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INTRODUCTION: POSITIONING UNIVERSAL HEALTH COVERAGE IN THE POST-2015 DEVELOPMENT AGENDA

Andrea L. Frey[†]

“I regard universal health coverage as the single most powerful concept that public health has to offer.”¹

– Dr. Margaret Chan, World Health Organization Director-General

Abstract: Protecting and promoting health is central to sustained economic and social development. Three of the eight United Nations Millennium Development Goals (“MDGs”) focused on health, including reducing incidences of HIV and malaria, improving maternal health, and reducing child mortality. Although specifying disease areas and health outcomes ensured that the targets had a clear focus, it also created many problems. In particular, the approach neglected the creation of strong, effective health systems. The UN’s adoption of the MDGs in 2000 created greater recognition that sustaining progress in health depends on such systems in the international community. The MDGs conclude at the end of 2015, making it an opportune time to shape policies and practices in the post-2015 development agenda that establish strong health systems. Such systems can be achieved by advancing the principle of universal health coverage (“UHC”) as a Sustainable Development Goal (“SDG”). UHC implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, and rehabilitative basic health services. Further, UHC would provide all people with essential, safe, affordable, effective, and quality medicines. It would also ensure that the use of these services does not expose individuals to financial hardship, emphasizing the needs of low-income and marginalized segments of the population. Accordingly, this piece introduces the *Washington International Law Journal’s* special issue devoted to the transition from MDGs to SDGs and proposes UHC as a goal for the post-2015 development agenda. In implementing this goal, negotiators should incorporate key lessons from the MDGs’ successes and limitations, as well as workable solutions based on national UHC experiences.

I. INTRODUCTION

As of May 18, 2015, 11,132 deaths and 26,885 confirmed and suspected cases of the Ebola virus disease were reported.² This epidemic

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¹ Margaret Chan, W.H.O. Director-General, Universal Coverage is the Ultimate Expression of Fairness, Acceptance Speech Before the Sixty-fifth World Health Assembly, Geneva, Switzerland (May 23, 2012).

² *Ebola: Mapping the Outbreak*, BBC NEWS (May 18, 2015), available at <http://www.bbc.com/news/world-africa-28755033>. The true numbers of cases and deaths are likely higher, given the difficulty of collecting data.

swept across West Africa—through Guinea, Liberia, Nigeria, Senegal, and Sierra Leone—and has now killed more people than all previous Ebola outbreaks combined.³ The epidemic began in December 2013, when a two-year old boy from Meliandou, a small village in southeastern Guinea, was infected.⁴ The World Health Organization (“WHO”) was officially notified of the rapidly evolving Ebola outbreak on March 23, 2014. By August 8, 2014, it declared the epidemic to be a “public health emergency of international concern.”⁵ Despite multinational and multi-sectoral efforts to control the spread of infection, the number of reported cases and deaths continued to grow, with the number of patients far outpacing the region’s capacity to manage them.⁶

The epidemic’s devastating course can, in large part, be attributed to the fragmentation of the health care systems in the affected countries. In particular, the scarcity of qualified health workers, poor surveillance and information systems, unreliable access to medical supplies, and limited public health infrastructure forestalled containment of the virus.⁷ However, the consequences of poor health care systems extend far beyond the Ebola epidemic. Globally, over one billion individuals suffer each year because they cannot obtain adequate healthcare.⁸ Additionally, about 150 million individuals who do utilize health services face financial hardship in paying for such services; two-thirds of these individuals are pushed below the poverty line by these large debts.⁹

Such global problems require global solutions. Adopted by the General Assembly of the United Nations in September 2000, the Millennium Declaration has framed our understanding of economic and social development and the manner in which they are advanced, particularly in the arena of global health.¹⁰ The Millennium Declaration established the

³ *Id.*

⁴ WHO Ebola Response Team, *Ebola Virus Disease in West Africa—The First Nine Months of the Epidemic and Forward Projections*, 371 N.E. J. OF MED. 1481, 1484 (2014).

⁵ *Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa*, WORLD HEALTH ORG. (Aug. 8, 2014), available at <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.

⁶ *Ebola: Mapping the Outbreak*, *supra* note 2.

⁷ Marie-Paule Kieny, *Ebola and Health Systems: Now Is the Time for Change*, WORLD HEALTH ORG. (Dec. 12, 2014), available at <http://www.who.int/mediacentre/commentaries/health-systems-ebola/en/>.

⁸ *Id.*

⁹ Fact Sheet No. 395, *Universal Health Coverage*, WORLD HEALTH ORG. (Sep. 2014), <http://www.who.int/mediacentre/factsheets/fs395/en/>.

