

## HEALTH IN THE FRAMEWORK OF SUSTAINABLE DEVELOPMENT

Technical Report for the Post-2015 Development  
Agenda

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18 September 2013

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All of the Sustainable Development Solutions  
Network**

The Sustainable Development Solutions Network (SDSN) engages scientists, engineers, business and civil society leaders, and development practitioners for evidence-based problem solving. It promotes solutions Initiatives that demonstrate the potential of technical and business innovation to support sustainable development ([www.unsdsn.org](http://www.unsdsn.org)).

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## Contents

Foreword - Working For a Better World.....	4
Executive Summary .....	6
Health is Central to Sustainable Development.....	8
Why is health central?.....	8
Current status of global health and challenges.....	8
Proposal for a Health SDG .....	10
Underlying principles in the goal towards UHC.....	11
Making the case for UHC: Externalities and Synergies.....	13
Universal Health Coverage as a Priority for the Post-2015 Agenda: Concept, Components and Collaborations.....	16
Concepts: What do we mean by Universal Health Coverage? .....	16
Components: What does Universal Health Coverage include?.....	16
Collaborations: Who does UHC involve?.....	17
Delivering Universal Health Coverage .....	19
Financing .....	19
Human Resources.....	20
Synergies and Stakeholders .....	22
Good Governance and UHC .....	23
Linking Health to other Development Goals .....	24
Appendix 1: Targets and Indicators.....	29
Appendix 2: Glossary .....	36
Appendix 3: Health Goals Suggested in Global Consultations and Reports (2011-13).....	38
Appendix 4: Evidence for Universal Health Coverage Indicators .....	40
Appendix 5: Universal Health Care as being built on the foundation of human rights and equity .....	44
References:.....	46

## Foreword - Working For a Better World

*Health equity cannot be concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of fairness and justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life and freedom. Health equity is most certainly not just about the distribution of health, not to mention the even narrower focus on the distribution of health care.*

- Amartya Sen (2002)

The collective efforts of the global community towards ending extreme poverty and hunger and to promote gender equality were successfully directed by the Millennium Declaration and the Millennium Development Goals (MDGs). The importance of health as a key feature of human development was recognized, with three MDGs explicitly linked to health indicators and the others structured around major determinants of health.

While considerable health gains have been achieved through the MDGs, there needs to be a continued commitment for accelerating progress related to those goals. Epidemiological and demographic transitions accompanied by changing exposures to risk factors have brought forth non-communicable diseases as major global contributors to preventable death and disability. At the same time, health inequities have persisted within populations, despite improvement in aggregate national health indicators. There is also a concern that segmentation into specific age groups misses critical periods of life like adolescence, which currently has unmet health needs despite its importance in laying the foundation for adult health. Similarly, the health needs of the elderly must also be addressed.

The fifteen year period of MDGs will end in 2015. In 2012, the Rio +20 Summit further resolved to put an end to extreme poverty and hunger by placing poverty reduction in the broader context of sustainable development. The Summit's final outcome was the call for new Sustainable Development Goals (SDGs) to be adopted by the United Nations (UN) post-2015. These SDGs will set global priorities for action and promote sustainable and equitable development worldwide. While continuing the commitments to the Millennium Development Goals (MDGs) set in 2000, the SDGs will provide a framework for integrating actions across multiple sectors to enable human development to proceed in a manner that optimizes the equitable use of planetary resources without endangering sustainability.

### **The Sustainable Development Solutions Network (SDSN)**

The SDSN was launched in August 2012, under the auspices of UN Secretary General Ban Ki-moon, as part of his efforts to promote sustainable development. The SDSN mobilizes global scientific and technological knowledge to address the challenges of sustainable development. The SDSN is an independent body of multi-disciplinary and multi-institutional experts from different sectors relevant to the SDGs. The SDSN was mandated to: (i) assist the UN process by providing well argued, evidence-informed and succinctly summarized policy briefs which would flow to the High Level Panel of Eminent Persons, the UN Secretary General's office, and to the Member States of the UN engaged in the inter-governmental process of defining the SDGs; (ii) to identify and evaluate innovative solutions that will overcome barriers to the attainment of those goals and accelerate progress towards sustainable development at the global level; and (iii) to enlist and strengthen universities and institutions in different countries/regions that can become catalysts and enablers of transformational processes

1 leading to sustainable development, especially through the design, delivery and evaluation of innovative  
2 solutions.

3  
4 The SDSN has established 12 Thematic Groups (TGs) comprising leading scientists, engineers, academics  
5 and practitioners from civil society and the business community to promote solutions to the key  
6 challenges of sustainable development. A Leadership Council oversees the work of the UN SDSN. Health  
7 has been a prominent focus area of the SDSN. The Thematic Group on Health for All has been discussing  
8 the priorities and position of health in the post-2015 development agenda. The mandate of the TG on  
9 Health is:

- 10  
11 1) To prepare a policy brief on 'Health for All,' commenting on the potential Health goals for  
12 submission to the UN Secretary General's office as part of the report submitted by the Leadership  
13 Council of the SDSN.  
14 2) To prepare a more detailed document, amplifying the evidence for goals prioritized by the SDSN  
15 and profiling the intersection of those goals with other development goals for submission to the  
16 UN.  
17 3) To continue to engage with the UN process for framing the post-2015 SDGs on health between  
18 September 2013 and September 2015.  
19 4) Identify and appraise innovations of transformational value in advancing the health MDGs and  
20 future SDGs, with an emphasis on both health system interventions and multi-sectoral initiatives.  
21 5) To work with the Leadership Council of the SDSN in building and strengthening institutional  
22 networks that will align with and assist in the implementation of the SDGs in the post-2015 phase  
23 of global development.

24 The TG on Health for All aims to review the global evidence related to health and its relevance to  
25 sustainable development, link health to the social determinants influenced by other sectors and identify  
26 pathways by which universal access to health can be advanced across the world. Through this effort, the  
27 TG aims to assist in the vision for a better world in the 21<sup>st</sup> century, wherein all people on earth can  
28 benefit from the fruits of sustainable development and lead long and productive lives enriched by health  
29 and wellbeing at all ages.

## Executive Summary

The framework for sustainable development in the 21<sup>st</sup> century must maximize healthy wellbeing at all ages through universal health coverage and pro-health policies in all sectors. Adopting a life course approach that will benefit all persons, we recommend the health goal ***Achieve Health and Wellbeing at All Ages.***

To accomplish this objective we propose that ***all countries achieve universal health coverage at every stage of life, with particular emphasis on primary health services, including mental and reproductive health, to ensure that all people receive quality health services without suffering financial hardship. Countries implement policies to create enabling social conditions that promote the health of populations and help individuals make healthy and sustainable decisions related to their daily living.***

Health is crucial for sustainable human development, both as an individual right and a contributor to the economic growth of society. Health is also a good summative measure of the progress of nations in achieving sustainable development. It contributes to national development through productive employment, reduced expenditure on illness care and greater social cohesion. By promoting good health at all ages, the benefits of development extend across generations. Investments in primary health care will promote health across all social groups and reduce health inequities within and across countries. Improving performance of health systems by enhancing financial and human resources, appropriate use of technology, community empowerment and good governance will advance this agenda. The potential for providing large-scale employment as frontline health workers, particularly to women and young persons, should be utilized to strengthen the economy and improve health services.

Universal health coverage must ensure equitable access to affordable, accountable, appropriate health services of assured quality to all people. These must include promotive, preventive, curative, palliative and rehabilitative services. They must be supported by policies and services addressing the wider determinants of health for individuals and populations. Governments must play the role of both guarantor and enabler, mobilizing all relevant societal resources for the delivery of health services.

Since the determinants of health extend across multiple sectors, the post-2015 development agenda must promote synergies and partnerships that align actions for better health, linking several stakeholders. Improved health of individuals and populations will also help in achieving other development goals such as poverty reduction, gender empowerment, universal education and conflict resolution. Several common determinants also link health to the environment, agriculture and food systems, water and energy security, urban development and transport, trade, communications, and human migration.

We believe that universal health coverage (UHC), delivered through an adequately-resourced and well-governed health system, will be capable of addressing these and other health challenges, especially if supported by pro-health policies in other sectors. Apart from intrinsic value of health, UHC will have positive externalities for development, gender empowerment and social solidarity. Within the health sector, primary health care should be accorded the highest importance because of its ability to provide maximum health benefits to all parts of society and to ensure sustainable health care expenditure levels.

**We recommend the following actions be undertaken at global and national levels to achieve health and wellbeing at all ages:**

- Build on the successes of the MDGs and address gaps in achievement of MDGs 4, 5, and 6, while expanding the agenda to include action on other major causes of disease burden such as non-communicable diseases.
- Adopt a life course approach to health promotion, disease prevention and health care, with particular attention to prevention and control of communicable diseases, non-communicable diseases, mental illness, injuries and disabilities; promotion of child and adolescent health; safe pregnancy and provision of sexual and reproductive health services; elderly care; and emergency health services.
- All countries allocate at least 3% of national GDP as public financing for health and reduce private out-of-pocket spending (OOPS) on health care, and ensure voluntary health insurance funding is less than 30% of all health expenditure.
- High income countries allocate at least 0.1% of GDP as international assistance for health, for supporting the efforts of low and middle income countries for implementing UHC, while raising the level of overall assistance for sustainable development.
- All countries provide high quality comprehensive primary health services (which include public health services as well as acute, chronic and emergency clinical services, in both community-based and facility-based settings) in rural and urban populations, without financial, geographic, gender or other social barriers to access.
- Create and support a skilled workforce to deliver the health services envisaged under UHC, with emphasis on expanding the size, skills and role of a cadre of socially empowered community health workers who are enabled to use appropriate technologies.
- Ensure access to essential medicines, vaccines and technologies, using pooled procurement and distribution of quality assured drugs and utilizing low cost generics and price controls to make drugs affordable to the health system as well individual patients.
- Effectively implement the Framework Convention on Tobacco Control (FCTC) to substantially reduce the one billion person death toll from tobacco-related diseases WHO projects for the 21<sup>st</sup> century, and use analogous demand and supply reduction measures to decrease the harmful use of alcohol.
- Align agriculture and food systems to assure that every person has access to a composite diet that is both calorically adequate and nutritionally appropriate, at each stage of life.
- Ensure availability of clean water for drinking and personal hygiene, improved public and domestic sanitation and reduction in air, water, light and sound pollution.
- Adopt pro-health policies in other sectors, such as trade, urban design and transport, while promoting policies and actions that mitigate climate change and develop adaptive strategies to make populations more resilient to the effects of climate change on health.

# Health is Central to Sustainable Development

## Why is health central?

Health is critical for human development and economic growth. It is inherently important as a human right. National aspirations for economic growth cannot be achieved without a healthy and productive population. While health benefitted from economic growth, its value as a critical catalyst for development led to health-related goals being centrally positioned in the MDGs. Child and maternal mortality became a measure of a nation's overall development, along with poverty eradication and the empowerment of women. At the same time, it was acknowledged that combating the spread of HIV/AIDS and reducing the burden of TB and malaria was critical, as these diseases disproportionately impact the development potential of dozens of countries.

Several reports in the last two decades such as the WHO Commission on Macroeconomics and Health (1999)<sup>60</sup> have emphasized the need for greater investments in health through increased public financing. These reports have highlighted the multiplier effects of investment in health and the 'cost of neglect' from preventable death and disability, emphasizing the need to address not just diseases but the wider dimensions and determinants of health.

As the world prepares to formulate and adopt Sustainable Development Goals (SDGs), the health goal proposed by the SDSN (*Achieve Health and Wellbeing At All Ages*) must be recognized as pivotal to global development. Even as economic development is pursued with vigor by a world that wishes to reverse the economic downturn of the past five years, it must be clearly recognized that economic progress can neither be secure nor sustainable if sufficient investments are not made to protect and promote the health status of all people across the world.

## Current status of global health and challenges

Three of the eight MDGs directly positioned health as critical indicators of development. Reductions in child (MDG 4) and maternal (MDG 5) mortality, and halting the incidence of HIV/AIDS, TB, and malaria (MDG 6) became key development targets. Other MDGs such as ending poverty and hunger (MDG 1), universal primary education (MDG 2) and the empowerment of women (MDG 3) are critical for improving health.

