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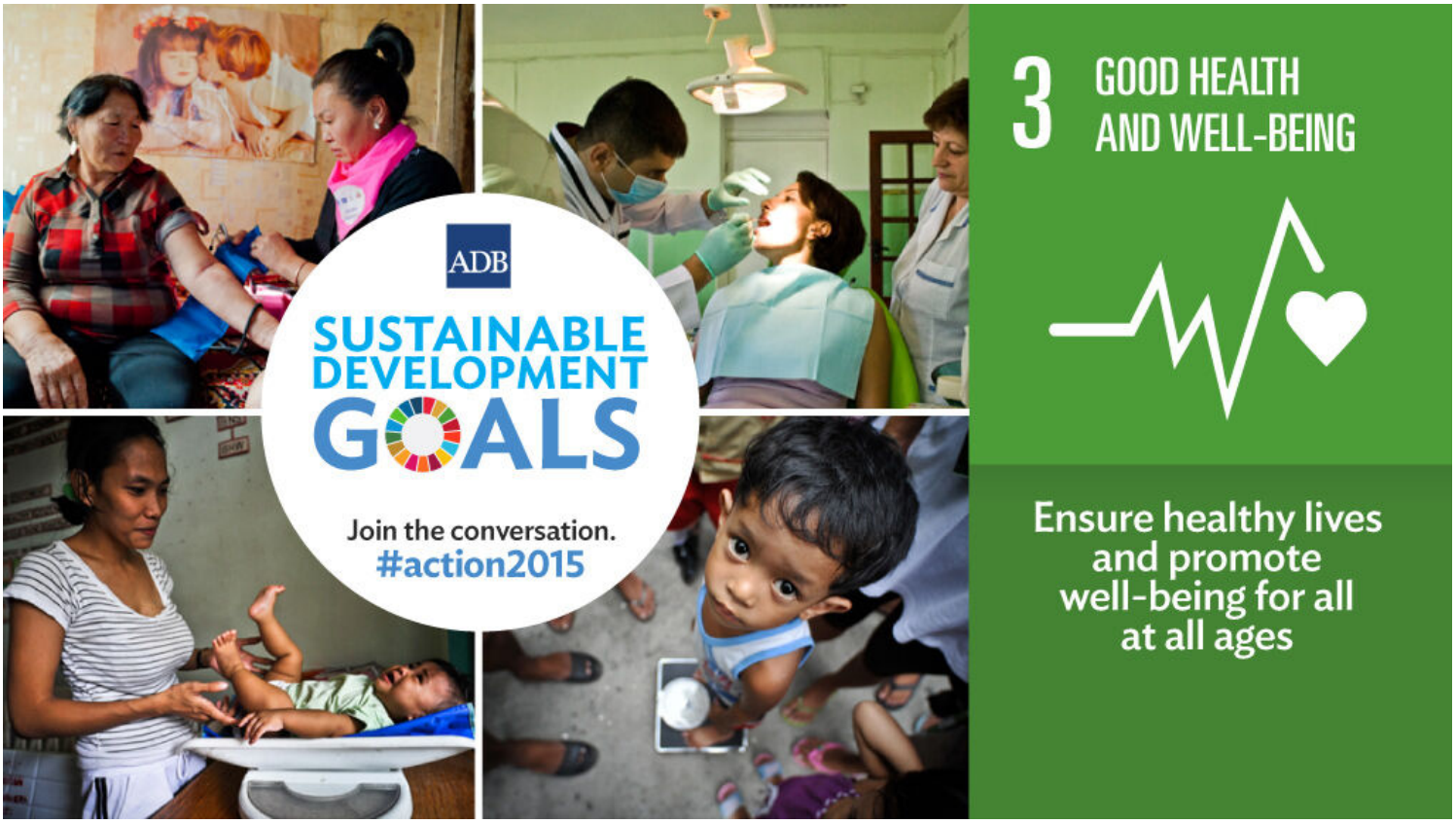
Inequity in Health Persists: Should Switzerland Be Concerned?

A paradigmatic shift on global societal structures and processes is needed

The unbearable lightness of SDG3

Von Eduardo Missoni

The SDG 3, "Ensuring a healthy life and promoting well-being for all at all ages" implicitly includes equity in health. The Agenda 2030, involves and commits all governments to the adoption of "indivisible" and universal goals toward ending poverty by 2030 "once and for all". The new agenda is not without contradictions. Among other things, it proposes among its economic objectives "sustainable, inclusive and sustained growth", in fact an oxymoron, due to the known "limits of growth" in a finite ecosystem. Thus, the challenge of sustainability is global and involves all national health systems.