¹⁰ See UNAIDS, UNICEF, UNFPA & WHO, THEMATIC THINK PIECE, UN SYSTEM TASK TEAM ON THE POST-2015 UN DEVELOPMENT AGENDA: HEALTH IN THE POST-2015 UN DEVELOPMENT AGENDA (2012), available at http://www.un.org/en/development/desa/policy/untaskteam_undf/thinkpieces/8_health.pdf.

“collective responsibility to uphold the principles of human dignity, equality and equity at the global level.”¹¹ This commitment translated into practice through the adoption of a set of eight time-bound, measurable national and international development goals, with eighteen globally agreed quantitative targets, and forty-eight specific indicators to be achieved by the end of 2015.¹² The simple format of the MDGs, with a concise set of focused goals, proved durably engaging and led to remarkable progress toward achieving the MDGs.¹³ However, this progress has also been patchy and limited both within and across countries.¹⁴

The approach of the 2015 target end date for the MDGs has stimulated reflection both on the successes and limitations of the MDGs, as well as what should succeed them. In June 2012, United Nations member states, civil society organizations, and academia met in Rio de Janeiro, Brazil, for the 2012 United Nations Conference on Sustainable Development (“Rio+20”).¹⁵ Rio+20 established the Open Working Group to develop a set of Sustainable Development Goals (“SDGs”) for consideration and appropriate action by the United Nations General Assembly at its 68th session.¹⁶ The Rio+20 outcome also mandated that the SDGs coherently build upon the MDGs to converge into the United Nations’ development agenda beyond 2015.

Given the dismal figures around health care access described above, there is an emerging consensus that the post-2015 agenda should include universal health coverage (“UHC”). This would ensure that everyone who needs health services is able to get them, without undue financial burden.¹⁷ This demand for UHC pushed the Open Working Group to include Item 3.8 in its draft proposal for the SDGs, which reads: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable

¹¹ G.A. Res. 55/2, U.N. Doc. A/55/L.2, United Nations Millennium Declaration, ¶ 2 (Sept. 8, 2000) [hereinafter United Nations Millennium Declaration].

¹² RICHARD MANNING, DANISH INST. FOR INT’L STUDIES, USING INDICATORS TO ENCOURAGE DEVELOPMENT: LESSONS FROM THE MILLENNIUM DEVELOPMENT GOALS 17 (2009), available at <http://www.oecd.org/site/progresskorea/44117550.pdf> (“Indicators establish one or more parameters against which progress can be measured. Targets typically set desired achievements against such indicators to be met by some date, thus giving them an explicit incentivizing purpose.”)

¹³ See Maya Fehling, et al., *Limitations of the Millennium Development Goals: A Literature Review*, 8 GLOBAL PUB. HEALTH 1109, 1109 (2013).

¹⁴ See *id.*

¹⁵ See RIO+20 UNITED NATIONS CONFERENCE ON SUSTAINABLE DEVELOPMENT, available at <http://www.uncsd2012.org/about.html> (last visited May 18, 2015).

¹⁶ See U.N. Rep. of the Open Working Group of the General Assembly on Sustainable Development Goals, U.N. Doc. A/68/970 (Aug. 12, 2014).

¹⁷ WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2013: RESEARCH FOR UNIVERSAL COVERAGE (2013).

essential medicines and vaccines for all.”¹⁸ As ambitious as this goal may sound, the United Nations and its member states should adopt Item 3.8 in the SDGs. Doing so will drive the development of health systems that can meet the challenges posed by Ebola and the global burden of non-communicable diseases. It will also be a great stride toward ensuring the “highest attainable standard of physical and mental health” for every global citizen.¹⁹

On a national level, many countries already have or are actively seeking to bring about UHC. Many countries aim to achieve UHC through national insurance systems that purchase services from public and private providers. Others do so through a public delivery system supplied by a governmental entity. These varied systems show that there is no one, single approach to UHC.

Against that backdrop, this introductory piece proceeds in three parts. Part II provides an overview of the transition from the MDGs to the SDGs, highlighting the lessons learned from the limitations of the MDG framework and health-related goals. Part III examines the positioning of UHC within the post-2015 development agenda and grounds the discussion by drawing on insights from both the history of UHC generally as well as specific national experiences in achieving and maintaining UHC. Finally, Part IV proposes considerations that should guide the development of the UHC framework to meet today’s public health challenges.

