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Note by the Secretary-General

The Secretary-General hereby transmits a report prepared by the Director-General of the World Health Organization on country experiences in moving towards universal health coverage, pursuant to General Assembly resolution 67/81.

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Report of the Director-General of the World Health Organization on global health and foreign policy

Summary

The present report describes efforts to implement the recommendations contained in General Assembly resolution 67/81 on global health and foreign policy.

The report compiles and analyses past and current experiences of Member States in the way they seek to move closer to, and maintain, universal health coverage. It considers the links to nationally determined social protection floors and actions that have been taken to share, establish and strengthen institutional capacity in order to facilitate policymaking based on the best possible information on the design of universal health coverage systems, including tracking the flows of health-care expenditure through the application of standard accounting frameworks.

The report also provides an initial insight into the importance and role of partnerships in achieving better health outcomes and addressing the challenges that the health-care sector and health-care actors face, including the path towards universal health coverage.

The conclusions acknowledge the important interrelationships between health and foreign policy. They highlight the importance of universal access to health-care services of high quality and to financial risk protection, the two components of universal health coverage that help improve the health and economic welfare of populations. The importance of timely, accurate information to help countries develop and implement policies to move closer to and maintain universal health coverage is stressed, including the need to share experience and capacity development across countries.

I. Introduction

1. The General Assembly, in its resolution 67/81, noted with particular concern that the right to the enjoyment of the highest attainable standard of physical and mental health remains a distant goal for millions of people, partly because they cannot afford to pay for health care at the point of use and partly because the need to do so discourages them from seeking or continuing needed care. The importance of ensuring universal access to health-care services of good quality, based on primary health care, with access to essential medicines and other medical services was highlighted, along with the need for health financing and social protection systems to ensure that people did not suffer financial catastrophe or impoverishment owing to high out-of-pocket payments.

2. The General Assembly noted that health-care services need to be included as an important element of the implementation of the Millennium Development Goals, covering the range of prevention, treatment, rehabilitation and palliative care and promotion of good practices for health.

3. The General Assembly welcomed the outcomes of a number of high-level meetings on the subjects of health, sustainable development and universal health coverage and the resolutions that emerged from them, including its resolutions 65/277, 66/2 and 66/288 in which the importance of universal coverage for health and sustainable development was emphasized.

4. Member States were invited to recognize the links between moving towards universal health coverage and many other foreign policy issues, such as the social dimension of globalization, cohesion and stability, inclusive and equitable growth and sustainable development and sustainability of national financing mechanisms. The link between universal health coverage and social protection mechanisms, including nationally determined social protection floors, was emphasized. Member States were also invited to adopt strategies to reduce health inequalities and ensure sustainable development through a multisectoral approach that focused on the determinants of health, including, as appropriate, the health-in-all-policies approach.

5. The resolution called on Member States to value the contribution of universal health coverage to achieving all interrelated Millennium Development Goals, with the ultimate outcome of more healthy lives, particularly for women and children; and to ensure that health financing systems evolve to avoid significant direct payments at the point of delivery through a method for prepayment with subsequent pooling of financial contributions for health. At the same time, Member States were encouraged to continue to invest in and strengthen health-care delivery systems to increase and safeguard the range and quality of services to adequately meet the health-care needs of the population.

6. The General Assembly then requested the Secretary-General to submit to the Assembly at its sixty-eighth session, under the item entitled “Global health and foreign policy”, a report compiling and analysing past and current experiences of Member States in the way they succeed in implementing strategies to move closer to universal health coverage, including links to nationally determined social protection floors. The report would also cover the ways countries share information on their own experiences and seek to establish and strengthen their own institutional capacities to generate the information and evidence they need for decisions on the design of health-care and health financing systems to move closer to universal

health coverage. The need to track health-care expenditures through the application of standard accounting frameworks was mentioned specifically in this context.

II. Universal health coverage and social protection

7. Universal health coverage means that all people obtain the health-care services they need without the risk of financial ruin as a result of paying for them. It concerns the two interrelated concepts of coverage, namely, needed health interventions (of good quality) and financial risk protection that ensures no one becomes poor as a consequence of out-of-pocket payments.

