HHR
Health and Human Rights Journal

EDITORIAL

The Contributions of Human Rights to Universal Health Coverage

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Recently, there has been a growing push for countries to achieve universal health coverage (UHC) in order to strengthen health systems and improve health equity and access to health services. UHC has been identified by some as the third global health transition—the first being public health improvements (such as basic sewage and sanitation) and the second being the epidemiological transition that reduced the toll of communicable diseases.[1] Major health and development organizations, including the World Health Organization (WHO), the World Bank Group, the Rockefeller Foundation, Oxfam, the Gates Foundation, the International Labour Organization, and the United Nations Children's Fund, have endorsed initiatives promoting UHC.[2] Dr. Margaret Chan, WHO's director-general, has described universal health coverage as "the single most powerful concept that public health has to offer" and has said that UHC represents the "ultimate expression of fairness."[3] In September 2015, UHC was selected as one of the key targets to implement the health goal in the United Nations Sustainable Development Goals (SDGs).[4]

Importantly, UHC has also been termed "a practical expression of the right to health."[5] UHC is explicitly enumerated as a core obligation for the realization of children's right to health.[6] It is also implicit in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which directs states parties to take steps toward the creation of conditions that ensure medical services and attention for all in the event of sickness.[7] The first of the core right to health obligations identified in General Comment No. 14 (GC 14) of the United Nations Committee on Economic, Social and Cultural Rights is "to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups."[8] The commitment to universality in access to key health services is also implicit in other international and regional human rights instruments. Significant progress toward UHC, consistent with the requirements of the right to health, has the potential to provide the approximately one billion people currently estimated to lack access to necessary health services the opportunity to obtain them.

Importantly, not all potential paths to a universal health system are consistent with human rights requirements. Simply expanding health coverage, especially if it continues to exclude poor and vulnerable communities, is not sufficient from a human rights perspective. As two health policy analysts warn, "beware—universal coverage is more difficult to achieve than to advocate. And people who are poor could

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Competing interests: None declared.

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well gain little until the final stages of the transition from advocacy to achievement if that coverage were to display a trickle-down pattern of spread marked by an increase first in better-off groups and only later in poorer ones."[9] A recent UHC progress analysis of 11 countries at different levels of development shows that this is often what occurs: UHC expansion usually begins with civil servants or urban, formal sector workers, with poorer people initially losing out. Further skewing the benefits of UHC, the clinical sector commonly favors expensive specialized health services that are accessible primarily to a small, privileged fraction of the population.[10]

A human rights approach to UHC imposes distinctive requirements. I have proposed that UHC consistent with the requirements of the right to health would include the following elements:

- Health care reforms designed to achieve universal access to essential health services would be placed within the context of a national effort to provide equitable access to the social determinants of health.
- Access to essential health services and public health protections would be made a legal entitlement, and individuals would have access to adequate means to seek redress for failures to provide these benefits.
- Coverage would be based on a true universality, providing benefits to all residents of a country regardless of their legal status.
- Explicit attention would be paid to equity considerations in the design of the universal health system and throughout the process of expanding coverage, especially to the implementation of measures to reduce barriers for low-income groups, rural populations, women, and other vulnerable groups that are often disadvantaged in terms of service coverage and health.
- An equitable and progressive system of health funding for financial risk protection would be put in place to eliminate or at least significantly reduce financial barriers, especially for poor and disadvantaged groups. The government would underwrite the health costs of the poor.
- Sufficient funding—at least 5% of the gross domestic product and 15% of the total government budget—would be provided for health system strengthening in order to expand health coverage and provide a publicly funded package of priority health services based on people's needs.
- Health system strengthening would be accorded priority in order to make good-quality health services widely available, especially in currently underserved communities and with a greater balance between rural and urban areas.
- There would be opportunities for consultation with and the participation of the population in the design of the path to UHC and the determination of benefits packages.
- The process for pursuing the progressive realization of UHC would first expand coverage for high-priority services to everyone, with special efforts to ensure that disadvantaged groups are reached.
- A uniform package of health service benefits closely linked to the population's needs would be universally provided by the government.
- An effective data monitoring system would be put in place to evaluate the distributional effects of efforts to achieve UHC and improve health outcomes. This system would have the capacity to track and assess data on a disaggregated basis in order to facilitate corrective action when necessary.[11]