II. TRANSITIONING FROM THE MDGs TO THE SDGs

A. *Adopting the Millennium Development Health Goals*

Adopted by the General Assembly of the United Nations, the Millennium Declaration established the “collective responsibility to uphold the principles of human dignity, equality and equity at the global level.”²⁰ This non-binding commitment translated into practice through the adoptions of a set of eight globally-agreed concrete goals. Separately, the United Nations Development Programme (“UNDP”) established eighteen quantitative targets, and forty-eight specific indicators as a focus for both international and national development policy.²¹ The MDGs focus on the following areas: poverty alleviation, education, gender equality and

¹⁸ Rep. of the Open Working Group of the General Assembly on Sustainable Development Goals, *supra* note 16, at 12.

¹⁹ International Covenant on Economic, Social and Cultural Rights art. 12, Jan. 3, 1976, 993 U.N.T.S. 3.

²⁰ United Nations Millennium Declaration, *supra* note 11.

²¹ MANNING, *supra* note 12, at 17.

empowerment of women, child and maternal health, reducing HIV/AIDS and communicable diseases, environmental sustainability, and the building of a Global Partnership for Development.²²

The MDGs' adoption was immensely significant. Shortly following, there emerged a nascent global consciousness galvanizing political momentum toward international development.²³ Governments, partners, organizations, and individuals committed themselves to the achievement of reaching these specific targets, both globally and in individual countries.²⁴

The health-related MDGs gained traction in large part because the goals encapsulated the most serious public health challenges of the twentieth-century. These include: Goal 4, to reduce child mortality; Goal 5, improve maternal health; and Goal 6, to combat HIV/AIDS, malaria, and other major diseases.²⁵ The simple format of concise, focused goals was intuitively attractive and readily understandable for both member countries and donors alike.

These three major health-related goals instrumentally mobilized key stakeholders, such as the World Health Organization and the Bill & Melinda Gates Foundation, to allocate significant resources around the MDG framework described above.²⁶ Indeed, since 2000 child and maternal mortality has declined at unprecedented rates in many countries, and demonstrable progress has been made against malaria, tuberculosis, and AIDS.²⁷ At the same time, however, rural areas and marginalized groups continue to remain behind on virtually all goals and targets, particularly in areas facing conflict, disaster, or economic instability.²⁸

As the 2015 target date for reaching the MDGs approaches, many in the international community—including United Nations member states, the

²² *Goals, Targets and Indicators*, UN MILLENNIUM PROJECT, available at <http://www.unmillenniumproject.org/goals/gti.htm> (last visited May 18, 2015) [hereinafter *Goals, Targets and Indicators*].

²³ See U.N. Secretary-General, *A Life of Dignity for All: Accelerating Progress Towards the Millennium Development Goals and Advancing the United Nations Development Agenda Beyond 2015*, U.N. Doc. A/68/202 (July 26, 2013).

²⁴ *Id.*

²⁵ *Goals, Targets and Indicators*, *supra* note 22.

²⁶ See *id.*; see also Nicoli Nattrass, *MDG 6: AIDS and the International Health Agenda* 14 (Harvard Sch. of Pub. Health Working Paper Series, 2013), available at <http://fxb.harvard.edu/wp-content/uploads/sites/5/2013/09/MDG-6-Nattrass-Working-Paper-092413.pdf>.

²⁷ Fact Sheet No. 290, *Millennium Development Goals*, WORLD HEALTH ORG. (May 2015), <http://www.who.int/mediacentre/factsheets/fs290/en/>. For example, “[g]lobally, the number of deaths of children under 5 years of age fell from 12.7 million in 1990 to 6.3 million in 2013. In developing countries, the percentage of underweight children under 5 years old dropped from 28% in 1990 to 17% in 2013. New HIV infections declined by 38% between 2001 and 2013. Existing cases of tuberculosis are declining, along with deaths among HIV-negative tuberculosis cases.”

²⁸ U.N. Secretary-General, *supra* note 23, at 5.

United Nations system, civil society organizations, and academia—began working on identifying the priorities of a post-2015 development agenda.²⁹ The consensus from such deliberations was that a new, more responsive framework should be created, rather than merely extending the time frame or making minor adjustments to the MDGs and their targets.³⁰ Thus emerged the SDGs as the post-2015 replacement for the MDGs.

B. Lessons Learned from the Limitations of the MDGs

Since the establishment of the MDG framework, practitioners and policy-makers have recognized both the successes and limitations of the MDGs. This section describes the wide variety of limitations identified in existing literature, both in the MDGs generally and the health related goals in particular. Doing so highlights opportunities for discussion and improvements for the post-2015 agenda.

