated in the final draft, reaching 60% if we exclude out-of-pocket spending and private development finance and concentrate on public resources (P. 19). This is of particular importance since the final draft falls short of declaring that out-of-pocket spending should be minimized and its catastrophic consequences should be eliminated.

Looking at nations that do not possess the needed economic capacity to finance UHC through domestic public health expenditures, the final draft astonishingly fails to address the contemporary

situation of these countries and disregards the necessity for a common roadmap rooted in the principle of international cooperation. Inconceivably, the document cites the WHO estimates that the mobilization of additional resources totalling 3.9 trillion US$ in low- and middle-income countries by 2030 would suffice to achieve UHC and prevent 97 million premature deaths, but ignores the minimum levels of government expenditure per capita required to achieve the respective coverage rates and health outcomes, which are outlined in the same scientific publication (P. 42). Owing to this deficiency, the actual financing need to achieve UHC in low-income countries and the resulting immense financing gap are overlooked. Whereas government spending for health needs to increase to roughly 100 US$ on average (prices and exchange rates of 2017), at present public health financing from domestic sources and ODA grants combined only reaches a quarter of this level in low-income nations. The mentioned target of an additional 1% of GDP is clearly insufficient as it hardly represents 10 US$ for health services considering that annual GDP per capita is projected to reach between 890 and 990 US$ in the final years of the SDG period (P. 43).

In order to adequately assess the financial need to realize UHC, the final draft should contain the commitment to develop specific public spending targets on how to finance SDG 3 and UHC in individual countries by 2020 with the support of WHO, UNAIDS as well as other relevant organizations. In this regard, nations should pledge taking all necessary measures to set appropriate spending targets from public sources that are commensurate to achieve the health targets of the 2030 Agenda, oriented at country specific needs with regard to health risks and patterns of mortality and morbidity as well as developed with democratic participation, in particular of the most disadvantaged populations. In addition, the final draft should encompass a commitment to provide adequate, predictable and sustainable funding through international cooperation, particularly Official Development Assistance (ODA) financed from public resources of high-income countries delivered in the form of grants and channelled through multilateral and regional organizations as well as coordinated bilateral partnerships with the public sector of recipient countries and civil society. This commitment should principally address countries whose economic capacities do not suffice to generate enough domestic resources to meet the countries' specific public spending targets to accomplish SDG 3 and UHC.

The lack of political willingness that characterizes this Declaration is clearly demonstrated by the fact that even the longstanding UN target to raise 0.7% of developed countries' GNI for overall development aid is omitted in the final draft altogether. Providing an adequate overall volume for development cooperation, however, lays the basis for sector specific efforts and helps to avoid destructive conflicts regarding the distribution of resources. Additionally, the recommendation to allocate at least 0.1% of GNI to health made by the WHO Commission on Macroeconomics and Health was disregarded in the final draft as well. Yet, building on these targets, any sincere declaration oriented towards the realization of the human right to health and the 2030 Agenda needs to contain an agreement to develop and implement a global plan for financing SDG 3 that brings together the common efforts of rich and poor countries, establishes needs-oriented targets, defines clear responsibilities and funding sources, and contains concrete time-bound steps.

Downgrading the Concept and Scope of Universal Health Coverage

Despite the fact that the Declaration reaffirms the human right to health and the Political Declarations adopted in health-related UN meetings in its initial general statements, it goes on to economize the central purpose of health promotion as "an investment in the human capital" (P. 7),

instead of clearly defining health above all as an elemental goal in itself. In this context, the document misses to acknowledge that good health constitutes one of the most essential basic needs of human beings, while representing at the same time a pre-condition for satisfying other fundamental needs. Furthermore, it fails to recognize the centrality of comprehensive health promotion and care in order to enable all people to live long, healthy and self-determined lives, an overarching goal that should guide all efforts of human development.

With regard to the range of interventions to be provided in order to realize UHC the wording of the respective commitment gives way to an arbitrarily defined set of services, that may well remain below the standards required for reaching the health targets of the 2030 Agenda, let alone the satisfaction of the fundamental health needs and rights. Whereas the general acknowledgement still mentions the access to the “needed” and “essential” services (P. 8), the actual commitment formulated in a later section (P. 25) avoids these characterisations and merely refers to “nationally determined sets of integrated quality health services”. The final version also excludes the specifications made in earlier versions of the declaration that described a broad range of diseases and conditions to be covered. As a consequence, the current vague phrasing implies a high risk that in the most disadvantaged countries the extremely restricted financial capacity finally will determine the sets of services.

