The Elders

CHARTER FOR EQUITABLE, INCLUSIVE AND SUSTAINABLE UNIVERSAL HEALTH COVERAGE

THE ELDERS

The Elders are independent leaders using their collective experience and influence for peace, justice, and human rights worldwide. The group was founded by Nelson Mandela in 2007.

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> **UHC is an essential element of a prosperous society, as well as a driver of social justice, human rights and inclusive economic growth.**

Cover image: COVID-19 testing in Madagascar, 2020.
Photo: World Bank / Henitsoa Rafalia.

Ernesto Zedillo and Gro Harlem Brundtland visit a health centre in Indonesia, 2017.
Photo: Agoes Rudianto.

FOREWORD

At the heart of Universal Health Coverage (UHC) lies a fundamental proposition: access to healthcare is a human right, and no-one should be denied the care they need because of their financial circumstances.

This is the basis on which The Elders prioritised UHC in their global advocacy agenda from 2016, and is the starting point for our new focus from 2023 on Pandemic Prevention, Preparedness and Response.

The political imperative to achieve UHC has been made even more urgent in the context of the COVID-19 pandemic and the stark inequalities it has both exposed and exacerbated. For the millions of people who have been pushed into poverty by the pandemic, UHC can literally be a lifeline.

Over the past six years The Elders have undertaken visits to countries including South Africa, India, Indonesia, Ethiopia, Tanzania and the United States to support UHC reforms at state and regional levels, and to meet health practitioners and patients at the community level to gain a representative and holistic understanding of each constituency's needs and aspirations.

Throughout this period, with the assistance of expert partners within civil society, academia and the public health community, we have also been developing and refining a rigorous understanding of what UHC should mean in practice. This has helped shape our thinking about how heads of state and government can oversee the implementation of UHC, unencumbered by dogma, ideology or the influence of vested interests.

This Charter on Equitable, Inclusive and Sustainable UHC is the culmination of our work on this subject, and I am enormously grateful to my fellow Elder Ernesto Zedillo for his tireless efforts in this endeavour, together with his colleagues at the Yale Center for the Study of Globalization.

His five precepts of UHC – its universality, the need for equitable and comprehensive insurance, public financing, efficient service delivery and progressive realisation – comprise a practical, accessible and flexible framework for politicians, policymakers, health professionals, workers and patients alike.

This Charter will act as a bedrock for The Elders' ongoing work on Pandemic Prevention, Preparedness and Response. The principles of justice, inclusivity and sustainability at its core will inform our advocacy in public and private, now and for many years to come.

Mary Robinson

Members of the Army and Air National Guard from across the United States were activated under Operation COVID-19 to support federal, state and local efforts in March, 2020. (Photo: Sgt. Amouris Coss / U.S. Army National Guard)

Ban Ki-moon and Gro Harlem Brundtland visit a healthcare centre in India. Photo: Hemant Chawla.

INTRODUCTION

The Constitution of the World Health Organisation adopted in 1946 stated that:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

This tenet has evolved over time to have as its practical expression the goal of universal health coverage (UHC) – **all people have access to the health services they need, when and where they need them, without financial hardship**. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

An international consensus on the meaning of UHC has developed gradually over the years, notably at landmark events like the 1978 Alma-Ata Declaration, the WHO's 2010 World Health Report and the 2015 "Agenda for Sustainable Development," which included a target to achieve universal health coverage for all by 2030.

The commitment to achieve UHC by 2030 was strongly reaffirmed in a high-level political resolution adopted by the UN General Assembly in the autumn of 2019, which occurred just a few weeks before the first outbreak of COVID-19.

Even before the pandemic, ensuring non-discriminatory access to essential health services should have been of paramount importance for all countries. However, the case for taking seriously the pursuit of UHC, both as a right and as a collective moral obligation, has been made even more patent by the global experience of COVID-19.

How many lives would have been saved, how much human suffering would have been avoided, and what economic and social losses would have been prevented, if more countries had made more progress towards UHC by early 2020?

This question cannot be answered, but the painful experience of COVID-19 has made it even more critical to achieve UHC to better prepare for and respond to the future pandemics which will undoubtedly come.

The importance of UHC to people and communities goes beyond safeguarding people's health. It is also an essential element of a prosperous society, as well as a driver of social justice, human rights and inclusive economic growth.

In addition, UHC can be one of the essential components of a substantive and consequential social contract between the people and the government of a nation that underpins the feasibility and legitimacy of broader transformative reforms.

Yet the question remains whether most countries – notwithstanding the purported willingness of their societies and governments – were, are, or will be on the right course to attain UHC.