8. Access to needed prevention, treatment, rehabilitation and palliative care and promotion of good practices for health helps people maintain and improve their health. It also protects their economic livelihoods by enabling children to learn and adults to work and earn a living. The financial risk protection component prevents people being pushed into poverty by out-of-pocket health payments. At the same time, people value universal health coverage for its own sake, as it provides the assurance that the health-care services they might need to use during their lifetime are available, accessible and affordable, thereby contributing to peace of mind.

9. Universal health coverage contributes to, benefits from, and provides a way of measuring progress on sustainable development. The importance of universal health coverage was noted at the United Nations Conference on Sustainable Development (see General Assembly resolution 66/288). Other international processes have reinforced the need for such coverage, including: the “Every woman, every child” initiative, launched in September 2010 and the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, held in September 2011.

10. The goal of social protection is “to guarantee income security and access to essential social services for all, paying particular attention to vulnerable groups”.[1] Income security implies that people know they will have sufficient income to live on over their lifetime, regardless of their employment status, and this is usually assured through cash transfers, such as child and maternity allowances, unemployment benefits and old-age pensions. Access to at least a basic level of all essential services includes access to water and sanitation, education, food security, housing and health care.

11. Social health protection is a term widely used to refer to social protection specifically relating to health care. It includes cash transfers associated with illness and disability, financial risk protection against the costs of paying for health care and access to essential health interventions.

12. Universal health coverage is integral to both elements of social health protection. The financial risk protection component of universal health coverage contributes to income security and prevents people from being pushed into poverty or suffering financial hardship because of out-of-pocket health payments. Access to needed health-care services contributes to the essential services component of social protection.

[1] International Labour Organization, “Social Protection Floor for a Fair and Inclusive Globalization” (Geneva, 2011).

13. The joint Social Protection Floor Initiative, with the International Labour Organization and the World Health Organization (WHO) as lead agencies, was one of the nine joint crisis initiatives outlined by the United Nations System Chief Executives Board for Coordination in response to the recent financial crisis. It called for countries to implement social protection floors to ensure that their populations had the assurance of income security and access to critical services even during times of economic and financial crisis.

14. Action to develop countries' health-care systems to move closer to universal health coverage is a vital part of the health component of the social protection floor, in terms of ensuring coverage that includes needed health-care services and financial risk protection as regards health care. Universal health coverage encompasses the ambition to raise the standards of such protection and to progressively increase coverage for needed health-care services, of good quality, and for financial risk protection, over time. Universal health coverage and social health protection embody a set of critical policy goals that all countries share, but they do not imply any particular set of institutional arrangements in the health-care system. Country experiences suggest that a variety of approaches can be successful, though certain key principles and common features can be distilled from those experiences.

III. Country experiences

15. The challenges of moving closer to universal health coverage and then maintaining the achievements are not limited to any particular group of countries. Even high-income countries, where populations generally have good access to health-care services of good quality, with effective mechanisms to assure financial risk protection, face constant pressure to expand services and maintain financial risk protection owing to ageing populations and increasing demands from the population as a whole, as well as new, generally more expensive technologies. The continuing effects of the financial crisis have also put additional financial pressures on countries seeking to maintain their past achievements.

16. Despite this, low- and middle-income countries as diverse as Brazil, China, Ecuador, Ghana, Indonesia, Morocco, Rwanda, Sierra Leone, Thailand and Turkey are among the many that have taken steps to modify their health-care systems in order to move closer to universal coverage. In the area of health financing alone, more than 80 countries have requested technical advice from the World Health Organization on ways to modify their health financing systems since the publication of the *World Health Report 2010*, entitled "Health systems financing: the path to universal coverage".

17. Their experiences have shown that accelerating progress towards universal health coverage requires concrete actions that reinforce health-care systems and create an enabling environment for them to effectively contribute to improved health outcomes and social and economic well-being. There are many obstacles: some financial, some administrative and some political, and most countries face a mix of challenges. Because of this, there is no general blueprint. Each country must find an approach to address the specific needs and problems, and take advantage of the opportunities, that the country context presents.

