NCD Alliance Advocacy Priorities
The 2019 United Nations High-Level Meeting on Universal Health Coverage

April 2019

This briefing paper aims to inform Member States about the crucial opportunity of the 2019 UN High-Level Meeting on Universal Health Coverage (UHC HLM) and the need to ensure that the prevention and control of noncommunicable diseases (NCDs) is included as an element of UHC in the outcome document of the UN HLM.

The Context and Opportunity

Following the first UN High-Level Meeting on Ending Tuberculosis and the third UN High-Level Meeting on Noncommunicable Diseases in 2018, Heads of State and Government will meet for the first time to discuss universal health coverage (UHC) at the highest political level in September 2019. This HLM will build upon previous health-related political declarations and commitments, and provide an opportunity to unify a somewhat fragmented health agenda. We call on governments to promote integrated health and social services and quality care that meets the needs of all people across their life course, while improving efficiency and equity in public financing for health.

The concept of UHC is firmly rooted in the principle that the highest attainable standard of physical and mental health is a fundamental human right. Defined as a situation where all people, everywhere, can access quality health services without incurring financial hardship, UHC is the single most powerful concept that public health has to offer, and vital to sustainable human development. The notion of a minimum standard of health for all, a precursor to UHC, was enshrined in the Universal Declaration of Human Rights of 1948 and the declaration of Alma-Ata in 1978. In order to achieve this standard, quality primary health care (PHC) must form the basis of strong health systems that are able to deliver UHC, throughout the continuum of care from prevention to palliation.

The urgency, scale and impact of the NCD epidemic on people's health and on economies poses both unique challenges and opportunities for the design and implementation of UHC. Continued lack of access and availability to essential NCD medicines, technologies and services in many countries is unacceptable. In part this lack of access is due to health systems being ill-equipped to respond to the growing epidemic, but primarily due to a lack of political will to invest in health. NCDs demand a more responsive health system that prioritises prevention and patient education, providing person-centred care with improved outreach and self-management to effectively manage and monitor risk factors, illness episodes and multi-morbidity over many years. Major inequalities persist in terms of NCD risk, access to services, and health outcomes, and the epidemic imposes a huge economic burden on national budgets, and too often pushes households into vicious cycles of poverty due to out-of-pocket payments (OOP). Over 60% of people living with NCDs have experienced catastrophic health expenditure, and this is most concentrated among the poorest, most marginalised populations in all countries, who are all too often left behind.

The progressive realisation of UHC must ensure prioritising NCD prevention and control in UHC design and implementation. When achieved, UHC can be a powerful tool to accelerate progress on NCD outcomes, reducing inequalities, socio-economic stability and sustainable development.

Our Advocacy Priorities

The NCD Alliance fully supports the UHC2030 Six Key Asks for the HLM, which cover the key building blocks of a successful HLM for advancing the UHC agenda. To complement these, the NCD Alliance has developed five advocacy priorities that respond to the unique dimensions of NCD prevention and control for UHC:

1. **Prioritise prevention as an essential component of UHC.**
2. **Provide primary health care (PHC) as the foundation for UHC.**
3. **Save lives by increasing equitable, universal access to quality and affordable essential medicines and products.**
4. **Increase sustainable financing for health and improve efficiency in investments.**
5. **Enable community engagement and empowerment in UHC design, development and accountability processes.**

See the table for more details on each of these priorities, including specific advocacy asks for each of the five priorities that can be tailored for all resource contexts.

	Priorities	Rationale	Advocacy Asks
1	**Prioritise prevention as an essential component of UHC.**	Investing in NCD prevention is essential for the success of UHC, but is too often seen as a dispensable luxury, rather than the bedrock of sustainable health coverage. Though many NCDs are preventable, the current trajectory of NCDs is set to cripple health systems and economies worldwide. Unless there is sustained focus on the upstream drivers (social, commercial and environmental) of these diseases and the modifiable risk factors, UHC will drift out of reach for many populations. UHC packages must include the proven, cost-effective prevention strategies in the WHO Framework Convention on Tobacco Control (FCTC), the global strategies for tobacco control, alcohol control, unhealthy diets, physical activity, air pollution and the WHO Best Buys and recommended policy interventions, which would save millions of lives. Inclusion of these interventions is an important litmus test for a health system that is reoriented towards primary health care that tackles the full continuum of care from health promotion, disease prevention, screening and diagnosis, treatment and care, rehabilitation, and palliative care across the lifecourse. UHC benefit packages must be designed with these two important NCD dimensions in mind – the continuum of care (including prevention), and action across all stages of life, given that many of the health problems we encounter in adulthood stem from our experiences early in life—in some cases, even from before we are born.	• Ensure that UHC services span the full continuum of care, including health promotion, disease prevention, screening and diagnosis, treatment and care, rehabilitation, and palliative care across the lifecourse; • Ensure policy coherence with national and international legislation on population health, such as tobacco legislation and full implementation of the Framework Convention on Tobacco Control (FCTC), and implement measures to rapidly improve both indoor and outdoor air quality; • Prioritise essential public health functions and address the commercial, environmental, and social determinants of health via implementation of the full set of WHO recommended cost effective interventions for the prevention and control of NCDs; • Recognise the need for a 'health in all policies' approach and work with non-health sectors to create health-promoting environments that reduce exposure to health-harming products and substances, including pollutants.
2	**Provide primary**	Primary health care is often the most frequent	• Build sustainable and resilient PHC that