Considerable progress has been made in the achievement of MDG targets. Profound reductions have been made in under-five deaths worldwide from more than 12 million in 1990 to less than 7.6 million in 2010. Around 6.5 million people living with HIV/AIDS now have access to anti-retroviral treatments (ART). The spread of tuberculosis is on target to be reversed by 2015, and the global incidence of malaria has fallen by 17% since 2000. The global target of halving the proportion of people without access to safe, clean water has been met.

Despite these achievements, much remains to be done. National and regional disparities remain the most formidable challenge. Several countries did not meet the targets, while others have reached their targets but require further reductions. Many countries making progress have done so only in certain populations, increasing inequalities. In addition to the mandate set by the MDGs, epidemiological and demographic transitions have driven an increasing burden of non-communicable diseases (NCDs), particularly in low and middle income countries, with rising incidence of cardiovascular diseases and risk



factors, diabetes, cancer, respiratory diseases and mental health conditions. This implies a need for reassessing health priorities in the post-2015 development mandate, both to accelerate MDG achievement and to include emerging health concerns.

The major barriers in achieving health for all relate to health systems challenges and the socioeconomic inequities that predispose, precipitate and perpetuate vulnerability of individuals and populations to health risks. The Thematic Group on Health for All strongly advocates global, national and regional actions for addressing these barriers.

As debates concerning the post-2015 development agenda intensify, more and more governments, development agencies and civil society organizations are calling for the achievement of Universal Health Coverage (UHC) as a health goal<sup>6,16,49,51,55,63</sup>. This can be attributed to a growing recognition that increasing health coverage delivers substantial developmental benefits - both in terms of better health indicators and improved economic wellbeing, including reduction of poverty levels. Furthermore political leaders are realizing that moving towards UHC is popular with populations across the world. By improving the health and economic welfare of all people, governments can foster social harmony, enhance the legitimacy of the state and secure considerable political benefits. This is discussed briefly in the next section.

In the past three years, several consultations (Appendix 3) have deliberated on the opportunities and challenges provided by the existing MDGs and the call for a new health goal which resonates with contemporary issues and concerns. These issues have ranged from universalism versus targeting, inclusion, equity, concerns regarding financial protection, and differences in interpretation, among others. This paper argues for a broad interpretation of UHC that goes beyond health services. Discussion on the core components of UHC is provided in Chapter 2, but below is a discussion of the several opportunities and challenges presented by the framework of UHC, when compared other pre-existing or potential frameworks.

**Table 1: UHC provides several opportunities and Challenges**

<b>Opportunities:</b>	<b>Challenges:</b>
<i>Inclusion:</i> UHC addresses a wide range of health problems across all age groups and through the life course.	<i>Diverse definitions and models:</i> Diverse definitions and conceptual models offer varying designs for implementation of delivery, thereby introducing difficulties in agreeing on a common goal or target for comparative assessment of progress.
<i>Equity:</i> If designed well, UHC has the potential for reducing health disparities.	<i>Measured by diverse metrics:</i> Adoption of specific metrics for measuring national and global progress towards UHC is a challenge.
<i>Financial protection:</i> UHC reduces out-of-pocket spending (OOPS) and catastrophic health expenditure, thereby decreasing the risk of poverty from health care spending by individuals.	<i>Potential for narrow interpretation:</i> UHC may be understood narrowly as just the provision of health care and many exclude action on the social determinants of health that have a profound influence on the health of populations and individuals. Such a restricted interpretation would overemphasize the biomedical model of clinical care without substantial impact on population health

	outcomes.
<i>Livelihood generation:</i> UHC emphasizes a multi-layered health workforce that delivers primary healthcare services. The employment of both physician and non-physician health care providers is encouraged, with particular emphasis on young women entering labor markets.	<i>Recognition of priority equity needs:</i> A 'universal' program may dilute the priority accorded to the needs of the poor and may permit the non-poor to benefit in a disproportionate manner though better access and negotiating power.
<i>Common global vision:</i> UHC is applicable to both HICs and LMICs, and can be implemented based on contextual priorities.	
<i>Unifying global rallying point:</i> UHC has been strongly endorsed by the WHO, UN, World Bank, Civil Society Organizations, many Governments and Private Sector Confederations, through reports, declarations, resolutions and statements issued in the past three years.	

## Proposal for a Health SDG

The MDGs were successful as a rallying point, clearly focusing on national policy efforts towards development. As simple, quantitative and measurable targets, they became important tools for assessing the progress made by nations in improving health policy. However, in their approach and implementation, the exclusive focus on disease-specific goals and the failure to integrate issues of inequity led to inter- and intra-national differences in progress towards achieving the goals. In the absence of a vision for strengthening systems ('horizontal' programs), the MDGs encouraged disease-specific programs ('vertical' programs), exacerbating the health differences between nations and diseases. At the same time, the emergence of new health challenges demonstrates the need for reassessing the scope and relevance of the MDGs over time and to HICs.

The new SDGs must follow an inclusive framework, encapsulating equity and a systems-approach in achieving new health targets for 2030. The SDGs must be set using a broad framework that is universal (i.e. relevant to both LMICs and HICs), context-specific and adaptive. A number of consultations and high-level panel meetings have deliberated on potential candidates for a health SDG (Appendix 3).

After reviewing consultations and reports, the SDG proposed by the TG is ***Achieve Health and Wellbeing At All Ages***. This implies that ***all countries achieve universal health coverage at every stage of life, with particular emphasis on primary health services, including mental and reproductive health, to ensure that all people receive quality health services without suffering financial hardship. Countries also implement policies to create enabling social conditions that promote the health of populations and help individuals make healthy and sustainable decisions related to their daily living.***

In its deliberations, the TG identified 3 interrelated targets and several indicators. While this list is not exhaustive, these targets and indicators provide a useful starting point for measuring the progress

towards achieving this SDG. The three targets are listed below, while their associated indicators are available in Appendix 1.

- ❖ Ensure universal coverage of quality healthcare, including the prevention and treatment of communicable<sup>1</sup> and non-communicable diseases, sexual and reproductive health, family planning, routine immunization, and mental health, according the highest priority to primary health care.
- ❖ End preventable deaths by reducing child mortality to [20] or fewer deaths per 1000 births, maternal mortality to [40] or fewer deaths per 100,000 live births, and mortality under 70 years of age from non-communicable diseases by at least 30 percent compared with 2015.<sup>2</sup>
- ❖ Implement policies to promote and monitor healthy diets, physical activity and subjective wellbeing; reduce unhealthy behaviours such as tobacco use by [30%] and harmful use of alcohol by [20%].

## Underlying principles in the goal towards UHC

The overarching goal embraces four cardinal principles.

- ❖ ***The Life course Approach:*** The TG proposes an inclusive health SDG that does not look at disease categories but instead looks at maximizing health and well-being through the life course. This goal is recommended based on criticisms of approaches that segment health and wellbeing into stages (such as healthy infancy, healthy childhood, healthy maternal health). A life course approach acknowledges that individuals may be affected by infectious diseases (HIV/AIDS, TB) as well as chronic diseases (diabetes, cancer) and provides a continuum of care across the lifetime of an individual. It also recognizes that illness at a particular age may be preconditioned by factors operating at an earlier age (e.g., childhood under-nutrition can predispose individuals to adult cardiovascular disease and diabetes).
- ❖ ***Adopting UHC, with Primary Health Care a Priority:*** The mandate for a broader UHC acknowledges the multiple dimensions of health and wellbeing. The focus of this broader mandate continues to be primary health care achieved through horizontal programs that focus on strengthening health systems. This approach recognizes the need to address challenges of human resources, drugs and essential medicines, and nutritional policies among others.
- ❖ ***Action on determinants and dimensions through multi-sectoral initiatives:*** The TG recognizes that the agenda for the unfinished burden of health and emerging health conditions cannot be addressed without the concerted engagement of a diversity of stakeholders, including government, civil society, academia, the media, and private industry. A detailed analysis of some intersectoral linkages is provided in Chapter 4 and shown in Figure 2.

<sup>1</sup> We recommend that countries adopt suitably updated MDG indicators for HIV/AIDS, TB and malaria, as well as for Neglected Tropical Diseases (NTDs).

<sup>2</sup> Countries that have achieved the mortality targets should set more ambitious aggregate targets that are commensurate with their development and ensure that the minimum quantitative targets are achieved for every sub-population.

