

Interconnectedness of UHC and health security

First Face-to-Face Meeting of the UHC2030 Working Group on Support to Countries with Fragile or Challenging Operating Environments

“Universal health coverage and health emergencies are cousins—two sides of the same coin. Strengthening health systems is the best way to safeguard against health crises. Outbreaks are inevitable, but epidemics are not. Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics.”

Tedros Adhanom Ghebreyesus, “All roads lead to universal health coverage”, The Lancet, 17 July 2017

1. Interconnectedness of the health security and Universal Health Coverage agendas

Health systems are critical to prevent, detect and respond to health crises. The Ebola outbreak and other epidemics such as the recent Yellow Fever, Zika virus or the Middle-East Respiratory Syndrome coronavirus outbreaks have highlighted the deficiencies in the capacity of health systems to deliver public health at critical moments. Governments, experts and development agencies now strongly advocate for health systems to be prepared and competent to guarantee the health security of the population and resilience of societies, clearly linking health system strengthening and the national and global health security agendas.

WHO and UHC2030 partners need to jointly work on health systems strengthening, IHR compliance and disaster preparedness to efficiently support the achievement of UHC and Health Security. Working on separate agendas in isolation leads to a duplication of efforts, misplaced priorities and inefficiency. WHO and UHC2030 partners need to set the example, promoting broader integration of IHR and preparedness into National Health System Strategies and Plans, health system strengthening into National Action Plans for Health Security, and better coordination between Emergency and Health Systems agendas.

Emergency preparedness can be achieved in all countries on the way towards achieving Universal Health Coverage, and its related SDG-targets.

The Emergency Preparedness and Health Systems frameworks are fully compatible, and a mutual reinforcement of emergency preparedness and health systems strengthening strategies is needed to ensure an **optimal use of scarce domestic and international resources**:

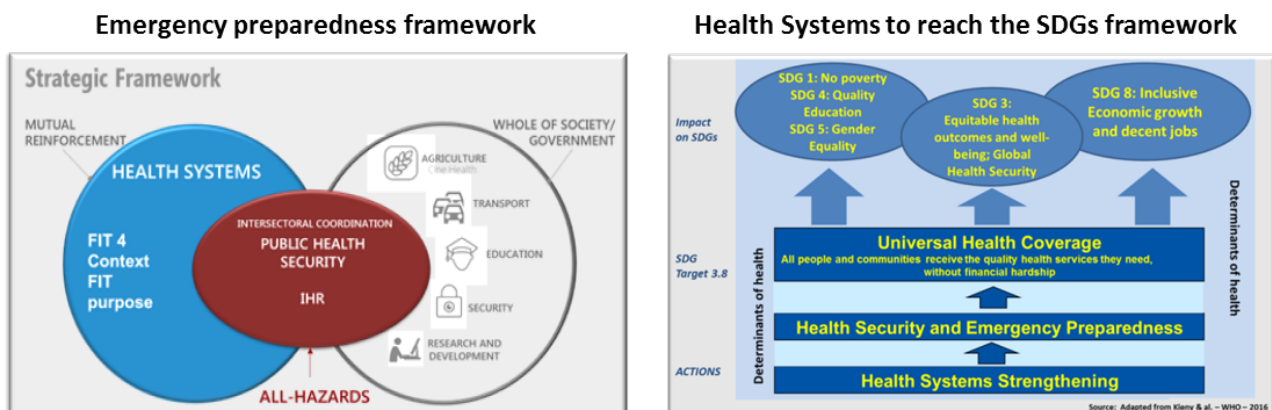


Figure 1: WHO Emergency preparedness and HSS for SDGs frameworks

But no cherry without the cake: investments in the institutions that guarantee health security need to be twined with investments in health systems’ foundations

2. What is the cost to achieve emergency preparedness for health security on the road to UHC?

Using a framework developed for health systems strengthening for attaining the health-related SDGs, WHO cost projections for 43 low- and middle-income countries¹ from 2016 to 2030 show that an **additional US\$21 billion average annual spending is needed to reach sufficient levels of Emergency Preparedness or Health Security²**. This is the equivalent of an average additional annual US\$ 14.3 per capita for the 43 countries considered³.

