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Promoting universal health coverage

Report[1]
Committee on Social Affairs, Health and Sustainable Development
Rapporteur: Mr Stefan SCHENNACH, Austria, Socialists, Democrats and Greens Group

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1. Reference to the committee: Doc. 15729, Reference 4734 of 26 May 2023.

A. Draft resolution[2]

1. Universal health coverage (UHC), based on the principle of “leaving no one behind”, is a central political commitment of the United Nations 2030 Agenda for Sustainable Development, and is the subject of target 3.8 of Sustainable Development Goal (SDG) 3. In the Pact for the Future adopted in 2024, the Heads of State and Government meeting at the United Nations General Assembly reiterated their commitment to redoubling efforts to achieve this goal.

2. Health is a political priority for the Council of Europe. As the Secretary General pointed out on the occasion of World Health Day (7 April), “Health is our most precious gift – and a top concern for all Europeans... Now more than ever, health care is about trust, safety and access – and this calls for a holistic approach... On this day, and every day, let us reaffirm that equitable, high-quality health care is essential to a healthy democracy.”

3. The objectives pursued in the field of health, both at global and regional levels, are based on a solid legal foundation for which there is broad consensus. The right to the highest attainable standard of physical and mental health, the right to protection of health and the right to social protection without discrimination are fundamental human rights, inseparable from human dignity and crucial for the effective exercise of all other rights.

4. The Parliamentary Assembly has already put this on its agenda in Resolution 2500 (2023) “Public health emergency: the need for a holistic approach to multilateralism and healthcare”. In that resolution, it recalls that primary healthcare is the cornerstone of UHC, providing prevention, health promotion, treatment and financial protection, and requires sustainable financing. In this context, since preventing and combating gender-based discrimination are essential, UHC must fully encompass sexual, reproductive, and mental health, as well as comprehensive care for victims of violence.

5. UHC is a strategic investment in sustainable development. It improves health outcomes, social cohesion, equity, gender equality and economic stability. It is recognised as an essential basis for global health security to withstand health, geopolitical, economic and climate crises. Despite this, progress towards UHC has stalled, with more than 4.5 billion people not fully covered by essential services, 2 billion facing hardship due to out-of-pocket health spending, and 344 million in extreme poverty due to health costs and worsening financial protection.

6. Although Council of Europe member States are making better progress than the world average, inequalities in access to healthcare and health disparities persist and are in some cases worsening. The Assembly stresses the urgent need to step up action to achieve target 3.8 of SDG 3 by 2030, by fully leveraging the 2024-2027 Strategic Framework of the UHC2030 platform, ahead of the next high-level meeting scheduled for 2027.

7. A leading advocate for the advancement of UHC, the Council of Europe makes a unique contribution based on human rights. Through its treaties – the European Convention on Human Rights (ETS No. 5), the European Social Charter (revised) (ETS No. 163) and the Convention on Human Rights and Biomedicine (ETS No. 164, “Oviedo Convention”) – it influences the social and public health legislation and policies of its member States. This holistic approach, centred on human dignity, combines the case law of the European Court of Human Rights and the European Committee of Social Rights, the efforts of the Steering Committee for Human Rights in the fields of Biomedicine and Health, the work of the Commissioner for Human Rights and initiatives by the Congress of Local and Regional Authorities. It is a crucial lever for making the right to health a reality for everyone, in line with the objectives of UHC and of SDG 3.

8. The Assembly recognises that the European Social Charter is the Council of Europe's key instrument for promoting UHC. Articles 11 and 13 of the Charter, interpreted in the light of the World Health Organization’s (WHO) definition of health, guarantee the right to protection of health for all persons present in the territory of the State Parties, regardless of administrative status. The case law of the European Committee of Social Rights reinforces this framework by specifying the positive obligations on States: to guarantee available, economically and geographically accessible, culturally acceptable and quality care, while ensuring effective access to essential healthcare. It also incorporates the social determinants of health (housing, energy, food), thus emphasising a comprehensive and integrated approach to UHC.

2. Draft resolution adopted unanimously by the committee on 4 September 2025.

9. The Oviedo Convention directly supports target 3.8 of SDG 3 by establishing the principle of equitable access to quality care, taking into account health needs and available resources. Building on this, Recommendation CM/Rec(2023)1 of the Committee of Ministers calls on States to provide equitable access to medicines and medical equipment, including in times of shortage, for people with serious health conditions. The Assembly also welcomes the efforts of the Steering Committee for Human Rights in the fields of Biomedicine and Health, which has made equitable and rapid access to medical innovations a strategic priority.

10. Against the backdrop of diminished political support, growing geopolitical tensions and budgetary constraints, the Assembly stresses the importance of conveying a clear, collective message that will galvanise support for UHC. The SDG commitments are binding on Council of Europe member States. For UHC to become a reality, it is vital that each State embrace these objectives, and that each parliament play an active role in implementing them in national public policies.

11. The Assembly considers it entirely appropriate that the Council of Europe should join the UHC2030 platform, alongside other international organisations such as the Organisation for Economic Co-operation and Development. Such a move would enhance its contribution to the global alignment of efforts to achieve UHC and provide an opportunity to promote its standards and tools within a multilateral framework. By joining the platform's Steering Committee and endorsing the UHC2030 Global compact, the Council of Europe could further rally support among its member State governments and parliaments, strengthen the place of human rights in health systems and help to make UHC a common, shared and measurable goal.

12. The Assembly calls on the member and observer States of the Council of Europe, and States whose parliaments enjoy observer or partner for democracy status with the Assembly:

12.1. with regard to UHC and health policies, to**:**

12.1.1. include the objective of UHC as a national political priority, in accordance with target 3.8 of SDG 3 and the commitments reiterated in the Pact for the Future adopted in 2024, allocating a sufficient budget for its achievement in accordance with, *inter alia*, the WHO recommendations;

12.1.2. ensure, in particular for people in vulnerable situations, equitable, affordable and quality access to physical and mental healthcare, including proactive intervention mechanisms for individuals who, due to their health condition, are unable to recognise their need for care or to travel to services;

12.1.3. invest more and sustainably in primary healthcare, recognised as the foundation of UHC and an essential condition for social and health resilience;

12.1.4. recognise and integrate the social determinants of health (such as access to housing, food, energy and a healthy environment) into public health and social cohesion policies;

12.1.5. include, within the framework of UHC, comprehensive and accessible services for prevention, sexual, reproductive and mental health, as well as support for victims of sexual violence;

12.2. with regard to leveraging Council of Europe instruments, to:

12.2.1. make progress towards wider acceptance of the provisions of the European Social Charter (revised) that are necessary to reduce health inequalities and move forward on the commitment to leave no one behind;

12.2.2. refer systematically to human rights standards and activities of the Council of Europe when developing health policies, in particular the European Social Charter (revised) and the Oviedo Convention;

12.2.3. apply the recommendations of the Committee of Ministers on equitable access to medicinal products and care, in particular Recommendation CM/Rec(2023)1, including in times of crisis or shortage;

12.2.4. actively promote the work of the Steering Committee for Human Rights in the fields of Biomedicine and Health on equitable and rapid access to medical innovation;

12.3. with regard to co-ordination and multilateralism, to:

12.3.1. affirm their commitment to UHC in the relevant international fora and make the case for a human rights-based approach in health systems;

12.3.2. support Council of Europe membership of the UHC2030 multilateral platform, in order to give voice to social rights and to promote alignment between international commitments and European standards;

12.3.3. enhance parliamentary accountability in implementing the objectives of UHC, in particular by providing parliaments with tools and resources offered by the UHC2030 platform and the Inter-Parliamentary Union guides, in order to monitor, guide, evaluate and adjust public health policies;

12.3.4. translate into national legislation the multilateral commitments made in the area of UHC (in particular within the framework of the UHC2030 platform), by adopting laws, dedicated budgets and parliamentary monitoring mechanisms, drawing on European standards and best practice gleaned from international co-operation.

B. Explanatory memorandum by Mr Stefan Schennach, rapporteur[3]

1. Introduction

1. On 21 March 2023, the Committee on Social Affairs, Health and Sustainable Development ("the Committee") tabled a motion for a resolution entitled "Promoting universal health coverage". The motion was referred to the committee for report and Ms Heike Engelhardt (SOC, Germany) was appointed rapporteur on 20 June 2023. As Ms Engelhardt has left the Parliamentary Assembly, I have taken over and was appointed rapporteur on 25 June 2025.

2. The motion for a resolution followed the high-level meeting on health held in September 2023 at the United Nations General Assembly, which placed universal health coverage (UHC) at the forefront of priorities and confirmed the political will to make it a reality by 2030. It was in this context that the Assembly was called upon to consider how Council of Europe member States should contribute to promoting UHC and co-operate with the World Health Organization (WHO), the International Partnership for UHC (UHC2030) and other key stakeholders to achieve this goal.

3. I should remind that the committee amended the French title of the report to refer to "couverture santé universelle" instead of "couverture sanitaire universelle" to translate "universal health coverage". Although the term "sanitaire" is still widely used, the term "santé" refers directly to equitable access for everyone to essential care as such (and not just to health infrastructure), which is the main objective of UHC, and better reflects the English term "health".[4]

4. My premise is the following: UHC is not merely a political goal or just another international commitment – it is a fundamental requirement to guarantee the human rights of all, without exception. It embodies the promise that every individual, regardless of their origin, social situation, or financial means, can access the essential care they need to live with dignity. In our societies, UHC is an essential foundation for social justice, cohesion, and resilience, as it protects the most vulnerable and strengthens our collective capacity to respond to crises. My report is therefore part of a resolutely committed approach: to make health an effective and universal right, at the heart of democracy and respect for human dignity.

5. The fundamental concepts of my report are widely recognised and accepted. Health has been recognised as a human right since 1948 (Article 25 of the Universal Declaration of Human Rights). The right to health as a fundamental right was subsequently enshrined at the global level in Article 12 of the International Covenant on Economic, Social and Cultural Rights (the right to enjoy the highest attainable standard of physical and mental health) and at the European regional level in Article 11 of the European Social Charter (ETS No. 35, right to protection of health).

6. Health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO Constitution, 1946). This definition plays a crucial role by emphasising a holistic approach and recognising that health is not merely the absence of disease, but also encompasses physical, mental and social well-being.

7. Universal coverage means that everyone has access, on an affordable and non-discriminatory basis, to the health services they need – from health promotion to treatment, prevention, rehabilitation and palliative care. UHC encompasses medical services and social protection mechanisms. It aims to ensure equity in the use of health services, quality of healthcare and financial protection. UHC is therefore the concrete expression of the right to health.[5]

8. All countries face the challenge of reducing the gap between the actual need for quality health services and their effective accessibility. It is therefore not surprising that achieving UHC has become a major political commitment, enshrined in the United Nations 2030 Agenda for Sustainable Development. It is based on the principle of "leaving no one behind" and giving priority to the most disadvantaged populations. This challenge requires choices to be made in terms of governance, budgetary priorities and solidarity mechanisms. These choices cannot be delayed or put aside amongst other priorities: every opportunity must be seized to keep UHC at the heart of political agendas, as this report demonstrates.

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3. This explanatory memorandum is drawn up under the responsibility of the rapporteur. Its original French version was translated into English by a machine translation tool.
4. Minutes of the Committee meeting held in Strasbourg on 6 December 2024.
5. WHO, "Health in the Post-2015 Development Agenda".

9. This report, which is primarily addressed to the parliaments of the member States of the Council of Europe, is part of a broader momentum driven by the Secretary General of the Council of Europe through the New Democratic Pact. This pact emphasises the interdependence between health, social justice and democratic resilience. Indeed, equitable, accessible and high-quality health systems are not only a lever for social cohesion, but also an essential foundation for ensuring inclusion, trust in institutions and citizen participation.[6]

2. Promoting universal health coverage as a driver of sustainable development

2.1. Universal health coverage, a cross-cutting lever for the Sustainable Development Goals

10. Beyond health itself, UHC is a strategic investment in sustainable development. It not only improves health outcomes but also strengthens social cohesion, equity, gender equality, and economic stability. A healthy population is more productive, better educated, and more capable of contributing to sustainable development. The link between health and sustainable development is recognised at the political level worldwide. This is evidenced by the decision to include a Sustainable Development Goal (SDG) specifically dedicated to health in the 2030 Agenda for Sustainable Development adopted by the United Nations in September 2015 (2030 Agenda).[7] This is SDG 3: "Ensure healthy lives and promote well-being for all at all ages." Target 3.8 includes the achievement of universal health coverage and specifies its elements: financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines.