18. Despite this, some common themes emerge. Moving towards universal health coverage is a dynamic process. It is not about a fixed minimum package of health-care services, it is about making progress on several fronts: the range of services that are available to people and their quality; the proportion of the costs of those services that are covered; and the proportion of the population that is covered. Ensuring the availability, quality and use of needed health-care services requires many different components, including universal access to essential medicines, health-care products and technologies; sufficient and motivated health-care workers, covering the necessary range of medical professions and located close to people; and information systems that provide timely information for decision-making.

19. Health financing systems that can ensure that health-care services of good quality are available close to people and that people can access them without fear of financial hardship requires action in one or all of the following areas: raising revenues for health care; ensuring that health-care services are affordable through mechanisms of prepayment and subsequent pooling of funds (general government revenues, insurance or a mix); and actively ensuring that the available funds are used as efficiently and equitably as possible.

20. Of the many possible examples, in the mid-2000s Chile embarked on a reform process incorporating the principles of equity in access to health-care services, quality of services and financial risk protection. It initiated the reform through a small increase in earmarked value added tax, channelling the additional funds to a mechanism that guaranteed everyone access to health-care services for a defined set of conditions that has expanded over time, established quality standards for treatment and set explicit limits on waiting times and out-of-pocket payments.

21. Ghana has built up its National Health Insurance Scheme in the past decade as a result of strong political support. The scheme has enabled the country to make significant advances in moving away from health financing based on direct payment at point of service use, and is Ghana’s first nationwide social protection scheme for health that includes rural and poor population groups in the same insurance pool as those working in the formal sector, who make mandatory social insurance contributions.

22. Thailand has a long history of health-care system reforms. After relying principally on contributory health insurance schemes in the 1990s, Thailand implemented a major reform in 2002 that ensured health coverage to the entire population not covered by one of the formal social security schemes. The Universal Coverage Scheme is funded entirely from general Government revenues, with the money pooled nationally in an independent public agency that contracts public and private service providers to ensure access and financial protection for a defined service package. A recent review showed that this reform has greatly improved both equity in service use and financial risk protection, while the contracting and payment methods used have enabled these gains to be achieved at a relatively low cost, compared to most other countries.

23. These are just some of the recent examples. Despite differences in the details, some common features of health financing systems that have enabled great progress towards universal health coverage include (a) predominant reliance on public/compulsory prepaid sources for most health-care system revenues, which is particularly important for ensuring access for the poor and vulnerable to health care; (b) pooling arrangements that maximize the risk-sharing capacity of these revenues

by reducing fragmentation or mitigating its consequences; and (c) moving towards strategic purchasing of services, in other words, using information on both the population's health-care needs and provider performance as the basis for allocating revenues to health-care service providers.

24. In some countries, modifications to health financing strategies have been linked closely with changes in general social protection mechanisms. For example, in 2009, Burkina Faso launched a multi-stakeholder policy dialogue that aims at implementing a national social protection floor. Within this process, health care has been a key component. A proposal for a universal health insurance scheme has emerged, aimed at combining the different forms of health insurance in the country in the move towards universal health coverage. It is seen as one part of the broader social insurance and safety net mechanisms.

25. Extending social protection through developing nationally defined social protection floors is a focus for many countries. More than 35 developing countries have concrete experience in this regard, having extended coverage of their social security systems during the past decade, and the movement towards extending social protection has been getting increased attention since the adoption by the International Labour Conference, in June 2012, of Recommendation No. 202 concerning national floors for social protection. Recent studies from 15 developing countries suggest that these actions reduced poverty, vulnerability and inequality.[2]

26. The result of country efforts to develop national health financing and service delivery systems to move closer to universal health coverage is reflected in improvements in the coverage of key interventions and in financial risk protection. For example, the annual reports on progress towards the Millennium Development Goals show that there has been a significant increase in the proportion of people covered by most of the interventions aimed at improving maternal and child health and by interventions to combat HIV/AIDS, tuberculosis and malaria since 2000. In developing countries, the proportion of births attended by a skilled health-care worker increased from 59 per cent to 66 per cent between 2000 and 2011. Over the same period, the proportion of children sleeping under insecticide-treated nets in sub-Saharan Africa increased from 2 per cent to 39 per cent, while the period 2009 to 2010 saw the largest year-on-year increase in the number of people receiving antiretroviral therapy for HIV or AIDS.