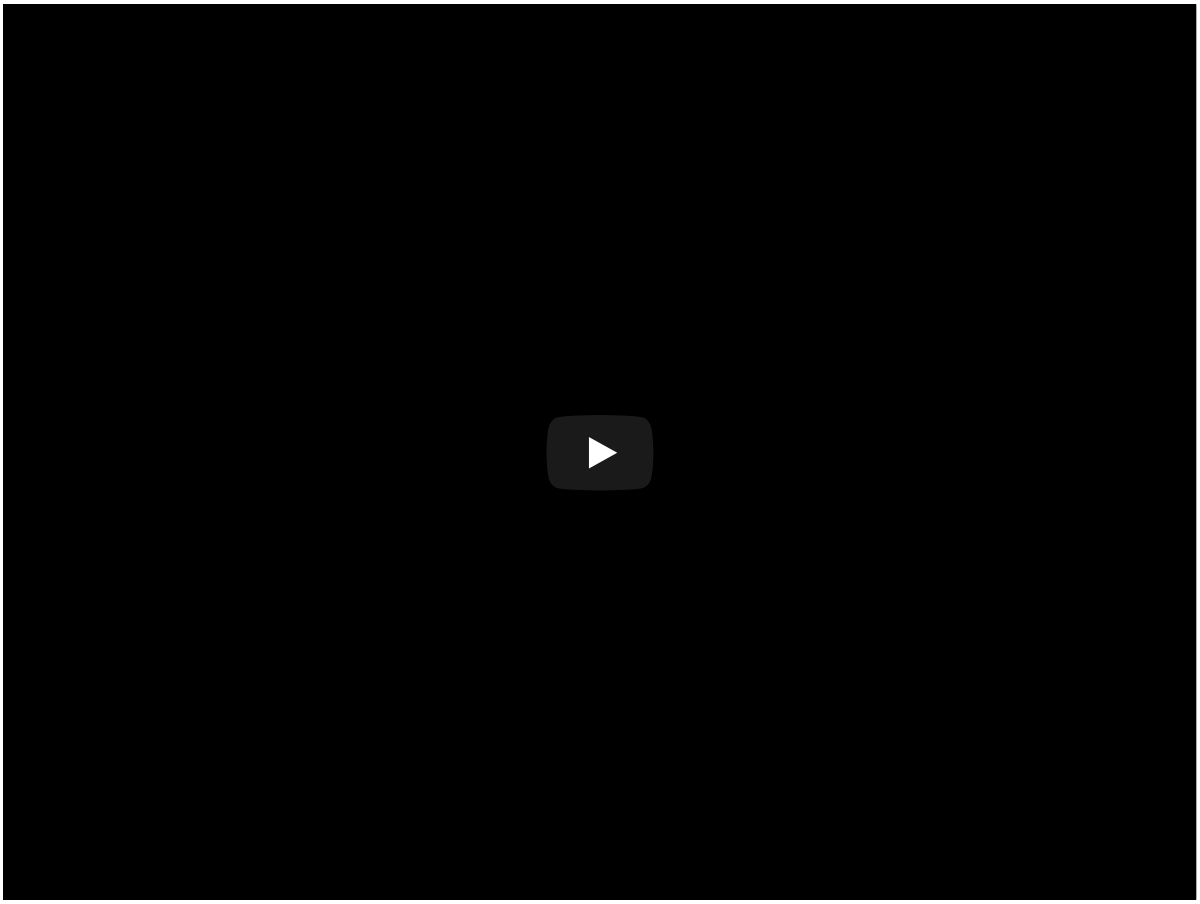


Sustainable Development Goal #3: Good Health and Well-being. Photo: Asian Development Bank/flickr, CC BY-NC-ND 2.0

Using the Health Systems 'building blocks' framework and Universal Health Coverage, the main driver of SDG 3, and equity as indicators, the argument is put forward that SDG 3's feasibility and sustainability is highly dependent on structural societal determinants which, if left unchallenged through appropriate global governance processes, may jeopardize its attainment. To ensure the effective sustainability of SDG 3 in general and of UHC in particular, an urgent paradigmatic shift in the approach to health and development is advocated.

The Agenda 2030

Following an intergovernmental process that involved also significant sectors of civil society, the Agenda 2030 for Sustainable Development was adopted on 25 September 2015 by the Summit of Heads of State and Government convened in New York by the United Nations (UN 2015). The new agenda committed governments to the adoption of a set of 17 "indivisible" goals to end poverty "once and for all" by 2030; to combat inequalities; to ensure lasting protection of the planet and its resources; and to create the conditions for "shared prosperity" and "sustainable, inclusive and sustained" growth (UN 2015).



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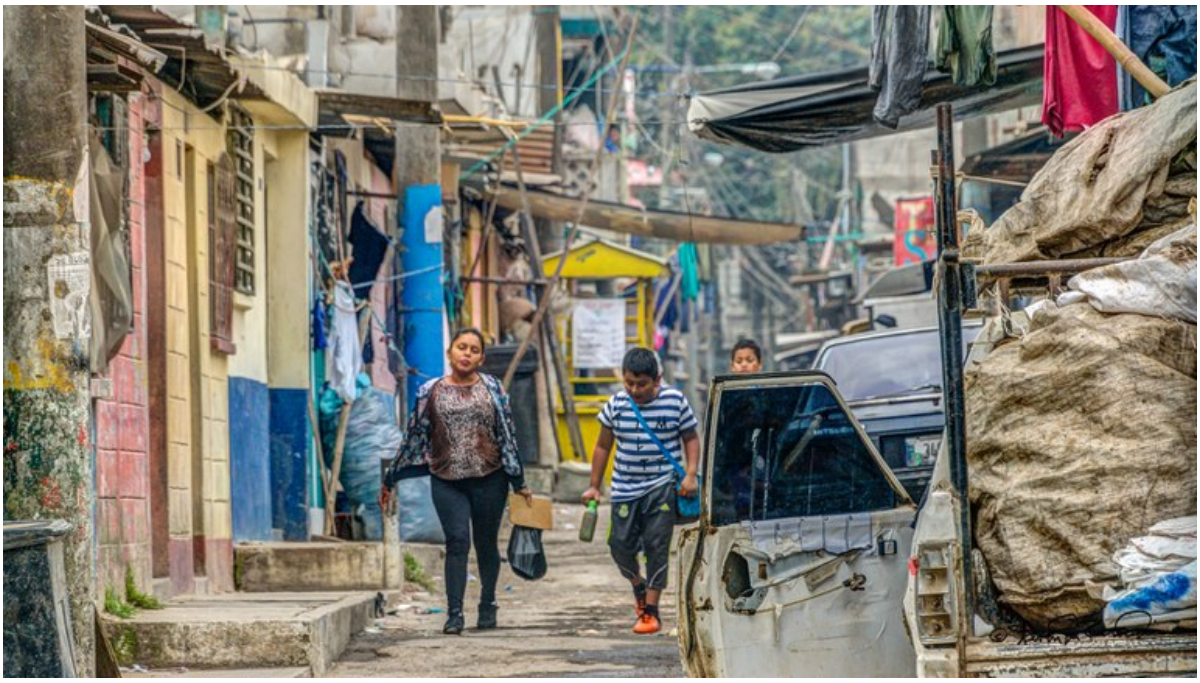
By definition sustainable development, which "meets the needs of current generations without compromising the ability of future generations to meet their own needs" (WCED 1987), includes intergenerational equity. It involves, on the one hand, the use of renewable resources and strict environmental protection, and on the other hand the ability to ensure that human progress (first and foremost the improvement of the living conditions of the populations) lasts over time.