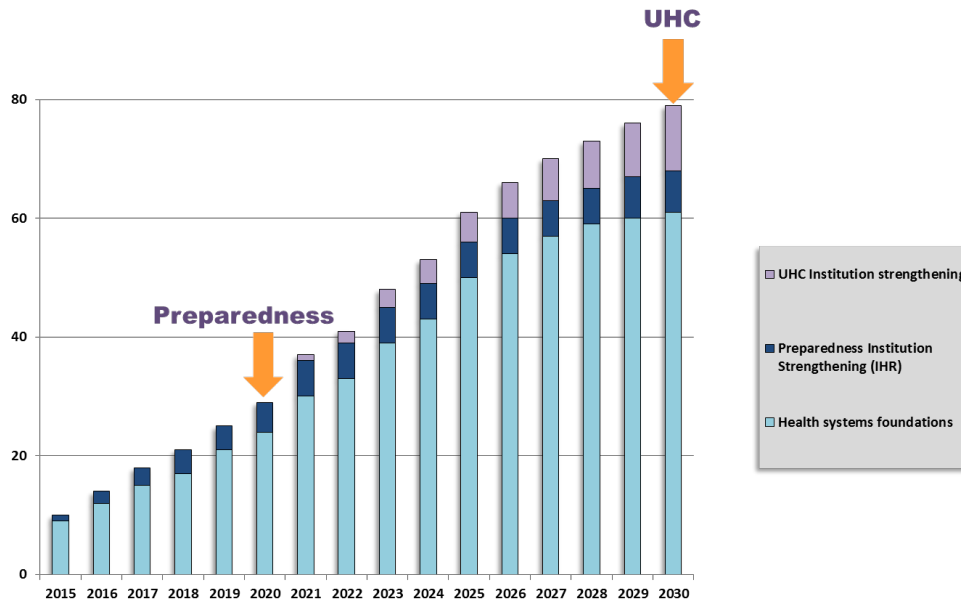


Figure 2. Investment needs on the road to Emergency Preparedness and UHC

This amount is reasonable. However, a **financing gap can be expected for many (mainly low-income) countries to reach sufficient levels of health security, being in total an average of \$8.6 billion a year**. Figure 3 below shows that while most middle and stable low-income countries should be able to finance these needs (left graphic), countries affected by conflict and those in vulnerable contexts are particularly likely to have a financing gap, while also being those countries with the greatest needs (right graphic). **External support will be needed to fill in this gap in these most fragile countries. This funding should cover priority HSS investments on the road towards health Security and UHC.**

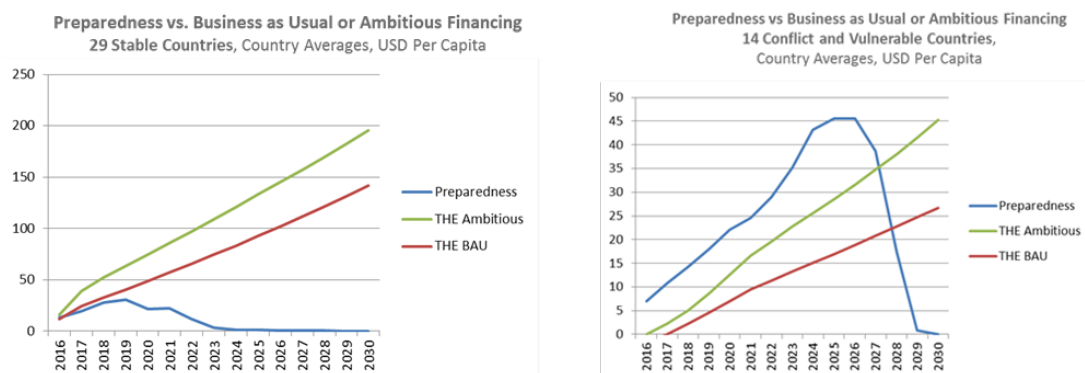


Figure 3: Investment needs vs projected Total Health Expenditure in 14 conflict & vulnerable states and in 29 stable countries