11. UHC cannot be achieved without effective access to mental health services. People living with severe mental disorders often remain invisible to the health system: they do not always recognise their need for care and face physical, social and financial barriers to accessing it. Proactive interventions – whether fixed, mobile or community-based – are therefore essential: they enable early identification of needs, ensure continuous follow-up, and help reduce health inequalities. UHC must integrate these mechanisms as a central pillar to protect vulnerable populations and to guarantee mental health services that are accessible, inclusive and free from stigma.[8]

12. By integrating a gender-sensitive approach, UHC offers in particular an opportunity to advance the rights of women and girls by addressing systemic inequalities linked to social roles, exposure to risk, and access to services, and by enhancing women's participation in decision-making processes regarding health.[9] It makes it possible to better address the specific needs of women exposed to sexual violence, including in the context of prostitution, by ensuring non-discriminatory access to prevention, healthcare and psychosocial support, while also helping to combat the stigmatisation and social exclusion of these women. These topics, which were very dear to my predecessor, are central to other reports that will be debated by our Assembly in the future,[10] so I will not dwell on it here.

13. Another crucial issue of equity and social cohesion in the implementation of UHC is migrants' access to healthcare.[11] This topic will also be the focus of a forthcoming report that will explore its legal and operational implications in more detail.[12]

14. According to WHO, each dollar invested in health yields an economic return ranging from USD 1.50 to 121 depending on the type of intervention, by boosting productivity, labour force participation, and family and community resilience to economic or climate shocks.[13] UHC is also recognised as a fundamental component of global health security. The World Bank and WHO stress that strong health systems based on UHC are essential for improving preparedness for pandemics, humanitarian crises, and climate change challenges.[14]

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6. "Roadmap Towards a New Democratic Pact for Europe – Building a resilient, inclusive and agile democracy", 29 April 2025, SG/Inf(2025)14.
7. A/Res/70/1, Resolution adopted by the United Nations General Assembly on 25 September 2015, "Transforming our world: the 2030 Agenda for Sustainable Development".
8. WHO, "Community outreach mental health services – Promoting person-centred and rights-based approaches".
9. WHO, "Global Monitoring Report on Universal Health Coverage" (2021), chapter on equity.
10. In particular the report entitled "Preventing and combating gender discrimination in health".
11. WHO, "Addressing the needs of refugees and migrants: an inclusive approach to Universal Health Coverage", 1 March 2023. Kerrie Stevenson et al., "Universal health coverage for undocumented migrants in the WHO European Region: a long way to go", *The Lancet*, 28 May 2024.
12. The report entitled "Migrants and refugees' access to healthcare".
13. For example, tobacco control (ratio of 1 to 8), actions promoting healthy diets (up to 1 to 12), and breastfeeding promotion (1 to 35) demonstrate these significant returns (WHO, "A healthier humanity: the WHO investment case for 2019-2023").

15. To accelerate progress toward UHC, a global multi-stakeholder platform – (UHC2030) – was established in 2016. Hosted by WHO in partnership with the World Bank, United Nations International Children's Emergency Fund (UNICEF), the Organisation for Economic Co-operation and Development (OECD), and many public, civil society, and parliamentary actors, this platform co-ordinates international efforts, to turn political commitments into concrete reforms. I will return to this in more detail later.

16. A new impetus for efforts to establish UHC was given on 10 October 2019, at the first High-Level meeting on UHC. The United Nations General Assembly adopted a political declaration entitled "Universal health coverage: moving together to build a healthier world." The declaration recognises that health contributes to the promotion and protection of human rights and commits States to ensure that an additional one billion people gain access to quality essential health services by 2023, with the aim of achieving universal coverage by 2030. The declaration recognises mental health and psychological well-being as an essential component of UHC and emphasises the need to fully respect the human rights of people with mental health conditions.[15]

17. The commitment to making health for all a reality by 2030 was reaffirmed on 21 September 2023, during the second High-Level meeting of the UN General Assembly, held at halfway through the 2030 Agenda. Heads of State and government unanimously recognised that UHC is essential for achieving all the SDGs.[16] Following this meeting, member States pledged to intensify efforts toward UHC and agreed to convene the next high-level meeting in 2027. This commitment is reaffirmed in the Pact for the Future adopted by the UN General Assembly in September 2024.[17]

2.2. Progress stalling

18. However, progress toward UHC is not on track. The global index of service coverage for UHC, which rose from 45 to 68 (out of 100) between 2000 and 2021, saw little improvement between 2015 and 2019 and has stagnated since 2019. According to the most recent data, about 4.5 billion people – more than half the world's population (ranging from 14% to 87% of the population depending on the country) – are not fully covered by essential health services. Financial protection is also deteriorating. The share of the population facing catastrophic health spending[18] is rising. In 2021, 2 billion people experienced hardship due to out-of-pocket health expenses, and 344 million were pushed into extreme poverty due to health costs.[19]

19. The Covid-19 pandemic had a significant impact on these indicators. Resources and efforts were redirected toward pandemic response, and financial protection was undermined by income loss from public health measures and reduced fiscal space in the public sector. At the same time, the pandemic also demonstrated globally that strong and inclusive health systems based on UHC fared better. They ensured better access to primary care, under more equitable conditions, and proved to be better prepared to and more capable of mobilising resources quickly.[20]

20. Even in member States of the Council of Europe, UHC has fallen off the agenda since the peak of the pandemic. Although progress toward UHC is greater than the global average, health inequalities among population groups have worsened over the past 10 to 15 years. Financial, geographic, and legal barriers, the cost-of-living crisis, migration and security policies – all constitute complex and multifaceted obstacles.[21] Furthermore, since 2022, Russia's war of aggression has destroyed essential infrastructure for health coverage in Ukraine and is putting pressure on the health systems of neighbouring countries hosting

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14. Arush Lal et al., "Pandemic preparedness and response: exploring the role of universal health coverage within the global health security architecture", *The Lancet*, November 2022.
15. Political Declaration of the High-Level Meeting on Universal Health Coverage, 23 September 2019, 74th session of the United Nations General Assembly.
16. In particular, the SDGs related to poverty eradication, access to education, gender equality, climate change, and the creation of peaceful and inclusive societies (Political Declaration of the High-Level Meeting on Universal Health Coverage, entitled "Universal Health Coverage: expanding our ambition for health and well-being in the post-COVID world", 21 September 2023, 78th session of the United Nations General Assembly).
17. "The Pact for the Future", Resolution adopted by the UN General Assembly on 22 September 2024 at its 79th session.
18. Defined as exceeding 10% of a household's budget.
19. WHO and International Bank for Reconstruction and Development, "Tracking Universal Health Coverage: 2023 Global Monitoring Report".
20. Ibid.
21. WHO Regional Office for Europe, "European Health Report 2021".

displaced persons, as well as on the health system of many European countries, which redirect resources toward security and defence. In all European countries, health system resources risk being diverted due to competition with other urgent priorities.