Sustainable Development Goal 3 (SDG3) has been set out in “Ensure healthy lives and promote well-being for all at all ages”. Undoubtedly, the goal cannot be achieved exclusively through efforts in the health sector, this is supported by the indivisibility of the 17 SDGs. Similarly, inequality in health is a mirror of all other inequalities, as well as constituting a "common danger" as stated in the Constitution of the World Health Organization (WHO).

On the other hand, the achievement of “Sustainable, inclusive and sustained” economic growth, one of the pillars of the Agenda 2030 (UN 2015), is conceptually an oxymoron (Kopnina 2016; Spaiser et al. 2017). Inside the planetary boundaries that define a safe operating space for humanity, ‘sustained’ growth, with unmodified production and consumption patterns, is not compatible with sustainability. The concern was made evident already more than forty years ago. The first Report to the Club of Rome, insisted on the existing “Limits to growth” and called for “the initiation of new forms of thinking that will lead to a fundamental revision of human behaviour and, by implication, of the entire fabric of present-day society” to avoid “the tragic consequences of an overshoot” (Meadows et al. 1972:185-196). The rapidly approaching global crisis forecasted some fifty years ago based on mathematical models was recently confirmed based on more solid data (Turner 2014).



Colonia Landivar, Guatemala City, Guatemata. Photo: Steven dosRemedios/flickr, C BY-ND 2.0

Despite good intentions, achievement of SDGs seems to step every year further away: "At the current pace, around 500 million people could remain in extreme poverty by 2030. Global hunger is on the rise. Violent conflicts, climate change, gender disparities, and persistent inequalities are undermining efforts to achieve the SDGs." (Steiner 2019)

Pursuing equity and the sustainability of "health for all", "leaving nobody behind", without leaving behind the current hegemonic economic growth paradigm, is a goal of unbearable lightness. Ingenuity or surreptitious, rhetoric discourse to avoid the indispensable societal change?

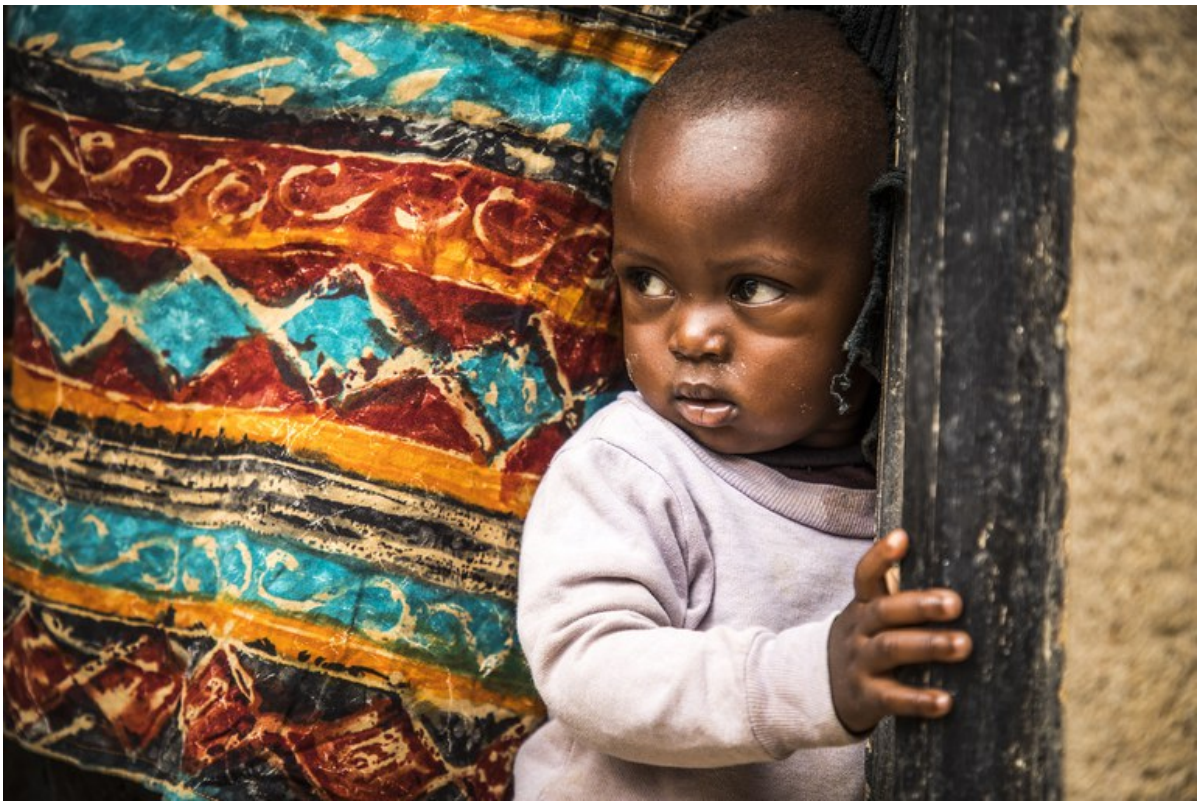
Among the nine health targets of SDG3, Universal Health Coverage (UHC) is considered "the centrepiece … This is the one target that, if achieved – or let's say when achieved – will contribute to all the others" (Ghebreyesus 2018).