One of the most commonly cited concerns regarding the MDGs generally was the manner in which they were developed. This includes who identified the goals and how and why particular goals were selected and designed.³¹ Many are critical of the process leading to the selection of the MDGs, calling it a top-down, technocratic, and donor-centric approach.³² Critics claim this approach was driven by the triad—the United States, Europe, and Japan—and co-sponsored by the World Bank, the International Monetary Fund (“IMF”), and the Organization for Economic Cooperation and Development (“OECD”).³³ While states formally adopted the eight goals, they did not do so with the targets or indicators. Rather, these were created by a consensus of experts from the United Nations Secretariat and the World Bank, IMF, and OECD. Consequentially, the MDG process failed to engage low- and middle-income countries directly in decision-making about the goals.³⁴ This resulted in global priorities that were not tailored to domestic situations and local challenges.³⁵ The ascendancy of the MDG approach as the linchpin of international development elevated the notion of development conceived as a collection of quantifiable global standards over

²⁹ The MDGs come to term at the end of 2015.

³⁰ WORLD HEALTH ORG., POSITIONING HEALTH IN THE POST-2015 DEVELOPMENT AGENDA (2012).

³¹ See, e.g., Deepak Nayyar, *UN System Task Team on the Post-2015 UN Development Agenda: The MDGs After 2015: Some Reflections on the Possibilities* (Apr. 2012), available at http://www.un.org/millenniumgoals/pdf/deepak_nayyar_Aug.pdf; Samir Amin, *The Millennium Development Goals—A Critique from the South*, 57 MONTHLY REVIEW 1 (2006).

³² MANNING, *supra* note 12, at 43.

³³ Amin, *supra* note 31.

³⁴ *Id.*

³⁵ See Fehling, *supra* note 13.

development as a comprehensive process entailing evolution and structural transformation.³⁶ Without their initial participation and engagement during the formulation of MDG priorities, many developing countries felt a lack of national ownership for the goals.³⁷

Many critics have also highlighted structural concerns with the MDG framework. For example, the MDGs can be considered too simplistic, creating an artificial separation of convergent issues.³⁸ In this regard, the health-related goals failed to embed policies in a wider social security context, and lacked an overarching perspective encompassing the social, economic, and environmental determinants of health. Goal 6 (to reduce HIV/AIDS incidence) exemplifies this point. With the rapid increase of international assistance to prevention and treatment programs, including antiretroviral therapy, HIV incidence and mortality declined.³⁹ However, progress was not uniform and not as fast as it could have been. This was particularly true in countries in Eastern Europe, Central Asia, and the Middle East, where infection rates continue to rise primarily due to the MDGs' failure to address the underlying social determinants of health.⁴⁰ In other words, investing in health services alone cannot improve health status. Rather, the complex realities of the world today mean that there are any number of health determinants at play. These determinants, such as the unavailability of clean water, or lack of transportation options must be addressed in addition to HIV/AIDS prevention and treatment programs to increase the efficacy of the MDGs.

Additionally, many point to the artificial separation of the health-related goals as reinforcing the vertical approach to programing, research, policies, and funding.⁴¹ Vertical programs refer to instances where "the solution of a given health problem [is addressed] through the application of specific measures through single-purpose machinery."⁴² In other words, health interventions are provided through stand-alone delivery systems that

³⁶ Charles Gore, *The MDG Paradigm, Productive Capacities and the Future of Poverty Reduction*, 41 I.D.S. BULLETIN 70, 71 (2010).

³⁷ See Sakiko Fukuda-Parr, *Millennium Development Goal 8: Indicators for International Human Rights Obligations?*, 28 HUMAN RIGHTS QUARTERLY 966–97 (2006); see also Andrew Haines et al., *Can the Millennium Development Goals Be Attained?*, 329 BRIT. MED. J. 7462 (2004).

³⁸ MANNING, *supra* note 12, at 43; see also Dorine Van Norren, *The Wheel of Development: The Millennium Development Goals as a Communication and Development Tool*, 33 THIRD WORLD QUARTERLY 825 (2012).

³⁹ UNAIDS, UNICEF, UNFPA & WHO, *supra* note 10, at 4.

⁴⁰ *Id.* at 4-5.

⁴¹ See Fehling, *supra* note 13.