¹ LICs: Afghanistan, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Rwanda, Sierra Leone, South Sudan, Tanzania, Togo, Uganda, Zimbabwe; MICs: Algeria, Angola, Dominican Republic, Ghana, Kazakhstan, Kenya, Nigeria, Pakistan, Romania, Sri Lanka, Sudan, Tunisia, Turkey, Yemen

² Method: (1) Benchmarks for each HSS component were based on median levels in the 24 countries in the SDG sample with demonstrated emergency preparedness, detection and response capacity (Azerbaijan, Bangladesh, Brazil, Cameroon, China, Colombia, Cote d'Ivoire, Ecuador, Egypt, India, Indonesia, Iran, Iraq, Malaysia, Mexico, Morocco, Myanmar, Peru, Philippines, Thailand, South Africa, Ukraine, Uzbekistan, Vietnam); (2) Costs for each health system component were counted until the weakest part of each component reached its respective benchmark (ie. human resource costs were modelled until all three health worker category densities reached their benchmarks); (3) For emergency preparedness, it included interventions such as strengthening risk communication, regulation and legislation, points of entry, laboratory capacities, all-hazard health worker training, emergency simulations and exercises, mass casualty management, emergency kits and equipment for rapid response teams, and national planning exercises.

³ Simple average of annual country per capita needs. A population weighted average per capita need for the 43 countries considered is \$21.4

3. Combined health security and UHC efforts should work!

As illustrated in figure 4 below, the resources needed for emergency preparedness in 14 conflict and vulnerable countries (left) and in 29 low and middle income stable countries (right), are mostly about addressing health systems foundational gaps, **mainly infrastructure and health workforce**. This demonstrates that emergency preparedness is an intermediate step towards having a health system that can deliver services on the path towards Universal Health Coverage (additional SDG needs blue line).