The 2019 UN Declaration on UHC endorses a focus on service accessibility; equitable distribution of essential medicines and technologies; increases in overall health funding; protection from financial burden; the rights of vulnerable groups; growth of the health workforce; and strong health system governance.

All these actions are indeed necessary, but are not alone sufficient to be on the right track to equitable, inclusive and sustainable UHC. A host of constraints and other complex challenges must be overcome.

Each country's history; capacities, present and future; and political willingness of its leaders, will influence decisively the particular design and construction for an equitable, inclusive and sustainable way to UHC.

The commitment to UHC involves a series of intricate policy decisions – some politically very challenging, even with significant income redistribution consequences.

Although there are many options within each of these sets of decisions, all of which entail trade-offs, only some of the options will support a path toward achieving the goals of equity, inclusiveness and sustainability inherent to UHC.

Fortunately, there is now a wealth of evidence and knowledge about the key features that will take countries closer to a system that provides truly universal, equitable health coverage.

Consequently, there is a substantial opportunity to take stock and distil the global experience and practical knowledge gained over the past several decades of working toward UHC, and with a broader human development, economic, and political perspective.

With this in mind, The Elders and the Yale Center for the Study of Globalization (YCSG) have endeavoured to synthesise that experience and knowledge into a set of concise criteria, principles or precepts indispensable for developing strategies and policies to advance countries unequivocally towards UHC.

A mother and child at a health center in Bangladesh. Photo: Rama George-Alleyne / World Bank

PRECEPT 1

GENUINE UNIVERSALITY

The commitment to Universal Health Coverage must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of economic and social exclusion or discrimination.

PRECEPT 2

EFFECTIVE AND EQUITABLE UNIVERSAL INSURANCE[1]

UHC requires effective and equitable universal social insurance. Provided the pertinent governance is effectively put in place, social insurance is best organised through a nationally consolidated institution that insures into a single pool all individuals and purchases on their behalf the needed health services.

PRECEPT 3

PRIMACY OF PUBLIC FINANCING FOR UHC

A system of public and prepaid financing from general taxation is best to achieve and sustain UHC. Furthermore, with this form of financing, UHC will contribute to fostering economic development with more and better paid jobs, not informal and precarious ones.

PRECEPT 4

EFFICIENT DELIVERY OF QUALITY HEALTH SERVICES

UHC requires a well-organised, adequately regulated, seriously supervised and fully accountable system of providers of the needed — people-centred and high-quality — services. Ultimately, the system should consist of a multiplicity of both public and private providers, all subject to precise and homogeneous standards of quality and accreditation. Competition among providers — with transparent and fair rules — to supply the services demanded by the single insurer/purchaser on behalf of the beneficiaries of UHC, should be a key feature of the system in order to foster efficiency, quality and innovation. Governments must have the pertinent policies to train, recruit, retain and retrain regularly the competent, committed and motivated health professionals required by the UHC system.

PRECEPT 5

PROGRESSIVE REALISATION OF UHC

In practice, because of resource constraints no country can achieve UHC immediately but a path to achieve it progressively should be determined and pursued from the outset. Achievement of UHC, even if done progressively, is dependent on creating the conditions for accomplishing dynamic economic growth along with inclusive, equitable and sustainable development, as well as effective rule of law.

[1] The term "insurance" is used here in its broader meaning (a means of guaranteeing protection or safety) not its narrower standard commercial meaning.

Graça Machel and Ricardo Lagos visit a health centre in Ethiopia, 2019. Photo: Kora Image.

PRECEPT ONE
GENUINE UNIVERSALITY

The commitment to Universal Health Coverage must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of economic and social exclusion or discrimination.

The WHO Constitution expressly articulates the principle that access to health care is a fundamental right. This means that exclusion of any individual, whether explicit or implicit, is unacceptable.

Consequently, universality means that the necessary health care services are afforded to all persons, unequivocally and without favouritism.

The principle was operationalised by the WHO into the concept of UHC, i.e. a system that provides all people with access to needed health services of sufficient quality to be effective – including prevention, promotion, treatment and rehabilitation – and ensures that the use of these services does not expose the user to financial hardship.

This definition has three crucial elements that are deeply consequential:

- UHC must be for all people.
- UHC provides the needed health services at sufficient quality.
- UHC entails insurance for all – constituted either formally or not formally as an insurance plan – that guarantees access to those services without any risk of financial distress.

The term "insurance" is used here in its broadest meaning – the means of guaranteeing protection or safety – not the narrow commercial one. The concept used in this Charter also encompasses systems that are not denominated or constituted formally as standard insurance plans, for example the models operating in Sweden and the United Kingdom. Regardless of whether the insurance arrangement is implicit or explicit, the important thing for UHC is to remove financial barriers and assure that everyone is protected from financial distress .

