INTERSECTION 3: HEALTH FINANCING AND OTHER BARRIERS TO UNIVERSAL ACCESS

The Universal Declaration of Human Rights proclaims that everyone has the right to "a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Drafted in 1948, this article represented not just a bold endorsement of the welfare state in industrialized countries, but also an affirmation of the idea that economic and social development is a central objective of the post-World War II human rights movement. As with other expensive public goods such as education and highway infrastructure, the last 60 years have posed significant challenges for advocates of universal access to health care as a human right, particularly as poor societies in Africa and Asia emerged from decades or centuries of colonial rule.

From the "Health for All" proclamation in 1978 to the 62nd World Health Assembly of 2009, which highlighted universal coverage as one of the four key pillars of primary health care and services, repeated affirmations of the principle stated in UDHR Article 25.1 have foundered on deep inequalities in resource distribution both within and between countries. The need for "effective health systems delivering comprehensive health services, including preventive services" to all of their citizens is a truism of development discourse. However, defining the actual "fair and sustainable financing structures" necessary to achieve such global health targets as Millennium Development Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health), and Goal 6 (Combat HIV/AIDS, malaria, and other diseases) has proven so contentious that many human rights advocates are reluctant to spend much energy addressing them for fear of distracting from more concrete and achievable objectives.

Health care is the most expensive element of any package of state interventions to guarantee a human right to "health and well-being." Therefore, the debate over how to pay for it, particularly in low-income settings, and whether universal access to the prerequisites of good health should be guaranteed by the international community where governments are unable to do so from local resources, has become a proxy for ideological contests about the relationship between market-oriented and state-centered models of development, or just distribution of resources worldwide.

The conundrum of health financing is deeply embedded in the project of human rights—and in many of the international agencies mandated to carry it forward. On the one hand, they advocate for sweeping norms, sometimes called "global public goods." On the other, they offer technical assistance to guide member states in their implementation of particular interventions. The World Health Organization represents the interests of both high disease-burden countries and donor nations, including their private-sector stakeholders. It is responsible for safeguarding the principle, enshrined in Article 27 of the Universal Declaration of Human Rights, that all can "share in scientific and technological progress," and meanwhile, on the ground, it tries to facilitate the rather less ambitious target of "the highest attainable standard of health" expressed in its constitution and restated in the Covenant on Social, Economic, and Cultural Rights.

These two mandates represent unresolved, perhaps irreconcilable, conflicts of mission, and the advent of so-called global health initiatives over the last decade has not succeeded in squaring the circle. Should equity—universal access—be a broadly normative target, with details to be worked out in the indefinite future, or should it be a practical rule of thumb? This question is not abstract; it underpins many strategic and programmatic decisions. If we are willing to accept "reasonable moral disagreement" on what universal access to treatment and care should mean in the near term, then attention will turn to determining which standards will be used in rationing, ensuring their transparency and due process, and surveillance of their population-level impact.[1] If, by contrast, we determine rationing to be unacceptable, then the question of cost immediately comes to the fore. The onus will shift to financing of services for those presently excluded.

One of the most contentious discussions relevant to health financing in a human rights framework has been about the appropriateness of extracting "user fees" or copayments for essential services. Whether by default or design, out of pocket payments have long been a key component of health financing in poor countries and affluent ones alike. The 2010 *World Health Report* documents widespread "financial catastrophe associated with direct payments for health services" and argues that "even when relatively low, any kind of charge imposed directly on households may discourage using health-care services or push people living close to poverty under the poverty line." In the view of many observers, copayments are not in fact a financing mechanism, but rather a rationing strategy that functions to mitigate demand that local health care institutions could otherwise not sustain. A number of key development institutions now sponsor country-level programs that deliver services without charge at the point of service delivery. In September 2009, leaders of Burundi, Ghana, Liberia, Malawi, Nepal, and Sierra Leone made public commitments to increase access to free health services.

Several recent studies affirm the argument that the barrier to access represented by direct out-of-pocket payments threatens achievement of the Millennium Development Goals' universal coverage mandate. A recent Cochrane Review based on 16 controlled studies suggests that introducing or increasing fees can indeed have a negative impact on health services utilization, while reducing or removing user fees increases the utilization of certain healthcare services (though this shift can have unintended consequences on utilization of preventive services and service quality). The authors note, however, that the studies of user fees all suffered from methodological weaknesses, likely due to the heated policy debate that surrounded them.[2]

In the end, the long struggle over user fees is only introductory to the practical dilemmas associated with a rights-based commitment to universal access. As suggested by Article 25.1 itself, barriers to effective care can include inadequate nutrition, transportation, education or health worker training and other key goods as well as cash resources. At a managerial level, many decentralized state health care delivery systems, where the margin between effective and ineffective action is narrow, tend to be refractory to new financing strategies. Other complicating factors include historical dynamics such as resistance to the banner of "free care" due to its longstanding association with dictatorship. The concept of health as a human right is a radical idea but given the forum to discuss, more active engagement may be possible.

Research into financing at the intersection of health and human rights would take the commitment to universal access as a starting point, but aim to inform the debate with data in place of assumptions. What are the actual costs supplied by copayments—what do user fees really cover? Meanwhile, from the patient perspective, what are the actual barriers to accessing essential services? How does this vary across different communities, and regionally between rural versus urban areas? Are user fees a significant proportion of costs to patients or their families, especially for non-communicable diseases? In settings where copayments have been abolished, how is care to be paid for, how large is the increase in demand and how well is it being managed? What national and transnational mechanisms can ensure the fiscal viability of high-quality health services in poor countries? What are the obstacles to successful implementation of free care programs, and what are the responsibilities of various stakeholders?

Health and Human Rights solicits articles on all of these topics, exploring the historical trajectory, current status, and future directions of sustainable financing mechanisms that promote the modern human rights movement's commitment to making the determinants of good health accessible to all.

REFERENCES

1. N. Daniels, *Just health: Meeting health needs fairly,* (Cambridge and New York: Cambridge University Press, 2008), p. 25.

2. M. Lagarde and N. Palmer. "The impact of user fees on access to health services in low- and middle-income countries." *Cochrane Database of Systematic Reviews* 2011, Issue 4.