Despite the challenge of sustainability, being global, national health systems will be confronted with it based on very different socio-economic conditions and expectations of their populations, although all facing global power and processes that may seriously undermine success.

The acceleration of globalization and the hegemony of the neo-liberal ideology led to the progressive deregulation and liberalization of trade regimes, to extensive privatization and scaling back of the State. These processes have intensified the commodification and commercialization of vital social determinants such as health and social services, water and electricity. Unhealthy products are aggressively marketed by global industries (tobacco, alcohol, pesticides and other chemicals, processed foods and beverages, etc.). Environmental deterioration is also a result of the dominant economic model, which also heavily influences labour and working conditions (CSDH 2008).

Health no longer depends solely on the specific situation of the country where people live but is largely determined by global forces acting outside the control of individual states becoming an issue of foreign policy, global security, international trade, overall sustainability of development, democratic governance and human rights (McInnes and Lee 2013).

The sustainability of SDG 3 and its "centrepiece" UHC may be usefully analysed using health systems' "building blocks" and their interaction with global determinants as a framework. The analysis also suggests some elements toward the indispensable systemic change.



DRC: A Trip to the Front Lines of the Fight Against Ebola. Photo: World Bank Photo Collection/flickr, CC BY-NC-ND 2.0

Health systems' functions

Based on the approach proposed by the WHO (2000; 2007; 2010), the core objectives of health systems, are:

1. protecting and improving the health of the population they serve and reducing health inequalities;
2. responding to people's non-medical expectations and enabling participation in decisions that have an impact on their health and health systems;
3. protecting individuals from the risk of financial hardship due to the costs of health services through risk pooling mechanisms, ensuring fairness for individual contributions and equity in access to services (i.e. access to and coverage for effective health interventions according to needs) and
4. ensuring the best use of available resources to reach the aforementioned three objectives.

While the latter three objectives are specific to the healthcare system. The attainment of the first objective relies only partially on healthcare and requires to extend action and even our understanding of a health system, to a system for health, i.e. a beyond "activities whose main purpose is to promote, restore and maintain health" (WHO 2000), to include all those policies and activities that have an impact on human health, thus challenging also the healthcare system, as it will be discussed below.

To reach their goals, healthcare systems rely on four functions, not all under the direct responsibility of the health sector (WHO 2000): a) leadership and governance; b) the generation of human, financial, physical and technological resources; c) collecting, allocating and pooling of financial resources, and d) delivery of personal and non-personal health services. The WHO Health Systems Framework summarizes health systems components with six "building blocks" (WHO 2007), capturing information as an additional cross-cutting function of increasing importance in supporting the overall functioning of the system. However, the six building blocks do not alone constitute a system; the system is the result of the multiple interactions among the blocks, with the people at its centre (WHO 2009).

It is generally accepted that universal access to quality care plays an important role in the improvement of population health and the reduction of health inequalities. In this sense, universal coverage is considered to be a particularly well-suited objective to address the complexity of the challenges facing health services (Franklin 2017).

It is well known that "health systems are subject to powerful forces and influences that often overwhelm the rational formulation of policies" (WHO 2010). Among others "these forces include a disproportionate focus on specialist care, fragmentation into a multiplicity of competing programmes, projects and institutions, and the pervasive commercialisation of health care into inadequately regulated systems" (WHO 2010).

Indeed, health-care systems' efficiency (appropriate use of resources) and effectiveness (achievement of objectives) and ultimately sustainability, are put to the test by many forces and phenomena, i.e.- determinants, which also require interventions and policies that are located outside the health system and often beyond the exclusive control of national authorities.

Determinants that affect the steering and governance function

Multiple domestic, international and transnational forces influence national health policies. Weaker states and economies are more susceptible to such influences and less prepared to deal with them. An example of such influences was the indebted countries' forced adoption of Structural Adjustment Plans (SAPs) in the 1980s, under the auspices of the international financial institutions leading to the dismantling of universalist health systems, fragmentation, privatization and commercialization of health services and the introduction of user fees (Missoni et al. 2019) Similar macroeconomic measures have been imposed more recently by international and supranational bodies also in more advanced economies affected by the economic crisis, causing the impoverishment of large sections of the population (Kondilis et al. 2013). Ideologically mandated "rigorous" one-fits-all austerity policies impose social expenditure "cuts", including on salaries, maintenance costs and investments (Geddes 2018). Where an explicit privatization of health services would inevitably cause social unrest (e.g. in the case of countries with well-established "Beveridge Model" National Health Services), progressive cuts on the budget of public services, respond to the undeclared purely political objective of promoting the privatization of services, to the benefit of private capital (Geddes 2018) in a veritable "assault on universalism" (McKee and Stuckler 2011).