⁴² RIFAT ATUN ET AL., WHEN DO VERTICAL (STAND-ALONE) PROGRAMMES HAVE A PLACE IN HEALTH SYSTEMS? 3 (World Health Organization Regional Office of Europe and European Observatory on Health Systems and Policies et al. eds., 2008).

have separate administration and budgets, generally with little structural, funding, and operational integration within the wider health system.⁴³ In contrast, horizontal programs work within the existing health-system structures.⁴⁴ For example, in areas of maternal and child health, funding over the course of the MDGs has overwhelmingly supported vertical approaches to activities, at the expense of strengthening national institutions.⁴⁵ Ultimately, while the target-based, disease-specific approach of the health-related MDGs ensured a clear end-point, they also exacerbated the fragmentation, inefficiency, and unsustainable nature of vertical interventions by neglecting the underlying structural basis for poor health.⁴⁶

Many also criticize the discordant and disparate targets and indicators on a technical level.⁴⁷ For example, Goal 4 is expressed in terms of a reduction in child mortality, and is set out in proportional terms (“reduce [child mortality rates] by two thirds”).⁴⁸ Goal 5 focuses on improvements in maternal health and expresses its intention through two targets, which are maternal mortality and increased access to family planning. Goal 5, like Goal 4, uses proportional terms (“reduce [maternal mortality rates] by three quarters”).⁴⁹ Lastly, Goal 6 presents three vaguely worded targets that are set out in terms of completion, rather than proportions. Two of Goal 6’s targets refer to combating the spread of HIV or malaria, and the third refers to HIV/AIDS treatment accessibility.⁵⁰ All of Goal 6’s indicators focus only on sexual transmission as a driver of HIV infection, and do not consider others such as contaminated needle use.⁵¹ The variability in the formulation of the targets and indicators created an incongruous and incomprehensible framework for member countries in guiding health development.

Finally, in all of the goals, except the last, there is an absence of any sort of framework for accountability.⁵² A key aspect of governance is accountability to encourage that governments fulfill their commitments.⁵³

⁴³ *Id.* at 1.

⁴⁴ *Id.*

⁴⁵ Sakiko Fukuda-Parr & Alicia Ely Yamin, *The Power of Numbers: A Critical Review of MDG Targets for Human Development and Human Rights OVERVIEW 4* (Harvard Sch. of Pub. Health Working Paper Series, 2013), available at <http://www.cesr.org/downloads/Overview.power.of.numbers.pdf?preview=1>.

⁴⁶ See Fehling, *supra* note 13.

⁴⁷ See e.g., Fukuda-Parr and Yamin, *supra* note 45, at 5.

⁴⁸ *Goals, Targets and Indicators*, *supra* note 22.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² See generally Thomas Davis, *The MDGs and the Incomplete Relationship Between Development and Foreign Aid*, 16 J. ASIA PAC. ECON. 562 (2011).

⁵³ See FIONA SAMUELS ET AL., OVERSEAS DEVELOPMENT INSTITUTE, *PATHWAYS TO PROGRESS: A MULTI-LEVEL APPROACH TO STRENGTHENING HEALTH SYSTEMS* 24 (2014).

Ultimately these critiques and concerns should inform the framework put into place to track progress of UHC in the post-2015 agenda.

III. THE ROAD TO UNIVERSAL HEALTH COVERAGE

The term universal health coverage (UHC), though understood in a variety of ways, generally means that all people can access quality health services, are safeguarded from public health risks, and are protected from impoverishment due to poor health.⁵⁴ UHC is not a novel concept; rather, both it and the underlying aspirations behind achieving it have a long history. In fact, it already exists in many countries in many different forms.

This section grounds the positioning of UHC as an SDG by looking to the historical context of UHC both at the international and national levels in an effort to understand the politics and economics behind the decisions to implement and maintain UHC.

A. *International Underpinnings to UHC*

On an international level, UHC was first recognized in the 1946 Constitution of the World Health Organization, which asserts that a right to health is “one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”⁵⁵ In 1978, the Alma-Ata Declaration prominently reinforced WHO’s vision in a campaign “Health For All by the Year 2000.”⁵⁶ The campaign aspired to achieve “the attainment by all peoples of the world by year 2000 of a level of health that will permit them to lead a socially and economically productive life.”⁵⁷ The Declaration particularly stressed the need to establish national health systems principally through the provision of universal primary health care.⁵⁸ Following its endorsement of the Alma-Ata Declaration, the World Health Assembly (“WHA”)⁵⁹ encouraged member

⁵⁴ David Stuckler et al., *Background Paper for the Global Symposium on Health Systems Research: The Political Economy of Universal Health Coverage 2* (Nov. 16-19, 2010), available at http://healthsystemsresearch.org/hsr2010/images/stories/8political_economy.pdf. Most commonly, UHC is referred to as universal coverage but varies as to whether it means a comprehensive set of healthcare services or a single intervention. For purposes of this piece, the author relied on the main themes proffered as UHC throughout various literatures.

