

Forum: General Assembly 3 (GA3)

Issue: Promoting basic healthcare for all

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Introduction

Although health has been officially recognized as a right since the World Health Organization (WHO) was created in 1946, access to basic healthcare remains uneven across and within countries, with many regions, such as those that are geographically isolated or economically challenged, unable to access even the most basic healthcare services. ([WHO, 2022](#))

The issue of promoting basic healthcare for all is fundamentally linked to the global failure to achieve universal health coverage (UHC). Universal health coverage is a broad policy goal. As defined by the WHO, it means that all people have access to the full range of quality health services they need, including prevention, treatment, rehabilitation, palliative care, and even health promotion, without facing financial hardship. However, as aforementioned, the international community has not yet achieved the goal of universal health coverage. This then leaves, currently, 4.6 billion people, which is over half of the world's population, without access to essential medical services, and 2.1 billion people experiencing financial hardship due to health-related concerns. ([WHO, 2025](#))

To achieve basic healthcare for all, preventing financial hardship alone is not enough; however, access is also shaped by infrastructure, geography, workforce shortages, weak governance, conflict, low health literacy, and substandard or falsified medicines.

This is a significant matter of international concern; these issues compound one another across borders. For example, a corrupt system or an under-resourced government in one state can allow counterfeit medicine to be trafficked across borders or let disease outbreaks go unchecked, with effects that reach its neighbours, and armed conflict generates problems extending far beyond the state in crisis.

Definition of Key Terms

Basic Healthcare

Basic healthcare refers to a standard, foundational set of services meant to protect the health and well-being of a population, giving everyone a functional level of health throughout their lives. This typically centers on services such as maternal and child health services, vaccinations, and treatment for common infectious diseases, which provide a baseline entry point into the broader health system. ([Biology Insights, 2025](#))

Primary Health Care (PHC)

PHC stands for primary health care—the most basic package of essential health services and products needed to prevent disease, promote health, and manage illness. ([PATH, 2019](#)) Primary Health Care and basic healthcare are closely correlated; the key difference is that primary healthcare is much broader, while basic healthcare is a narrower set of essential clinical services.

Universal Health Coverage (UHC)

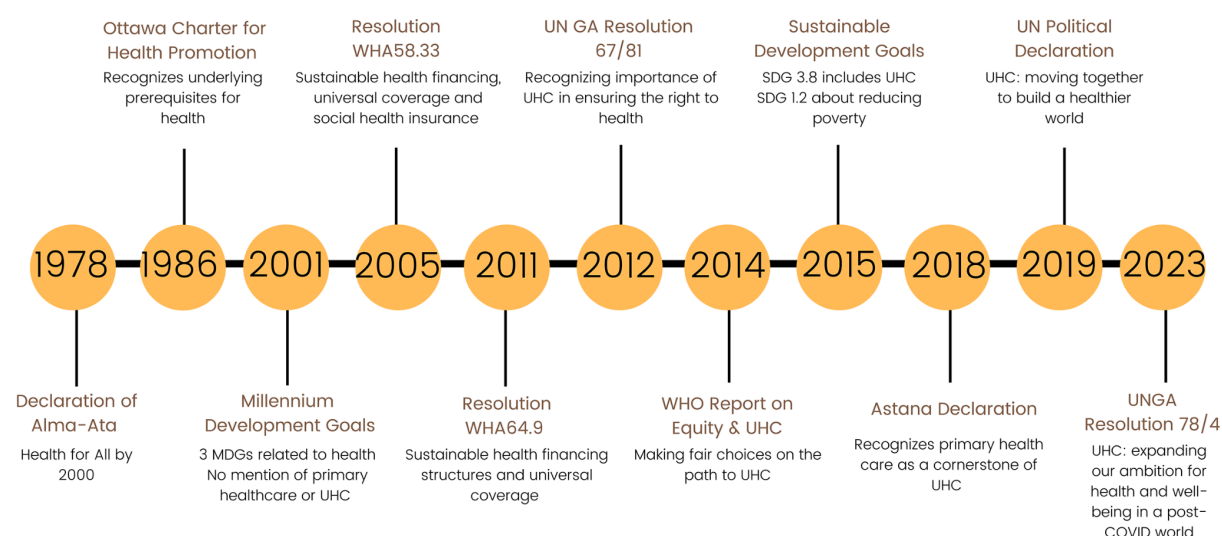
Promoting basic healthcare for all is fundamentally tied to universal health coverage. Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. ([WHO, 2025](#))