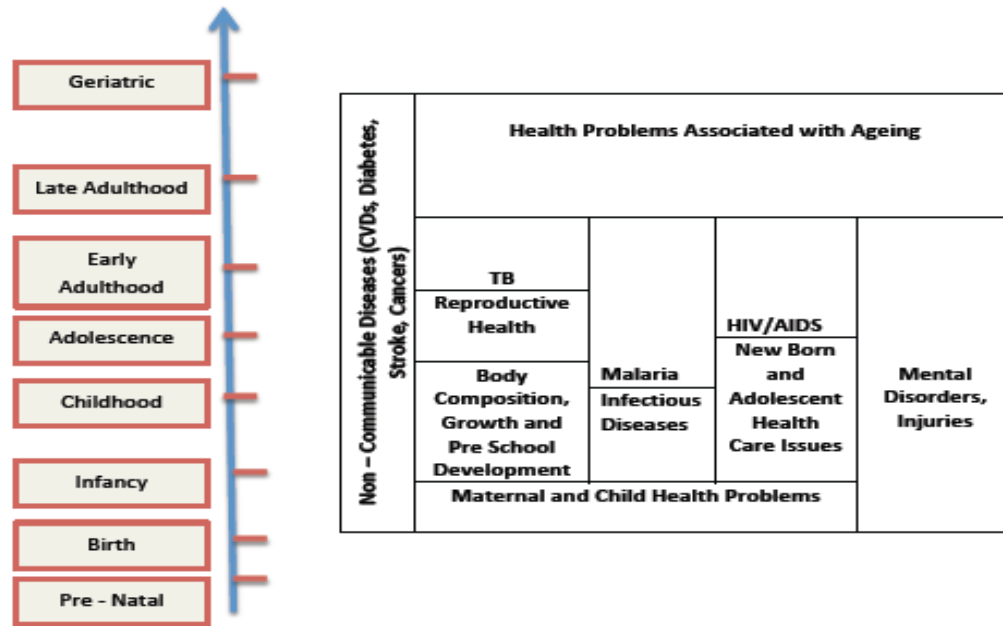


Figure 1: A Life course Framework of Illness and Health

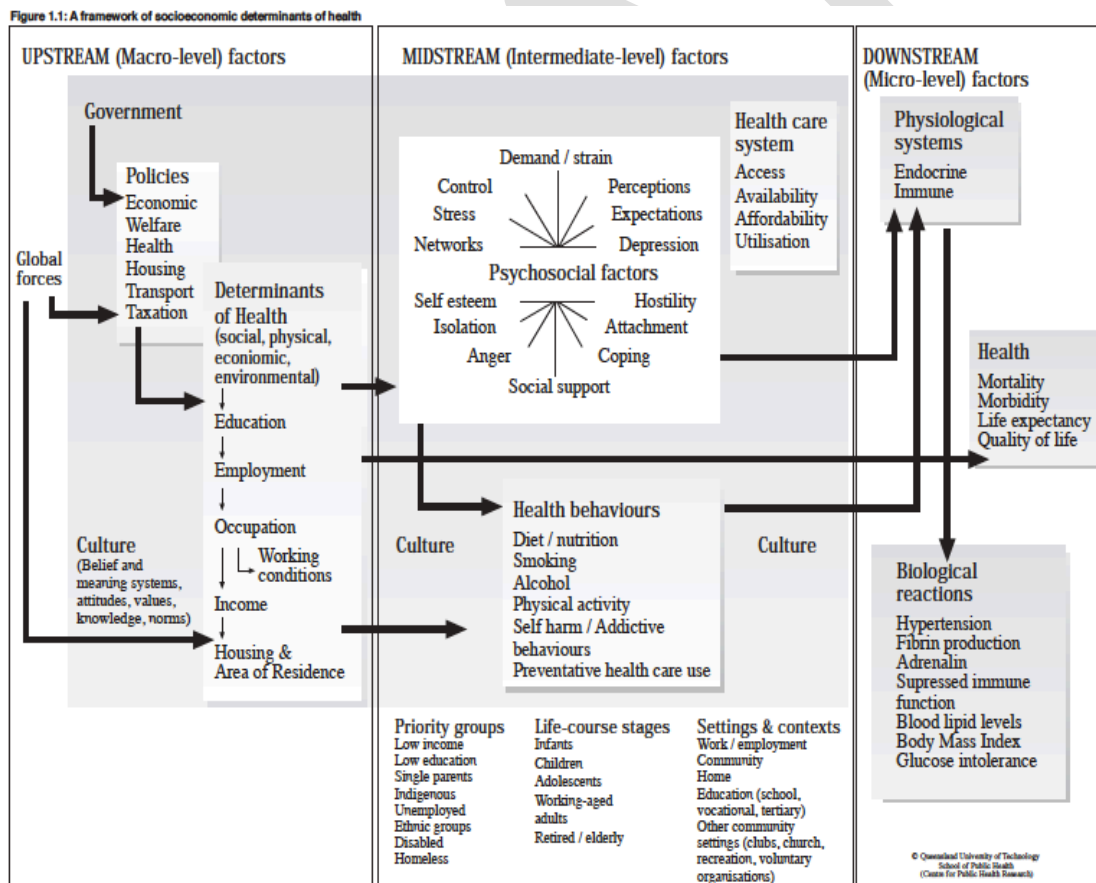
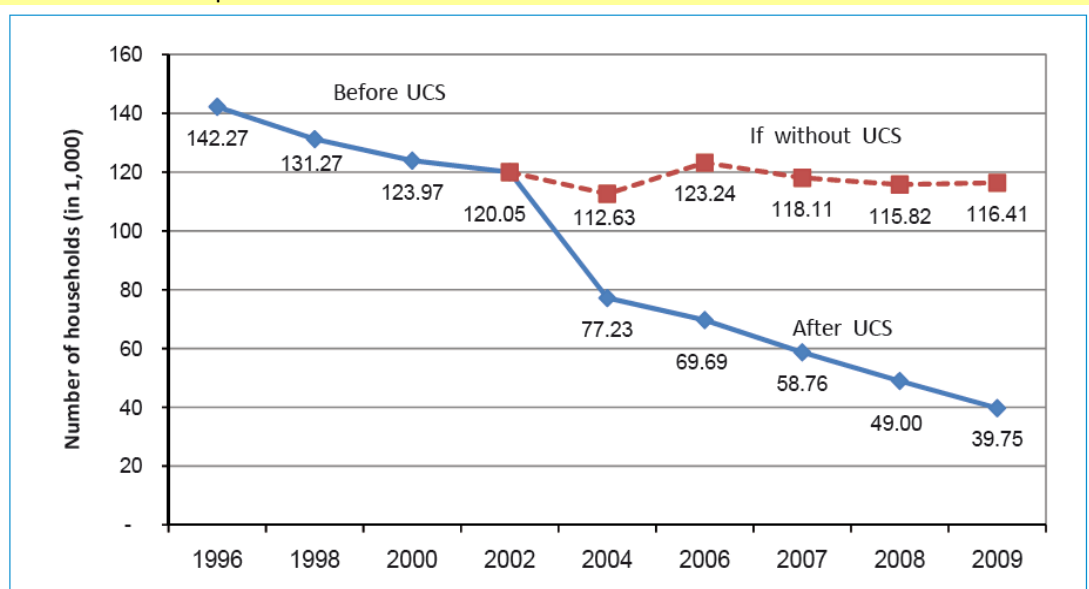


Figure 2: Upstream, Midstream and Downstream Determinants of Health requiring multisectoral action<sup>39</sup>

- ❖ **Equity, through models for financial protection:** The adopted SDG must recognize critical concerns regarding equity, in particular ensuring that poor and socioeconomically disadvantaged groups are protected financially from catastrophic expenditures. The TG proposes that the broader vision for UHC must disproportionately benefit poor and deprived populations, protecting them from high healthcare costs and from a diversity of conditions.

An independent review of the first ten years of **Thailand's** Universal Coverage Scheme (UCS) shows a dramatic reduction in the proportion of out-of-pocket spending (OOPS), decline in catastrophic health expenditure and falls in impoverishment due health care costs<sup>11</sup>. Between 1996 and 2008 the incidence of catastrophic health care expenditure amongst the poorest quintile of UCS members fell from 6.8% to 2.8%. Furthermore, the incidence of non-poor households falling below the poverty line because of health care costs fell from 2.71% in 2000 to 0.49% in 2009. The review calculated that the comprehensive benefit package provided by the UCS and the reduced level of out-of-pocket expenditure protected a cumulative total of 292,000 households from health related impoverishment between 2004 and 2009. This is equivalent to the area between the two lines:



**Figure 3: Number of households protected from health impoverishment in Thailand (1996- 2009)**

## Making the case for UHC: Externalities and Synergies

Several arguments highlight the large positive externalities and impact of UHC on health outcomes. In addition to human rights and equity as the basis for UHC (Appendix 5), arguments in its favor also highlight its political and economic benefits. Below, we summarize some of these arguments:

### **UHC improves health outcomes**

There is broad consensus that the ultimate goal of the health sector is to improve health outcomes (increasing healthy life expectancy, reducing maternal and child mortality rates and reducing the burden of disease). It is vitally important that health inequalities are eliminated to prevent improvement for some groups but not others. Making progress towards UHC, as defined above, will reduce health

1 inequalities. Causal analyses from 153 nations<sup>29</sup> has shown that “broader health coverage generally  
2 leads to better access to necessary care and improved population health, with the largest gains accruing  
3 to poorer people.”  
4

5 Impressive health outcome results have been demonstrated in low income countries in Sub-Saharan  
6 Africa. In a Countdown to 2015 Case Study on **Niger**, published in the Lancet (2012), Amouzou et al<sup>1</sup>  
7 celebrated the impact of Niger’s UHC approach in reducing child mortality from 226 deaths per 1000 live  
8 births in 2000 to 128 in 2009 – an annual average reduction of 5.1%. They attributed this success to  
9 “government policies supporting universal access, provision of free health care for pregnant women and  
10 children, and decentralized nutrition programs.” This provides evidence that increasing the coverage of  
11 effective services, combined with the removal of health service user fees that increased financial  
12 protection and improved access, is vital for success in achieving health MDGs and SDGs.

### 13 14 **UHC Delivers Economic and Political Benefits**

15 The World Health Report in 2010 demonstrated the catastrophic effects of healthcare costs, with nearly  
16 150 million people worldwide suffering financial hardship and 100 million being pushed below the  
17 poverty line as a result of OOPS. In the affluent Indian state of Gujarat, 88% of households falling below  
18 the poverty line did so as a consequence of health care costs<sup>24</sup>. In the United States, over 50% of  
19 personal bankruptcies have been attributed to medical expenses<sup>53</sup>. Avoiding financial losses associated  
20 with unaffordable, and sometimes sudden, health care expenditure can help households stabilize their  
21 disposable income and spend more on other goods and services, improving the welfare and future  
22 prospects of the family. At a macroeconomic level, greater ability to consume and invest stimulates  
23 growth. Worries about health care bills are the main cause of excessively high savings rates in some  
24 countries, such as China<sup>31</sup>, with negative impacts on economic growth. Recent experience in Mexico  
25 highlights the tangible benefits of UHC reforms for households.  
26

27 **Mexico** recorded higher levels of financial protection from health care costs following nationwide UHC  
28 reforms. In 2002 approximately 60 million people in Mexico did not have adequate financial risk  
29 protection and had to pay for the majority of their health services through out-of-pocket payments<sup>22</sup>.  
30 Recognizing that this had a damaging impact on the health and economic wellbeing of households, the  
31 Government of Mexico introduced a national protection program called the Seguro Popular. This  
32 program was mostly financed through taxation with only richer households being asked to make modest  
33 annual contributions. Within a decade, 53 million people enrolled in Seguro Popular, the majority  
34 coming from the 4 poorest income deciles.  
35

36 A 10 year review of these reforms shows an increase in the utilization of essential services by  
37 households, improved health outcomes and increased financial protection. From 2000 to 2006, effective  
38 coverage of a number of key maternal and child health interventions (e.g. antenatal care,  
39 immunizations, and treatment of diarrhea) increased significantly with Seguro Popular members  
40 achieving higher coverage rates than uninsured people. This increased service coverage contributed to a  
41 sustained fall in child and maternal mortality rates and a reduction in health outcome inequality.  
42 Looking at the economic benefits of increased financial protection, survey data showed falls in  
43 impoverishing health expenditure with greater reductions amongst Seguro Popular members. From  
44 2000 to 2010, the incidence of catastrophic expenditure fell from 3.1% of the population to 2.0% and  
45 impoverishing health expenditure from 3.3% to 0.8%.  
46

1 If financed and implemented well, UHC reforms can be popular with the public, reaping political  
2 benefits. Political leaders associated with such reforms have seen their personal popularity increase as a  
3 result. Many major UHC processes have been initiated by political leaders in the run up to elections and  
4 immediately following a transition of power. Political leaders in the process have derived substantial  
5 benefits from successful reforms, helping them retain power in subsequent elections such as in the  
6 United States<sup>8</sup>. Several political pioneers of UHC have become national heroes. In 2004, the Canadian  
7 public voted in a national poll for the Greatest Canadian<sup>4</sup> and chose the architect of their UHC reforms,  
8 Tommy Douglas.

9  
10 For all these reasons, the Director General of the World Health Organization (WHO), Dr. Margaret Chan,  
11 has called UHC: “the single most powerful concept that public health has to offer.”<sup>7</sup>  
12

# Universal Health Coverage as a Priority for the Post-2015 Agenda: Concept, Components and Collaborations

## Concepts: What do we mean by Universal Health Coverage?

As UHC emerges as the common rallying point for health policy and advocacy, it is important to define its conceptual framework. Several definitions of universal health coverage exist with varying complexity<sup>56</sup> that reflect the contextual interpretations in high, middle and low-income nations. A simple definition incorporating the key concepts is:

Universal Health Coverage is when all people receive the quality health services they need without suffering financial hardship.

Underlying this definition of UHC is a complex framework that represents the interactions between health systems and populations. For this report, we have defined UHC comprehensively as referring to **equitable access to affordable, accountable, appropriate health services of assured quality to all people**, including promotive, preventive, curative, palliative and rehabilitative services. In defining UHC, it is crucial to recognize that UHC must be supported by policies and services addressing the wider determinants of health, delivered to individuals and populations. The role of governments and public systems as guarantors and enablers is key, even as efforts are made to mobilize all relevant societal resources for the delivery of services.

This definition is consistent with earlier definitions provided by the WHO in 2010<sup>56</sup> and by the SDSN in 2013<sup>36</sup>. Recognizing that a narrow definition of UHC may exclude action on social determinants, the High-Level Expert Group on Universal Health Coverage in India<sup>18</sup> expanded the definition to include a package of essential health services as well as a broader set of policies relevant to public health. The goal as proposed by us includes both components.

Any definition of UHC, while including key principles, must also link to appropriate metrics for measurement of progress towards the goal. Metrics may be selected to include assured access (e.g., percent of children covered by immunization; percent of women having access to reproductive health services; percent of population provided with essential drugs as prescribed by a doctor) AND financial protection (e.g., proportion of OOPS to total health expenditure; proportion of the population experiencing catastrophic health expenditures). Even as a set of essential services is provided to all, programs targeting the poor, for assured coverage of those services or the delivery of additional services, can still be accommodated within a UHC framework. Further, an equity measure can be added to each metric of UHC (e.g., gaps in access and financial protection between the highest and lowest income quintiles are narrowing as the UHC programs are progressively implemented). At each stage of the evolution of UHC in a country, the health needs of the poor and marginalized must be prioritized.

## Components: What does Universal Health Coverage include?

**Any definition of UHC must include two core components:**

- A. **UNIVERSALISM:** Everybody should have access to needed promotive, preventive, curative, palliative and rehabilitative health services. Furthermore, these services must be of sufficient quality to have an appropriate impact on the health of the people who are using them. It is no



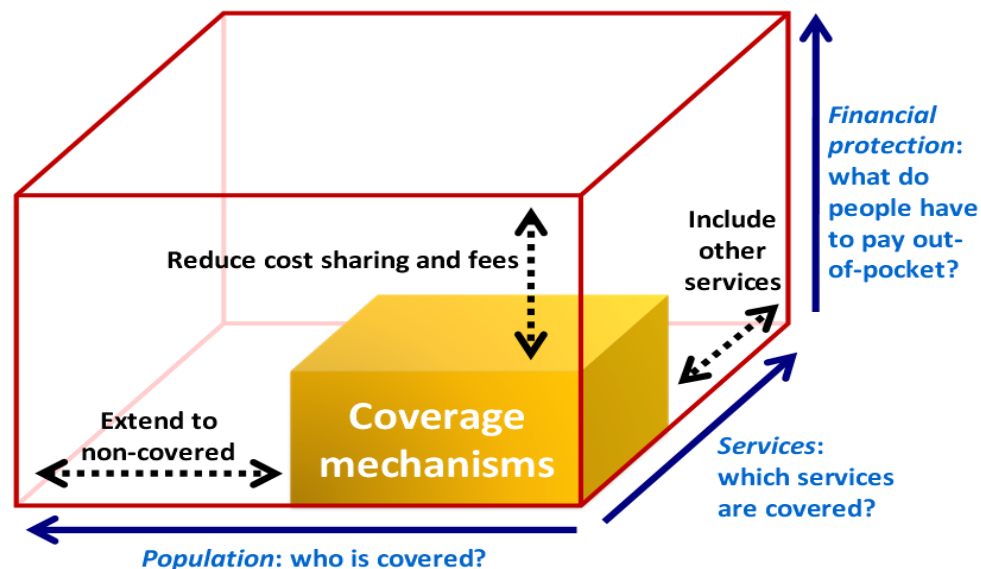
1 use having access to health workers if they are not trained to make a correct diagnosis or if they  
2 prescribe inappropriate or ineffective medicines.