⁵⁵ Constitution of the World Health Organization Preamble, para. 2, July 22, 1946.

⁵⁶ Declaration of Alma-Ata, Int’l Convention of Primary Health Care, Alma-Ata, USSR, art. V (Sept. 6-12, 1978).

⁵⁷ *Id.*

⁵⁸ *Id.* at art. VI.

⁵⁹ WHA is WHO’s legislative organ. See WHO CONST. arts. 9-23, in WORLD HEALTH ORGANIZATIONS, BASIC DOCUMENTS 4-8 (48th ed. 2014).

states to design regional, national, and global strategies to achieve Health for All.⁶⁰

While the campaign brought about modest improvements in global health statistics, the WHO could not sustain national or international commitment to the program.⁶¹ In conjunction with world economic decline, a lack of national motivation to address health outcomes, many of WHO's development partners, such as the World Bank, did not back the "Health For All" approach, but rather insisted on disease-specific interventions.⁶²

Despite this setback, the WHO continued to remain committed to strengthening national health systems. In 2005, the WHA passed a resolution urging Member States "to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, and to attaining international agreed development goals."⁶³ This time around, the World Bank and similar organizations supported the WHA's view. Indeed, under President Jim Kim, the World Bank now views UHC as a fundamental step toward reducing poverty. He recently stated that, "countries need to invest in a resilient primary healthcare system to improve access and manage healthcare costs."⁶⁴

Ultimately, while organizations like the WHO and World Bank do not exert influence on state governments to compel universal health access, they have had a profound effect on developing a normative standard for universal health coverage. By setting principles, benchmarks, and process through which countries may implement UHC, as well as by providing technical and financial resources, these international bodies have squarely placed UHC on the forefront of the post-2015 development agenda.

⁶⁰ See generally WORLD HEALTH ORGANIZATION, FORMULATING STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000 (1979); see also Allyn Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J. L. & MED. 301, 314 (1992) for a great discussion on WHO's Health for All Campaign.

⁶¹ Taylor, *supra* note 60, at 323.

⁶² *Id.* See also Don Matheson, *Will Universal Health Coverage (UHC) Lead to the Freedom to lead Flourishing and Healthy Lives?*, 4 INT. J. HEALTH POL. MGMT. 49, 49 (2015).

⁶³ World Health Assembly [WHA], WHA 58/2005/REC/1, *Sustainable Health Financing, Universal Coverage and Social Health Insurance* (May 25, 2005).

⁶⁴ World Bank & CSIS, *Speech by World Bank Group President Jim Yong Kim on Universal Health Coverage in Emerging Economies* (Jan. 14, 2014), available at <http://www.worldbank.org/en/news/speech/2014/01/14/speech-world-bank-group-president-jim-yong-kim-health-emerging-economies>.

B. From Past to Present: National UHC Systems

UHC originated in the 1883 launch of Germany's Social Health Insurance ("SHI") system—the first national health insurance scheme.⁶⁵ The country's first chancellor, Otto von Bismarck, introduced the Health Insurance Act of 1883 after overseeing the unification of Germany. The Act established mandatory enrollment in so-called "sickness funds," whereby members would contribute a portion of their wages to an insurance fund. This fund pooled risk and provided members with defined benefits like sick pay, free pharmaceuticals, and some inpatient and outpatient services. Initially, the eligibility criteria effectively limited coverage to only 10 percent of the population.⁶⁶ The government subsequently expanded these funds, however, and over the course of roughly a century, these expansions fundamentally evolved the SHI into a system of universal health coverage. The mandatory enrollment was extended piecemeal to cover different industries and workers—the German government enrolled agricultural and forestry workers in 1911, civil servants in 1914, the unemployed in 1918, all primary dependents in 1930, all pensioners in 1941, all handicapped in 1957, students in 1975, and artists in 1981.⁶⁷ At the same time, the system expanded its defined benefits, like minimum sick pay, inpatient and outpatient services, and more.⁶⁸ Eventually, the SHI system provided coverage to almost the entire German population.⁶⁹

The United Kingdom followed suit and began its system in 1948 with the establishment of the National Health Service ("NHS"). The country did so in the aftermath of World War II, amidst a broad consensus that health care should be accessible to all.⁷⁰ During the war, the Emergency Medical Service was temporarily created to care for the nation's injured by facilitating medical services and setting up a coordinated hospital service, including laboratory work, surgery, psychiatry, and rehabilitation.⁷¹ Both providers and patients alike grew to depend on the national presence in the health care system. As a result, following the war there was very strong popular support for a national health insurance scheme. Thus, the NHS was

⁶⁵ JAMES A. JOHNSON & CARLEEN H. STOSKOPF, *COMPARATIVE HEALTH SYSTEMS: GLOBAL PERSPECTIVES* 154 (Katey Birtcher et al. eds., 2d ed. 2011).