Yet many existing health policies, even in systems that purport to adhere to the principles of UHC, may often explicitly exclude some groups for practical, fiscal or political reasons.

For example, the principles of equity and inclusivity under UHC are violated when, for any reason including budgetary ones, health insurance schemes permanently exclude, or cover only partially, informal workers -- usually a large and vulnerable group. Instead, **informal workers must have the same right to insurance and access to health services as formal, well-organised workers**.

Explicit exclusions may also be politically motivated, such as when policies permit entitlements only to citizens and legal immigrants, leaving others without those benefits. Undocumented migrants represent a uniquely vulnerable sub-group, experiencing particular barriers to health related to their background as well as insecure living and working conditions. **UHC implies that health needs must be met regardless of migrant status**.

Implicit exclusions occur when coverage does not match certain specific needs, or when physical or cultural barriers and discriminatory attitudes and practices are allowed to persist that effectively limit access to the care that is needed. Inequities and cultural practices related to stigma around disease, such as HIV/AIDS and mental health, are a source of implicit exclusion, as are inequities and cultural practices related to gender discrimination. Although women may not be explicitly excluded from coverage, they are implicitly excluded when the benefits package does not cover those conditions that are unique to women and often represent their most pressing health needs.

The principle is also violated when the elderly and disabled populations suffer from implicit exclusions. Even in well-performing health systems, people with disabilities do not have their needs properly recognised and face several obstacles, like financial and cultural barriers, including misconceptions about disabilities as well as access to buildings and lack of transportation.

Health inequity and exclusion cannot be solved within the health system alone. Better anti-discrimination and civil rights laws with proper enforcement, are also a necessary, although not sufficient, step to achieve the equity and inclusiveness in UHC. More active citizen and civil society engagement against discrimination is also needed.

Fundamentally, realising the right to health requires progress on health care as well as on the underlying determinants of health. This requires attention to the broad, community-wide focus on the essential social and economic conditions in which people live, not just to the immediate needs of any one individual.

Gro Harlem Brundtland and Ricardo Lagos visit a hospital in South Africa, 2019.

PRECEPT TWO
EFFECTIVE AND EQUITABLE UNIVERSAL INSURANCE

UHC requires effective and equitable universal social insurance. Provided the pertinent governance is effectively put in place, social insurance is best organised through a nationally consolidated institution that insures into a single pool all individuals and purchases on their behalf the needed health services.

UHC means that **every individual must have access to and insurance for needed health services, irrespective of that individual's particular health and economic situation**.

This means that **UHC is first and foremost about providing insurance to every individual in the country**.

This universal insurance, which can be explicit or implicit – in other words, a formal or not formal insurance plan, is an indispensable element of a genuine UHC system.

For UHC to exist, insurance must be compulsory for all; but this requires that the cost of insurance, for those in society who cannot afford it, must be subsidised by the rest.

Voluntary insurance should be avoided; poor people will not take it because invariably they cannot afford it.

Those who are more prosperous will also tend not to join a voluntary system, precisely to avoid sharing the risks – health and financial – of the worse off in the population. This kind of outcome is known as **"adverse selection"** and constitutes a key conundrum that must be solved in the process of building a UHC system.

The most effective way to prevent adverse selection is to make it **legally mandatory for all individuals to have health insurance**, with the proviso of subsidising the premium of those who cannot pay for it. Nearly all countries that have achieved population coverage of 90 percent or higher have legally mandated participation in health coverage.

Clearly, compulsory participation would not be fair or feasible for the poor without subsidies to make participation affordable. **Subsidisation is therefore an essential element of UHC policies** to ensure the full and equitable inclusion of the poor in the health system.

A national pool with all risk shared and the burden distributed across the entire population provides the highest degree of predictability, risk-sharing, and equity.

With one insurer, it is easier to regulate and enforce the equal protection included by the UHC system at any given time.

One single insurer would also have the capacity to effectively supervise the services delivered by each provider to ensure they comply in quantity and quality with UHC standards. This constitutes a powerful instrument to fix a "market failure" practically immanent to the demand and supply of health services.

The failure is the one of "asymmetric information": that is, information held, on the one hand, by patients and, on the other, by the providers of the health services. In health care, due to asymmetry of information, **patients do not have the knowledge to be an effective purchaser**.

A single insurer/purchaser not only offers a better capacity to guarantee the quality of the product (the needed health services) but also, very importantly, it provides **market power** to acquire it at a cost lower than would be the case in a system with multiple insurance pools.