27. Over 130 countries had a list of essential medicines by 2007, and 81 per cent of the low-income countries among those had updated their lists in the previous five years.

28. Brazil, Chile, Costa Rica, Cuba, Germany and the Netherlands are among the countries developing integrated health-care service delivery networks to assure equitable, comprehensive, integrated and continuous health-care services to their populations; reforms in many other countries are currently addressing the organization, financing and staffing of primary health-care services.

29. These efforts to strengthen health-care systems and social health protection are one of the major reasons why the ratios of child and maternal mortality have fallen in most parts of the world since 2000, although some of the improvements could

[2] United Nations Development Programme/International Labour Organization/Global South-South Development Academy, "Successful social protection floor experiences" (New York, 2011).

also be attributed to improvements in overall social and economic conditions. From 2005 to 2011, the human development index reveals improvements in all parts of the world in terms of health, education and national income, with improvements most rapid in the least developed countries. The proportion of the world's population living in poverty also declined.

30. Improvements in the extent of financial risk protection for health can also be seen. Between 2005 and 2011, the average country's reliance on out-of-pocket payments to fund their health-care systems fell in all regions, as reliance on prepaid and pooled funding, which provides financial risk protection, increased. Some countries made particularly strong progress. In 29 countries, spanning different income levels and regions, the proportion of health-care expenditure represented by out-of-pocket expenses was reduced by at least 25 per cent since 2005.

31. Despite this, much remains to be done. An estimated 1 billion of the world's poor still do not receive the health-care services they need. For example, the proportion of deliveries attended by skilled health-care workers increased from 44 per cent to 48 per cent between 2000 and 2011 in sub-Saharan Africa, which is still far from the goal of 100 per cent of deliveries. Coverage for many of the health-care services needed to prevent or treat non-communicable diseases is believed to be low in many parts of the world, although accurate data are in short supply. Inequalities remain considerable in health-care service coverage and in levels of financial risk protection within countries.

32. Many countries still have critical shortages of health-care workers and find it hard to retain them in underserved areas. Access to affordable essential medicines was higher in the period 2007 to 2011 than in the previous five years, but the availability of essential (generic) medicines in a sample of low-income and lower-to-middle-income countries was only about 50 per cent in public health facilities and 67 per cent in private facilities.[3] In the majority of cases, information systems remain unable to provide data on coverage for most interventions relating to the prevention and treatment of non-communicable diseases.

33. Despite increased spending on health care, funds are still insufficient to ensure universal coverage for even a minimum set of health-care services (that is, to support prevention, treatment, rehabilitation and palliative care and promotion of good practices for health) in many countries. The High-level Task Force on Innovative International Financing for Health Systems estimated that countries required an average of $44 per capita in 2009, an amount expected to rise to $60 in 2015, in order to ensure coverage with even a minimum set of services.[4] In 2010, the average health-care expenditure per capita in low-income countries was $38 per capita; 22 of the member States of the World Health Organization still spent less than $44 per capita on health care, from all sources, including donor support.

34. The level of out-of-pocket payments remains high in many countries. An estimated 150 million people suffer financial catastrophe because they are not sufficiently covered by some form of financial risk protection, and 100 million are pushed under the poverty line for the same reason.

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[3] United Nations, *The Global Partnership for Development: Making Rhetoric a Reality, MDG Task Force Report 2012* (New York, September 2012).

[4] All averages are unweighted unless otherwise indicated.

