

SPEECH

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Universal health coverage—leaving no one behind

Your Royal Highness, your excellencies, ladies and gentlemen.

It is an honour and privilege to be here today. The Prince Mahidol Award Conference has been for many years a place for important discussion and debate on global health. This meeting is a fantastic platform for bringing together renowned global health policy experts and implementers.

I want to thank Princess Maha Chakri Sirindhorn personally for her commitment. Thailand has become a model country for shining a light on universal health coverage (UHC) as an integral part of the Sustainable Development Goals (SDGs). UHC is about the health of everyone, including the poorest people and people forgotten by society. It is about leaving no one behind.

It is timely and topical that we are here in Bangkok, Thailand, at the dawn of a new era in development, for these important discussions on priority-setting. Thailand should be applauded for the transformations it has achieved for the health of its people. Thailand has demonstrated that countries can reach universal access to HIV services, and that the day when the AIDS epidemic will be ended as a public health threat can be envisioned. HIV treatment has been fully integrated into the country's UHC system, with spectacular results: in just seven years, the number of people accessing treatment has grown from 40 000 to more than a quarter of a million.

Thailand has also shown great coverage in leveraging TRIPS (Agreement on Trade-Related Aspects of Intellectual Property Rights) flexibilities to make life-saving medicines available to people for free. Thailand gives undocumented migrants equal access to HIV treatment. This is exactly what we mean by leaving no one behind. It is about changing the paradigm for scaling up to UHC.

Critical linkages

UHC is much more than making a package of services available. The ultimate measure of our success must be whether the poorest, the most marginalized and the most vulnerable people enjoy health and well-being. This requires going upstream and assessing and addressing—in specific contexts, and for specific populations—the causes of exclusion and ill health. It is time to address the critical linkages between health, injustice, inequality, poverty and conflict.

We live in an unequal world and we cannot leave anyone behind. Half of all children born in sub-Saharan Africa and South Asia have no birth certificates. Currently, 50 million people are displaced from their homes and communities. Just 62 people control half of the world's wealth. Twenty-two million people lack access to HIV treatment and 17.1 million people still do not know their HIV status.

UHC puts the focus on people, not diseases. This approach has been transformative for the AIDS response over the past 30 years. Thanks to the engagement of empowered communities, the conspiracy of silence has been broken. People have been brought out of the shadows—sex workers, men who have sex with men, people who use drugs and lesbian, gay, bisexual, transgender and intersex (LGBTI) people—who had no access to health services because they had to hide themselves and exist “underground.”

The AIDS response demonstrates the power of activism and political will. Leveraging this experience and knowledge will be critical to making UHC a reality. It will happen because we know how to use community engagement to create demand for services.

We know how to use innovations in science and technology to bring medicines and services to the greatest number of people. The cost of HIV treatment has been reduced from US\$ 15 000 per person per year to just US\$ 80. Dosages have been reduced from 18 pills a day to just one, and soon to just a single injection every four months. UHC will require the same effort to democratize access to affordable services, medicines and diagnostics and to exploit the full range of tools already available, including TRIPS flexibilities. We must be able to quickly apply new science, not wait 10 years before we move from research to implementation. This is what makes universal access possible.

Balancing equity and efficiency

Priority-setting must keep human rights at its heart by ensuring careful arbitration between equity and efficiency. Equity means that quality health services reach all people in need; efficiency means that limited public resources are used for health programmes that provide maximum returns on investment. Managing this trade-off will be critical, and it won't be easy.

The social determinants of health must be taken into account, with the the root causes of fragile and neglected communities addressed, structural barriers dismantled and laws, policies and practices that restrict access reformed. Services must be focused at the community level, moving from the comfortable but unsustainable disease approach to the primacy of the health of the individual.

There can be no global health security without proper management of individual health risks. We saw this with Ebola, and we are already seeing it with the Zika virus. If the world is unable to transfer competencies and cannot reach people efficiently with knowledge and information, it will not be able to manage global health risks in the future.

For UHC, let us think not in terms of “health systems,” but rather, “systems for health,” with people at the centre. This means completely changing our service delivery approach to reinforce the interface between providers of health services and the community, tapping into

non-conventional capacities. For example, Ethiopia's Health Extension Programme, funded by HIV investments, has recruited, trained and supported more than 35 000 rural community health workers, who now provide sustainable, comprehensive primary care in some of the hardest-to-reach areas. They are addressing the root causes of fragile communities.

Health inequities between countries need to be reduced. When Ebola struck, there was one doctor for every 45 000 people in Sierra Leone and fewer than two doctors for every 100 000 people in Liberia. In the United States of America, there is one doctor for every 400 people. It is very difficult to sustain the thought of UHC with these dramatic differences.

Our current global health architecture is unsustainable. A new governance system for UHC that will reduce duplication and push governments to build systems that reach all people needs to be built. It is not enough to reach millions of people who are sick. Billions of people must be reached with services to stay healthy, because UHC is also about nutrition, education and lifestyle choices. This requires a global health architecture that supports equitable, inclusive and resilient systems for health while also responding to crises and emergencies.

Civil society will be key to accountability and transparency for UHC. We must support communities to play their role effectively as agents of change, ensuring space and support for civil society both as partners in the design and delivery of UHC and as advocates, watchdogs and whistle-blowers. The AIDS response has been a pathfinder in engaging with sex workers, men who have sex with men, people who use drugs and LGBTI people. Leveraging this experience will be critical to making UHC a reality.

Investing beyond official development assistance

Providing quality health services free at the point of delivery helps end poverty, boosts economic growth and saves lives. It is simply not acceptable that 150 million people fall into poverty every year paying for health services out of their pockets. Building architecture that supports UHC means going beyond official development assistance (ODA) financing. We need shared responsibility, and that means more domestic financing. Countries must increase their budgets and per capita spending targets on health. This need not represent a costly burden: UHC can deliver benefits 10 times greater than investments. And government spending on health is not an expenditure, it is an investment for transforming society.

Low-income countries still need support, especially in the interim period, so it will be essential for wealthy countries to meet their pledge to provide 0.7% of gross national income in ODA and to ensure that the SDG agenda is fully financed.

Shared responsibility has made all the difference in the AIDS response over the past five or six years. African countries have increased their domestic spending on AIDS by 150%. South Africa is spending US\$ 2 billion from its own budget for AIDS programmes, compared to almost nothing a few years ago. We see the results in millions more people on treatment and millions fewer new HIV infections.

UHC is not a charitable enterprise. It is good governance. It is an essential thread among the rights that are woven into the very fabric of modern society. If you are accused of a crime, you

are entitled to a lawyer. You have a right to a fair trial. If you are sick, you are entitled to a health provider. You have the right to health.

The time to act is now. Together, we will make UHC a matter of rights. Together, we can achieve the single most critical objective of the entire SDG agenda—to leave no one behind.

Thank you.