- 3
- 4 B. **EQUITY:** When accessing services, people should not face high out-of-pocket expenditures that  
5 might lead to financial hardship or deter people from using services. It is imperative that three  
6 dimensions of equity be incorporated: equity in opportunity (the ability of individuals and  
7 populations to maximize their potential for better health), equity in access (in the design and  
8 delivery of health and other allied systems such as food, built environment and urban systems),  
9 and equity in outcomes (for the measurement of which evidence needs strengthening).

10 In 2010, the World Health Report depicted UHC as Figure 3, illustrating the policy choices faced by  
11 governments and exemplifying the two core principles of *universalism* and *equity*. The diagram asks  
12 three critical questions:

- 13
- 14 a) Populations: Who is covered?  
15 b) Services: What services are covered?  
16 c) Finances: What do people have to pay out of pocket?
- 17

## Towards universal coverage



18  
19 **Figure 3: The Universal Health Coverage Cube**

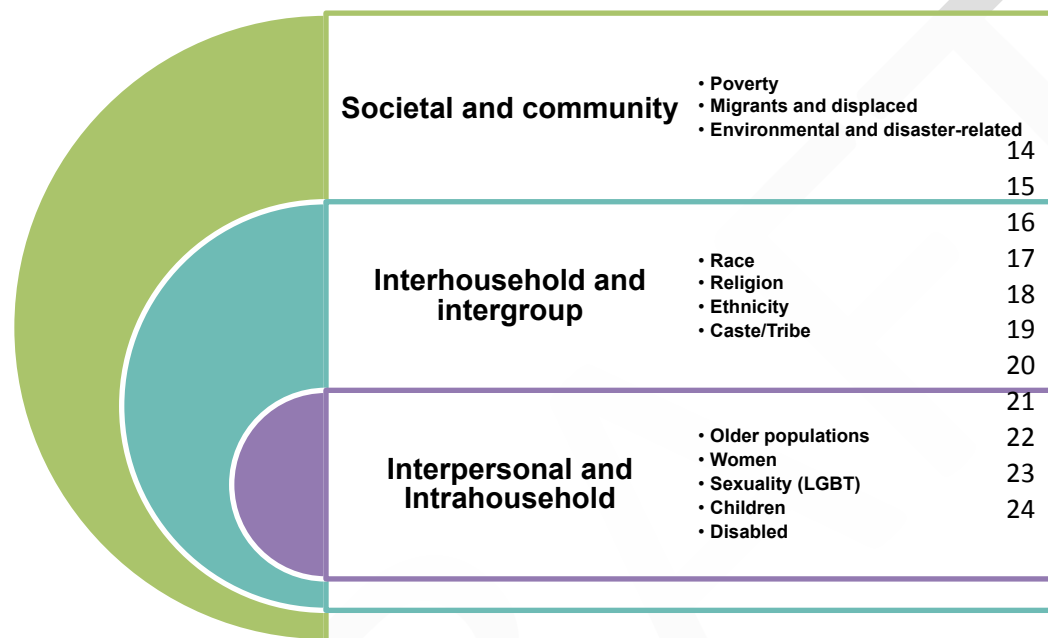
20

21 The UHC approach is useful as it recognizes that progress needs to be made along multiple dimensions;  
22 progress along only one dimension may not be enough to improve outcomes. For instance, promising  
23 free health services is an ineffective strategy if there is inequity in access or if services are of poor  
24 quality. Similarly, UHC is effective in adjusting the relative burden of public and private financing on the  
25 health system, both in terms of service and population coverage, which is useful for financing  
26 institutions. Finally, UHC is also effective in the push towards increasing population coverage and  
27 expanding the beneficiary base.

28 Collaborations: Who does UHC involve?

29

To progress towards UHC, all stakeholders must be involved in setting the strategy, including development partners, local and national governments, civil society organizations, the private sector, and, most importantly, the general population. Further, keeping in mind the country context is essential. This strategy should incorporate priority actions and investments along each axis, along with recognizing the necessary trade-offs. For instance, if greater financing resources become available to nations, particularly low- and middle-income countries (LMICs), more should be invested by purchasing medical equipment or eliminating co-payments for some services.



**Figure 4: Key Stakeholder Groups at Multiple Levels**

The agenda for UHC must be inclusive, and must recognize the disproportionate burden of disease and sickness faced by specific disadvantaged groups. UHC must consider determinants that *predispose, precipitate or perpetuate* individuals and populations to risks and reduce their resilience. A depiction of disadvantage within households, between households, between social groups, and at the societal level is presented in Figure 4. This representation reaffirms that, while UHC stresses Health for All, there is a need to strengthen equity mechanisms to make the delivery of UHC more effective.

# Delivering Universal Health Coverage

There are three core requirements for implementing UHC:

- 1) Financing,
- 2) Human resources and infrastructure, and
- 3) Capitalizing on synergies between sectors and involving all stakeholders

All of these involve complex issues of policy, governance, equity and participation. Some of these are discussed below:

## Financing

Globally, nations at all income levels have recognized that health financing reforms are essential to achieve UHC. In the strategies for undertaking such reforms, the WHO has advised<sup>56</sup> that governments must consider three main functions of the health financing system. These are:

1. Raising sufficient financial resources to cover the costs of the health system
2. Pooling resources to protect people from the financial consequences of ill-health
3. Purchasing health services to ensure the optimum use of available resources

### Raising and pooling sufficient financial resources for UHC

The level of financial resources required for UHC in any particular country is a function of the 'UHC cube' (Figure 3), i.e. the population covered and the range, quantity and quality of services covered. A key to UHC implementation is raising domestic funding to ensure access to quality services and financial protection to the *entire population*. In the past, low-income countries were advised to provide an 'essential package of services,' frequently focusing on MDG priorities (maternal and child health; HIV/AIDS, TB and malaria). Today there is increasing recognition that all countries must strive towards good quality, *comprehensive* primary healthcare (PHC) services for all. This comprehensive approach must incorporate greater equity, as evidence shows poor and disadvantaged groups have a greater service need and therefore reap greater benefits. While the majority of the current disease burden can be addressed in LMICs through primary care interventions (preventive, curative and rehabilitative), over time resources need to be increased and services expanded beyond PHC. Increased resources are also needed by governments to meet emerging challenges such as ageing, epidemiological changes and greater availability of new technologies.

An increasing global consensus on the better performance of public (or mandatory pre-payment) financing mechanisms has been emerging, in terms of both efficiency and equity<sup>29,34</sup>. This has been attributed to the compulsory nature of general taxation and other government revenue sources (e.g. royalties on the exploitation of natural resources) and social health insurance contributions. Governments have been successful in raising substantial levels of revenue with relatively low administration costs. When these resources have been pooled, mandatory pre-payment mechanisms ensure equity, as healthy and wealthy populations are compelled to subsidise the sicker poor. In contrast, point of service fees (which the President of the World Bank recently called "unjust and unnecessary"<sup>63</sup>) raise little revenue, are associated with high administration costs and are fundamentally inequitable because of their reliance on ability to pay. Private, voluntary health insurance (including community-based insurance) schemes tend to have low coverage rates, high administration costs and often exclude the poor<sup>5</sup>. Several low- and middle-income countries have dramatically increased

government revenue through improved collection efficiency and promoting greater tax compliance (e.g. South Africa<sup>17</sup>, Kenya<sup>21</sup>). Similarly, domestic government revenue in LMICs could be dramatically enhanced through improved global governance on tax competition and tax havens, and increasing transparency, especially on payments related to natural resource extraction. Of equal importance to generating sufficient government revenue for the health sector is integrating funding from different public sources in large risk pools to avoid the inefficiencies and inequities associated with fragmented pools, which often translate into tiered health systems.

In 1988 **Brazil** initiated an extensive program of health reforms with the intention of increasing the coverage of effective services for poor and vulnerable people, especially those who had experienced poor quality care and high user fees. Following significant increases in public financing, the government was able to provide universal free health services to the entire population and as a result health indicators improved markedly. From 1990 to 2008, infant mortality in Brazil fell from 46 per 1000 live births to 18 and life expectancy for both sexes increased by 6 years over the same period. Moreover, these UHC reforms reduced health inequalities, with the life expectancy gap between the wealthier south and poorer north falling from 8 years to 5 years between 1990 and 2007.

There is a growing trend amongst LMICs to develop home-grown systems appropriate for their own contexts. Of particular note have been the successes of middle income countries in Latin America (e.g. Brazil<sup>32</sup>, Mexico<sup>22</sup> and Costa Rica<sup>9</sup>) and Asia (Thailand<sup>11</sup>, Taiwan<sup>25</sup> and Sri Lanka<sup>33</sup>) to use increased public financing to scale up coverage. These models are subtly different but all have one common feature. In recognising that it is very difficult to collect insurance contributions from those employed in the informal sector, they rely heavily on tax financing to fill gaps. Funding the provision of comprehensive PHC services for everyone will not be feasible for the lowest income countries unless there is continued external funding support, through a mechanism that allocates external funding according to each country's shortfall in domestic funding, as these countries work to raise domestic funds and close the shortfall gap over time.

**Burundi** has recorded a spectacular decline in infant and child mortality, which each fell 43% in only five years, from 2006 to 2011<sup>19</sup>. The decline began when the government provided free universal health care for pregnant women and children under age five. In addition to removing financial barriers, therefore increasing demand and financial protection, the Government of Burundi also substantially raised public financing and introduced new performance-based financing systems. This helped channel public funds (including aid) to front line services more efficiently and enabled the government to meet the huge increase in demand for services. The higher utilization of maternal and child health services has been one of the major factors contributing to Burundi's improved health indicators.

## Human Resources

The global push to UHC cannot be successful without a multi-layered, skilled health workforce, contributing to preventive, curative and rehabilitative services<sup>44</sup>. Many challenges face human resources for health (HRH), including complex discourses on human rights and development (both of those receiving services and those engaged in service delivery), as well as around the economics of health and healthcare. Unresolved debates have led to a) global shortage of HRH, b) between-country and within-country disparities in the distribution of the workforce, and c) inadequacies in skills and training of the existing workforce. This equation has been further complicated by the growing burden of NCDs that require not just vertical program delivery, but the provision of both acute and chronic care. As plans for

1 the post-2015 development agenda take shape, these unresolved questions need greater research and  
2 program implementation focus, while simultaneously dealing with the most urgent needs of health.

3  
4 The agenda of UHC emphasizes the need for equitable coverage and access to health services. A major  
5 obstacle to equity is the shortage of workers, which is particularly acute in rural areas, areas without  
6 access to transport or communication, low income neighborhoods, and areas without other supportive  
7 infrastructure such as schools. In several LMICs, governments have been engaged in discussions on  
8 incentives to lure doctors and skilled medical staff to these areas. Inequities in the distribution of  
9 healthcare are further exacerbated by HRH-flight, or the relocation of trained medical staff from LMICs  
10 to HICs. The shortage of nurses and support staff in several LMICs is particularly serious. This places  
11 increasing pressure on existing staff, with impacts on efficiency and quality of services.