21. The human cost of lack of progress on UHC is enormous. Maternal mortality has not declined since 2015, with nearly 300 000 women dying each year during pregnancy or childbirth. Childhood immunisation has stalled, with 2.7 million more children under-vaccinated or unvaccinated in 2023 compared to 2019. Non-communicable diseases are on the rise: 17 million people die each year from them before the age of 70, and 86% of these deaths occur in low- and middle-income countries. The fastest, most efficient, equitable, and inclusive way to achieve UHC is through a primary healthcare approach. This could enable to provide 90% of essential health services, potentially saving 60 million lives, and increasing global life expectancy by 3.7 years by 2030, while delivering about 75% of the expected progress in the field on health, thanks to the SDGs.[22] To achieve this, WHO recommends that each country allocate or reallocate an additional 1% of its GDP to primary healthcare.[23]

2.3. A central role for parliaments in translating commitments into action

22. In this context of waning political support, geopolitical tensions, budgetary crises, and other challenges, I am convinced that the case for UHC must be made collectively, more clearly, and in a way that is persuasive to all stakeholders. The commitments to the SDGs bind Council of Europe member States and their national parliaments. Each country holds primary responsibility for implementing the 2030 Agenda in line with its national policies and priorities, taking into account its specific circumstances and capabilities. For the 2030 Agenda to deliver the expected outcomes, it is essential that each State takes ownership of it, and that every parliament contributes to turning sustainable development policies into concrete national measures. I will return later to the specific levers available to parliamentarians to act in this regard.

23. The Assembly has the means to convey these messages: if we want to prepare for the future, making substantial progress toward UHC in terms of primary care by 2030 is essential. This is a goal that is within reach for most countries on our continent. The Assembly has already echoed this in Resolution 2500 (2023) "Public health emergency: the need for a holistic approach to multilateralism and healthcare", which calls on member States to invest in primary healthcare (9.3.1) and to provide universal health coverage to everyone within their territory, regardless of legal status, nationality, ethnicity, religion, gender, sexual orientation, disability, including mental disability, health status, socio-economic background, or any other relevant status (9.3.3).

24. I call on the Assembly to step up its engagement and champion the three pathways for change outlined in the 2024-2027 Strategic Framework developed by the UHC2030 platform in the run-up to the next High-Level meeting on UHC in 2027: advocacy (influencing the decisions of political, economic, and social institutions to advance UHC), accountability (monitoring the implementation of commitments to drive actions, decisions, policies, and programmes in favour of UHC), and alignment (bringing stakeholders together to exchange information and highlight the importance of aligning around a single national plan and working within national structures to strengthen health systems).[24]

3. Supporting advocacy: the Council of Europe's contribution to achieving universal health coverage

25. My research for this report has highlighted that, even if the Council of Europe does not frame its work in these terms, its bodies, treaties, and activities contribute systematically and in a co-ordinated manner to the achievement of UHC. This is not surprising: the right to health and the right to social protection without discrimination are fundamental human rights in their own right and are recognised as essential prerequisites for the exercise of other human rights. They have long been invoked at both global and regional levels to support UHC.[25]

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22. Report by the WHO Director-General to the WHO Executive Board, 23 December 2024.
23. WHO, "Universal Health Coverage Global Monitoring Report 2019".
24. 2024-2027 Strategic Framework, "Fostering the implementation of global commitments on universal health coverage through advocacy, accountability and alignment, UHC2030" (www.uhc2030.org).
25. General Comment No. 14: The right to the highest attainable standard of health (Article 12), adopted at the twenty-second session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (document E/C.12/2000/4. General Comment No. 19: The right to social security (Article 9), adopted at the thirty-ninth session of the Committee on Economic, Social and Cultural Rights, on 4 February 2008 (document E/C.12/GC/19). Council of Europe Commissioner for Human Rights, Human Rights Comment, "Learning from the pandemic to better fulfil the right to health", 23 April 2020.

26. Given the scope of my report, I will not delve into the indirect protection provided by the European Convention on Human Rights (ETS No. 5). While keeping in mind that the three treaties are inseparably linked by the same foundation, that is human dignity – a core value and the cornerstone of European human rights law, of which healthcare is an indispensable condition[26] – I believe that the universal and inclusive approach of the European Social Charter (revised) (ETS No. 163) and the case law of its monitoring body composed of independent experts – the European Committee of Social Rights – as well as the Convention on Human Rights and Biomedicine (ETS No. 164, "Oviedo Convention") and the actions of its intergovernmental monitoring body – the Steering Committee for Human Rights in the fields of Biomedicine and Health – constitute the main legal and operational assets of the Council of Europe for supporting advocacy for UHC.[27]

27. In addition to these instruments, there is the essential contribution of the European Directorate for the Quality of Medicines & HealthCare (EDQM), which is responsible for developing and promoting high standards concerning the safety, efficacy, and quality of medicines and medical practices. This role is fundamental in ensuring effective UHC by guaranteeing that the care provided meets rigorous criteria, thereby strengthening trust in health systems within the member States.

28. I also place particular importance on the independent watchdog role of the Council of Europe Commissioner for Human Rights, who places UHC at the heart of the mandate, challenges governments on financial barriers, promotes the strengthening of primary care, and calls for the elimination of excessive direct out-of-pocket payments to ensure non-discriminatory access to health services.[28] I refer in particular to the outstanding thematic contribution published by the former Commissioner after the pandemic and to the recommendations made by her and her successor to strengthen our health systems through a human rights-based approach.[29] I also invite the Assembly to call on member States to support the initiatives of the Council of Europe's focal point on the territorial dimension of the SDGs – the Congress of Local and Regional Authorities – to reduce territorial inequalities in order to improve UHC.[30] Although my report cannot explore in detail the specific contributions of these two bodies, their work is crucial to giving full effect to the Council of Europe's human rights standards in any strategy to advance UHC.

29. Finally, I wish to point out that, for the sake of clarity, this chapter adopts a fragmented presentation. However, it is important to stress that UHC requires a holistic approach: member States must view the Council of Europe's health-related initiatives as complementary tools. In this respect, I encourage special attention to the upcoming Council of Europe Conference on the Protection of Health to be held in Strasbourg on 15 October 2025. This event will specifically highlight the Organisation's cross-cutting and multisectoral action to make the right to health a genuine human right and thereby contribute to achieving SDG 3.