IV. Establishing and strengthening country capacity for universal health coverage

35. There are a number of critical platforms that can be used to guide the development of the institutional and individual capacities needed as a foundation for progressing towards universal health coverage. The first is a health-care service platform to provide extensive geographical coverage of needed health-care services of good quality, including prevention, treatment, rehabilitation and palliative care and promotion of good practices for health. This is essential in ensuring equitable access for the population to needed health-care services, with the strengthening of primary health-care services that are close-to-client as the priority, backed by an appropriate referral system, an adequate number of skilled health-care workers, covering the necessary range of medical professions, and the availability of essential medicines and other technologies relating to health care. It is critical that capacities be developed to plan for and provide necessary health-care services, of good quality, and to develop and implement the health financing system that supports service delivery.

36. The second is the evidence platform, which entails strengthening and sustaining institutional capacity to generate evidence and effectively translating that evidence to policy decisions on the design, implementation and mid-course corrections of policies and strategies oriented towards universal health coverage. In this regard, attention must be given to developing, strengthening, sustaining and maximizing the use of data emerging from routine health information systems and processes and studies for monitoring and policy evaluation. Institutionalizing processes to ensure regular tracking of health-care expenditures (how much was spent, by whom, on what, and what was achieved) is one critical part of this.

37. Research of all types is one important component of developing the evidence platform. The *World Health Report 2013*, on the topic of research for universal health coverage, emphasized the importance of building national capacity for both clinical and applied policy research. National capacity to generate, analyse and use information to support decision-making is essential for a country to design a coherent set of measures to move towards universal health coverage, monitor progress and anticipate and adapt to changing circumstances. While countries can learn from the experiences of others, the unique context of each country demands that it have the analytical capacity to adapt lessons from elsewhere to local circumstances.

38. In Kyrgyzstan, for example, efforts to develop capacity for applied health policy research began in 2000, and the country used the results of that research as it designed and implemented its health-care reforms over the subsequent decade. For example, research requested by the Minister for Health on the first phase of reforms designed to reduce informal payments by hospital patients provided much needed evidence that convinced the Government and external partners to support the roll-out of those reforms nationwide.

39. The third platform relates to operational capacities and good governance. In the domain of health financing, for example, improving the efficiency and equity in resource use through the strategic purchasing of services requires the ability to analyse data on service use and provider performance and link the data to resource allocation decisions. It is essential that regulatory capacities are in place to enforce

contracts agreed with health-care service providers and apply sanctions in cases where they fail to be accountable to patients. In turn, ensuring that those actions are aligned with overall health-care system goals and that the funds are being put to best use requires mechanisms for ensuring public accountability, such as a governing board for the agency responsible for such purchasing decisions.

40. For example, the Estonian Health Insurance Fund promotes accountability through its annual report, in which it not only reports transparently on the use of its revenues, but also on its performance relative to a set of indicators to measure access, quality, improving the health behaviours of the population, the efficient use of resources and internal operational procedures. It routinely reports on surveys of population satisfaction, and on numerous occasions, the Fund received a Public Sector Transparency Flagship award, recognizing it as the Estonian government organization with the most transparent and substantial annual report.[5]

41. Although training in applied health and social policy research is necessary for increasing capacity, simply increasing the number of people with these skills will not be sufficient to create evidence-informed policymaking. The supply must be complemented by demand for policy-relevant research and monitoring by key decision makers. In addition, countries need to find appropriate institutional arrangements that enable them to retain the people they have trained, in order to ensure that their work is responsive to public policy priorities, while simultaneously ensuring the independence and objectivity of their work. It is a balancing act, and solutions must be tailored to the specific context of each country.

42. Evidence-based policymaking for universal health coverage requires reliable information on many topics, including the availability and distribution of all aspects of health care, including financial and human resources, medicines and other technologies relating to health care, as well as infrastructure; current levels of population coverage in terms of needed health-care services and financial risk protection; the impact on people's health and economic well-being; and the nature of inequalities in all such issues.

43. The General Assembly, in its resolution 67/81, requested the Secretary-General to include information, in his report, on the tracking of the flows of health expenditure through the application of standard accounting frameworks. A standard framework for tracking health expenditures, known as the System of Health Accounts, was published by the Organization for Economic Cooperation and Development (OECD) in 2000. After 10 years of implementation in countries across all income levels, a revised version, the System of Health Accounts 2011, was developed as a collaboration between OECD, Eurostat and WHO, with input from many other organizations, agencies and country experts.