Unlike other markets for goods and services, health care must be regulated, both on its supply and demand sides, to make sure that it achieves its health objectives, certainly its UHC aspirations.

A single entity, properly financed and governed, should be able to stimulate a competitive and cost-effective provision of the UHC benefits that can be financially sustained and enhanced over time.

Ernesto Zedillo and Gro Harlem Brundtland visit a health centre in Indonesia, 2017. Photo: Agoes Rudianto.

PRECEPT THREE
PRIMACY OF PUBLIC FINANCING FOR UHC

A system of public and prepaid financing from general taxation is best to achieve and sustain UHC. Furthermore, with this form of financing, UHC will contribute to fostering economic development with more and better paid jobs, not informal and precarious ones.

If compulsory participation and subsidisation are indispensable to achieve true UHC, then **any voluntary contribution or payment, certainly out-of-pocket payments at the time of service, should be discarded** as coherent and legitimate sources of financing.

The case for eliminating out-of-pocket payments for health services at the time of delivery is overwhelming. This form of health financing discriminates, first and foremost, against the poor, who will either forego necessary treatment for lack of means to pay for the service, or suffer a catastrophic impact by paying a large share of their modest income to get the needed services.

Public funding is the most equitable and efficient path toward the progressive realisation of UHC.

Given that public funding is essential to achieve equitable and sustainable UHC, **governments are faced with pressure to match political commitments to UHC with fiscal commitments**. This requires prioritising health within the budget and taking on the political obstacles to freeing up fiscal space, and ultimately improving overall revenue collection to secure adequate funding for UHC and other government priorities.

The obvious link between UHC and economic development consists of the benefits that countries derive when their populations have broad access to high quality health services.

However, there are other links that if ignored and left unattended may unduly limit the positive economic benefits from a healthier labour force. These links are associated with the **dependency of access to health insurance on employment status and the mechanisms used to finance UHC**. These links are relevant to all countries, but are particularly important in developing ones with large informal sectors.

In order to maintain the UHC principles of fairness and equity, it is essential that all citizens' financial contribution to the system – either through taxation or combined with specific mandatory contributions for insurance – are unrelated to an individual's medical circumstances and risks, or employment status. Funding health from public resources is the only way to meet these criteria, and as such, public funding is the most equitable and efficient path toward the progressive realisation of UHC.

Many countries have historically funded UHC through earmarked payroll taxes, largely because of the historical connection between health protection and labour. **Payroll tax-funded coverage, however, creates the dual problem of distortions in the labour market and often explicit exclusions of those not employed in the formal labour market**.

Employer-based health insurance may generate "employment lock," "job lock" or "entrepreneurial lock." When a country moves away from employer-based health insurance, studies show that occupational mobility increases and, in some cases, it enables workers to move into better and higher paid jobs.

Lower formal employment will translate into a combination of more informal employment and higher unemployment, a mix that depends very much on country characteristics. The key point is that **reduced formal employment will hurt economic performance**, since most studies show that informal jobs are on average less productive and consequently worse paid than formal ones.

Informal workers pose **difficult trade-offs** for governments seeking UHC. Because these workers will never be covered if health services are funded only from payroll taxes, many countries have created **parallel systems of health service provision** funded from general taxation. The result is a segmented health system.

Parallel and distinct mechanisms to provide health services to workers cause smaller and thus insufficient risk-pooling along with higher administration expenses, making the overall system costlier. In general, services for formal workers are better than for informal ones, thus betraying the objective of equity inherent to genuine UHC articulated in Precept One.

The combination of population aging and the epidemiological transition will put increasing pressures on health systems everywhere in the world. Additionally, despite its central importance to social welfare, health competes with other priorities for resources.

UHC requires public funding to avoid out-of-pocket expenditures, ensure mandatory participation, prevent adverse selection, and make the pooling of risks through the largest possible population. For coverage to be truly universal, entitlement must be de-linked from employment, and from direct contributions more generally.

Equity and efficiency considerations jointly support the proposition that UHC needs to be mostly funded from general tax revenues.

Ban Ki-moon, Ricardo Lagos and Mary Robinson visit Zuckerberg San Francisco General Hospital in California, 2018.

PRECEPT FOUR
EFFICIENT DELIVERY OF QUALITY HEALTH SERVICES

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The universality principle of UHC is aspirational for many countries and may not be immediately feasible given constraints. These countries should prioritise their investments in UHC and make step-by-step progress over what may take a number of years – i.e. **progressive realisation** of UHC.