The weak language on confronting major health threats, such as the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, child mortality or deaths and injuries from road traffic accidents, points in the same problematic direction. Compared with the corresponding SDG 3 targets that established ambitious and measurable benchmarks, the respective commitments made in the declaration are limited to the noncommittal and elusive phrase to “strengthen efforts” in these areas (P. 32-35). Similarly, the declaration fails to mention the key populations of the HIV response, specifically men who have sex with men, people who inject drugs and sex workers, among the people who are vulnerable or in vulnerable situations. Moreover, the final draft omits to embrace the necessity to combat discrimination on grounds of sexual orientation or gender identity, which still represents an important cause of human rights violations and aggravated health risks. These deficits cast serious doubts on the proclaimed “endeavour to reach the furthest behind first” and raise concerns that not only extreme economic inequality but also inhuman ideological prejudice could impede the realization of urgent actions to accomplish UHC.

Another noticeable detail is the elimination of the necessity to implement price and tax measures on harmful products, in particular tobacco and alcohol, which were still included in the first versions. Thus, it appears that the range of UHC interventions is also limited by the tendency to avoid any commitment that could affect particular economic or commercial interests.

Avoiding to Take Action on Availability and Affordability of Essential Medicines

Again, we observe a clear tendency to underestimate the impact of an important barrier to realize UHC. First, the final version reduces the “concern on high prices” to "some" health products only, producing the false impression that unaffordable medicines represent an exceptional problem, when in reality this constitutes a typical situation for newer pharmaceutical products subject to patent regulations (P. 50). In addition, the imbalances and inefficiencies of the present model of research dominated by the private sector and shaped by expansive monopoly rights, such as the allocation of investments according to high profit opportunities instead of urgent needs, the quite moderate rates

of reinvestment of sales as well as the obstruction of follow-on innovation, are ignored altogether. Similarly, the Declaration disregards the necessity to evaluate the consequences of existing intellectual property rights provisions on health technologies innovation and access already mentioned in previous UN Documents (See the Declaration of Commitment on HIV/AIDS, June 2001, P. 24, 26). Increasing transparency of the costs of research and the pricing of medicines that would enable this critical analysis was limited in the final version to the latter dimension only, precluding the assessment of the magnitude and priority-setting of investments in health innovations.

The failure to appropriately address the health innovation gaps coincides with the extremely low importance given in the document to public funding of research. Instead, it highlights the role of the private sector without mentioning that it frequently relies on the basic research done by public academic institutions. Even though the declaration supports the promotion of innovative incentives and financing mechanisms for the research and development of new health products, it avoids any indication of the sources and dimensions of the required resources. A serious document, however, should devise clear commitments to set appropriate targets for increasing the financial support provided by governments of economically privileged countries for needs-oriented research and development. And this public engagement should be seen as an essential part of the global plan to finance SDG 3.

Notably the declaration reaffirms that the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the corresponding 2001 WTO Doha Declaration on the TRIPS Agreement and Public Health should be interpreted in a way that benefits public health and access to medicines. However, it falls short of the stipulation made in the most recent UN Declaration on HIV and AIDS, which explicitly guarantees the full use of the safeguards established in the TRIPS Agreement and commits to ensure that intellectual property rights provisions in other trade agreements do not undermine these existing flexibilities. Lastly the final draft suppresses the commitment of sharing and transfer of technologies with the aim to improve the local capacity of disadvantaged countries for the development and production of pharmaceutical products that would also enable the actual implementation of compulsory licences, as the most essential of the safeguard measures.

This critical statement does not reflect on the text and language used on the topics that are still under negotiation, such as Sexual and Reproductive Health and Rights, gender equality and access to health care for migrants, refugees, internally displaced persons and indigenous peoples.

About Action against AIDS:

Action against AIDS Germany is a nationwide network of about 300 groups and organizations. These include local AIDS service organizations, Protestant and Catholic churches and organizations, one-world shops as well as organizations working in the field of development cooperation, humanitarian aid, HIV & AIDS, and health issues.

As a Germany-wide network, Action against AIDS advocates for the necessary attention and consistent pursuit of the aim of an end of AIDS by 2030.

Authors: Joachim Rüppel, Tilman Rüppel, Medical Mission Institute Würzburg