3.1. The principal normative framework: the European Social Charter

30. Enshrined in the WHO Constitution since 1946, the right to health is reflected at European level in Article 11 of the Social Charter (the "Charter"), which guarantees the right to protection of health. By accepting this provision, contracting Parties undertake to recognise everyone's right to benefit from all measures enabling them to enjoy the highest possible standard of physical and mental health. Taken alone or in conjunction with Article E (non-discrimination clause), this commitment implies that States must ensure access to healthcare for all and make sure the health system is accessible to the entire population.[31]

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26. International Federation for Human Rights (FIDH) v. France, Complaint No. 14/2003, decision on the merits of 3 November 2004, para. 31.

27. To gain an understanding of the Council of Europe's human rights-based approach, I would particularly recommend two reports. One commissioned by the CDBIO: Rumiana Yotova, "Human Rights Based Approaches to Health Care", June 2023; and the other by the Commissioner for Human Rights: "Issue Paper – Protecting the right to health through inclusive and resilient health care for all", 2021.

28. Report, Sexual and reproductive health and rights in Europe: progress and challenges, 2024. Report, Reform of mental health services: an urgent need and a human rights imperative, 2021. Human Rights Comment, Learning from the pandemic to better fulfil the right to health, op. cit.

29. Thematic report, "Protecting the right to health through inclusive and resilient health care for all", 2021.

30. Priorities 2021–2026 of the Congress of Local and Regional Authorities.

31. See, for example: Defence for Children International (DCI) v. Belgium, Complaint No. 69/2011, decision on the merits of 23 October 2012. FIDH v. France, Complaint No. 14/2003, decision on the merits of 3 November 2004. International Commission of Jurists (ICJ) and European Council on Refugees and Exiles (ECRE) v. Greece, Complaint No. 173/2018, decision on the merits of 26 January 2021. See also Conclusions I (1969), general observations on Article 11; Conclusions 2005, general observations on Article 11; and Conclusions 2021, general observations on Article 11 and gender equality.

31. To define health under Article 11, the European Committee of Social Rights aligns itself with the WHO's definition – state of complete physical, mental, and social well-being – and considers that respect for physical and psychological integrity is an integral part of the right to protection of health. Given that the "aim and purpose of the Charter [is] to protect rights not only in theory but also in practice," compliance with Article 11 is assessed both legally and in terms of practical implementation.[32] Following the example of UN specialised treaties, which are widely ratified by Council of Europe member States, the Charter and the Committee's case law also set more detailed standards for certain groups with specific and often overlooked needs regarding access to healthcare.[33],[34]

32. What particularly struck me when reviewing the case law of the European Committee of Social Rights on Article 11 – and what I wish to highlight – is that it adopts all elements of the AAAQ analytical framework. This framework is the normative and methodological tool developed under international human rights law to operationalise the right to the highest attainable standard of health as recognised in Article 12 of the International Covenant on Economic, Social and Cultural Rights, and is used to evaluate the effective realisation of Target 3.8 of SDG 3.[35] It is based on four interrelated components: availability (sufficient services), accessibility (economic, geographic, and informational), acceptability (respect of cultural differences and individual needs), and quality (medical adequacy and effectiveness).[36]

33. Article 11 of the Charter, as interpreted and applied by the European Committee of Social Rights, legally embodies these four dimensions through positive obligations placed on the contracting Parties. Regarding availability, the Committee emphasises the need to provide sufficient facilities, hospital beds, and trained health professionals to avoid delays in care provision.[37] Non-discrimination is used to assess compliance with Article 11.[38] For rural populations, the necessity of ensuring physical access to care is emphasised.[39] The Committee also stresses the importance of making healthcare economically accessible (affordable); this overlaps with the scope of Article 13 (see below).[40] The accessibility and acceptability of information, particularly through awareness of health issues, diseases, available treatments, and culturally appropriate education, have been repeatedly highlighted.[41] The case law have also focused on the quality of health services.[42]

34. This interpretation is especially relevant for vulnerable groups. Access to healthcare must be guaranteed to all without discrimination (even during a pandemic). This implies that healthcare must be effective and affordable for everyone, and that particularly exposed groups must be adequately protected.[43]

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32. See among others: Validity Foundation – Mental Disability Advocacy Centre v. Czech Republic, Complaint No. 188/2019, decision on the merits of 17 October 2023, para. 69–70.
33. Articles 15 (persons with disabilities), 16 (family), 17 (children and adolescents), 19 (migrant workers), and 23 (elderly persons) of the European Social Charter (Revised).
34. See, for example: European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 151/2017, decision on the merits of 5 December 2018. ERRC and Mental Disability Advocacy Centre (MDAC) v. Czech Republic, Complaint No. 157/2017, decision on the merits of 17 June 2020. ERRC v. Belgium, Complaint No. 185/2019, decision on the merits of 8 December 2022.
35. Karin Lukas, "Article 11: the right to protection of health", in The Revised European Social Charter, An Article-by-Article Commentary, Elgar Commentaries series, 2021. Yana Litins'ka, "What Healthcare Services Temporary Protection Entitles to Have? Navigating the European Social Charter*", European Journal of Health Law*, 29 September 2023. Eloïse Gennet, "The Council of Europe's Underrated Role in Fostering Equitable Access to Quality Health Care in Times of Pandemic", *Health and Human Rights Journal*, 2024.
36. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights, op. cit.
37. Conclusions 2017, Serbia, Article 11 para. 1 (2018). Conclusions XIX-2, Latvia, Article 11 para. 1 (2010). Conclusions 2009, Georgia, Article 11 para. 1 (2010). Conclusions XXI-2, Germany, Article 11 para. 1 (2017). Conclusions 2017, Turkey, Article 11 para. 1 (2017). ECRE v. Greece, Complaint No. 173/2018, decision on the merits of 26 January 2021, para. 225-227.
38. Conclusions 2005, general observations on Article 11 (2005). Conclusions XIX-2, Slovak Republic, Article 11 para. 1 (2010).
39. Conclusions 2017, Russian Federation, Article 11 para. 1 (2017). Conclusions I (1969), general observations on Article 11.
40. Conclusions 2017, Lithuania, Article 11 para. 1 (2017). Conclusions 2009, Ukraine, Article 11 para. 1 (2010). Conclusions XIX-2, Slovak Republic, Article 11 para. 1 (2010).
41. International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia, Complaint No. 45/2007, decision on the merits of 30 March 2009, para. 43 and 54. Conclusions 2003, Italy, Article 11 para. 1 (2003). Conclusions 2017, Slovak Republic, Article 11 para. 2 (2017).
42. Transgender Europe and ILGA-Europe v. Czech Republic, Complaint No. 117/2015, decision on the merits of 15 May 2018, para. 79. Conclusions XXI-2, Luxembourg, Article 11 para. 1 (2018). Conclusions 2017, Romania, Article 11 para. 1 (2017).
43. Statement of interpretation on the right to protection of health in times of pandemic, adopted on 21 April 2020.