12  
13 To reap the benefits of UHC, health workers, particularly those at the frontline, need to be at the core of  
14 the global health agenda. There are roles for highly skilled doctors, frontline workers, and village-level  
15 health and nutrition workers. Village-level health workers in LMICs play a crucial role in reducing  
16 mortality from communicable diseases, a large share of which is attributable to the undernourishment  
17 of the child. Simple but important skills such as training village-level health workers in weighing the child  
18 according to growth charts can play a vital role in the global war on under-nutrition. Similarly, frontline  
19 workers can play a major role in prevention by measuring and systematically recording risk factors for  
20 NCDs, in order to initiate risk reduction measures through counseling and guideline-based therapies.  
21 The role of simple technology in ensuring a systematic approach can be vital.

22  
23 While the right to health of those receiving health services is important, the rights of those delivering  
24 services are equally critical. Nations cannot resolve issues around inequality in health care delivery  
25 without addressing the structural issues pertaining to socioeconomic conditions. A disproportionate  
26 amount of research currently focuses on the 'push' factors, i.e. how to get the HRH to work in less-  
27 served areas. A greater emphasis is needed on both research and policy action around the 'pull' factors,  
28 i.e. how to attract the work force to work in rural or less-served areas, even if it is for stipulated periods  
29 of time (e.g. 3, 5 or 10 years). This complex agenda, involving some of the social determinants around  
30 rural-to-urban migration, rural prosperity and urban development, holds the key to finding sustainable  
31 solutions to health disparities.

### 32 33 **One Million Community Health Worker Project<sup>28</sup>**

34 Community health workers have been recognized for their success in reducing morbidity and averting  
35 mortality in mothers, newborns and children. While they are most effective when supported by a  
36 clinically skilled health workforce, they have proven crucial in settings where the overall primary health  
37 care system is weak. Community health worker programs exist in several countries (Ethiopia, Kenya,  
38 Malawi, Nigeria, Rwanda, Senegal and Tanzania), but there is a critical need to scale them up and  
39 integrate them into national health systems. To succeed, it is essential that this work force is trained in  
40 delivering care according to standardized protocols, and provided technology through mobile devices  
41 for monitoring services.

42  
43 The initiative estimates that training and financing health workers to serve an average of 650 rural  
44 inhabitants will cost \$6.58 per patient per year, adding to an estimated \$2.5 billion. This is estimated to  
45 fall under projected governmental health budgetary constraints and within the boundaries of donor  
46 assistance being pledged and anticipated. The program works through emphasis on four aspects: a)  
47 Point of care diagnosis, b) scalable supervision, c) standardized care, and d) rapid training

## 1 Synergies and Stakeholders

2  
3 Health linkages with other major sectors such as agriculture, education, climate change, gender and  
4 women's empowerment, and urban development, provide an important framework for engagement. It  
5 is essential that the post-2015 development agenda and resulting policies recognize these linkages.  
6 When designing policies to achieve future development goals, impact across multiple sectors should be  
7 taken into account to increase synergistic effects and reduce detrimental results. In particular, health  
8 should be considered when designing policies in all of the allied sectors. Some of these interlinkages  
9 have been developed and are discussed in the next chapter.

10  
11 Several examples from policy show the benefits of intersectoral policies. Controlling indoor air pollution  
12 through improved cook stoves or fuel switching can benefit for human health, while reducing fuel costs  
13 and carbon emissions. Policies on indoor air pollution with a narrow focus on health may increase  
14 greenhouse gas emissions; the key is in identifying possible co-benefits to be achieved in the policy  
15 design stage. When designing public transportation systems, urban air pollution can be reduced, traffic  
16 flow ameliorated, and road safety improved. Planning walkable and bikeable cities has the added  
17 benefit of increasing exercise and reducing greenhouse gas emissions. However, to reap all these  
18 benefits, urban planners must work with health officials to design coherent plans.

19  
20 It is important to identify the potential positive and negative impact of policies while designing them, to  
21 ensure that these can be monitored. For instance, agricultural policies seeking to improve incomes by  
22 raising the yields of cash crops may reduce food security. A more thoughtful approach to agriculture  
23 policy would examine yields, linking them to socioeconomic prosperity, improved food security and  
24 nutrition. Carefully designed policies supported by cost-benefit analyses have the potential to capitalize  
25 on linkages between sectors, maximizing positive results supporting all four pillars of sustainable  
26 development: economic, social, environmental and governance<sup>36</sup>. It is therefore critical that health be  
27 prioritized when crafting policies on agriculture, education, women's empowerment and other future  
28 priorities.

29  
30 A critical component to successfully achieving multiple policy goals is the involvement of all stakeholders  
31 throughout the design, implementation, and evaluation stages of a particular policy. Representatives of  
32 governments, civil society, the private sector, academia, international organizations, and other key  
33 constituencies must be represented. Stakeholder participation also ensures effective priority setting, as  
34 community representatives are often better suited to recognize challenges than people outside the  
35 community. The involvement of the expert community, in the form of both academia and the private  
36 sector, encourages innovation in policymaking and the implementation of solutions, provided conflicts  
37 of interest are identified and excluded. Non-profits and aid organizations have proven to be critical in  
38 providing both knowledge and financing in interventions. In many instances, greater stakeholder  
39 involvement has also led to better efficiency in outcomes through the pooling of resources.

40  
41 There is a significant call for greater participation of all stakeholders in the post-2015 agenda. The report  
42 from the Secretary-General called for participatory data collection ("crowd sourcing" as one example) as  
43 well as greater involvement of stakeholders in monitoring and evaluation<sup>50</sup>. The interim report of the  
44 Open Working Group also calls for greater participation of all parts of society in setting and achieving  
45 the post-2015 development agenda. Further, the SDSN report highlights involvement of stakeholders to  
46 be a key component of improving governance through increasing accountability and transparency.

UHC stands to benefit greatly from involvement of stakeholders from different health fields and other sectors. Many successful partnerships emerged to achieve the MDGs; the GAVI Alliance to increase vaccine coverage and access in the poorest countries is perhaps the most successful, and was greatly strengthened by the inclusion of representatives from a diversity of sectors and backgrounds. Successful implementation of UHC will require similarly high levels of involvement from all groups, as will the inclusion of health in all policies to ensure the reaping of co-benefits.

### **HealthMap: Engaging the Virtual World for the Detection and Reporting of Outbreaks<sup>3</sup>**

The use of technology and online systems for mapping emerging infectious diseases is increasingly acknowledged as a useful and participatory tool for monitoring and surveillance. While still in its early stages, the potential for reporting infectious diseases in diverse parts of the world is significant. As a tool, it delivers real-time information on a broad range of emerging infectious diseases for a number of consumers, including governments, local health departments and international travelers.

HealthMap and other similar applications are user-friendly. In an increasingly connected world, these systems use local contributions of information to simulate data that can be used for infection control and can be an aid to local surveillance systems, the latter of which may be inadequately resourced to deal with the challenges of emerging infections.

One challenge is the sensitivity and specificity of information when supplied by the general population instead of medical practitioners. However, these systems provide a bottom-up approach to information and can be a useful supplement to existing surveillance systems.

## **Good Governance and UHC**

However well designed, UHC will not achieve its objectives unless the governance of the health system can assure commitment, integrity, transparency and accountability at all levels. Far too often, inefficiencies in the supply chain of medicines and vaccines or corruption in the process of procurement leads to program failure. Corruption or lack of transparency in the recruitment or transfer of health workers affects morale, retention and performance. Effective monitoring and accountability mechanisms are essential to ensure quality and price control in the public and private sectors. This becomes even more critical when public-private partnerships are proposed. Community participation in monitoring has been shown to yield good results in improving governance.

## Linking Health to other Development Goals

It is universally recognized that several critical determinants of health and illness lie outside the health sector. Education, finance, agriculture, food processing, trade, environment, urban design, transport, communications, law and human rights are some of the many areas where actions can enable or erode health. Health impacts several core dimensions of development. A sick child cannot go to school and malnourished students perform poorly in academics as well as sports. A sick employee either stays away from work ('absenteeism') or underperforms after turning up ('presenteeism'), affecting overall economic performance. At the level of household economics, poor health impoverishes families through costs for care, lost wages, and even permanent loss of employment. Long periods of illness lead to stress and domestic strife within households. For all of these reasons, every SDG should consider pro-health strategies. Achieving Health and Well-being at All Ages is impossible without intersectoral action and enabling policies that link diverse SDSN priorities. Some key areas of intersection are described below.

**Health and its relationship with the eradication of extreme poverty and hunger:** Poverty, at multiple levels, continues to be the most formidable challenge to improvements in health. The World Food Program estimates that 870 million people go to bed hungry each day, and 45% of under-5 mortality is caused by poor nutrition. Micronutrient deficiency is further responsible for much morbidity in children and adults. The SDGs must therefore prioritize the eradication of hunger, a key component of improving global health. In HICs and LMICs, the increasing cost of healthcare and rising out-of-pocket spending (OOPS) burdens households; in many regions healthcare costs are a major reason for households falling below the poverty line. Poor nations are unable to afford publically financed healthcare services for their populations and often rely on donor support, especially to reach vulnerable populations. In the absence of adequate resources, LMICs have had to adopt 'targeted' instead of universalistic approaches which often miss those in greatest need. By prioritizing UHC in the post-2015 development agenda, and with adequate resources, we can transform households impoverished by healthcare costs into resilient households that are active in the community. Over time, as poverty is reduced and incomes rise, countries will need to rely less and less on donor support and will eventually be able to finance UHC.

**Health and achieving development within planetary boundaries:** The SDSN's report "An Action Agenda for Sustainable Development" states that all countries have a right to development that respects planetary boundaries, ensures sustainable production and consumption patterns, and helps to stabilize the global population by mid-century. UHC plays a key role in accomplishing this goal. UHC ensures universal sexual and reproductive health rights are achieved, empowering all women and men to make educated decisions about their own sexual and reproductive healthcare and family planning.

**Health and its relationship with ensuring effective learning for all children and youth:** Education and health are profoundly linked; both are human rights, and are inputs into human capital. Better education contributes to better health, through increased employment generating income, increasing the ability of households to afford better nutrition and healthcare. There is abundant evidence from across the world that education positively impacts the health status of individuals within countries, even independent of income. Education, especially women's education, is another key investment with a direct impact on family planning, child health and development, and family nutrition. This is because education increases awareness of risk factors, health seeking and health utilization behaviors. In turn, better health has significant impact on education. As discussed, healthy, well-nourished children do better in school. Stunting from under-nutrition in early childhood has been shown to have an impact on IQ and cognitive development, affecting learning and long-term career prospects. The relationships



1 between education and health are vital and cannot be ignored. In the post-2015 agenda, it is crucial that  
2 synergies between education and health be realized, such as described in the SDSN report “An Action  
3 Agenda for Sustainable Development.”

4  
5 Universal education must be advanced vigorously, health literacy, in fact, could be fast-tracked through  
6 mass media and settings-based non-formal health education. A variety of communication channels and  
7 social networks can be used for this purpose. Increasing the health literacy of young persons is an  
8 especially high priority to empower the global citizens of the 21<sup>st</sup> century with the knowledge,  
9 motivation and skills needed to help them to protect personal health and act as societal change agents  
10 for promoting population health.

11  
12 **Health and its relationship achieving gender equality, social inclusion, and human rights for all:** UHC  
13 will be a significant step in realizing the right to health for all. UHC ensures coverage and access to  
14 health services for all people. However, social policy at the national level cannot be successful without  
15 recognizing within-household gender inequities, and within-country inequalities based on discrimination  
16 due to race, ethnicity, age, disability, religion, refugee status, or other status. It is therefore important  
17 that health indicators be disaggregated and achievements between groups be compared to ensure  
18 equity in improvements. Further, by ensuring equity in both access to and utilization of health services  
19 by all people, inequalities will be reduced. In addition, the post-2015 development agenda should call on  
20 countries to address assault and violence against women and other marginalized groups, violent crime,  
21 female genital mutilation, service provision for displaced and refugee communities, and other  
22 determinants of health that are driven by political and/or cultural factors.

#### 23 24 **Gender, Health Systems and Knowledge Translation:**

25 In resource-poor contexts with discriminatory gender relations, obstetric risks such as anaemia and  
26 gestational hypertension from the cultural practice of early marriage and childbearing are widely  
27 prevalent and often result in obstetric complications. However, these risks tend to be normalised by  
28 village communities and health providers, and ignored by health policies and programmes that focus on  
29 institutional deliveries. In 2008, a project in Koppal, Karnataka (India)<sup>14,15</sup> combined a nuanced gendered  
30 framework to strengthen evidence and advocacy to reduce maternal morbidity, mortality and violence  
31 against women. The project’s verbal autopsies of maternal deaths and near misses since 2008 revealed  
32 systemic failures and the need for accountability in obstetric care and health systems that fuelled high  
33 levels of maternal mortality despite rising rates of institutional delivery.