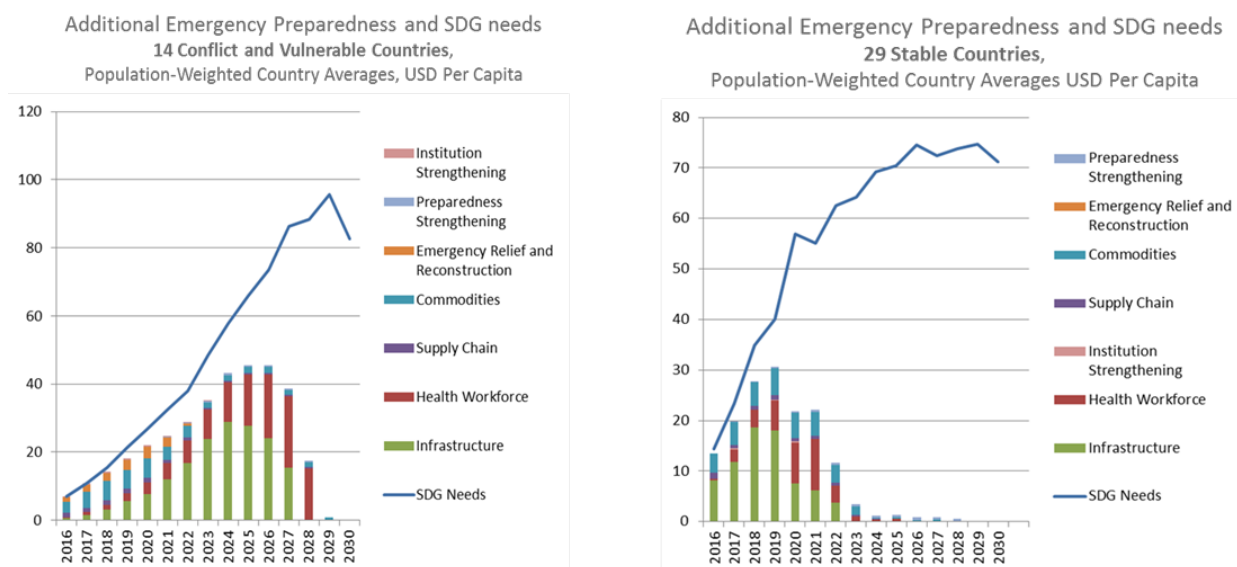


Figure 4: resources needed – breakdown in 14 conflict & vulnerable countries and in 29 stable countries

4. Four WHO modalities⁴ to support countries on their journey towards health security and UHC

All countries are different and WHO country specific approaches tailored to country context are needed.

As formulated in its recent draft 13th General Programme of Work⁴, WHO intends to take operational action in a limited set of highly fragile, vulnerable and conflict-affected States. In a larger set of countries, WHO will strengthen its technical assistance capacity and strategic advisory function, supporting governance in institution building and the strategic development of high performing health systems. In all countries, it will engage in policy dialogue on the evolution and increased investments in health systems, continuous innovation and the sharing of best practices.

To this end, four WHO support modalities need to be used:

- **WHO Modality 1 – Policy Dialogue partner:** drive *Policy Dialogue* in all Member States. The focus and topics of this policy dialogue will vary depending on the maturity of the health system. In very high performing health systems, this dialogue is likely to focus on innovations and building health systems of the future that can then be used to inspire other countries striving for excellence.
- **WHO Modality 2 – Strategic Supporter:** provide specific *Strategic Support* to assist countries which have maturing and already fairly resilient health systems in place, but which seek to maximize their robustness and systems performance in terms of health results, equity and financial sustainability.

⁴ WHO draft 13th General Programme of Work – November 2017: http://apps.who.int/gb/ebwha/pdf_files/EBSS4/EBSS4_2-en.pdf?ua=1&ua=1

Strategic support will be delivered through in-country national-level presence, subregional offices or direct support from regional offices or headquarters, depending on the context.

- **WHO Modality 3 – Technical Assistance partner:** provide hands-on *Technical Assistance*, working side-by-side with the government and in tight collaboration with other partners to identify, respond to and overcome key health systems and health security bottlenecks, attract sufficient financing and build more robust institutions over time, in settings of weak health systems and moderate to high vulnerability, including countries facing recurring acute crises to manage and/or ongoing protracted crises at a subnational level. Assistance in such settings would be delivered through a combination of national and, where appropriate, subnational presence.
- **WHO Modality 4 – Service Delivery Partner:** Provide intensified Service Delivery support to help (re)build health systems and security foundations, and ensure continued service delivery in contexts of extreme fragility, vulnerability and large-scale conflict. It is an existing modality in relation to the WHO Health Emergencies Programme that will also include actions related to health system strengthening and preparedness. Sometimes it may only cover part of the country.. WHO and its UHC2030 partners will operate through a combination of national and substantive subnational presence. In such settings, coordination among United Nations agencies and development partners will be particularly important.

Depending on the prevailing situation in countries, WHO and its UHC2030 partners will need to optimize the sequencing and combination of the above four modalities that can co-exist simultaneously (figure 5):