Dainius Puras, the current Special Rapporteur on the right to health, has identified additional requirements for UHC to be consistent with the right to health. In his recent report on the 2030 Agenda for Sustainable Development and the Sustainable Development Goals, he references the GC 14 provision that "the right to health requires that health care goods, services and facilities be available in adequate numbers; financially and geographically accessible, as well as accessible on the basis of non-discrimination; acceptable, that is, respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements; and of good quality."[12] He cites the need for an effective and integrated health system to incorporate the human rights principles of equality and non-discrimination, transparency, accountability, and participation.[13] He makes the further point that states should ensure that rights-holders, including those from marginalized groups, are provided with the conditions to participate in the design, implementation, and monitoring of laws, policies, and strategies.[14] He underscores the need for UHC policies to make an explicit commitment to prioritize the poor and marginalized in the process of expanding coverage and in determining which services to provide in order to avoid entrenching inequality.[15]

Even if there is consensus within the human rights community about the importance of grounding UHC in human rights law, there are many practical questions regarding how this should be done. The seven articles in this special issue of *Health and Human Rights* address some of these questions. They also offer evidence of the challenges and benefits of adopting a rights-based model of UHC.

The goal of achieving UHC can generally be realized only in stages, through a long process of gradual realization, much like the achievement of economic, social, and cultural rights. Moreover, limitations in resource availability and administrative capacity, as well as political constraints, impose difficult trade-offs along the way. In a 2014 report, *Making Fair Choices on the Path to Universal Health Coverage*, the WHO Consultative Group on Equity and Universal Coverage articulates principles for making such trade-offs in an equitable manner consistent with human rights norms. It proposes a three-part strategy: first, categorize services into priority classes on the basis of criteria such as cost-effectiveness, priority to the worse off, and financial risk protection. Second, expand coverage for high-priority services that tend to benefit the worse off and to be the most effective for everyone. Third, as coverage is expanded, take special measures to ensure that disadvantaged groups, such as low-income groups and rural populations, are not left behind.[16] The article written by Alex Voorhoeve, Tessa Edejer, Lydia Kapiriri, Ole Norheim, and their colleagues applies these principles to three case studies to show how they can guide practical decision making and inform progressive realization of the right to health, including generating the greatest total health gain, priority for those who are worse off in a number of dimensions, and financial risk protection.

Lisa Forman, Claudia Beiersmann, Claire Brolan, Martin McKee, Rachel Hammonds, and Gorik Ooms consider what human rights principles, particularly core obligations related to the right to health, bring to formulating and implementing UHC. One of the limitations they identify is the Committee on Economic, Social and Cultural Rights' interpretation of the right to health in GC 14, which moves from the fairly substantive notion of core obligations in the committee's General Comment No. 3 as requiring the provision of essential primary health care to a far more procedural/structural approach encompassing equitable distribution, non-discrimination, and a comprehensive participatory national plan of action. According to Forman and her colleagues, because the focus of core obligations in GC 14 is more on processes than outcomes, it is not clear which health services fall within the core other than essential medicines and underlying determinants, such as food, basic shelter, housing, sanitation, and water, which are identified in the document. The specific health care services referenced in the general comment are categorized as obligations of comparable priority, and it is unclear what the relationship is between obligations of comparable priority and minimum core obligations. The article concludes that the core obligations identified in GC 14 do not prescribe a globally applicable and fixed set of health care benefits but rather a framework for action encompassing non-discrimination (including affordability), equity, participatory decision-making, essential medicines, and the social determinants of health.