34  
35 **Health and its relationship with improving agricultural systems and raising rural prosperity:** The MDGs  
36 put emphasis on improving food security, but did not devote much attention to improving rural  
37 infrastructure (irrigation, safe drinking water, sanitation, fuel, power/electricity, banking, transport,  
38 health service provision, education, and information technology) as a means to improve rural livelihoods  
39 and increase production sustainably. The post-2015 agenda needs to consider how rural prosperity can  
40 improve the lives of millions of smallholder farmers while simultaneously improving diets and nutrition  
41 for rural and urban dwellers. This can also reduce the health impact of deforestation, air and water  
42 pollution and zoonotic diseases to which agriculture contributes. Since women are employed in very  
43 large numbers in farming, their health is directly linked to safety of agricultural methods and in turn on  
44 their ability to contribute to agricultural productivity.

45  
46 A detailed framework for Sustainable Agroecological Intensification (SAI) and rural development can be  
47 found in the report of the SDSN’s TG on Sustainable Agriculture and Food Systems<sup>37</sup>. A key component  
48 of this framework is expanding health coverage to smallholder farmers, especially the rural poor who

currently have low access to care. Ensuring their health has implications for increasing farm productivity and improving food and nutrition security. Hitherto, the objective of agriculture systems was to provide energy (caloric) security, without taking into account the multiple nutrient needs that can only be obtained through balanced composite diets. This resulted in a disproportionate emphasis on supply of cereals as the source of calories. From now on, agriculture systems have to become better aligned to nutrition goals, so that all persons, everywhere in the world, will have access to diets that are calorically adequate and nutritionally appropriate.

**Health and its relationship with empowering inclusive, productive and resilient cities:** The growth of cities and progressive urbanization of the global population presents challenges as well as opportunities for health. The urban poor suffer daily deprivations of shelter and food security, with millions living in slums and squatter settlements prone to water and sanitation-related diseases. Urban dwellers, rich and poor, are at greater risk of harmful health behaviors like smoking, alcohol and drug use, respiratory diseases like TB, and road traffic injuries, relative to their rural counterparts. Urban populations, particularly those residing in unplanned housing or densely populated areas, are disproportionately affected by environmental disasters.

Services related to the provision of clean water supply (for drinking and hygiene), sanitation, green spaces, community recreational facilities, protected cycling lanes, safe pedestrian paths, traffic safety, pollution control and public protection from crime are among the health needs that the SDSN's Thematic Group on Sustainable Cities address in their report<sup>38</sup>. It is important that UHC also be realized in urban settings, as a complement to better city planning policies. The health needs of rural to urban migrants and slum communities need particular attention, particularly as spatial design is developed for accessible primary health care through suitably located community health centers. The SDGs are an opportunity for health-friendly urbanization and to invest in gathering greater evidence on the costs and benefits of urbanization on human health.

**Health and its relationship with curbing human-induced climate change and ensuring sustainable energy:** While urban and rural residents face different health problems as a result of energy consumption, sustainable energy is a common solution. The WHO estimates that indoor air pollution from the burning of wood or bio-fuel for cooking is responsible for as much as 2.7% of the global burden of disease, especially in LMICs, affecting women and children disproportionately. In urban areas, air pollution from automobile exhaust, industrial facilities, and electric power plants causes severe ambient air pollution. The WHO estimated that in 2008 urban air pollution was responsible for 1.34 million premature deaths. The solution to both these problems is to ensure access to modern, clean energy services and increase efficiency. There are many innovative programs working with solar, wind and natural gas in both rural and urban settings. Modern and efficient energy services also assure easy transport of patients, health personnel, medical supplies, and food and water. Reduced energy consumption is not only eco-friendly and reduces health-risks from air pollution.

Improving energy efficiency and increasing the amount of energy coming from renewable sources also helps slow climate change, which is increasingly shown to affect human health. Vector-borne diseases, like malaria or West Nile virus, can shift range under global warming. Natural disasters, like droughts, heat waves, floods, landslides, hurricanes (typhoons) and other extreme weather events are linked to climate change and pose direct threats to health. The effects on agriculture, livelihoods, mental health, population displacement and conflict have direct impacts on health. Inequity is an important aspect of this relationship since a disproportionate burden is borne by socioeconomically disadvantaged populations.

**Health and its relationship with securing ecosystem services and biodiversity, and ensuring good management of water and other natural resources:** Research in health is increasingly showing linkages between environment and health. The role of ecology is evident in the rise of new infections, particularly zoonotic infections resulting from the interface between humans and domestic animals in processes such as deforestation and livestock farming. Air and water pollution also impact health and the effects of marine pollution on seafood are a significant threat to the health of the coastal poor. Freshwater is essential for human life. Potable water is needed for daily drinking and cooking. Contaminated water is a cause of many infectious diseases, especially childhood diarrhoea which is the second leading cause of under-5 mortality. Water is also needed for personal hygiene (bathing, hand-washing) and ablutions. As the availability of clean water is reduced, health is endangered. Protecting our water resources is an essential component of the SDG framework. UHC, implemented with an equity lens provides a safety net to buffer the effects and impact of the environment on human health.

**Health and transforming governance for sustainable development:** Trade policies related to essential drugs, vaccines, health-relevant technologies, agricultural produce, food products, tobacco, alcohol and international agreements related to services (including health worker migration) have important implications for health. While trade policies have largely remained agnostic or sometimes even antagonistic to public health concerns in the past, in the post-2015 development framework they need to become more sensitive and better aligned to public health priorities, in keeping with the goals of sustainable development. Additionally, the provision of UHC depends on adequate financial resources. All high-income countries should provide 0.7% of gross national income (GNI) in ODA, with 0.1% earmarked for health.

There are also strong linkages between poor governance, civil conflict and ill health. Political instability and sociocultural challenges have impeded the achievement of basic health targets of immunization linked to diseases that are eradicable. The cases of polio from northern Nigeria, Afghanistan, and lately, parts of Pakistan, provide daily challenges in implementation and personal safety of medical staff in sensitive areas. These factors have led to disparities in commitment towards health policy, in implementation of programs and in the resulting health outcomes. Global economic slowdown (recession) and resulting austerity measures by governments have affected public systems of health (apart from other social sectors) and have further exacerbated health disparities.

#### **Health in All Policies: Case of Tobacco Control**

According to the WHO, 100 million persons died due to tobacco related diseases in the 20<sup>th</sup> century. WHO also estimates that the death toll due to tobacco will be one billion human lives in the 21<sup>st</sup> century. Sustainable development is inconceivable and unachievable, if the elimination of tobacco is not an integral part of the framework for development.

Tobacco is not only a health hazard. It is a threat to the environment through deforestation (wood fuel is burnt for curing wood and cigarette machines use 4 miles of paper an hour), extensive pesticide use, high levels of water and soil nutrients depleted for cultivation, soil erosion and strewing of butts. It is a fire hazard, responsible for dangerous domestic and forest fires. It is unacceptable that around 4 million hectares of arable land are wasted on a killer crop instead of growing nutrient crops. Across the world, poor consume tobacco more frequently and the tobacco habit is a cause of families being pushed into poverty.

1 Recognizing this multi-dimensional nature of tobacco related harm to several areas of human  
2 development, WHO developed the Framework Convention of Tobacco Control (FCTC). The first ever  
3 international public health treaty has been ratified by 177 countries since its adoption in 2003. The  
4 treaty provisions call for actions across multiple sectors: raising tobacco taxes; comprehensive ban on all  
5 forms of advertising, sponsorship and promotion; ban on smoking in public and work places; strong  
6 rotating health warnings on tobacco products packs; control of illicit trade; support for cessation  
7 programs; provision of economically viable alternate livelihoods to tobacco farmers and workers;  
8 integration of tobacco control in health, education, development and poverty reduction programs.

## Appendix 1: Targets and Indicators

**TARGET A:** Ensure universal coverage of quality healthcare, including the prevention and treatment of communicable<sup>3</sup> and non-communicable diseases, sexual and reproductive health, family planning, routine immunization, and mental health, according the highest priority to primary health care.

### Universal coverage indicators

<i>Financial protection indicators</i>			
Indicator	Details	Disaggregation	Target/threshold
1. Impoverishment from out-of-pocket (OOP) payments for health services	Percent of population pushed below the PPPUS\$2 poverty line due to OOP payments (on health services and transport to a health facility) and those already below this poverty line who incur any such OOP payments	None (already focuses on the poorest)	Zero percent
2. Catastrophic OOP payments	Rank weighted	None (as rank weighted, income differentials accounted for)	Zero percent incurring OOP payment exceeding 25 percent of non-food household expenditure
3. Public health care expenditure as a percent of GDP	Health care expenditure funded from domestic mandatory pre-payment sources (government revenue and mandatory health insurance contributions) as a percent of GDP	None	Minimum of: <ul style="list-style-type: none"> <li>• 3% of GDP in low-income countries</li> <li>• 3.5% in lower-middle income countries</li> <li>• 4% in upper-middle income countries</li> </ul>

<sup>3</sup> We recommend that countries adopt suitably updated MDG indicators for HIV/AIDS, TB and malaria, as well as for Neglected Tropical Diseases (NTDs).

			<ul style="list-style-type: none"> <li>• 5% in high-income countries</li> </ul>
4. Voluntary health care expenditure as a percent of total health expenditure (THE)	Health care expenditure funded from OOP payments and voluntary health insurance contributions as a percent of THE	None	Maximum of 30% of THE
5. ODA for health as percent of GNI	ODA funding by each high-income country as a percent of their GNI	None	Minimum of 0.1% of GNI
<b>Access to and use of health services</b>			
<b>Indicator</b>		<b>Disaggregation</b>	<b>Target/threshold</b>
6. Outpatient consultations with a licensed health care provider per person, per year	Average of all consultations (preventive and curative) with a licensed provider in a health facility or in the community (including formally trained & registered community health workers, but excluding pharmacists for over-the-counter medicines), per person, per year	Income: <ul style="list-style-type: none"> <li>• Quintile 1 should meet threshold (as well as population overall)</li> <li>• Equal utilisation by quintiles 1 &amp; 5</li> </ul>	Minimum of 4 per person per year
7. Inpatient admissions per 1,000 population	Admissions, involving at least one night's stay in a health facility (hospital, health centre, etc.), within a year, per 1,000 population	Income: <ul style="list-style-type: none"> <li>• Quintile 1 should meet threshold (as well as population overall)</li> <li>• Equal utilisation by quintiles 1 &amp; 5</li> </ul>	Minimum of 70 per 1,000 people per year
8. Core service coverage indicators: a. Full immunisation rate b. Antenatal care (ANC) coverage c. Skilled birth attendance coverage d. Family planning need met e. Percent children sleeping under	a. Percent of children receiving all immunisations (measles, DPT3, BCG, Polio) b. Percent of pregnant women with at least 4 ANC visits c. Percent of deliveries by skilled birth attendant	<ul style="list-style-type: none"> <li>• Income quintile</li> <li>• Urban/rural</li> </ul>	Ultimately 100%; at least reduce coverage gap

<p>ITN</p> <p>f. Percent pregnant women receiving malaria IPT</p> <p>g. Percent HIV positive pregnant women receiving PMTCT</p> <p>h. ART coverage</p> <p>i. Percent with hypertension diagnosed &amp; on treatment</p> <p>j. Cervical cancer screening</p>	<p>d. Only applicable to malaria endemic countries</p> <p>e. Only applicable to malaria endemic countries</p> <p>f. Dependent on availability of data (included in increasing number of household surveys)</p> <p>g. Among women 20-64 years (using screening frequency specified nationally)</p>		
<p>9. Additional service coverage indicators:</p> <p>a. Postnatal care (PNC) coverage</p> <p>b. Emergency obstetric care coverage</p> <p>c. Treatment of diarrhoea with ORT</p> <p>d. Children with ARI taken to facility (treated with antibiotics)</p> <p>e. Fever treated with anti-malarials</p> <p>f. TB cure rate</p> <p>g. HPV vaccination coverage</p> <p>h. Percent with diabetes diagnosed &amp; on treatment</p> <p>i. Percent of those diagnosed with hypertension controlled</p> <p>j. Percent of those diagnosed with diabetes controlled</p> <p>k. Depression treatment coverage</p>	<p>a. Percent of pregnant women with a PNC visit</p> <p>b. Percent of ....</p> <p>c. Percent of children with diarrhoea treated with ORT</p>	<ul style="list-style-type: none"> <li>• Income quintile</li> <li>• Urban/rural</li> </ul>	<p>Ultimately 100%; at least reduce coverage gap</p>