44. The System of Health Accounts 2011 provides a policy-oriented approach for determining financial flows, from revenues to financing schemes, within a health-care system. For national policymakers, a robust health-care expenditure tracking methodology will enable them to adapt to rapidly evolving contexts and to receive feedback on the strategies and policies they have put in place. This allows for a

[5] Triin Habicht, "Governing a single-payer mandatory health insurance system: the case of Estonia", William D. Savedoff and Pablo Gottret, eds. *Governing Mandatory Health Insurance: learning from experience* (Washington, D.C., World Bank, 2008).

more reactive decision-making process and for better overall accountability regarding the financial flows in the health-care system.

45. Many countries are now moving to implement the revised System. Since its publication, over 50 countries have received support from international and bilateral organizations to train their staff and develop capacities in order to apply this standard accounting framework. Until recently, it was mainly the high-income countries that routinely tracked and reported their health-care expenditures and used this information for policymaking. However, an increasing number of low- and middle-income countries are now taking steps to do so, including Benin, the Lao People's Democratic Republic, Liberia, Togo and the United Republic of Tanzania.

46. The work in support of the recommendations of the Commission on Information and Accountability for Women's and Children's Health of WHO is also contributing to this. By 2015, 60 countries will have implemented exercises to track overall health-care expenditures, as well as expenditures on women's and children's health and on a variety of diseases and conditions, and to link them to results.

V. Enabling environment through partnerships

47. The United Nations Millennium Declaration and Goal 8 of the Millennium Development Goals gave huge impetus towards forging new partnerships for development. It provided a framework for a compact between developed countries to provide assistance to developing countries in their efforts to reduce poverty and achieve other development goals.

48. However, working in partnerships to achieve better health outcomes has a long history in the health-care sector. The World Health Organization is mandated by article 2 of its Constitution to "act as the directing and co-ordinating authority on international health work". WHO manages a network of over 800 institutions as part of WHO collaborating centres. WHO also hosts seven partnerships, such as the Stop TB Partnership and the Alliance for Health Policy and Systems Research; and co-sponsors such programmes as the African Programme for Onchocerciasis Control.

49. The number of global health partnerships, initiatives and other forms of collaboration has increased steadily over the past decade. The Joint United Nations Programme on HIV/AIDS (UNAIDS) is, by definition, an innovative partnership.

50. The Paris Declaration on Aid Effectiveness, of 2005, and the Accra Agenda for Action, of 2008, set out principles for making aid more effective by improving its quality and the alignment of all development partners. Over 130 countries and 28 international organizations adhered to those documents. In the context of the Paris and Accra processes, the approach to improving health has demonstrated, through initiatives such as the International Health Partnership, that despite the diversity of the actors involved in the health-care sector, coordination around national health-care strategies can be improved.

51. In 2011, the Busan Partnership for Effective Development Cooperation signalled a shift in thinking from traditional aid effectiveness to a broader, more inclusive approach to development cooperation, with a greater emphasis on considering domestic and external resources together and on results. The concept of mutual accountability is taken a step further with the domestic accountability by

which national Governments are held accountable by citizens and civil society organizations for safeguarding public health.

52. The approach adopted in Busan, Republic of Korea, attempts to address the changing development challenges, as the majority of the world's poor live in countries that are considered as middle-income countries according to the level of their economic growth. Official development assistance, which has in some cases been reduced as a result of the global financial and economic crisis, is no longer the only way in which development assistance is being funded.

53. Safeguarding the gains achieved through programmes funded by one-off resource transfers from rich to poor countries requires a new approach where those funds are supplemented by longer-term, predictable funding agreements, integrated in the countries' national financial and administrative systems. Resources from domestic sources, tax revenue, remittances, concessional financing from foundations, foreign direct investment and global solidarity taxes are contributing to financing for development.

54. After more than 10 years of rapid growth, development assistance for health care has levelled off. The number of health-care actors at the national, regional and international levels has continued to rise, with increasing challenges of fragmentation, duplication and high transaction costs. In the light of new trends and emerging challenges, the place, role and the main characteristics of partnerships, that would enable the achievement of a transformative, people-centred and planet-sensitive development agenda, must be reviewed.