Substandard and Falsified (SF) Medical Products

Substandard products are authorized medical products that fail to meet either their quality standards or specifications, or both. Falsified products are medical products that deliberately or fraudulently misrepresent their identity, composition, or source. ([WHO, n.d.](#))

Background Information

Global Commitments

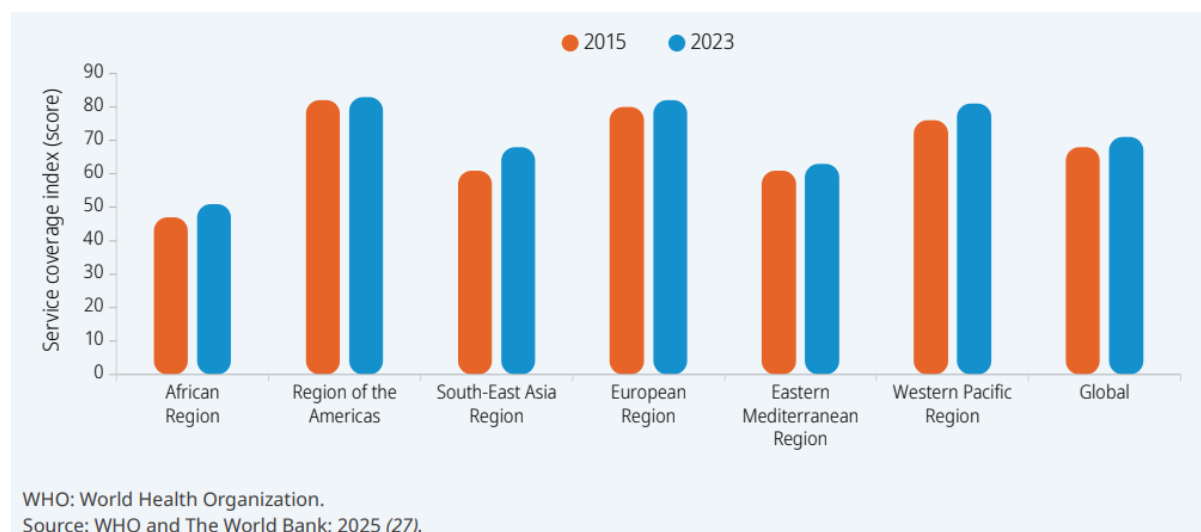


Timeline of UHC-related events (Foster, 2025).

Promoting basic healthcare for all traces back to the 1978 Alma-Ata Declaration. Within the declaration, it highlights the inequality between developed and developing countries; it also first initiated the movement of “Health for All”, which is a global goal that aims to ensure that all people can achieve a level of health that allows them to have an economically and socially productive life. This commitment was later reaffirmed by the 2018 Declaration of Astana and further reinforced by Sustainable Development Goal Target 3.8 in 2025, which strengthened primary health care as a cornerstone for universal health coverage and established universal health coverage as an international benchmark,

respectively ([World Health Organization and UNICEF, 2018](#); [UN](#)). The throughline connecting Alma-Ata, Astana, and SDG 3.8 is rather significant, as each successive commitment has narrowed the distance between a general principle and an actually operational goal or mechanism. This suggests that the impediment to basic care is not an absence of consensus, but rather a failure of implementation capacity.

Uneven Progress Within National Averages



Universal health coverage service coverage index, globally and by WHO region 2015 and 2023; score is composite WHO/World Bank score built for SDG indicator 3.8.1 ([WHO](#))