In Official Development Assistance (ODA) recipient countries, health policies and priority setting are strongly influenced by earmarked resources and donor conditionality, which often do not take into account the priorities and needs of partner countries and may foster inequities (Biesma et al. 2009). Moreover, the steady increase in the number of public and private aid actors and their profound diversity in strategies and procedures, in the absence of recognized alignment and harmonization strategies (OECD 2005), further contribute to making aid fragmented, unequally distributed, inefficient and ineffective, and even counterproductive as it may generate an unsustainable administrative burden on already weak, resource-poor institutions.

The promotion of equity in health starts with prioritizing health, or at least avoiding negative impact on people's health and wellbeing in all public policies (economic, industrial, agricultural, social, etc.). It is not acceptable to sacrifice environmental quality and population's health, for the sake of economic goals. Policy-makers at all levels and in all sectors should be aware and made accountable for the impact of their decisions on people's health. To counteract forces that interfere with health systems' governance a solid alliance is required between public authorities and civil society organizations that at all levels - local, national, supranational, and global – pursue public interest and are committed to the common good. At global level the WHO should be re-empowered and use all its authority to push public health needs and priorities also on the political agenda of other sectors and initiatives, e.g. in trade negotiations, both at global and regional level (Missoni 2015).

Determinants that affect the resource generation function

Several global determinants influence the generation of human, technological and financial resources that health systems need for their proper functioning.

Human resources

Health workers are possibly the most important asset of health care systems. Shortage and inadequate competence seriously challenge healthcare systems sustainability and are strictly interrelated.

The inadequacy of health workers training in relation to the needs of the population, is a longstanding issue. With a few exceptions medical faculties continue to follow a bio-medical approach, leading to 'hospital-centrism' at the roots of the failure in achieving the health for all goal (WHO 2008), and functional to the reproduction of the consumeristic, marketized and globalized social model (Stefanini 2014). Practice in medical studies is mainly based on the observation of an hospitalized individual in a "horizontal" position, a "patient" in bed (Missoni 2018) and in a context too often socially and/or culturally alien to the social reality in which people in their countries "are born, live, work, grow old and die" (CSDH 2008).

The standardization of skills and learning objectives (specialization, high complexity, technological sophistication, etc.) respond to healthcare models that are scarcely sustainable even in middle-high income countries, and elsewhere are accessible only to high-income population groups. Besides producing health workers who are incapable of "usefully becoming part of an urban or rural community, of taking care of it, of understanding the problems of its illness and of defending its right to health" (Maccacaro 1971), such an approach tends to produce "export" health personnel. Indeed, health workers and in particular doctors, who are not prepared and unmotivated to serve in their own communities, will seek (often unsuccessfully) elsewhere - first in the private sector and large urban centres, then abroad – the kind of professional integration that requires the skills, and meets the aspirations suggested in their medical studies and that respond to the globalized stereotype of the successful doctor, the mythical hero of most popular series (Missoni 2018). "Brain drain", is fuelled by "import" agencies from high-income countries lacking human resources, often bypassing the norms that some of those countries have adopted based on the WHO global code (WHO 2010a).

To address the shortage of health workers and their distribution, policies and investments should be reviewed in depth to align health workers competences (knowledge, experience, motivation, values) to the context and needs of the population they are intended to serve.

Health workers curricula need to be radically rethought, moving the primary focus on health determinants and consistently linking teaching, methodology, technology and experience, to local realities. Solidarity with people most in need and commitment to service should inspire and orient health workers throughout their studies and later their profession.

Biomedical and technological resources

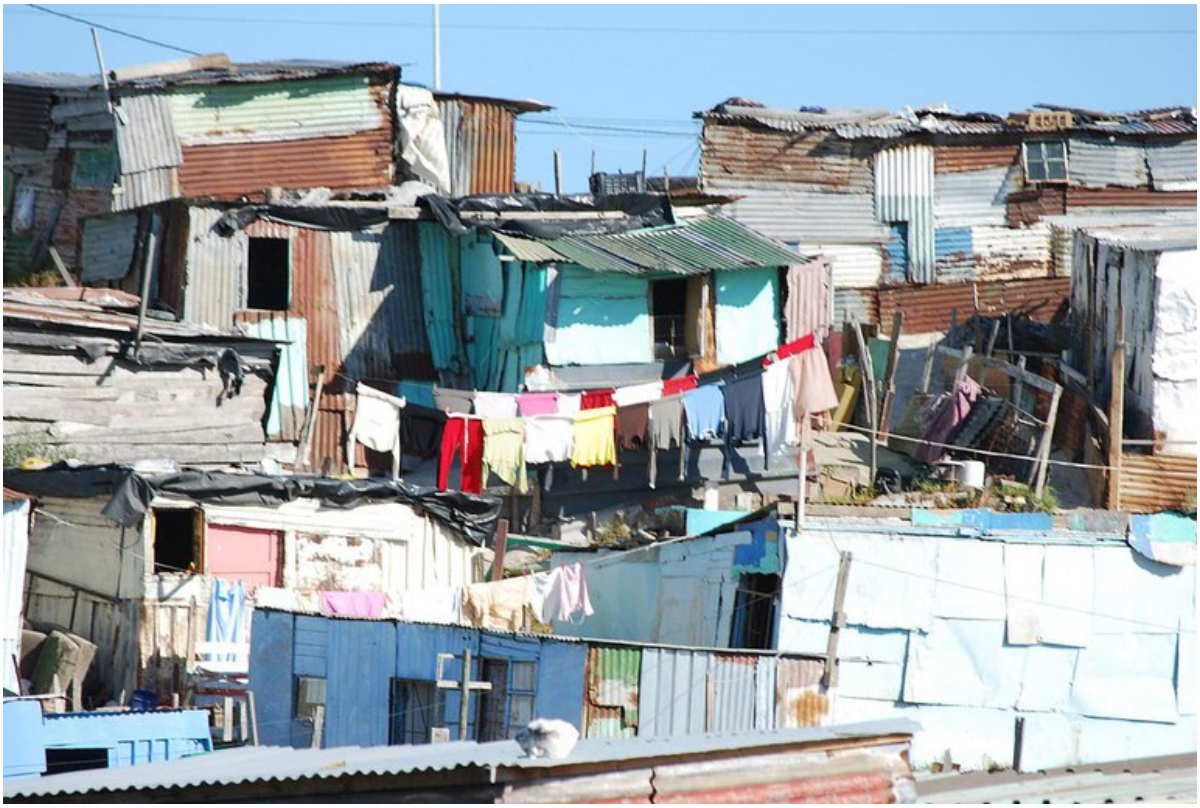
The generation of biomedical products and devices (Research and Development (R&D)) is essentially in the hands of the transnational corporate sector, which invests only if a – sometimes disproportionate - Return on Investment (RoI) can be predicted, without taking into account health needs and health burden. Between 2000 and 2011, only 1% of the new active ingredients on the market were for neglected diseases (Pedrique et al. 2013).

