

Anchoring universal health coverage in the **right to health:**

What difference would it make?

Policy brief

Acknowledgment

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Contents

| | |
|---|-----------|
| Introduction | 1 |
| Methodology | 1 |
| Proponents and opponents of UHC | 4 |
| UHC, equity and the right to health | 7 |
| The norms of UHC and the norms of the right to health: comparative assessment | 10 |
| Monitoring UHC and monitoring the right to health: comparative assessment | 12 |
| Key guiding questions for policy-makers implementing UHC anchored in the right to health | 19 |
| Annex 1 – The OPERA grid | 26 |



Introduction

Universal Health Coverage UHC is a critical component of the new Sustainable Development Goals (SDGs) which include a specific health goal: “*Ensure healthy lives and promote wellbeing for all at all ages*”. Within this health goal, a specific target for UHC has been proposed: “*Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all*”. In this context, the opportunity exists to unite global health and the fight against poverty through action that is focussed on clear goals.

Supporting the right to health and ending extreme poverty can both be pursued through universal health coverage.

For WHO, “UHC is, by definition, a practical expression of the concern for health equity and the right to health” (1); thus promoting UHC advances the overall objective of WHO, namely the attainment by all peoples of the highest possible standard of health as a fundamental right (3), and signal a return to the ideals of the Declaration of Alma Ata and the WHO Global Strategy for Health for All by the Year 2000 (4). Yet some argue that the “current discourse on UHC is in sharp contrast with the vision of Primary Health Care envisaged in the Alma Ata declaration of 1978” (5).

The underlying assumption of this paper is that efforts towards achieving UHC *do* promote some, but not necessarily *all*, of the efforts required from governments for the realization of the right to health. While this publication explores how efforts to advance towards UHC overlap with efforts to realize the right to health, its main focus is the gaps that exist between UHC efforts and right to health efforts.

Methodological challenges

The first methodological challenge stems from a somewhat circular debate between proponents and critics of UHC. The former argue that UHC is a platform to promote the right to health; and that any claim to UHC that does *not* serve this purpose is simply not truly universal health coverage.

There are two main options for dealing with this conundrum. The first is to determine an authoritative definition of UHC, and to establish means to ensure that all efforts towards UHC do indeed promote the right to health. The second is to incorporate a benchmark of quality against which efforts towards achieving UHC in line with the right to health are measured and assessed.

For this study we tried to use a mixture of both approaches, but we leaned towards the second because we thought it would be more useful to identify what policy-makers should

keep in mind if they want to use UHC as a way to promote the right to health, rather than to make a judgement as to whether efforts towards UHC usually contribute to the realization of the right to health or not. It is important to understand the limitations of our approaches.

We used four different approaches:

- First, we identified the major areas of controversy surrounding UHC, using a simple Google Scholar search for academic papers published in 2012, 2013 and 2014. This approach was particularly plagued by the debate cited above whereby opponents and proponents seem to have different conceptions of UHC. We did not try to side with opponents or proponents; we distilled their main arguments and reframed them in right to health language, to serve as guiding questions (for policy-makers who want to use UHC as a way to promote the right to health).
- Second, we revisited the questions about equity in health in relation to UHC, as identified and examined by the WHO Consultative Group on Equity and Universal Health Coverage (6). The approach of the Consultative Group is similar to ours: it tried to make recommendations for policy-makers who want to use UHC to promote equity in health, instead of trying to judge whether UHC contributes to equity in health.
- Third, we included the findings of the comparative assessment of the norms UHC imposes on governments and the norms the right to health imposes on governments – this comparative assessment was undertaken earlier for the Go4Health project (7). This approach leans towards judging whether UHC as defined in authoritative statements promotes the right to health, or not. The main limitation of this approach is that these authoritative statements are fairly short; they do not necessarily capture everything that proponents of UHC have in mind. The advantage of this approach is that it warns of omissions in UHC implementation: issues that may be overlooked and that are essential for the realization of the right to health.
- Fourth, we compared how progress towards UHC is monitored with how the realization of the right to health is being monitored. We used the so-called OPERA framework, developed by the Center for Economic and Social Rights (8), adapted it, and applied it to the PLoS Medicine collection, published in September 2014, on “Monitoring universal health coverage”, which includes 13 peer-reviewed country case studies (9). The idea was to compare what public health practitioners are looking for when they assess progress in UHC with what human rights lawyers would be looking for if they were to assess the realization of the right to health in the same countries. The main limitation of this approach is that we really evaluated the authors of these papers – what they look for or do not look for when they monitor UHC – rather than the actual efforts made by the 13 countries to achieve UHC.