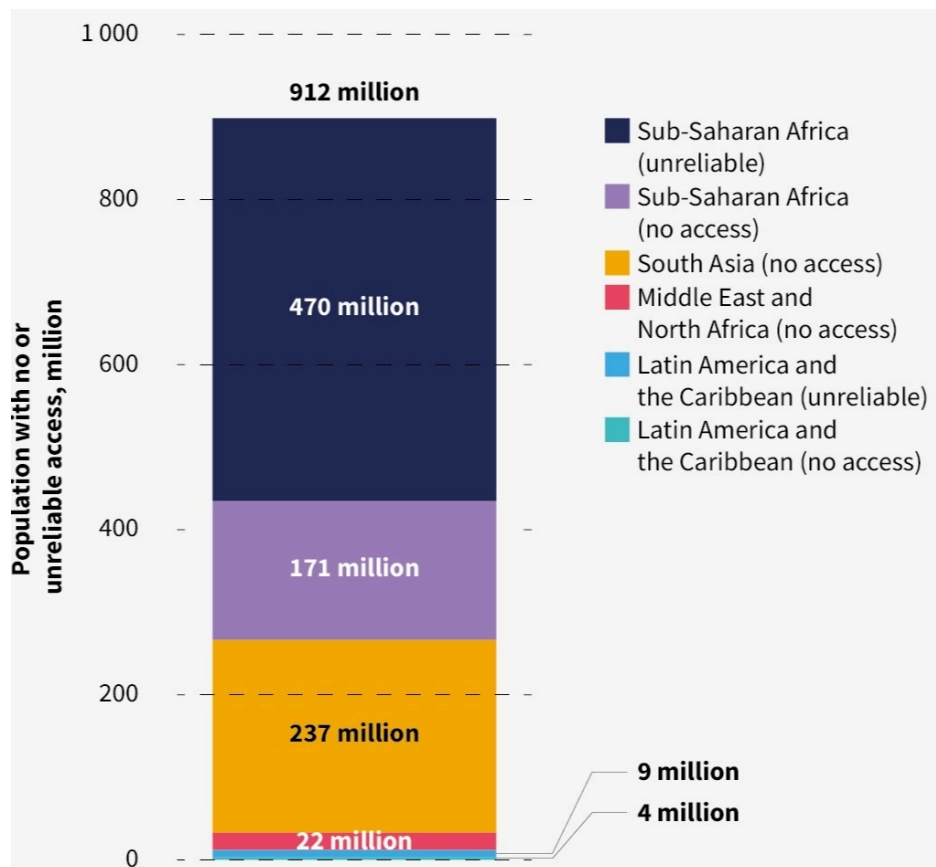
National healthcare coverage data, although informative, can sometimes be misleading and obscure substantial disparities. The universal health coverage service index (the index is scored from 0 to 100, where 100 represents full coverage of essential health services) rose only slightly, from 68 to 71 between 2015 and 2023, a pace that, if extrapolated, would not reach the 2030 target ([WHO, 2026](#)). Yet, even more alarmingly, three in four individuals within the poorest socioeconomic group experience financial hardship due to health costs, compared with fewer than one in twenty-five among the richest ([WHO, 2025](#)). This implicates a disparity that national averages alone fail to disclose, and one should consider the differences in income, location, and demographic groups when evaluating healthcare coverage so that overall progress does not hide inequalities.

Financing Pressures and Responses

Global health financing, from 2025, entered a period of pressure and constraint, mainly caused by a lack of donor contributions and contraction of national budgets. In response, the WHO's Civil Society Commission held discussions throughout 2025-2026 to promote an "Economics of Health for All" framework, which essentially says that healthcare is an investment rather than a cost ([WHO, 2026](#)). Whether finance ministries accept this idea remains uncertain, and the continued lack of funding despite these efforts shows that changing how healthcare spending is viewed is not enough in the absence of fiscal

commitments.

Infrastructure Challenges



Estimated population, based on region, with no or unreliable access to electricity 2015-2022. (WHO, 2023)

Financial reform is not enough to operate a functional clinic; you also need infrastructure. Only 50 percent of hospitals in sub-Saharan Africa possess reliable electricity, and approximately 1 billion people worldwide depend upon facilities with no or unreliable power. (WHO, 2026)

Geographic Exclusion: The “Last Mile”

Rural communities isolated by inadequate roads, absent bridges, seasonal flooding, etc., remain confined to what practitioners call the “last mile”. This makes it difficult for them to access basic healthcare even when national healthcare programs are available to them. (NLM, 2022)

Workforce Shortages

Universal Health Coverage is only effective when there is personnel to practice healthcare. WHO’s 2026 workforce records reveal a global shortage of up to 11 million workers by 2030, concentrated disproportionately in the very rural regions with the most acute infrastructural deficits. (WHO, 2026)