⁶⁶ *Id.* Most of those included were industrial workers, whose loyalty Bismarck sought to buy.

⁶⁷ Jesse B. Bump, *The Long Road to Universal Health Coverage: A Century of Lessons for Development Strategy*, PATH 15 (Oct. 19, 2010).

⁶⁸ *Id.*

⁶⁹ JOHNSON & STOSKOPF, *supra* note 65, at 154.

⁷⁰ Donald W. Light, *Universal Health Care: Lessons From the British Experience*, 93 AM. J. PUB. HEALTH 25, 25 (2003).

⁷¹ *Id.* at 26.

born, a tax-based national health service offered by the British government as a public good.⁷²

As countries' gross domestic product rose over the past century, the number of countries adopting health insurance coverage expansion programs rapidly accelerated. By 2009, over seventy-five countries adopted legislation mandating universal access to health care.⁷³ Of these, fifty-eight countries met health care access criteria for UHC, as measured by insurance coverage and access to skilled birth attendance (both arguably adequate proxies for access to health care).⁷⁴ Developed and developing nations alike joined the movement, including countries as diverse as Brazil, Ghana, India, and Vietnam.⁷⁵

Achieving UHC is a complex, long-term undertaking that challenges both high- and low-income countries. Countries like Germany, with an advanced health system, still struggle to ensure sustainable health services financing. Even in Brazil, which is considered to be making significant progress towards achieving UHC, the quality of health services are often poor and patient contributions remain high.⁷⁶ In low-income countries, the challenge to achieve UHC is further exacerbated by unique obstacles, such as corruption and weak management.⁷⁷ Above all else, the road to UHC is uniquely political to each country. The trajectory toward UHC usually begins when social forces drive the creation of public programs that expand access to care, improve equity, and create financial pools through taxes or premiums.⁷⁸ Thus, governments must be willing to spend more on health care, and citizens have to commit to paying into these health-financing pools. The above case studies highlight the different approaches to UHC and demonstrate how government objectives often determine how a country pursues UHC.

Accordingly, as a Sustainable Development Goal, UHC must incorporate national targets and indicators that are relevant or can be customized to address each individual country's own challenges and needs.

⁷² *Id.*

⁷³ Stuckler, *supra* note 54, at 75.

⁷⁴ *Id.*

⁷⁵ *Country Reform Profiles*, JOINT LEARNING NETWORK (Apr. 29, 2015), available at <http://programs.jointlearningnetwork.org/programs>.

⁷⁶ Robert Marten et al., *An Assessment of Progress Towards Universal Health Coverage in Brazil, Russia, India, China, and South Africa (BRICS)*, 384 LANCET 2164, 2165 (2014).

⁷⁷ *Id.*

⁷⁸ William D. Savedoff et al., *Political and Economic Aspects of the Transition to Universal Health Coverage*, 380 LANCET 924, 924 (2012).

IV. POSITIONING UHC AS A GLOBAL GOAL IN THE POST-2015 DEVELOPMENT AGENDA

With the recent and widespread political recognition of the societal and economic impact of poor health outcomes, UHC has advanced into the forefront of the global health agenda. As a result, many health policymakers have a renewed interest in returning to the principles set out in the “Health for All” approach. In December 2012, the United Nations General Assembly took note of this interest and passed a resolution encouraging states to recognize the importance of UHC in national health systems.⁷⁹ The resolution additionally recommended UHC “be given consideration” in discussions of the post-2015 development agenda.

Taking this resolution to heart, the United Nations Open Working Group included Goal 3 in its SDG proposal, which pledges to “[e]nsure healthy lives and promote wellbeing for all at all ages.”⁸⁰ Item 3.8 also sets out the Group’s commitment to “[a]chieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”⁸¹ The next step, which the Open Working Group will finalize in September 2015, will determine the goals’ targets and indicators.

Important considerations for the global future of health emerge upon reviewing MDGs limitations and the development of UHC. The Open Working Group should advance UHC as a post-2015 SDG. In doing so it should inform its specific health related goals by examining the limitations and success of the MDGs. Additionally, the Open Working Group should consider national experiences with the UHC. Doing so will promote successful implementation, both at the global and national levels.