We formulated our conclusions as key guiding questions for policy-makers who want to implement UHC anchored in the right to health.

The second methodological challenge is related to the scope of UHC and the scope of the right to health. The right to health covers more than the right to health care. According to the United Nations Committee on Economic, Social and Cultural Rights, which monitors progress towards the right to health, the right to health is “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health” (10). At present, much debate surrounding UHC remains focused on health-care services, under which are included “prevention, promotion, treatment and rehabilitation” (1).

In our opinion, it would not be problematic in itself if UHC remains focused on health care, so long as it is clear that UHC defined in this way contributes only partially to the realization of the right to health. What is problematic is the lack of clarity about whether UHC includes access to broader determinants of health, including water and sanitation, nutrition and housing and so on. If the authorities who are in charge of realizing UHC consider that this is not their job, while the authorities of other sectors think that UHC includes all of these issues, in the end nobody is taking responsibility. Comprehensive social spending, spending on education, housing, water and sanitation are vital for good health. Working across sectors to get commitments on domestic spending targets as a percentage of gross domestic product (GDP) is one way of making headway on the broader determinants of health, UHC and the realization of the right to health.

For this study, we focused on efforts to advance the right to health care: i.e. we worked towards key guiding questions for health sector policy-makers who want the health sector to contribute to the realization of the right to health as best it can, while keeping in mind that the realization of the right to health depends on other sectors as well. Even some aspects of the right to health care depend on action outside the health sector. So health sector policy-makers should, at a minimum, assume responsibility for advocacy aimed at other sectors that impact on health, including education, sanitation and nutrition.

The proponents and opponents of UHC, and their main arguments in right to health language

Rationale of this approach

There are many reasons why people and organizations support or oppose UHC; some of these reasons are related to the right to health, some of them are not. The arguments related to the right to health are not always expressed as such. While trying to avoid legal jargon, we expressed the key arguments in right to health terms and assessed them accordingly.

Debates between the proponents and the opponents of UHC can be hard to follow because they do not always use the same benchmarks. Debates between the proponents and the opponents of UHC can be hard to follow because they do not always use the same benchmarks. Proponents commonly refer to the present situation and the short-comings - in terms of inequities - of the former health-related Millennium Development Goals (MDGs) that UHC seeks to redress. Some of the opponents also refer to the present situation and argue that UHC is a step backwards from the highly focused health-related MDGs. Other opponents refer to the ideal of primary health care. Other opponents refer to the ideal of primary health care. Below we summarize and compare the key arguments of the opponents and the proponents of UHC.

1. Equity in health through ending financial exclusion

A key argument in support of UHC – perhaps *the* key argument – is that it focuses on removing the financial barriers impeding access to health care (11), thus bringing an end to the exclusion from health care that is ascribable to poverty (12). While the right to health is defined in a way that acknowledges that it may be impossible for governments to provide all forms of health care to all people at once, it does impose the obligation that whatever forms of health care a government provides, it must provide them to all people who need them, without discrimination, and that includes discrimination on financial grounds (7). Therefore, if UHC succeeds in removing financial barriers to access to health care, it contributes to a key feature of the right to health.