**Target B:** End preventable deaths by reducing child mortality to [20] or fewer deaths per 1000 births, maternal mortality to [40] or fewer deaths per 100,000 live births, and mortality under 70 years of age from non-communicable diseases by at least 30 percent compared with the level in 2015.<sup>4</sup>

Indicator	Details	Disaggregation	Target/Threshold
1. U5MR Rate per 1,000 live births	Under five mortality	<ul style="list-style-type: none"> <li>Income Quintiles</li> <li>Gender</li> <li>Urban/Rural</li> </ul>	[Target specified]
2. IMR per 1,000 live births	Infant mortality	<ul style="list-style-type: none"> <li>Income Quintiles</li> <li>Gender</li> <li>Urban/Rural</li> </ul>	Same target as for U5MR
3. Maternal mortality ratio	Maternal mortality		SBA and ANC 100% coverage
4. Healthy Life Expectancy	Overall Health		Undefined target: suggestion by Salomon et al. to be debated
5. Mortality and morbidity between ages of 30-70 years from: a) CVD b) Diabetes c) Cancer d) Chronic respiratory diseases	NCDs	<ul style="list-style-type: none"> <li>Income Quintiles</li> <li>Gender</li> <li>Urban/Rural</li> </ul>	[Target specified]
6. Morbidity: mental health and neurological disorders	Mental Health	<ul style="list-style-type: none"> <li>Income Quintiles</li> <li>Gender</li> <li>Urban/Rural</li> </ul>	Same target as that for NCDs
7. Mortality and morbidity: injuries	Injuries	<ul style="list-style-type: none"> <li>Income Quintiles</li> </ul>	Same target as that

<sup>4</sup> Countries that have achieved the mortality targets should set more ambitious aggregate targets that are commensurate with their development and ensure that the minimum quantitative targets are achieved for every sub-population.



		<ul style="list-style-type: none"> <li>• Gender</li> <li>• Urban/Rural</li> </ul>	for NCDs
8. Stunting (height for age), Wasting, Underweight	Malnutrition	<ul style="list-style-type: none"> <li>• Income Quintiles</li> <li>• Gender</li> <li>• Urban/Rural</li> </ul>	Target unspecified: MDG related to reducing hunger by half
9. Households with access to improved sources of water	Water	<ul style="list-style-type: none"> <li>• Income Quintiles</li> <li>• Urban/Rural</li> </ul>	100% coverage
10. Households with access to safe sanitation	Sanitation	<ul style="list-style-type: none"> <li>• Income Quintiles</li> <li>• Urban/Rural</li> </ul>	100% coverage
11. Options a) Gini index b) Palma ratio	Income inequality		TBD
12. Options a) AFR b) Access to early childhood programs	Gender inequality	<ul style="list-style-type: none"> <li>• Income Quintiles</li> <li>• Urban/Rural</li> </ul>	TBD

**Target C:** Implement policies to promote and monitor healthy diets, physical activity and subjective wellbeing; reduce unhealthy behaviours such as tobacco use by [30%] and harmful use of alcohol by [20%]

Indicator	Details	Disaggregation	Target/Threshold
1. Probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	Mortality		80% reduction of mortality due to NCDs for under-40 by 2020
2. Age-standardized prevalence of heavy episodic drinking	Harmful use of alcohol		
3. Prevalence of insufficiently	Defined for adolescents as less than 60		

physically activity	minutes of moderate to vigorous intensity activity daily; for persons 18+ years as 150 minutes of moderate-intensity activity per week		
4. Percent of person trips/kilometers travelled by urban public transportation/transit and cycling/walking	Implementation of national policies to promote physical activity including walking, biking, recreation, and road safety		
5. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years			
6. Age-standardized prevalence of current tobacco use			
7. Age-standardized prevalence of raised blood pressure	aged 18+ years (defined as systolic blood pressure $\geq 140$ mmHg and/or diastolic blood pressure $\geq 90$ mmHg) and mean systolic blood pressure		
8. Prevalence of raised blood glucose/diabetes	aged 18+ years (defined as fasting plasma glucose concentration $\geq 7.0$ mmol/l (126 mg/dl) or on medication for raised blood glucose)		
9. Prevalence of overweight and obesity in adolescents			
10. prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day	defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex		

11. Proportion of total energy intake from saturated fatty acids	<p>Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply</p> <p>Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt</p>		
12. Prevalence of depression and wellbeing	assessed by appropriate instruments [ such as EQ5D or SF12]		
13. Implementation of national policies for mental health.			

## Appendix 2: Glossary

**Health equity:** Refers to ideals of fairness and social justice. Inequities in health refers to disparities within and between countries, that are judged to be unfair, unjust, avoidable, and unnecessary (neither inevitable nor irremediable) and that systematically burden populations rendered vulnerable by underlying social structures and political, economic, and legal institutions.

**FCTC:** The WHO Framework Convention on Tobacco Control is the world's first global public health treaty negotiated under the auspices of the World Health Organization (WHO). It includes several measures for reducing the demand and supply of tobacco products, with the aim of reducing the prevalence of tobacco consumption globally and thereby reducing the harm to health from tobacco exposure. It was adopted in 2003 by the World Health Assembly and came into force in 2005. The treaty has now been ratified by 177 countries.

**Out of Pocket Expenditure (OOPS):** Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

**Primary Health Care (PHC):** Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (Alma Ata Declaration, 1978)

**Social Capital:** Social capital refers to the institutions, relationships, and norms that shape the quality and quantity of a society's social interactions. Increasing evidence shows that social cohesion is critical for societies to prosper economically and for development to be sustainable. Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together. (World Bank)

**Subjective Wellbeing:** Refers to how people evaluate their lives, both at the moment and for longer periods (such as for the past year). This includes emotional reactions to events, moods, and judgments about life satisfaction and fulfillment, as well as satisfaction with domains such as marriage and work. (Diener 2003)

**Sustainable Development:** Development that meets the needs of the present without compromising the ability of future generations to meet their own needs. (Brundtland Commission, 1987)

**Universal Health Coverage:** The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. For a community or country to achieve universal health coverage, several factors must be in place, including:

1. A strong, efficient, well-run health system that meets priority health needs through people-centered integrated care (including services for HIV/AIDS, tuberculosis, malaria, NTDs, and other communicable diseases, non-communicable diseases, sexual and reproductive health, and maternal and child health) by:
  - Informing and encouraging people to stay healthy and prevent illness;
  - Detecting health conditions and risk factors early;
  - Having the capacity to treat disease; and
  - Helping patients with rehabilitation.
2. Affordability – a system for financing health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways.
3. Access to essential medicines and technologies to diagnose and treat medical problems.
4. A sufficient capacity of well-trained, motivated health workers to provide quality services to meet patients' needs based on the best available evidence. (WHO 2012)
5. Recognition of the critical role played by all sectors in assuring human health, including transport, education, agriculture, urban planning etc.

**Harmful tobacco/alcohol use:** Excessive use to the point that it causes damage to health and often includes adverse social consequences. (WHO)

**Verbal autopsies:** Identification of the medical and social causes of death by interviewing knowledgeable persons about the events leading up to it. (WHO 2004)

## Appendix 3: Health Goals Suggested in Global Consultations and Reports (2011-13)

The movement towards the adoption of a new set of development goals in 2015 catalyzed several consultations, involving diverse constituencies, over the past two years. Some of these have been initiated under the auspices of UN agencies while others were led by civil society groups. The TG carefully studied the reports and recommendations, which emerged from several groups and critically appraised the leading candidates for the Health SDG. The table below synthesizes a list of priorities identified by these groups.

Major Consultations	Specific Goals
High Level Consultation convened by WHO and UNICEF (Gaborone, Botswana, March 2013)	Suggested Goals: -Maximize healthy lives -Accelerate progress on health MDGs -Reducing burden of major NCDs -Ensuring universal health coverage and access
Report of the High Level Panel of Eminent Persons (UN, May 2013)	Health & Related Goals Goal 4: Ensure healthy lives Goal 5: Ensure food security and good nutrition Goal 6: Achieve universal access to water and sanitation
UN High Level Meeting on Prevention and Control of Non Communicable Diseases (New York, September 2011)	25% reduction in mortality due to NCDs, in the age group of 30-70 years, by 2025
World Health Assembly (Geneva, May 2013)  Also endorsed by the NCD Alliance of four major health NGOs (UICC, WHF, IDF & IUATLD)	2025 Goal: Achieve the global target of 25% relative reduction in overall mortality from CVD, cancer, diabetes or chronic respiratory disease, along with 8 other voluntary Global  Targets: -Diabetes/obesity 0% increase -Raised BP 25% reduction -Tobacco use 30% reduction -Salt/sodium intake 30% reduction -Physical inactivity 10% reduction -Harmful use of alcohol 10% reduction -Essential NCD medicines and technologies 80% coverage -Drug therapy and counselling 50% coverage
Ending Poverty in a Generation: Save the Children's Proposal for a Post-2015 Framework (2012)	Goal 2: By 2030 we will eradicate hunger, halve stunting, and ensure universal access to sustainable food, water and sanitation Goal 3: By 2030, we will end preventable child and maternal mortality and provide basic healthcare for all Goal 5: By 2030 we will ensure all children live a life free from all forms of violence, are protected in conflict and thrive in a safe family environment. Goal 8: By 2030, we will build disaster-resilient societies

	<p>Goal 9: By 2030, we will ensure a sustainable, healthy and resilient environment for all</p> <p>Specific Health Targets</p> <ol style="list-style-type: none"> <li>1. End preventable child and maternal mortality</li> <li>2. Achieve universal health coverage</li> <li>3. Tackle the social determinants of health</li> </ol>
Report of The United Nations Sustainable Development Solutions Network (June 2013)	<p>Overarching Goal: Achieve Health and Well Being At All Ages</p> <p>Enabling Goals:</p> <ol style="list-style-type: none"> <li>a) Ensure universal access to primary healthcare that includes sexual and reproductive healthcare, family planning, routine immunizations, and the prevention and treatment of communicable and non-communicable diseases.</li> <li>b) End preventable deaths by reducing child mortality to [20] or fewer deaths per 1--- births, maternal mortality to [40] or fewer deaths per 100,000 live births, and mortality under 70 years of age from non-communicable diseases by at least 30 percent compared with the level in 2015.</li> <li>c) Promote healthy diets and physical activity, discourage unhealthy behaviors such as smoking and excessive alcohol intake, and track subjective wellbeing and social capital.</li> </ol>

## Appendix 4: Evidence for Universal Health Coverage Indicators

### **Rationale for financial protection indicators**

A key component of UHC is to ensure that everyone has protection from the risk of incurring costs associated with using health services. Effective financial risk protection in the health systems context involves:

- Protecting individuals and families against (further) impoverishment from spending on health; as well as
- Protecting them against large health care expenses (whether from recurrent episodes of acute illness, such as malaria; chronic care requirements, such as diabetes or HIV; or inpatient admissions) that substantially deplete their assets and available resources for meeting basic household needs, thus jeopardizing household livelihoods or well-being in the long term.

Both of the above represent different aspects of financial protection, with intrinsic importance and should be given equal emphasis. Building on the globally established body of work and accumulated experience and evaluation in a wide range of countries, we propose two key indicators:

- (i) Impoverishing expenditure: the percentage of the population pushed below, or further below, the PPP\$2 poverty line, as a result of out-of-pocket (OOP) payments to use health services in the past month. It is critical that global efforts to eradicate extreme poverty are not undermined by impoverishing expenditure to use needed health services.
- (ii) Catastrophic expenditure: the rank-weighted percentage of the population whose households spent more than 25% of their non-food expenditure on out-of-pocket payments to use health services in a given month. We propose a rank-weighted measure as it gives greater weight to catastrophic expenses incurred by poor households, which is in line with the overall concerns with equality and solidarity, which recognize the reduced means and ability to share burdens of the poorest people.

Given the differential geographic access to health services, we propose that these indicators focus not only on OOP payments to a health care provider or for medicines, but also OOP payments for transport to use services. Both these indicators are easily computable in all countries using household budget surveys, and estimates currently exist for most countries, permitting easy estimation of baseline estimates when setting targets. In terms of the targets that should be set, we propose that the levels of both impoverishing and catastrophic expenditures be set at zero, recognizing that the concept of UHC requires the complete elimination of all financial hardship when accessing health care.