At first glance, the question of who should be included in a universal health system seems quite simple. Universality is a fundamental principle of human rights. Therefore, UHC implies that all persons in a country, including refugees, asylum seekers, and undocumented and documented migrants, should be provided with health entitlements for affordable and necessary health care. However, the explosion of migration as many thousands of persons flee areas of conflict and large numbers of other persons seek to relocate to countries of greater economic promise, juxtaposed with the bleak post-2008 economic climate, has imposed challenges for the implementation of this principle, even in Europe's affluent countries. Claire Lougarre's article considers the effectiveness of the global health policy commitment to guarantee access to affordable health care for non-nationals. She points out that non-nationals often face obstacles in accessing health care in Europe that nationals do not face, such as restricted legal entitlements, administrative hurdles, and language barriers. Lougarre proposes that the right to health as enshrined in the ICESCR has the potential to promote UHC goals by legally demanding non-nationals' access to affordable health systems; however, she acknowledges that the scope of protection under the ICESCR is unclear. Moreover, provisions in many of the regional human rights instruments restrict the application of the right to health to nationals. She concludes that supranational human rights bodies that are mandated to supervise the implementation of human rights treaties can play a role protecting non-nationals' right to access affordable health systems on the same basis as nationals.

One of the core principles of the right to health is the importance of enshrining the right in national law. By extension, a state's commitment to UHC should also take the form of a binding legal provision. But even if such a legal provision is necessary, is it sufficient? Everaldo Lamprea and Johnattan Garcías's study of Colombia indicates that it may not be. In 1993, Colombia reformed its health law in order to achieve universal health care coverage through a national, comprehensive, and mandatory social insurance system subsidized by the government for the poor in which health care was to be provided through private health insurers. An important 2008 ruling handed down by the Constitutional Court required the integration of the hitherto unequal baskets of health services provided through the contributory and subsidized regimes. Nevertheless, despite the legal guarantees of health coverage, 2.3 million people out of Colombia's population of 48.7 million currently lack access to health care; in addition, others have had to resort to legal action to secure their benefits. This situation leads Lamprea and García to make the useful distinction between formal (legal) and material (actual) health coverage in Colombia and to identify factors accounting for this disparity, some of which (such as the unequal unavailability and access to health care in the wealthiest and poorest departments and regions) are likely to impede other countries' efforts to achieve UHC as well.

The type of health system financing adopted is a critical factor in securing universal health care and determining whether it is affordable both for the state and for the system's users. Anja Rudiger's article identifies ways in which the human rights framework offers valuable guidance for designing a financing strategy that meets these goals. Rudiger reports on a rights-based public financing plan and model—which included a new business tax directed against wage disparities—that was a component of recent universal health care reform efforts in the US state of Vermont. According to Rudiger, modeling results suggest that a health system financed through a rights-based public financing plan that includes equitable taxation could produce significant redistributive effects and thus contribute to economic equity while generating sufficient funds to provide comprehensive health care as a universal public good.

After several decades of inadequate funding and insufficient investment in health institutions and services, the health systems of many countries are seriously weakened. According to WHO, in many countries, health systems are underfunded and struggle to provide even basic health service coverage, particularly for rural and poor populations.[17]

Faced with this situation, some countries are turning to the private sector for the provision of health care and health services in order to expand health coverage. Antenor Hallo de Wolf and Brigit Toebes's article considers the legal human rights obligations imposed on states to regulate private sector involvement in health care. They emphasize that the obligation "to protect" the right to health requires that health services be available, accessible, acceptable, and of good quality, regardless of whether they are provided through the state or through private actors. They also propose that governments be encouraged to conduct human rights impact assessments to evaluate the consequences of privatization prior to its introduction. In addition, they identify the duty of governments to mitigate any financial problems related to out-of-pocket expenses charged by private actors.

Four decades ago, the Declaration of Alma-Ata identified comprehensive primary health care as key to the attainment of health for all.[18] Primary health care is both pro-poor and pro-rural. Moreover, there is historical evidence (such as in Thailand and Brazil) of primary health care serving as a foundation for the progressive realization of UHC.[19] Toby Freeman, Fran Baum, Angela Lawless, and their colleagues provide a case study of an Aboriginal community-controlled, universal, rights-based, publicly funded comprehensive primary health care service in Australia. They report how the Central Australian Aboriginal Congress community model of comprehensive primary health care has demonstrated impressive outcomes in a variety of areas—including intersectoral work on the social determinants of health, community participation, cultural respect, accessibility, and preventive and promotive health services—and therefore deserves attention as a promising model of primary health care based on health as a human right.

Like the Special Rapporteur, I would like to celebrate the momentum to progressively achieve UHC in the Sustainable Development Goals and elsewhere. But also like him, I would like to caution against simplifying the challenges and underscore the importance of incorporating a human rights approach.

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