55. At the same time, world leaders have consistently recognized the centrality of health to development through several high-level political processes. At the United Nations Conference on Sustainable Development, it was reaffirmed that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development. It was also recognized that health-care systems strengthened and geared towards the provision of equitable universal health coverage are a prerequisite for enhancing health, social cohesion and sustainable human and economic development.

56. In the Political Declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (General Assembly resolution 66/2), it was acknowledged that such diseases, as a contributing factor to poverty and hunger in developing countries, constitute one of the major challenges for development in the twenty-first century. This political process highlighted the realization that only a multisectoral response to non-communicable diseases can prevent the impoverishment of families and even the bankruptcy of nations in all parts of the world.

57. The discussions around the post-2015 development process have reiterated the crucial role of partnerships in the next agenda. In its report, the High-level Panel of Eminent Persons on the Post-2015 Development Agenda has identified five transformative shifts in moving towards sustainable development. Forging a new global partnership is identified as "an overarching change in international cooperation that provides the policy space for domestic transformations".[6] The report proposes a new global partnership with a broad range of actors, each of whom

[6] Available from www.un.org/sg/management/pdf/HLP_P2015_Report.pdf.

has a specific role to play: national Governments; local authorities; international institutions; business; civil society organizations; foundations, other philanthropists and social impact investors; scientists and academics; and individuals.

58. Inclusive partnerships mark the shift from traditional relationships between donors and recipients to a concept of development partners. Partnerships, coalitions and initiatives gathered around a specific issue have shown their value by making rapid progress in tackling diseases such as HIV, tuberculosis or malaria. The “Every woman, every child” initiative launched by the Secretary-General has instigated an exceptional global movement by mobilizing the highest officials in different countries and galvanizing health-care actors at all levels to improve the health of women and girls.

59. These initiatives also gain importance in monitoring results and tracking pledged and spent resources. The work of the Commission on Information and Accountability for Women’s and Children’s Health showed the increasing importance of tracking and monitoring in identifying the bottlenecks and appropriate strategies to tackle them.

60. Partnerships in the past decade have consistently included governments, civil society and the private sector as equal partners not only in funding terms, but also in governance and decision-making capacity. Networks have reached politicians and individuals at the local and community levels. New information and communications technology, including social media, have reshaped the way information is disseminated and new groups have gained voice and influence.

61. The High-level Panel of Eminent Persons received feedback from more than 5,000 civil society organizations and 250 chief executive officers of major corporations. Over 800,000 people took part in the “My World” survey (available from www.myworld2015.org) and ranked the priority areas for themselves and their families for the post-2015 development agenda. “Better health care” is ranked as the second highest priority overall and it is also the second highest for 11 out of 15 groups disaggregated by gender, age, education and earning quintiles.

62. Ensuring the sustainability of the large number of targeted health interventions can be achieved through their integration as part of national health-care systems. Rapid economic growth in different parts of the world did not bring commensurate gains in social services and well-being. More and more countries face similar challenges relating to increasing life expectancy, and achieving universal health coverage is relevant to all countries, regardless of their development phase; similarities across countries are also reflected in the obstacles hindering progress towards such health-care goals.

63. A significant amount of new resources for the achievement of the Millennium Development Goals relating to health is being raised through partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the International Drug Purchase Facility (UNITAID). However, the countries that most need external assistance are usually not the best equipped to manage it. Multiple channels of funding can distort national priorities and divert efforts from where they are needed the most. The International Health Partnership works towards aligning funding from domestic and international sources around nationally defined objectives and strategies. It also provides a tool for jointly appraising national policies and monitoring progress in adhering to the principles of aid effectiveness.

64. A systemic approach to better health outcomes requires addressing the social determinants of health. Coordinated action across multiple sectors that support the whole-of-government and whole-of-society approach is a way to achieve better health outcomes for the whole population. Proactive policymaking monitors risks by applying lessons learned from both the health-care and environmental sectors. Diseases related to the environment could be prevented by linking health and environment concerns into national development plans and capacity-building at all levels. The Health and Environment Strategic Alliance for the Implementation of the Libreville Declaration acts as a basis of plans of joint action and a regional platform for intersectoral dialogue in Africa.