As a result, the Committee has recognised specific obligations regarding access to healthcare for transgender persons,[44] people with disabilities,[45] Roma women,[46] migrants or those in irregular situations.[47] The same logic applies also to the homeless, elderly, institutionalised persons, and prisoners.[48]

35. Access to healthcare is an essential prerequisite for the exercise of the right to health. This right is enshrined in Article 9 of the International Covenant on Economic, Social and Cultural Rights, which recognises the right to social security, including access to medical care. This principle is also central to the standards and recommendations of the International Labour Organisation, especially Convention No. 102, which serves as a reference for national social security systems.

36. At the Council of Europe level, this requirement is reaffirmed in the Charter. Article 12 calls on States to maintain their social security systems at a satisfactory level and to progressively improve them, guided by the European Code of Social Security (ETS No. 48). However, it is Article 13 that I find particularly significant in measuring the contribution of the Charter and the case law of the European Committee of Social Rights to UHC. This article primarily aims to ensure economic access to care (accessibility under the AAAQ framework).

37. Article 13 guarantees the right to emergency social and medical assistance to anyone on the territory of a contracting Party.[49] By accepting it, contracting Parties commit to providing care free of charge or ensuring full or partial financing to make services affordable when care is otherwise economically inaccessible.[50] This is an individual right that must be subject to effective legal remedy.[51] The medical acts covered include at least emergency medical care but are not limited to it.[52] The article covers both primary and specialised outpatient care.[53] Assistance cannot be restricted based on length of stay, residence status, or presence on the territory.[54] There can be no time limit on medical assistance.[55] Eligibility for help must not depend on contributions to the social security system.[56] Lastly, the right cannot be waived due to fault or misconduct.[57]

38. Finally, another aspect of the case law of the European Committee of Social Rights is particularly useful for advocating in favour of UHC: by going beyond access to medical care to include the social determinants of health – such as housing, food, and energy – the Committee's case law clearly embraces these dimensions.[58] The Committee's jurisprudence clearly embraces these dimensions. It asserts that lack of basic services – water, electricity, heating – has serious repercussions on hygiene, sanitation, and both mental and physical care and treatments, including clinical and preventive care.[59] Likewise, the Committee emphasises that adequate nutrition is a fundamental prerequisite for health and that States must guarantee sufficient nutritional security to prevent diseases and developmental disorders.[60]

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44. General question on Article 11 and gender identity, Conclusions 2021.
45. European Disability Forum (EDF) and Inclusion Europe v. France, Complaint No. 168/2018, decision on the merits of 19 October 2022.
46. ERRC v. Bulgaria, Complaint No. 151/2017, decision on the merits of 5 December 2018.
47. Defence for Children International (DCI) v. Belgium, Complaint No. 69/2011, decision on the merits of 23 October 2012, para. 28. FIDH v. France, Complaint No. 14/2003, decision on the merits of 8 September 2004, para. 30–31.
48. Statement of interpretation on the right to protection of health in times of pandemic, op. cit.
49. See, among others: *Médecins du Monde – International v. France*, Complaint No. 67/2011, decision on the merits of 11 September 2012.
50. Conclusions 2017, Bosnia and Herzegovina, Article 13 para. 1 (2017).
51. Conclusions I (1969), General observations on Article 13 para. 1.
52. *Conference of European Churches v. the Netherlands*, Complaint No. 90/2013, decision on the merits of 9 July 2014, para. 105. *European Federation of National Organisations Working with the Homeless (FEANTSA) v. the Netherlands*, Complaint No. 86/2012, decision on the merits of 2 July 2014, para. 107. Conclusions 2017, Romania, Article 13 para. 1 (2017). Conclusions 2015, Romania, Article 13 para. 1 (2015). Conclusions 2009, Bulgaria, Article 13 para. 1 (2010).
53. *ERRC v. Bulgaria*, Complaint No. 46/2007, decision on the merits of 3 December 2008, para. 44. Conclusions 2017, Bosnia and Herzegovina, Article 13 para. 1 (2017). Conclusions 2017, Italy, Article 13 para. 1 (2017). Conclusions 2015, Romania, Article 13 para. 1 (2015).
54. *Médecins du Monde – International v. France*, Complaint No. 67/2011, decision on the merits of 11 September 2012, para. 176 and 177. *FEANTSA v. the Netherlands*, Complaint No. 86/2012, decision on the merits of 2 July 2014, para. 139, 171. Conclusions 2017, Austria, Article 13 para. 1 (2017). Conclusions 2017, Portugal, Article 13 para. 1 (2017) Conclusions XVI-1, United Kingdom, Article 13 para. 1 (2003).
55. Conclusions XXI-2, Greece, Article 13 para. 1 (2018). Conclusions 2017, Bosnia and Herzegovina, Article 13 para. 1 (2017).
56. Conclusions 2013, Bosnia and Herzegovina, Article 13 para. 1 (2013). *Finnish Society of Social Rights v. Finland*, Complaint No. 88/2012, decision on the merits of 10 October 2014, para. 110.
57. Conclusions XX-2, Luxembourg, Article 13 para. 1 (2013). Conclusions XIX-2, Luxembourg, Article 13 para. 1 (2010).
58. United Nations Political Declaration on UHC (2019).

3.2. The ethical compass: the Oviedo Convention

39. Another key legal lever of the Council of Europe in contributing to the achievement of UHC is the Convention on Human Rights and Biomedicine, known as the Oviedo Convention. It is the only binding international legal instrument in the biomedical field, aiming to protect human dignity, identity, and integrity in the face of advances in biology and medicine. Often described as a shared ethical framework, it translates biomedical issues – such as genetics, medical research, informed consent, and organ transplantation – into normative principles drawn from international human rights law.

40. In accordance with Article 11 of the Social Charter, Article 3 of the Oviedo Convention requires Parties, taking into account health needs and available resources, to take appropriate measures with a view to providing, within their competence, equitable access to healthcare of appropriate quality. The ultimate goal is to eliminate avoidable, unfair, or remediable disparities between groups of people.[61]

41. On this basis, the Convention's intergovernmental monitoring body – the Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO) – makes a substantial contribution to the implementation of Target 3.8 of SDG 3. The second thematic pillar of the strategic action plan 2020-2025 developed by the CDBIO is specifically dedicated to equity in healthcare and the elimination of health disparities created by social and demographic changes in Council of Europe member States.