2. Comprehensive/holistic approach in line with national priorities

Proponents claim that UHC has the potential to unify different health constituencies, gain political support and thus expand on the successes of the MDGs while overcoming their shortcomings, notably the uneven progress in advancing health beyond specific focus areas (13). They argue that this is because UHC aims “at a strong, efficient health system that can deliver quality services on a broad range of country health priorities” (1), rather

than on specific interventions for priorities identified by the international community. The strengthening of health systems was affirmed as a priority in the June 2012 Rio+20 resolution (14). The focus on health systems that deliver quality services in line with national priorities echoes the demands of the right to health. The right to health entails a right to health care that responds to the priority needs of people, which may or may not be the priorities identified by the international community, depending on the context. In addition, the right to health requires that these services be accessible, available, locally acceptable and of quality (AAAQ) (15). Therefore, if UHC succeeds in providing access to an AAAQ health-care system that provides services in line with national priorities, it contributes to advancing key components of the right to health.

3. Global applicability and relevance

Whereas the MDGs – implicitly at least – advanced health goals for low- and middle-income countries, UHC has universal applicability as it has relevance for all countries no matter what their income level. As Kutzin notes, no country can ever fully achieve UHC but continuous efforts to expand UHC will progressively improve access to health care for all (16). The right to health entails an obligation of so-called progressive realization: the International Covenant on Economic Social and Cultural Rights (ICESCR), which includes the right to health, obliges countries to take steps “with a view to achieving progressively the full realization of the rights recognized in the present Covenant” (17). Thus the right to health, like UHC, is never fully realized – further steps are always possible.

4. Ambiguity as to the scope and definition of UHC entailing a risk of exclusive focus on the health sector, backward steps

Many of the drivers of health inequity cannot be addressed through the health sector alone and require a broader multisectoral approach, including addressing the role of trade and education (18). As Sridhar et al. note, “it is unclear what health services UHC covers (e.g. whether it fully covers public health services such as sanitation, vector abatement, and tobacco control), and questions arise over whether UHC includes only services within a state’s health sector or services and interventions outside the health sector” (19). Realizing the right to health requires progress on health care and the underlying determinants of health, and it is unclear whether UHC also addresses these key underlying determinants. In particular, documents about UHC remain vague about the notion of shared responsibility, expressed as an obligation to provide “international co-operation and assistance” under human rights law (17), which is fundamental to the global response to HIV/AIDS. Achieving UHC anchored in the right to health will require continued international support (21).

5. Lack of attention to vulnerable and marginalized groups

UHC's focus on exclusion through financial barriers may divert attention from other forms of exclusion. As Fried et al. note, "[e]fforts to realize rights necessarily extend beyond services and commodities and draw attention to other social determinants of health and issues of discrimination within the health system" (20). Monitoring health outcomes to identify gaps due to discrimination requires monitoring and evaluation systems that are designed to identify gaps in coverage that arise from multiple types of discrimination that may stem from factors outside the health system (see point 4 above).

6. The role of the state and the private health-care providers in UHC

Last but not least, some public health activists are concerned that, as currently framed, UHC leaves too much leeway for the inclusion of private for-profit providers, and does not sufficiently emphasize the responsibility of governments (5). The right to health, as enshrined in the ICESCR, makes no mention of the role of private providers in realizing rights. However, the ICESCR is clear that the state is the primary duty bearer responsible for realizing rights: if the state relies on private providers, it must ensure these providers fulfil their role on behalf of the government (22).

Conclusions from this approach

UHC can make significant contributions to the realization of the right to health, notably by ending financial exclusion and by contributing to strengthening national health systems that provide health care that responds to local needs instead of health care in line with international priorities, and by contributing to the progressive realization of the right to health in all countries. However, to be anchored in the right to health, the scope of UHC should be clarified, its proponents should ensure that UHC does not mean backward steps on particular issues, that UHC looks beyond the health sector, that UHC is based on shared – i.e. national and international – responsibility, and that it pays more attention to vulnerable and marginalized groups. Last but not least, the public role of private providers should be affirmed.