First, as a starting point, any consultative process going forward should engage participation from both lower- and middle-income countries when forming the post-2015 development agenda. While universal targets can be agreed at the global level for global monitoring, each country must determine its own targets, consistent with its own comprehensive, broad-based development agendas. When designing a national indicator set, countries must define their own priority health areas that are seen as having some social value, be underpinned by governmental health objectives, and

⁷⁹ G.A. Res. 67/81, U.N. GAOR, 67th Sess., U.N. Doc. A/RES/67/81 at 3 (Dec. 12, 2012).

⁸⁰ Rep. of the Open Working Group of the General Assembly on Sustainable Development Goals, *supra* note 16.

⁸¹ *Id.*

address problems that could be changed through public policy and initiatives. This will ensure a sense of country ownership over development toward UHC, and avoid the goals being seen as the creation of donor and global development institutions only.⁸²

Second, addressing the social, economic, and environmental determinants of health (“SDH”) are critical to both the equitable pursuit of healthy lives and the provision of health services for all. To create and sustain strong health systems, both state and global actors must invest in the different building blocks of health system development: the delivery of effective and safe health services; a qualified workforce provided with appropriate medical products, vaccines, and other technologies; adequate and fair health financing; health information systems; good leadership; and governance.⁸³ The UHC framework must therefore envision and expressly incorporate engagement with other sectors in integrated multi-sectoral interventions. As an “umbrella goal,” UHC will avoid the artificial separation of convergent issues for which the health-related MDGs are criticized while also empowering countries to confront the underlying structural bases for poor health.⁸⁴

Third, the goal of UHC must include some sort of an accountability mechanism. Such transparency will help encourage governments and providers (private sector included) to deliver services equitably. The United Nations Secretary General’s Commission Information and Accountability for Women’s and Children’s Health is an example of an independent group that oversees countries’ progress toward specified goals.⁸⁵ Developed by the Commission, the Independent Expert Review Group (iERG) is comprised of nine experts who review countries’ progress toward implementing goals. In addition, they identify obstacles to implementing the Commission’s recommendations, and obstacles to maintain best practices in policy, delivery, accountability, and value for money.⁸⁶

⁸² MANNING, *supra* note 12, at 43.

⁸³ EVERYBODY’S BUSINESS: STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES: WHO’S FRAMEWORK FOR ACTION, WORLD HEALTH ORG. 44 (2007).

⁸⁴ *Questions and Answers on Universal Health Coverage and the Post-2015 Framework*, WORLD HEALTH ORG., available at http://www.who.int/contracting/documents/QandA_UHC_post-2015.pdf?ua=1 (last visited May 18, 2015).

⁸⁵ *Commission on Information and Accountability for Women’s and Children’s Health*, WORLD HEALTH ORG., available at http://www.who.int/woman_child_accountability/about/coia/en/ (last visited May 18, 2015).

⁸⁶ *Accountability for Women’s and Children’s Health: iERG Monitoring Framework*, WORLD HEALTH ORG., available at http://www.who.int/woman_child_accountability/iERG/reports/monitoring_framework/en/ (last visited May 18, 2015).

This model might be adapted at the regional level with a mix of global and regional representation to help monitor progress on UHC indicators. Such a mechanism could also support countries that fall behind attainment toward UHC; for example, through periodic formal reviews conducted by independent groups, which would measure countries' progress toward targets. In addition, these independent groups could perform an advisory role, and give advice on how to improve performance. The groups might include representatives of neighboring countries, or countries at a similar level of income so that peers would be reviewing one another and providing advice and counsel based on a familiarity with similar circumstances. Lastly, an accountability mechanism should also include a strong mandate concerning the public identification and recommendation of areas where individual countries should improve.

V. CONCLUSION

In order for a response to public health challenges ranging from the current Ebola outbreak to non-communicable diseases to be effective and sustainable, it needs to be thoughtfully crafted. Such an approach would not only provide critical aid in the short term, but also to invest in creating integrated health care systems that provide enduring security. There is an opportunity in the post-2015 development agenda to encourage the development of strong health systems through emphasis on universal health coverage. This introductory piece therefore urges the Open Working Group to adopt a normative framework for UHC, and in doing so, incorporate lessons learned from the health-related MDGs while drawing on national experiences implementing and maintaining UHC. This process needs to be country-specific, whereby states may take the lead in setting the direction, developing plans and strategies, implementing them, then monitoring progress and making adjustments as necessary. Through an inclusive and comprehensive UHC framework, the international community can work together to build a world where health can be claimed as a universal right on which post-2015 generations fully deliver. As Nelson Mandela said, "it always seems impossible until it's done."