42. In this vein, Recommendation (2023)1 of the Committee of Ministers[62] was developed by the CDBIO to protect the fundamental rights of people with serious or life-threatening health conditions, including in a situation of shortage. This policy guidance document urges the 46 member States to guarantee equitable access to medicines and medical equipment and to uphold fundamental rights. It introduces procedural safeguards and principles of action inspired by international human rights law: non-discrimination, prioritisation based on objective medical criteria, transparency of decisions, accountability of authorities, and inclusive stakeholder participation. This text is particularly relevant to advocacy for UHC, as the measures it recommends address all aspects of healthcare provision in line with the AAAQ framework: accessibility (non-discrimination and affordability), availability (strategic stockpiles), acceptability (addressing the needs of vulnerable groups), and quality (product certification and control).

43. The second thematic pillar of the strategic action plan of the CDBIO also includes a further dimension: promoting equitable and timely access to innovative treatments and appropriate health technologies in the field of healthcare. While an increasing number of innovative treatments and health technologies have become available on the market, their high costs, among other factors, often undermine access. This ambition aligns with the aim of Article 3 of the Oviedo Convention and implies that special efforts must be made to improve access for disadvantaged individuals and groups, and to ensure that new developments do not create or exacerbate existing inequalities.

44. I also took note with interest of the CDBIO's work on Guide to Health Literacy (knowledge and understanding of health issues), which aims to reduce health disparities linked to social and demographic determinants.[63] This guide seeks to empower vulnerable individuals, to facilitate their effective, informed, and equitable access to care, including sexual and reproductive health services.

4. Strengthening accountability: parliamentary levers to help achieve universal health coverage

45. The Council of Europe's standards on social rights and bioethics, discussed in the previous chapter, are not limited to informing advocacy: their full effectiveness depends on concrete implementation, in which parliaments have a key role to play. The 2024-2027 Strategic Framework of the UHC2030 platform identifies the need to strengthen accountability at all levels as the second pathway for change. This implies that governments must be held accountable for their commitments and that legislators must have the necessary tools to monitor, regulate, evaluate and adjust public health policies. This chapter focuses specifically on this

59. *International Commission of Jurists (ICJ) and European Council for Refugees and Exiles v. Greece*, Complaint No. 173/2018, decision on admissibility and on immediate measures of 23 May 2019, para. 14. DCI, *FEANTSA, MEDEL, CCOO and ATD Quart Monde v. Spain*, Complaint No. 206/2022, decision on the merits of 11 September 2024.
60. Analytical Review of the ECSR on Social Rights and the Cost-of-Living Crisis (2025), para. 113.
61. CDBIO, "White Paper on equitable and timely access to appropriate innovative treatments and technologies in healthcare" (CDBIO 2024(18)).
62. Recommendation CM/Rec(2023)1 of the Committee of Ministers on equitable access to medicinal products and medical equipment in a situation of shortage, adopted on 1 February 2023.
63. "Guide to Health Literacy: Contributing to trust building and equitable access to healthcare", January 2023.

dynamic: it explores the levers available to parliamentarians to link legal and ethical standards to the effective implementation of UHC. The objective is clear: to make UHC and financial protection for health a political priority and to enshrine this commitment in national parliamentary roadmaps.

46. In this regard, parliaments appear to be key players. Voting on the budget, passing laws, defining national health policies and establishing evaluation and monitoring mechanisms are all legislative powers that are crucial to achieving UHC and making it a sustainable national priority. Whether it is the commitments made by States in the political declaration of the United Nations High-Level Meeting on UHC (2019), the conclusions of the European Committee of Social Rights and its decisions on collective complaints, or the recommendations of the CDBIO, member States are required to set out concrete guidelines on health, social security, access to healthcare and equal access, and to translate these into legislative proposals, evaluation reports or budgetary measures.

4.1. Drawing on the resources of the UHC2030 platform

47. The UHC2030 platform[64] is a valuable first resource for parliamentarians wishing to play an active role in achieving UHC. On 6 December 2024, the Committee on Social Affairs, Health and Sustainable Development heard Ms Marjolaine Nicod, Head of the WHO UHC2030 Secretariat. She shared with us an impressive list of tools and frameworks provided by the UHC2030 platform to enable parliamentarians to monitor progress and ensure transparency in the implementation of UHC commitments.

48. Among the resources offered by the UHC2030 platform, several tools struck me as particularly relevant.

– Firstly, the progress monitoring interface provides updated country profiles combining quantitative and qualitative data, visualisations, indicators on the availability and quality of health services, financial protection, inequalities in access and citizen participation. These profiles are accompanied by comparative dashboards that make it easier to compare results between countries.[65]

– Secondly, the review of commitments made at the United Nations High-Level Meeting on UHC (2019) provides a summary analysis of each country's progress.[66] This ready-to-use analytical document, co-ordinated with national and international stakeholders, identifies progress, gaps and areas for improvement.

– Thirdly, the document “Monitoring, Evaluation and Review of National Health Strategies”[67] provides a clear methodological framework for setting up national platforms for monitoring and evaluating health strategies. This guide identifies the principles, structures and practices to be adopted to ensure independent, regular and transparent evaluation of public policy. Parliamentarians can draw on it to propose such mechanisms in their own countries.

– Finally, the Toolkit on Health Budget Literacy[68] aims to strengthen the capacity of parliamentarians, journalists and civil society actors in budget analysis. It provides practical tools for accessing budget information, understanding the issues at stake, and formulating well-argued proposals on health resource allocation.

49. I encourage every member of the Assembly to take full advantage of these tools. Based on evidence, proven methodologies and indicators that are comparable across countries, they can inform parliamentary debates, guide the evaluation of existing policies and support reforms.

4.2. Putting the guides developed by the Inter-Parliamentary Union into practice

50. The guides developed by the Inter-Parliamentary Union (IPU) in partnership with WHO are also among the most relevant tools to support parliamentarians working towards UHC.[69] They provide a structured framework and examples that can be directly applied to different national contexts. Guide No. 35, “The path towards UHC”, presents the foundations of UHC and the legislative levers available to parliamentarians, from the design of laws to the monitoring of their implementation. It is supplemented by the handbook

64. www.uhc2030.org.
65. www.uhc2030.org/what-we-do/knowledge-and-networks/uhc-data-portal/. See also the digital platform: https://apps.who.int/dhis2/uhcwatch/#/.
66. www.uhc2030.org/what-we-do/voices/state-of-uhc-commitment/.
67. www.who.int/publications/i/item.
68. www.uhc2030.org/what-we-do/knowledge-and-networks/civil-society-engagement/budget-toolkit.
69. www.ipu.org/fr/ressources/publications/guides/2022-11/la-voie-de-la-couverture-sanitaire-universelle.