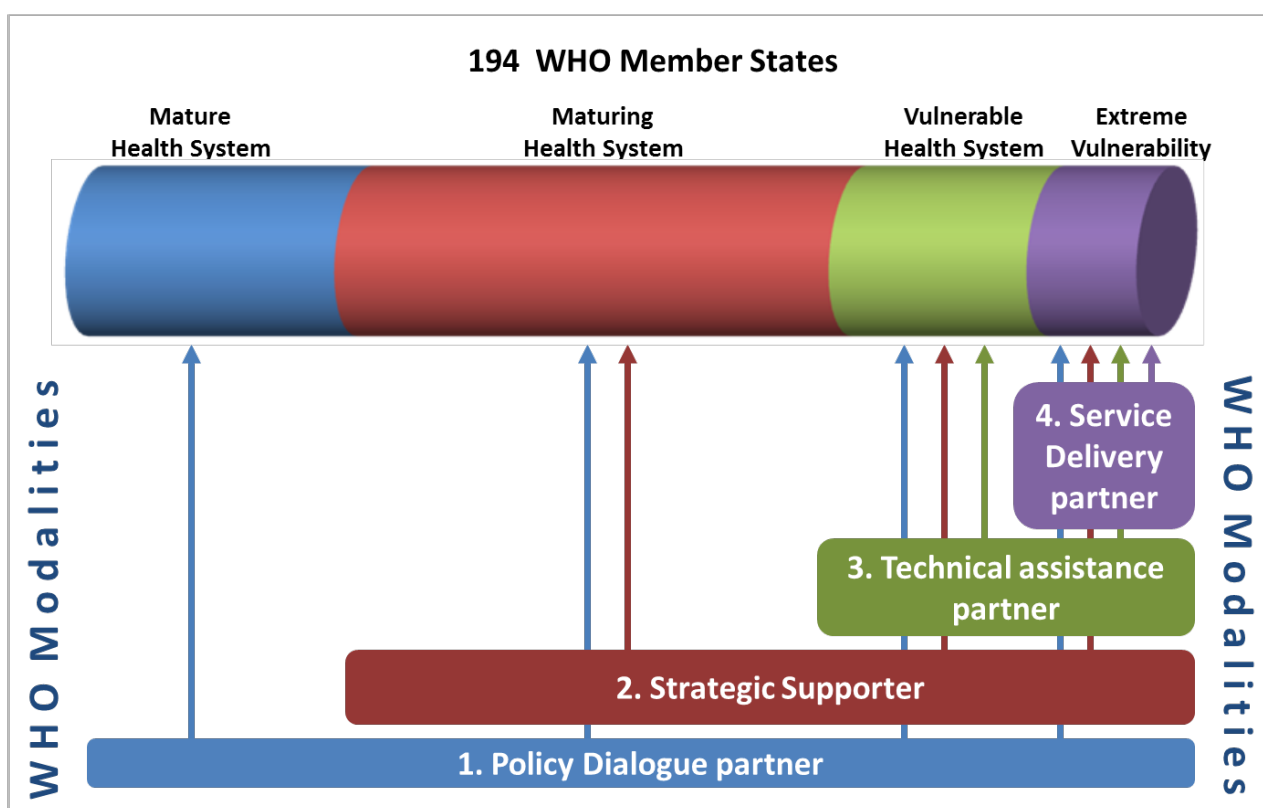


Figure 5: Four WHO strategies to be combined and sequenced adequately to reach health security and UHC

As illustrated in figure 6 below, the Technical Assistance and Service Delivery modalities 3 and 4 will mainly focus on addressing six critical health systems gaps:

Six Critical Gaps

1. **Financing:** Invest in financial engineering to build a unified and transparent financial management system (FMS) and procurement procedures,
2. **Health workforce:** Invest in skills for a community based health care workforce
3. **Essential medicines:** Invest in basic workforce capacity to manage supply chains and diagnostic facilities.
4. **Health information:** Invest in unified health information systems, including surveillance.
5. **Governance:** invest in local health governance systems through district health management and community engagement.
6. **Service delivery:** invest in basic infrastructure and equipment.