With progressive realisation, a UHC framework is stated explicitly as an over-arching goal for universal population coverage, starting with a comprehensive essential service package provided in a way that does not present any risk of financial hardship for any user. Certain population groups or services should be included rapidly, but with a clear strategy to expand towards universality as fiscal and other resource constraints ease.

It is crucial, though, to define at the outset the elements of the system that must be universal from the beginning, such as data systems comprising all patient activity, the planned trajectory of unified benefits and of core public health functions to be organised on a system-wide basis. Along the same lines, it is important to state as soon as possible the path for the progressive universalisation of services for key communicable diseases and in general basic primary care.

Once a country has unequivocally taken the political decision to pursue and achieve UHC, robust planning for transiting from its available health system to the one that will deliver UHC must be undertaken.

It is important to stress, again, that simply advancing in the provision of health services and reducing the financial stress stemming from their use may not imply progressive realisation of UHC. Just extending coverage for some and even reducing financial risk, if not done with a view, and clear strategy, to achieve universality (as defined in Precept One), may in fact deviate from its progressive realisation.

Progressive realisation of UHC recognises that fiscal and other capacities are limited and prioritisation is required. Unquestionably it is necessary to clearly target certain groups, like the poorest of the population, for the provision of health services, but it should be done without deepening the fragmentation of the health system because this would make it even harder to eventually consolidate the system as required by UHC.

Progressive realisation demands explicit commitments from the government, with mechanisms to hold it accountable for progress. First, the government is obliged to develop, and constantly update, plans, policies, and processes to ensure the path is clear for maintaining progress toward UHC commitments. Second, the government must allocate more resources to UHC as the budget envelope increases, and make the most effective use of those resources. And very importantly, the government has the obligation to protect UHC progress even during times of crisis.

Information about government decisions and actions for the progressive realisation of UHC should be transparent and accessible via freedom of information laws. The public's role is to actively hold the health authorities accountable; and institutions, such as Ombuds offices, courts and other independent review mechanisms, are required to enforce health rights in practice.

Given the importance of understanding the personal experiences of vulnerable people in accessing needed care, the information used for policy decisions should include qualitative measures. Participatory models are needed that involve representation for all citizens, particularly members of vulnerable populations, in policy development and decision-making processes at all levels.

The progressive realisation of UHC in any particular country will depend critically on whether progress is consistently pursued and achieved in other crucial aspects of its development. A stagnant or sluggish economy will make it much harder, or even impossible, for the state to obtain the resources needed to advance towards UHC through general taxation.

Achieving UHC and the economic and social conditions it enables also need effective rule of law, including respect for the principle of equality before the law.

All the reforms needed to enable a successful strategy to achieve UHC, and with it a prosperous and equitable economy, transit through the formation of solid and effective institutions. As countries and their political leaders commit to seriously go after UHC they also do so to achieve an even greater good: sustained, sustainable and inclusive development. This and its essential component, UHC – Amartya Sen's affordable dream – will be the prize for embracing this undertaking.

Gro Harlem Brundtland speaking at the UN General Assembly Seventy-fourth session high-level meeting on Universal Health Coverage, 2019. Photo: UN Photo/Kim Haughton.

PRECEPT FIVE
PROGRESSIVE REALISATION OF UHC

In practice, because of resource constraints no country can achieve UHC immediately but a path to achieve it progressively should be determined and pursued from the outset. Achievement of UHC, even if done progressively, is dependent on creating the conditions for accomplishing dynamic economic growth along with inclusive, equitable and sustainable development, as well as effective rule of law.

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This publication is an abridged version of the document, *Charter for Equitable, Inclusive and Sustainable Universal Health Coverage*, prepared at the Yale Center for the Study of Globalization under the direction of a member of The Elders, Ernesto Zedillo. The Associate Director of the Center, Haynie Wheeler, contributed to the planning, organisation and execution of the study, which can be found at https://ycsg.yale.edu/universal-health-coverage. Proper acknowledgements of experts consulted and authors of working papers, as well as the relevant bibliography, are available in the same link. However, special recognition must here be given to Cheryl Cashin whose expertise and thoughtful observations are reflected throughout the document and who was herself the author of various working papers. Also of critical importance were the contributions of ideas by Santiago Levy and Joseph Kutzin. Financial support for the realisation of the study by the Rockefeller Foundation and Citi is gratefully recognised.

> **The Elders can speak freely and boldly, working both publicly and behind the scenes.**
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> **They will reach out to those who most need their help.**
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> **They will support courage where there is fear, foster agreement where there is conflict and inspire hope where there is despair.**
>
> **Nelson Mandela**, 2007, Founder of The Elders

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