	health care (PHC) as the foundation for UHC.	entry point for people to the health system and offers the greatest potential to detect high-risk individuals who may be interacting with the health system for other reasons. Integrated primary health care can be an instrumental tool in reducing health inequalities, and, when person-centred, can have better outcomes, equipping individuals with the knowledge and tools to understand, participate, and actively manage their own health. PHC is essential for NCD prevention and control. It is essential that health systems utilise strong referral networks from primary level through to specialised care, as many diseases require such networks for successful treatment. It will also better support health systems to manage patients' changing needs over time and respond to the increasing burden of multi-morbidities, including the impact of NCDs on mental health and well-being.	meets all people's needs across the continuum of care; • Design and implement UHC that addresses the growing burden of multi-morbidities and considers the practical needs of people living with more than one chronic condition; • Ensure strong referral networks from PHC to more specialised care at secondary and tertiary levels. • Invest in the education, training, recruitment, motivation, and retention of a well-resourced and supported health workforce, including nurses, midwives, dentists and community health workers; • Utilise existing platforms for infectious diseases and maternal and child health to deliver integrated health and social services for people-centred care; • Ensure appropriate and adequate social support mechanisms.
3	**Save lives by increasing equitable, universal access to quality, affordable essential medicines and products.**	Access to treatment and care is a prerequisite for the fundamental human right to achieve the highest possible standard of physical and mental health and well-being. Availability and access to essential lifesaving medicines and products for people living with NCDs is, unacceptably, still out of reach for millions of people around the world, particularly in low- and middle-income countries and for the world's poorest and most vulnerable populations. A particular issue is the insufficient access to controlled opioid analgesics for pain relief and palliative care. Challenges of access relate to fragile and ill-equipped health systems in many LMICs, including the lack of adequate preparation and training of the health workforce, insufficient financial resources and rising prices, poor procurement policies and weak supply chains, inefficient information systems, and lack of patient education and low health literacy. Furthermore, too often people are shouldered with the cost of treatment for NCDs, with over 60% of people living with NCDs having experienced catastrophic health expenditure.	• Implement policy measures and actions, such as those outlined by WHO, to increase access to affordable, safe, effective, and quality assured medicines, vaccines, and technologies; • Include essential NCD medicines and products in UHC benefit packages to reduce catastrophic financial expenditure, and include NCD essential medicines and products, including disease preventing vaccines such as the HPV vaccine, in national essential medicines drug lists and national drug procurement systems; • Commit to increase access to affordable, safe, effective, and quality medicines, diagnostics and health technologies, reaffirming that the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), in line with the 2001 WTO Doha Declaration on the TRIPS Agreement and Public Health; • Strengthen supply chain and health systems to increase access to affordable,

			quality-assured essential medicines and health products.
4	**Increase sustainable financing for health and improve efficiency in investments.**	Sustainable public financing for UHC will require increased domestic mobilisation of resources. Current funding levels are insufficient to meet UHC by 2030. Governments need to increase domestic investment and allocate more public financing for health through equitable and mandatory resources, as well as improve efficiency and equity in the use of existing resources and reduce impoverishing out-of-pocket payments. For NCDs, few LMICs provide care for NCDs within their health benefits packages, and most care is therefore financed out of pocket, pushing families into vicious cycles of poverty and hindering national economic development. Adopting smart fiscal policies and pro-health taxes (sugar, tobacco, alcohol taxes, referred to as STAX) that promote health can provide a source of revenue for countries, and has the dual benefit of reducing consumption of and exposure to unhealthy commodities. Development assistance for health remains an important form of catalytic funding for LICs for progress on UHC and NCDs.	• Commit to increase and prioritize budgetary allocations for the achievement of UHC; • Increase public financing for health and pool health financing through mandatory contributions to ensure universality and equity of coverage; • Commit to reducing the burden of NCDs and broadening fiscal space by implementing progressive, pro-health taxation (STAX); • Fulfil all official development assistance (ODA) commitments, including 0.7% of gross national income for developed countries, and commit to increasing catalytic ODA for UHC and NCDs; • Channel investment into integrated health systems strengthening (including for NCDs) via existing financing mechanisms, including the Global Fund and the Global Financing Facility, capitalising on cost-effective delivery of integrated services.
5	**Enable community engagement and empowerment in UHC design, development and accountability processes.**	People must be at the centre of UHC, and therefore people and communities, including people affected, must be meaningfully engaged from the design and development of national UHC packages, through to their implementation, monitoring, evaluation and accountability. The lived experiences of people who interact with the health system, and especially of those people living with multiple conditions, must shape UHC systems to meet the needs of people and populations.	• Acknowledge the role and contribution of people affected and civil society, including their full involvement and participation in the design, planning, implementation and evaluation of UHC programmes and services; • Partner with local leaders and civil society, including community-based organisations, to develop and scale up community-led services; • Increase investment in civil society to support the implementation of UHC, particularly in LMICs; • Establish and/or strengthen effective national accountability mechanisms for UHC that are transparent and inclusive, with the active involvement of civil society and people affected.