## The 2019 UN high-level meeting on universal health coverage

In their discussion of universal health coverage (UHC), the Editors (Jan 5, p 1)1 rightly state that "simply convening a UN high-level meeting is not enough" to achieve UHC. The Civil Society Engagement Mechanism for UHC2030 (CSEM) strongly agrees and is concerned that, without a radically different approach, the meeting will be a business-as-usual global health event. We are concerned that speakers at the high-level meeting on UHC on Sept 23, 2019, will declare support for UHC and leaving no one behind, but will not be held to account for their contradictory policies and actions. Bilateral and multilateral donors, and the intentions of the Sustainable Development Goals 3 Global Action Plan, will be applauded without scrutiny of stagnating aid that is tied to disease-specific priorities, thereby limiting the funding for and focus on primary health care. Participants will propose inclusion of the private sector without mitigating the inequality that the private sector drives.

UHC is far from reality for many countries, both in high-income and low-income countries, and especially for poor and marginalised citizens. The proportion of poor people spending too much of their household income on cash payments for health is rising, not falling.<sup>2</sup>

As the civil society constituency of UHC2030, the CSEM calls for this one-off opportunity of the high-level meeting on UHC to be truly transformative. The meeting must be able to document the member states' concrete, measurable commitments and their milestones and accountability measures. Member states must make commitments to increase public financing for health, raise progressive taxation, and eliminate out-of-pocket payments. Member states should also, on the basis of their commitment to

prioritise those left furthest behind,<sup>3</sup> make legal commitments to ensure that these populations are included in the planning, budgeting, and implementation of health services. Discussions should be held on specific changes that donors will make to support UHC and increased public financing, and ensure effective, adequate funding.<sup>4</sup>

The CSEM is calling on the high-level meeting co-chairs to request commitments, in advance of the meeting, that specifically address the gaps in achieving the Sustainable Development Goal 3-8 targets on coverage and financial risk protection. Learning from the Every Woman Every Child accountability process,<sup>5</sup> the commitments should be published in advance so that the national civil society can publicise them at country level and mobilise and empower citizens to hold their governments to account.

With just more than a decade until 2030, the upcoming UN high-level meeting on UHC needs to be the moment when change happens at the global, country, and local level for the millions of people still in need of essential health services. History must look back on this meeting as not just another moment when good things were said, but the moment when all actors changed their actions to achieve UHC by 2030.

We declare no competing interests.

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## Trend analysis of diabetic mortality

We read with great interest the Article by Edward Gregg and colleagues (June 16, 2018, p 2430).¹ Here, we note some of our concerns on the methodology.

First, age standardisation is widely used in epidemiological trend analyses to reduce the bias introduced by the variations in age distribution across different calendar years. We commend the investigators for their use of age adjustment, which, however, modelled an even distribution of the age groups in the population (unless data were already age standardised) and probably changed the reported population mortality rates. Age adjustment is valid for inferential analysis but is inferior to age standardisation in trend analysis. Considering the study period of 27 years (1988-2015) and the different age trends in the diabetes (no changes) and non-diabetes (gradually increasing) groups, we recommend analysis of age-standardised mortality rates based on the US standard population from the 2000 national census.

Second, insurance coverage,<sup>2</sup> poverty,<sup>3</sup> rural residence,<sup>4</sup> and geographic location were linked to diabetic mortality. These socioeconomic factors might contribute to the large variations in diabetes-related mortality, as the authors rightfully noticed. Most of these socioeconomic factors were indeed surveyed in the National Health Interview Survey and perhaps should be included in the analyses.

Furthermore, 3-year percentage changes are more sensitive in detecting turning points for different line slopes

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