UHC, equity and the right to health

Rationale of this approach

In line with the intention of UHC to be “a practical expression of the concern for health equity” (1), WHO convened the WHO Consultative Group on Equity and Universal Health Coverage. As health equity is in many respects an ideological sibling of the right to health, we revisited the main conclusions of the WHO Consultative Group on Equity and Universal Health Coverage and assessed these conclusions from a right to health perspective.

The 2004 *World report on knowledge for better health*, published by WHO, defines inequity in health as “systematic and potentially remediable differences in one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups” (23). Equity is defined (in the same report) as the “[p]rinciple of being fair to all persons, with reference to a defined and recognized set of values”. The inherent weakness of the equity approach is the lack of a well-defined and widely accepted set of values. The right to health offers a partial solution to this weakness: it is somewhat better defined than equity, and widely recognized in the sense that the majority of WHO Member States have ratified the key treaties including references to the right to health: the ICESCR, as mentioned above, but also the Convention on the Rights of the Child (CRC) (24), and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (25).

The WHO Consultative Group on Equity and Universal Health Coverage proposes a three-part strategy for “countries seeking fair progressive realization of UHC” (6):

Countries can do the following:

- (a) Categorize services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to the worse off, and financial risk protection;
- (b) First expand coverage for high-priority services to everyone. This includes eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds;
- (c) While doing so, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations.

(a) Prioritization in accordance with cost–effectiveness, priority for the worse off and financial risk protection

As mentioned above, the right to health is defined in a way that acknowledges that it may be impossible for governments to provide all forms of health care to all people at once (7). Therefore, the prioritization of services provided under UHC – which implies that some services will not be provided, at least temporarily – is not necessarily a violation of the right to health. Based on the general concept that all lives – or all years of life – have equal worth, using cost–effectiveness criteria should ensure that the available resources are distributed fairly, the prioritization of the worse off (the vulnerable and the marginalized people, for example), should correct types of discrimination that are rooted in societies, and financial risk protection should ensure that discrimination due to financial barriers is brought to an end.

Thus the right to health perspective confirms this principle, and adds that it is not optional but a matter of legal obligation. However, cost–effectiveness criteria can push rationalization below the limits that are acceptable from a human rights perspective. As the United Nations Committee on Economic, Social and Cultural Rights – created to monitor compliance with the ICESCR – noted, “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party” (26). Thus there is a minimum level of the right to health; not providing the services needed to achieve this minimum level cannot be justified with cost–efficiency arguments or prioritization of another sector. If some governments are unable (not unwilling) to provide this minimum level, the international community must step in and provide assistance. International assistance is not a substitute for domestic investment (27).

(b) Expanded coverage for high-priority services to everyone, including eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds

This recommendation is entirely in line with the right to health; we can only add that it is a matter of legal obligation.

(c) Ensuring that disadvantaged groups are not left behind

This recommendation is entirely in line with the right to health; we can only add that it is a matter of legal obligation.

Conclusions from this approach

If and where UHC is implemented in line with the recommendations of the WHO Consultative Group on Equity and Universal Health Coverage, it comes close to being UHC anchored in the right to health. But UHC anchored in the right to health requires that cost–effectiveness criteria are used with care, to avoid justifying UHC below the minimum level demanded by the right to health.



Identifying and removing the multiple barriers stemming from socioeconomic exclusion and/or discrimination is certainly vital to advancing UHC but it is not sufficient in itself. Efforts are required to identify the specific groups that are vulnerable or marginalized in a given country and region(s) and include them in UHC plans to ensure that health coverage is truly universal.