Research and development of technologies should reflect population health problems and needs, rather than being left to the logic of the market. The market has the ability to influence consumption, but in return the consumer may influence the market. In the health sector, the main consumer is often the State. Thus, governments have an enormous responsibility in orienting and regulating consumption according to real needs and cost-effective approaches. In many contexts the support to the development, systematization and promotion of natural therapies and holistic approaches may highly contribute to the sustainability of health care.

Financial resources

Countries' macroeconomic framework (including the quality and effectiveness of their fiscal system) determines their capacity to generate financial resources for health. Weaker economies have greater difficulty in bearing the costs of their healthcare systems and are those most exposed to financial crisis and to the imposition of international provisions. In addition, they generally suffer of weak and inequitable fiscal and social protection systems, while redistribution through social protection and progressive general taxation, are prerequisite for equitable and universal access to health services.

In poorest countries health services are largely dependent on development aid resources. Unfortunately, external financing is often volatile and unpredictable, making planning impossible; funds are often tied to particular activities or diseases, are detached from local needs and priorities and use autonomous management procedures leading to reduced efficiency and increased transaction costs (Missoni et al. 2019).



Khayalitsha township, Cape Town, South Africa. Photo: Jason & Molly Kehrer/flickr, CC BY-NC-ND 2.0

Determinants affecting the financing of the system

There is a correlation between the increase in health spending and increased life expectancy. However, above a spending threshold of about 75 US dollars per capita that relationship becomes unpredictable and improvements in health outcomes depend mainly on the efficiency of the system (how money is spent) and on political choices related to social solidarity and equity (Savedoff et al. 2012).

In the same way, beyond a certain threshold of GDP per capita, economic growth is no longer correlated to health outcomes; rather, it is the inequality in the distribution of income directly correlates to disease burden. The efficiency of health care systems largely depends on how funds are collected, allocated, pooled and finally used for the purchase of services. Inequity is a structural characteristic of healthcare systems with insufficient allocation of resources, absence or limited use of advance payment mechanisms and dependence on inherently regressive out-of-pocket payments of services. Every year more than 100 million people end up in poverty as a result of direct spending on health care (Haider and Nibb 2017); when in need, people without guarantees of access to care tend to turn to the much more expensive hospital emergency services.

Systems based on the private coverage and insurance market are the most inefficient, with the sharpest increase in both public and private health expenditure (Unger and De Paepe 2019; Geddes 2018), which obviously makes that approach the less sustainable one.

Private insurance systems also promote overdiagnosis and induce health consumerism, without benefits for the public sector even in terms of waiting lists reduction, use of services or costs reduction. Costs control is much more problematic in systems where different providers compete, let alone the negative impact on the equity of the system (Geddes 2018; Stendaam et al. 2019).

To increase efficiency, reduce inequalities and promote equity, it will be mandatory to reduce systems' fragmentation, merging collecting institutions, and above all pooling risk as widely as possible across the population (Evans and Antunes 2011). Stepping away from healthcare privatization policies is essential to reduce inequality and costs, increase quality, efficiency and public control, and optimize the use of health workforce (Stendaam et al. 2019).

Adequate, context-specific managerial approaches, processes' simplification, reduction of administrative complexity, proper monitoring and reduction of waste, will all contribute to health systems' efficiency and effectiveness (Geddes 2018). In this sense, unified national health systems allow considerable economies of scale and greater efficiency in terms of planning, procedural and technological standardization, and centralization of procurement.

In countries where external aid plays a significant role development assistance should be more predictable (with long-term commitment), less fragmented and respectful of well-known principles of aid effectiveness (ownership, alignment and harmonization) (OECD 2005).

Determinants that affect the service delivery function

Ensuring that health-care offer meets demand is the greatest challenge that health systems are increasingly facing to provide sustainable universal access.

The steady increase in the world's population and its progressive ageing, with its corollary of chronic and multi-morbidity diseases are among the main causes of increased demand for health services. Between 2015 and 2050, the proportion of the world's population over 60 years of age will almost double from 12% to 22% (WHO 2018).