Corruption and Substandard Medicines

Even if all the aforementioned criteria are met, deficient governance may obstruct the

delivery of healthcare to patients. Transparency International estimates that \$560 billion, roughly 7 percent of global health expenditure, is lost annually to corruption and fraud. ([Transparency International UK, 2025](#)) Alongside weak governance, a related threat is the circulation of substandard and falsified medicines: WHO estimates that at least 1 in 10 medical products in low- and middle- income countries fail quality standards, and countries spend an estimated US\$ 30.5 billion per year on substandard and falsified medical products. ([WHO, 2024](#))

Conflict

Conflicts around the world remain one of the most severe disruptors of basic healthcare. Take, for example, Sudan's civil war, which has left more than a third of health facilities non-functional, with 20 million people requiring health assistance ([UN News, 2026](#)). In Gaza, more than 18,500 WHO-approved patients remained stranded, awaiting medical evacuation as of early 2026 because transfer routes were closed ([UK Parliament, 2026](#)).

Previous attempts at resolving the Issue

The UN made UHC SDG Target 3.8 in 2015, and then reaffirmed it in 2019 and 2023. WHO's UHC Partnership now operates in over 125 countries ([WHO, 2026](#)). Regionally, the African Union's 2001 Abuja Declaration pledged 15% of national budgets to health; Nigeria's 2026 budget allocated roughly 4.2% ([Premium Times Nigeria, 2026](#)), and Liberia's allocated 8.4% ([AllAfrica, 2025](#)).

Organisations and Major Countries Involved

WHO (World Health Organization)

The WHO is responsible for UHC targets and, through its Global Surveillance and Monitoring System, tracks substandard medical products and infrastructure gaps worldwide. ([WHO, n.d.](#))

Sudan

There is currently an ongoing civil war, which has rendered more than a third of the country's health facilities non-functional, leaving 20 million people in need of health assistance.

Yemen

More than a decade of conflict and severe underfunding has left over twenty million Yemenis without access to basic medical care, with at least 50% of health facilities entirely non-functional. ([Al Jazeera, 2026](#))

Chad

The physician-to-civilian ratio in Chad stands at a mere 0.09 per 1,000 people, 96% below the global average, reflecting one of if not the most severe health workforce shortages of any country in the entire world. ([WorldStats, 2026](#))

India

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, the world's largest publicly funded health insurance scheme, was expanded in September 2024 to cover all citizens aged 70 and above regardless of income. ([Vajiram and Ravi, 2025](#))

Possible Solutions

Strengthening Domestic Health Financing

Member states should commit to binding domestic health financing targets and prepaid insurance mechanisms to reduce reliance on volatile donor aid and out-of-pocket spending. Reframing health expenditure as long-term investment rather than a cost could help sustain funding even during fiscal contractions. These targets could be incorporated into existing accountability mechanisms, such as WHO's UHC monitoring framework. Binding commitments could be made through regional agreements or conditional financing arrangements, where continued access to development funding is tied to meeting agreed spending benchmarks.

Close the Infrastructure Gap

States and international partners should direct a greater share of investment toward underserved rural facilities rather than urban centers. More economically developed countries could also support less economically developed countries.

Reaching the “Last Mile”

Mobile outreach clinics and community health workers embedded within villages can extend services to communities isolated by poor roads, seasonal flooding, or other related events.

Addressing Workforce Shortages

States should adopt workforce planning that scales up community health worker training, paired with rural placement incentives such as housing support and loan forgiveness. Regional training partnerships can help ease shortages.

Improving Governance and Medicine Quality

States should strengthen surveillance systems and national regulatory capacity to detect substandard or falsified medicines, alongside mandating transparent sourcing, which would close governance gaps. This would be achieved by requiring manufacturers and distributors to register medicines in a shared regulatory database and disclose supply-chain information, allowing products to be traced back to their origin. National medicine regulatory authorities, supported by WHO's surveillance programs, would be responsible for auditing suppliers and verifying compliance.

Protecting Access in Conflict Settings

Negotiated humanitarian corridors and enforceable protections for health workers and facilities can help sustain access as conditions deteriorate.

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