Although these indicators provide important insights into the extent to which a country is (or is not) providing adequate financial protection for its residents, it is not feasible to move towards UHC through providing such financial protection in the absence of adequate levels of domestic public funding<sup>5</sup>, with associated decreases in 'voluntary' payments, accompanied by continued

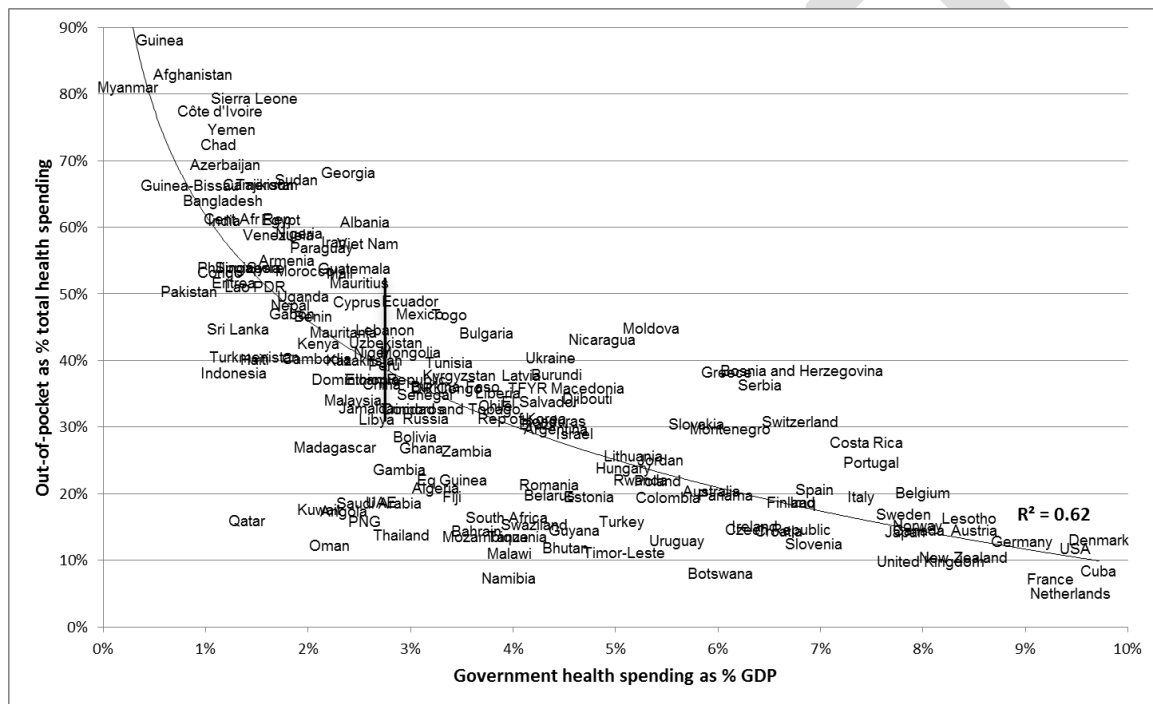
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<sup>5</sup> Domestic public funding is defined as including all sources of mandatory pre-payment funding, including government revenue and possibly also mandatory health insurance



donor funding support in lower-income countries. It is, thus, critical to include specific indicators that encourage changes in financing sources that will promote UHC. We propose three key indicators in this regard.

First, *domestic public* funding for health care should reach at least 3% of GDP in low-income countries. As shown in the figure below, there is a strong correlation between public health spending as a % of GDP and the share of total health expenditure comprised of OOP payments. The WHO has recommended limiting OOP payments to a maximum of 30% of total health expenditure to promote financial risk protection<sup>57</sup>; Figure 5 shows this requires that public health expenditure be at least 4% of GDP.

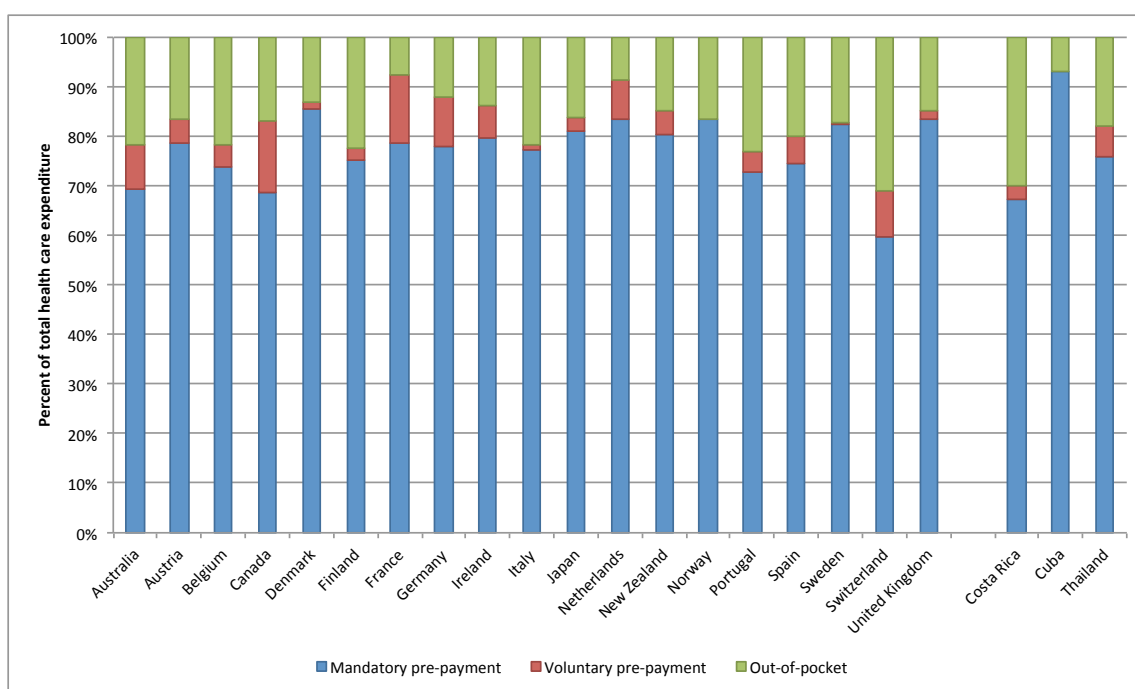


**Figure 5: Relationship between government health spending and dependence on out-of-pocket payments (2010)**

Source: Updated from McIntyre and Kutzin (2011)<sup>27</sup>

Recognising that many low-income countries currently devote the equivalent of 2% of GDP or less to public health care spending on health care, we conservatively recommend moving to a target of domestic public spending on health of 3% of GDP for low-income countries, increasing to a minimum of 5% of GDP for high-income countries.

Second, international experience clearly indicates that countries that have made considerable progress to UHC fund their health services predominantly from domestic public (i.e. mandatory pre-payment) sources (generally comprising 70% or more; see Figure 6 for original OECD countries and some LMICs with considerable progress to UHC). Conversely, as explicitly stated in the 2010 World Health Report, it is not possible to achieve UHC through voluntary payments for health care. On this basis, we recommend an indicator that OOP payments and voluntary health insurance contributions comprise a maximum of 30% of total health care expenditure.



**Figure 6: Financing sources for UHC.**

Source: Data derived from WHO National Health Accounts dataset

Finally, continued donor funding support is required for low-income countries to provide basic PHC services. Even if these countries achieved the target of domestic public spending on health of 3% of GDP, they would be spending no more than US\$35 per capita on health services. This is well below the necessary per capita spending levels for such services. We recommend that all high-income countries devote 0.1% of their GNI to ODA for health services. Several upper-middle-income countries are beginning to provide ODA funding on a voluntary basis. We recommend that there should be an explicit requirement for any country reaching high-income status to provide ODA for health and other social services, in line with the need for shared responsibility for global human development.

### Rationale for service use indicators

The second core component of UHC is that everyone within a country should be able to access needed, quality health services. The ultimate goal of this element of UHC is that those who need care actually *use* services and that these services effectively address health care needs. The ideal in assessing achievement of this aspect of UHC is evaluate if everyone who has a need for health care actually uses the appropriate service. This requires that one is able to measure both the numerator (use of services) and denominator (need for health care) accurately. It is easiest to do this for individual services, particularly where the denominator can be accurately estimated on the basis of demographic data (such as for immunisation coverage of young children or antenatal visits and assisted delivery by a qualified health worker for pregnant women). Given the ease of measurement, it is unsurprising that measures of maternal and child health services are the most frequently measured and reported indicators. However, there have been criticisms of this narrow focus on maternal and child health services. Indicators have also been put forward for measuring treatment in relation to communicable diseases, particularly TB, HIV and malaria. More recently, efforts have been made to estimate the need for and use of

non-communicable diseases (NCDs), particularly hypertension and diabetes. We recommend that indicators of coverage include maternal and child health, communicable and non-communicable disease services, with an additional set of indicators for countries where data are already available.

While these indicators provide very valuable insights into how the health system is performing in relation to specific services, they only do so for a very small sample of the hundreds of different health services provided. An alternative approach is to focus on measuring total use of outpatient and inpatient services, i.e. average number of outpatient visits per person per year and average number of admissions per 1,000 people per year. This would provide a more comprehensive indication of the use of the full range of health services. Although it is difficult to determine what level of outpatient service utilisation is *needed* within a particular country, as this is influenced by its demographic and epidemiological profile, we recommend basic minimum utilisation rates that all countries should achieve. We propose relatively conservative thresholds for assessing whether a country has achieved UHC. These thresholds lie at the lower end of the ranges of levels observed in countries that are generally recognized as having made considerable progress to UHC. For outpatient services, the threshold rate required would be 4 visits per capita per year. This compares with average rates of 6.5 in OECD countries, and rates of 4-6 in developing countries with UHC. For inpatient services, we propose a rate of 70 per 1,000 population per year. This is at the lower end of the range observed in both developed and developing countries with UHC today (the OECD average is 158 per 1,000). WHO has proposed similar but higher levels in its SARA tool.

## Appendix 5: Universal Health Care as being built on the foundation of human rights and equity<sup>16</sup>

Whilst the health MDGs rightly encouraged overall improvements in population health outcomes, concerns regarding equity within societies remained largely unaddressed. Large or growing health disparities have remained major barriers for realization of human capabilities, and in the ability of people to live a life with dignity. In essence, this contradicts the shared fundamental value of equality that is espoused in the Millennium Declaration.

The Universal Declaration of Human Rights in 1948 recognized the right of everyone to “*a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness.*” Similarly, the UN International Covenant on Economic, Social and Cultural Rights of 1966 has guaranteed the “*right of everyone to the enjoyment of the highest attainable standard of health.*” Both of these declarations have called for “*the creation of conditions which could assure to all medical service and medical attention in the event of sickness.*” The SDGs offer another such opportunity. However, this would require a shared commitment to a global health development agenda that facilitates and promotes the development of health systems and policies, guaranteeing all individuals accessible and affordable health, including health prevention and promotion dimensions, healthcare services and financial protection when needed. These fundamental rights were recently re-affirmed in a UN General Assembly resolution on UHC passed unanimously in December 2012. This resolution also explicitly recognized that inadequate coverage levels at present were compromising the attainment of these rights:

*“Noting with particular concern that for millions of people the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote, that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care and that excessive out of pocket payments can discourage the impoverished from seeking or continuing care”.*

To redress this situation, the recent UN General Assembly Resolution emphasizes the importance of achieving universal **population** coverage. Specifically it acknowledges that “*universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.*”

Universal means that any strategy leaving any person (especially people with greater needs or with fewer financial resources) uncovered is unacceptable. Fulfilling this commitment does not imply using the same financing sources or same providers. If economically advantaged sections of society choose to purchase health services using out-of-pocket financing or private insurance schemes then they should be free to do so. However, selective health strategies catering to the

preferences of privileged groups and ignoring the needs of the poor are fundamentally inequitable and contravene rights based approaches.

The post-2015 development agenda must ensure that countries reach UHC equitably, with health service benefits distributed according to need and pre-paid financial contributions determined by one's ability to pay. Only then will health systems and policies be compatible with the core global values of freedom, solidarity, equality and human security, which motivated the MDG process.

Embedding progress towards attainment of UHC as a common global priority and development goal in the post-MDG framework addresses the longstanding failure of the global development agenda to incorporate the internationally accepted right to health. This right must guarantee effective and equitable access to healthcare services as well as security against financial risks from illness as basic elements of human wellbeing.

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