Health of elderly people is heavily influenced by social, economic and environmental determinants, including the quality of food, housing conditions and the consistency of family and community networks, as well as by life experiences since early childhood. Thus, the social determinants that affect young people today, will influence the type and frequency of diseases in the coming decades. Complex multimorbidity geriatric syndromes, lead to a greater demand for health care and require totally new care approaches (WHO 2018).

The considerable increase in the global burden from chronic diseases cannot be attributed exclusively to the ageing of the population. In fact, it affects all age groups and almost all countries, with a much greater impact in poorer countries which are experiencing an epidemiological transition with a double burden of disease, i.e. both infectious and chronic non-communicable diseases. Three quarters of deaths from chronic diseases are recorded in low- and middle-income countries (Haider and Nibb 2017).

An "epidemic" of chronic diseases, especially heart disease and cancer, observed since Second World War, clearly parallels the globalization of western societal and lifestyle model and its constant increase in consumption. Faster, resource intensive, highly contaminant production, transformation and distribution cycles, inexorably destroy natural resources, increase pollution of soil, water and air, and are at the roots of climate change, with dramatic impact on populations' health and increase in health care expenditures. Aggressive market strategies further push consumption of harmful food (processed foods with added sugar, salt, preservatives and colorants; high-calorie drinks, etc..), alcohol and tobacco, and other unhealthy or otherwise potentially harmful consumer products (such as home and personal care), which all contribute to the dramatic increase of chronic diseases such as obesity, metabolic diseases (first of all diabetes), respiratory diseases, cardiovascular, neoplastic, as well as neurodegenerative and mental illnesses. Packaging and its mostly unsustainable disposal close the cycle. Microplastics in the food-chain are just one of the latest concerns about the impact of waste on human health (WHO 2019).

With the externalization of social and environmental costs - diseases and environmental degradation – companies increase their RoI while impoverishing community and to health systems.

Future generations may pay an even higher price, besides environmental depletion. Many widely disseminated pollutants have been shown to produce epigenetic changes transmitted from one generation to the other (Skinner et al. 2010).

Besides increasing the unequitable condition of inaccessibility, ongoing commodification of water is the subject of growing concerns in relation to water security, as well as quality and water-related diseases, (Brisman et al. 2018).

Mental and relational pathologies (depression, suicide), and physical pathologies deriving from the use of new technologies (reduced physical exercise, pathologies of postural origin) are associated to globalized changes in lifestyle, including excessive use of electronic devices (WHO 2015).

The direct and indirect impact of the ever-increasing global exposure to electromagnetic fields on human health is widely underestimated and is a matter of increasing concern calling for adopting strict precautionary principles (Bortkiewicz 2019).

In the long term, the reduction in demand due to chronic diseases can only derive from interventions on systemic determinants, for example through laws and regulations that impose the internalization of the social costs of production cycles, practices, services and products that are harmful to health, rather favouring the accessibility (wide availability, lower costs, etc.) of healthy products and services. Unfortunately, this type of interventions clash with strong interests and requires considerable courage and political will. Health education campaigns aimed at promoting the change of individual behaviours (stop smoking, reduce the consumption of alcohol or sugar, do more exercise, consume healthy food, etc.) are an easier alternative (politically and socially less problematic), considerably less effective, though (Swinburn et al. 2011). At the local level, changes in consumption patterns and behaviour can benefit greatly from the initiatives of single groups and communities. Instead, at a global level only a strong connection through national and transnational networks of civil society, and alliances between those and international institutions, first of all the WHO by mandate "the directing and coordinating authority on international health work", will generate the necessary alliance to combat the "globalization of unhealthy lifestyles" and oppose "the commercial interests of powerful economic operators" (Chan 2013).

Ageing and the growing burden from chronic diseases also calls for a rethinking of the model of care and even of socialization, which can be implemented in the short to medium term.

In general, the focus must be shifted from treatment to primary prevention, from the hospital (or care institution) to the community where the disease originates, improving the living and working conditions of the population (housing, workplace, public spaces, transport, recreational and sports facilities, etc.).

Health care must be re-focused on communities and people-centred. Holistic - rather than “selective” - Primary Health Care remains the strongest pillar for “health for all”. Primary care must link the community to the rest of the health care system, which should be able to appropriately provide complexity and intensity of care according to the level of care. The health care system should link to community social networks (volunteering, self-help groups, self-managed centres, etc.) and involve the patient as an active player in the care processes (Wagner et al. 2001).

The integration of natural, traditional and complementary medicine (TCM) into national health systems could also contribute to pathways toward UHC and should be seriously and openly considered (Lee Park and Canaway 2019).

Extended families, life-communities, the sharing of living spaces (co-housing) offer opportunities to reconsider intergenerational experiences of solidarity, which are valid alternatives to hospitalization and institutionalization of people with reduced autonomy, including disabled and elderly people (Missoni 2015).

Today the connection between primary care and higher level of complexity may take advantage from new information and communication technologies (e-health, m-health, big-data, social networks, etc.), however these also require guidance, regulation and organization within the health system for their optimization. The digital revolution of the health system is in fact a "Tsunami" directed by "numerous, powerful and intelligent forces and actors" with an "immense thirst for technological and economic conquest" (Comptesse 2017). Health systems are not prepared to face the challenge. Due to its transnational dimension, response needs a phenomenal commitment to global analysis and direction. In general, a system approach to new information and communication technologies is still missing almost everywhere and the projects described in the literature generally refer to pilot experiences, while systematization seems to be lacking. The WHO itself states that: "In order for e-health to play a full role in supporting health systems to achieve universal health coverage, a solid legal framework is needed" which is obviously still missing (WHO 2016).