65. A human rights-based approach to health care can contribute to enhancing the affordability, accessibility, acceptability and quality of health-care services and facilities by insuring the inclusion of beneficiaries in all discussions and their participation in relevant decision-making processes. Inequalities and discrimination in access to health-care services remain underlying determinants that have an impact on the ability to lead a healthy life.

66. Traditional technical assistance is giving way to upstream policy advice, which favours hands-on experience that can be gained through triangular cooperation, South-South cooperation and public-private partnerships. The Declaration of the Fourth High-level Forum on Aid Effectiveness, held in Busan, recognized that the nature, modalities and responsibilities that apply to South-South cooperation differ from those that apply to North-South cooperation.

67. The three types of partnership demonstrate approaches combining solidarity and cooperation in the face of global challenges. Protecting the health of populations from new and emerging infectious diseases requires a chain of surveillance and response at the global level. The health-care workforce and its increased mobility require global solutions, including training, distribution, retention and incentive policies, which are shared concerns in many developing countries. Equitable access to basic health care, sexual and reproductive health care and maternity services remains extremely difficult for women in many parts of the world.

VI. Conclusions

68. **People are increasingly demanding access to health-care services of good quality at an affordable price, which is the essence of universal health coverage. Such coverage provides them with the peace of mind that they can afford to use the health-care services they need in the event of an emergency, and that these services will be of good quality. Access to needed health-care services also helps people to promote and maintain their health, thereby giving them the opportunity to learn, work and earn an income. As such it is a critical component of sustainable development.**

69. **Access to health-care services is also closely linked to the concept of social protection, and health is an important component of social protection floors. Efforts towards universal health coverage are raising the standards of such protection, as rapidly as possible, so that everyone can access the health-care services they need without financial barriers or hardship.**

70. **Universal health coverage is relevant to countries at all income levels, all of them faced in different ways with questions of resource scarcity as a result of increasing needs and demands from their populations. The path to universal coverage, however, is country-specific, though country experience also shows that any approach must focus not only on health financing strategies, but also on the health-care service delivery system with all its components, as well as on social determinants of health.**

71. **Increasing the ability of countries to learn from each other's experiences is one important way of moving forward more rapidly. Another is for countries to increase their own capacities to design policies based on the best evidence, to implement them and then monitor and evaluate their impact, so as to modify them as necessary.**

72. **The move towards universal health coverage needs to rely on robust information systems that provide timely data that are relevant to policymaking. Tracking health-care expenditure flows through the application of standard accounting frameworks is one important element and with the roll-out of the System of Health Accounts 2011 framework, countries have internationally agreed guidance on the approaches that can be used.**

73. **The International Health Partnership and related initiatives has identified seven specific behaviours needed for increasing harmonization and alignments in aid, with a clear focus on health outcomes. They are focused, inter alia, on agreed priorities reflected in a national health strategy, based on joint assessments and jointly monitored, with a reduction in separate exercises; resources recorded on budget and aligned with national priorities and national commitments; financial management and procurement systems that are harmonized and aligned, with capacity-building to strengthen country systems and the use of those systems; systematic learning; and the provision of strategically planned and coordinated technical support.**

74. **Fine-tuning the instruments that already exist would contribute to a partnership that would promote technological innovation in developing new medical services and medical devices, while ensuring the education, training and professional capacity of health-care workers to use them. Research and development in developing new vaccines or drugs would contribute to improving their availability and affordability, while combating substandard/spurious/falsely labelled/falsified/counterfeit medicine.**

75. **Partnerships need to strengthen, rather than overburden, existing country capacities. They need to place emphasis on the quality of aid, more than the quantity. Instead of a proliferation of reporting requirements and indicators, systemic arrangements that look at the whole-of-health approach are needed. Partnerships built around common goals, with a sense of ownership by multiple actors with a shared interest, can contribute to creating durable solutions while solving current problems.**