Figure 6: Critical gaps – Photos D. Porignon - Sierra Leone 2016

5. Roles and responsibilities

In most countries, domestic resources should cover health related investment plans. However, in countries benefiting from modalities 3 and 4, UHC2030 partners’ external investment will be needed, in addition to technical expertise:

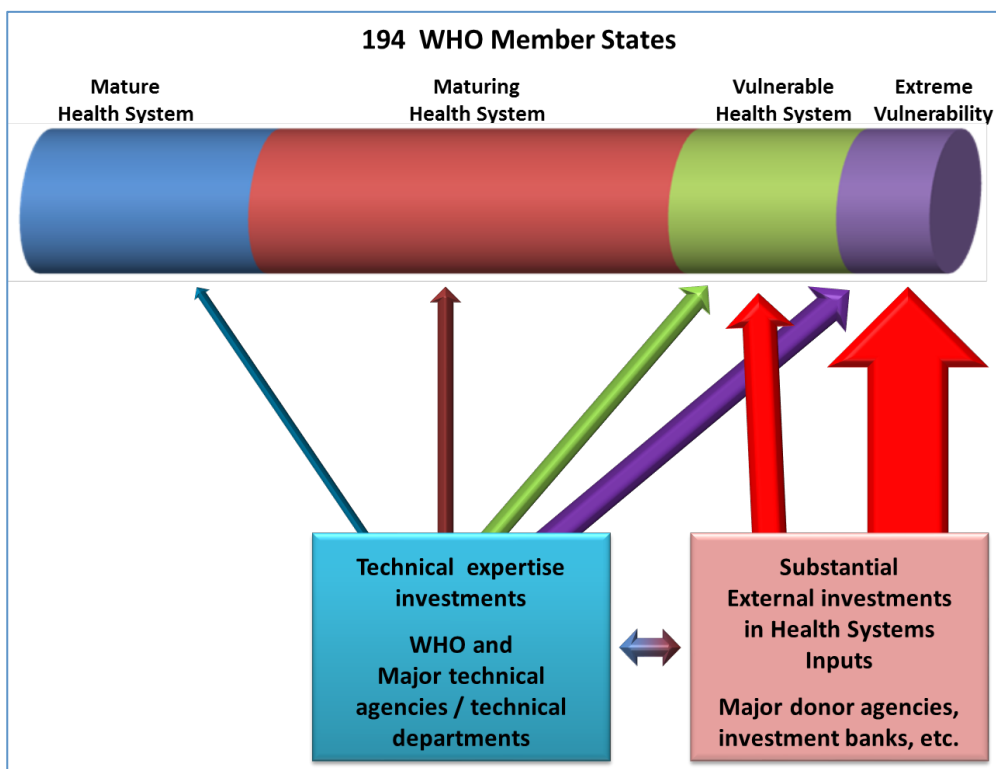


Figure 7: Health security and UHC in motion: roles and responsibilities

6. Preparedness & IHR

Integral to the *Technical Assistance* modality 3 and *Service Delivery* modality 4 is the building of core capacities for epidemic and disaster preparedness, in particular human resources, surveillance and information management, and diagnostic services.

The *Strategic Support* modality 2 will aim at strengthening institutions to guarantee efficient health system emergency preparedness strategies in full compliance with the International Health Regulations.

And the *Policy Dialogue* modality 1 will make sure that the health system emergency preparedness strategy ensures enough flexibility to cope with changing environments and unexpected emergencies.

Depending upon the situation prevailing in the country, WHO will decide which combination and sequencing of modalities 1, 2, 3 and 4 as needed.

7. Points for discussion

- UHC2030 partners have a large role to play in helping countries towards being prepared for the next big health emergency, as part of being key partners along each country's path towards health security and UHC.
- Each country can benefit from a right combination and sequencing of investments and technical expertise, all of which would fit into larger national priority setting processes and sectoral planning strategies.
- In concerned countries, UHC2030 partners need to support countries in leveraging domestic and external resources to address critical foundational gaps, and on convening and facilitating dialogue with national and international stakeholders (in line with the IHP+ principles) on resource allocation for health security and UHC.
- UHC2030 partners need to agree on roles and responsibilities, and make sure foundational investments (the six critical gaps) are duly addressed.
- In line with the UHC2030 and the IHP+ principles of aid effectiveness, in concerned countries, partners need to agree on ways of working, roles and responsibilities and financial contribution in terms of investments and technical expertise. This could be formalised in a UHC2030 "New Compact" for Health Security and UHC.