Demand of health services is also induced through Big Pharma’s market strategies. Through disease mongering strategies, i.e. creating patients, offering a distorted perception of the severity of a condition or presenting as pathological a physiological condition, pharma industry induces unnecessary consumption of drugs, contributing to the increase in health expenditure (Doran and Henry 2008).

Many new pharmaceutical products placed on the market do not offer significant therapeutic advantages, while the global system of protection of intellectual property rights (IPR) may contribute to price increases and reduced access to medicines and vaccines (Smith et al. 2009). Speculation rather than R&D costs determine the prices of new drugs offered on the market. In addition, “evergreening” of pharmaceutical patents - introducing minor changes and formulations that

allow for extension of the length of the exclusivity period beyond the legitimate patent term - seriously challenges the access to affordable drugs as it delays the generic competition without improvement in the efficacy of the already patented drug (Abbas 2019).

The global expansion of the Internet has additional impacted on the increase in health demand. Social networks represent an easily accessible market of hundreds of millions of users through direct-to-consumer advertising of improper or illegal use of, often counterfeit medicines with considerable health risks and an inevitable increase in health expenditure. Online interaction now allows legal restrictions to be violated everywhere (Liang and Mackey 2011). Interventions aimed at controlling the impact of internet mediated activities on health and health consumption necessarily require international synergies. National laws are easily circumvented on the web, making global measures urgent (Liang and Mackey 2011).

Increased demand may also come from within the health care system. For example, the health care system is one of the causes of the spread of antibiotic resistance, although 80% of antibiotic consumption happens in the livestock industry. Return to pre-antibiotic era is not an improbable scenario (IACG 2019).

Over-prescription is another cause of increase in health care costs. The abuse of medicines, technologies and services, including ineffective or inappropriate, is also linked to the culture and choices of prescribers (often under the marketing pressure of manufacturers and pharmaceutical representatives); patients' requests (induced by misleading and increasingly pervasive advertising); conflicts of interest; levels of care fragmentation leading to repetition of clinical investigation; and remuneration criteria for facilities and professionals (Geddes 2018).

In the health sector "the increase in supply generates demand" (Geddes 2018), particularly in the absence of control mechanisms and in health systems mainly based on private care. Particularly in developing countries, governments are mostly in control only of the public sector and are not able to create appropriate mechanisms to regulate private sector's activities and performance.

Secondary prevention (i.e. screening and early detection) programs offered by health services are of great importance. However, policy decisions should always consider risks in terms of safety, effectiveness and possible risks. Geddes (2018) for example warns against "periodic check-ups", which are often promoted as part of well-designed market strategies of the biomedical industry, but have "no effect in reducing diseases and deaths from either cancer or cardiovascular disease", rather leading to an increase in diagnoses and "incidentalomas" with consequent risks related to further for investigation.

While technological innovation can contribute to more accurate diagnoses and better therapeutic responses, it is not always real progress and can create sustainability problems. New bio-medical technologies are introduced responding to companies' RoI and do not necessarily bring a real therapeutic advantage. The health sector is also often a prey to "planned obsolescence" as a market strategy for manufacturers to induce the replacement of equipment with new models that bring nothing substantive in terms of diagnostic or therapeutic results; instead they create dependence on accessories and consumables (Rosenthal 2014). What is too often lacking is good management of existing technology and an adequate maintenance culture, an often-forgotten aspect in infrastructural and technological aid projects in low income countries.

Finally, in many countries, healthcare management is substantially inspired by theories and practices adopted in culturally, economically and technologically distant countries. Management and governance systems are often imposed from above and are not consistent with the local context, while the "western" model, dominated by neoliberal market-oriented policies, has become the universally adopted standard (Fattore and Tediosi 2011). With resources being taken away from the public system to the advantage of the private system, important sections of the population are excluded from access to both curative and preventive care (UNRISD 2007).

Health priority in all public policies - is the challenge too big?

The achievement of the universal and indivisible SDGs set with Agenda 2030, represents a considerable challenge also for health systems worldwide.

UHC is a central goal for the health sector in the wider context of SDG3, intimately linked to equity in health. However, the feasibility and the sustainability of universal coverage is heavily dependent on the intertwined action of multiple and diverse forces and determinants acting at various levels, with global determinants playing an enormous role. Thus, pursuing "health and wellbeing for all at all ages" will require strong intersectoral collaboration and pushing the health priority into all public policies; success of Agenda 2030 undoubtedly rests on the respect of the principle of indivisibility of the SDGs.

Wide disparities in wealth, health and life conditions are also the outcomes of a prevailing neoliberal market civilization capitalist development model, involving accelerated, energy-intensive production, consumption and distribution systems.

Global societal structures and processes that perpetrate the hegemonic, unfair, environmentally and socially unsustainable market civilization model of capitalist development, which measures its success on economic growth and competitiveness, without caring for social and human costs, nor considering the impact on the ecosystem, are incompatible with equity in health or in any single domain of human life (Gill and Benatar 2019).

Updating the known Hobbesian observation, we could say "Homo homini … et naturae … lupus". Evidence shows that earth-system's tipping points are real and the tragic consequences of the overshoot of those limits are already before us.

Little time (if any) is left for a drastic paradigm shift toward a more inclusive, cooperative, equitable, ethical and ecological human society which may allow truly sustainable development, and with it "health for all at all ages".

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