"Guaranteeing UHC" – which includes case studies and recommendations on health system financing, reducing inequalities and equitable access to care – and the guide "Six action steps to achieve UHC", which offers a structured approach to assessing needs, allocating resources and monitoring the impact of reforms.

51. These documents, combined with the work of the European Committee of Social Rights,[70] have given me a better understanding of the concrete role that parliamentarians can play. Several examples struck me as particularly inspiring:

– Firstly, concerning international mobilisation: at the 141st IPU Assembly in Belgrade (13-17 October 2019), more than 1 800 parliamentarians adopted a resolution calling for the adoption of effective national laws to achieve UHC by 2030. Inter-parliamentary workshops also provided an opportunity to exchange strategies and best practices in this area.

– Secondly, concerning national reforms promoting UHC: in France, the creation of universal health coverage, followed by the complémentaire santé solidaire (solidarity-based supplementary health insurance), has provided access to healthcare regardless of professional status or income, with progressive reimbursement based on resources.[71] In Sweden, the law guarantees universal access to primary care based on the principles of dignity, need and solidarity.[72] In several Central and Eastern European countries (Hungary, Latvia), annual out-of-pocket ceilings and targeted exemptions protect the most vulnerable from catastrophic health costs.[73]

– Lastly, regarding sustainable policy planning: in Ireland, the Sláintecare programme, adopted by cross-party consensus in the Oireachtas, illustrates the potential impact of cross-party commitment. This ten-year plan aims to progressively transform the healthcare system into a truly universal model based on equity and accessibility.[74]

4.3. Leveraging the UNITE network

52. Finally, parliamentarians committed to achieving UHC can draw on the UNITE network,[75] a parliamentary organisation working to build sustainable, equitable and effective health systems. It promotes health legislation reforms, facilitates the exchange of experiences and supports the Sustainable Development Goals, in particular SDG 3. Composed of current and former parliamentarians at different levels – local, national and regional – UNITE offers, through its political offices, a platform for exchange between parliamentarians and civil society organisations, providing guidance to influence and improve health policies.

5. Conclusion: strengthening stakeholder alignment by joining the UHC2030 platform

53. The effective achievement of UHC requires strategic and operational alignment among all stakeholders: governments, parliaments, international organisations, civil society, development partners, the private sector and academia. This principle is the third pathway for change identified by the UHC2030 platform's 2024-2027 Strategic Framework. It is based on a simple and powerful idea: to succeed, UHC must be collectively owned, within inclusive, co-ordinated and results-oriented systems.

54. With this in mind, I propose that the Council of Europe officially join the UHC2030 platform, following the example of the OECD, a co-ordinated organisation with which our Organisation shares common values. The Council of Europe would have everything to gain, as explained to the committee by Ms Francesca Colombo of the OECD (Head of the Health Division of the Directorate for Employment, Labour and Social Affairs) during a hearing on 3 June 2024. By becoming a member of the steering committee or by joining the platform's activities, it would contribute to the global alignment of efforts in favour of UHC while affirming its commitment to linking human rights and health policies. In concrete terms, membership would make it possible to mobilise parliamentarians through targeted tools and international campaigns – such as the

70. European Committee on Social Rights, "Analytical Review on Social Rights and the Cost of Living Crisis" (2025), para. 113.
71. The summary in French is available on www.agenda-2030.fr/17-objectifs-de-developpement-durable/article/odd3.
72. Yana Litins'ka, "What Healthcare Services Temporary Protection Entitles to Have? Navigating the European Social Charter", European Journal of Health Law, 29 September 2023. Mio Fredriksson, "Universal health coverage and equal access in Sweden: a century-long perspective on macro-level policy", *International Journal for Equity in Health*, 28 May 2024.
73. Marzena Tambor, Jacek Klich and Alicja Domagała, "Financing Healthcare in Central and Eastern European Countries: How Far Are We from Universal Health Coverage?", Int. J. Environ. Res. Public Health, 2021.
74. www.oireachtas.ie/en/debates.
75. www.unitenetwork.org/.

International UHC Day on 12 December – to promote the integration of UHC into national political agendas in order to accelerate the implementation of the SDGs, as well as investment in primary healthcare (by spending better, not necessarily more) and to support inclusive approaches, in line with the resolution adopted in May 2024 by the World Health Assembly on strengthening social participation for UHC.[76]

55. In concrete terms, as explained by the head of the UHC2030 Secretariat during a hearing before the committee, joining the platform would mean endorsing the UHC2030 Global compact – a voluntary political commitment proposed by the UHC2030 platform that recognises UHC as a global priority and calls for a primary health care-based, equitable and people-centred approach. Its six fundamental principles are fully aligned with the values and work of the Council of Europe and its member States in the field of health: leaving no one behind, adopting a human rights-based and equitable approach, focusing on strong, effective and resilient health systems, increasing transparency and accountability, involving all actors, and investing more, smarter and in a sustainable manner. This would also involve formal membership of the steering committee, enabling the Council of Europe to participate in the development of the platform's strategic guidelines and to represent the specific features of the European social rights framework. Finally, collaboration would be possible through joint campaigns, advocacy events or knowledge sharing.

56. The Council of Europe's accession to the UHC2030 platform would also naturally resonate with the Conference on the Protection of Health that the Organisation will host in Strasbourg on 15 October 2025. This event will highlight its cross-cutting and multisectoral approach to health and human rights, in line with the principles of UHC. It will also serve as a useful preparatory step ahead of the next United Nations High-Level meeting on UHC scheduled for 2027, positioning the Council of Europe as a committed actor contributing concretely to the achievement of SDG 3.

57. Finally, it is crucial to emphasise that this commitment to UHC is fully aligned with the momentum of the Council of Europe’s New Democratic Pact. Equitable and accessible healthcare is not only a fundamental driver of social justice and cohesion, but also a key pillar for democratic resilience, trust in institutions, and citizen participation. Advancing UHC therefore means strengthening the very foundation of our Organisation’s values and mission.

76. Resolution on Strengthening social participation for universal health coverage, health and well-being (WHA77.10) adopted in May 2024 at the 77th World Health Assembly.