The norms of UHC and the norms of the right to health: comparative assessment

Rationale of this approach

The right to health is enshrined in international human rights law, which sets the norms that governments are supposed to abide by. UHC too has been captured in norms – albeit less explicitly than the right to health. Comparing these norms highlights the difference between UHC anchored in the right to health and UHC not explicitly anchored in the right to health (28). With colleagues from the Go4Health project, we undertook this comparative assessment, the detailed findings of which were published in a journal article (7). Here, we will briefly explain the authoritative sources we considered and the main findings as they inform our key guiding questions.

The authoritative sources of the norms that underpin the right to health are fairly easily identifiable. The human rights mentioned in the Universal Declaration of Human Rights (UDHR) (29) were further elaborated in two covenants that together with the UDHR make up the International Bill of Rights: the International Covenant on Civil and Political Rights (30), and the ICESCR, already mentioned (17). The right to health is included in the ICESCR. To monitor compliance with the ICESCR, the above-mentioned Committee was created, which issues authoritative interpretations of rights included in ICESCR: the so-called general comments. General Comment 14 clarifies the scope and the content of the right to health (10).

With regard to UHC, the 2005 World Health Assembly (WHA) resolution on “Sustainable health financing, universal coverage and social health insurance” (Resolution WHA58.33) (31), has been accepted. All WHO Member States are represented at the WHA, and each country has one vote. We can therefore consider it as similar to a resolution adopted by the General Assembly of the United Nations. Furthermore, in 2012, the General Assembly voted in support of a resolution on “Global health and foreign policy”, which was essentially about UHC (2012 UNGA Resolution) (32). Both resolutions are relatively short and may not fully reflect the concept of UHC. We therefore decided the 2010 World health report on “Health systems financing: the path to universal coverage” (33), and the WHO discussion paper on health in the post-2015 agenda (2012 WHO Discussion Paper) (1) in our analysis as well.

These are the main findings of our comparative assessment.

1. Like the right to health, UHC (as described in the authoritative sources) promotes *comprehensive* health-care services, as opposed to disease- or issue-specific services.
2. UHC is in line with the principle of *progressive realization* as enshrined in the Covenant.

3. UHC explicitly aims to put an end to the discrimination that is caused by direct payments, and thus UHC affirms at least that element of the principle of *non-discrimination*. On other causes of discrimination, the authoritative sources of UHC are less clear.
4. UHC seems to embrace the principle of *cost-effectiveness prioritization* as it promotes nationally determined sets of health services, developed within the epidemiological context of each country.
5. With regard to the principles of *participatory decision-making* and *prioritizing vulnerable or marginalized groups*, UHC is less straightforward than the right to health care: the principle of national ownership advanced in the 2012 UNGA Resolution does not necessarily imply that the relevant decision-making processes will be participatory or will prioritize vulnerable or marginalized groups.
6. While the right to health entails a *core content* – related to a set of core obligations which apply to all countries, regardless of their wealth – and thus guarantees a minimum level of health care, UHC does not seem to have any kind of “floor”. If the economic context of a given country leads to a level of health care that does not even address standard health threats, UHC seems to tolerate that.
7. Related to the previous point, the authoritative sources of UHC have little to say about the principle of *shared responsibility*. Although the 2010 World health report mentions that low-income countries will need international assistance to achieve UHC, it does not mention that this assistance is a matter of legal obligation.

Conclusions from this approach

UHC can make significant contributions to the realization of the right to health, notably by promoting comprehensive health-care services, by supporting the principle of progressive realization, by putting an end to discrimination on financial grounds and by supporting prioritization based on cost-effectiveness. However, UHC is less clear when it comes to other forms of discrimination or exclusion, and UHC does not imply a minimum level or core content of the right to health – thus cost-effectiveness criteria may push UHC below the minimum level. Shared – i.e. national and international – responsibility for UHC is not clearly mentioned in the norms underpinning UHC, and these norms pay little attention to vulnerable and marginalized groups and participatory decision-making.

Monitoring UHC and monitoring the realization of the right to health: comparative assessment

Rationale of this approach

If the proof of the pudding is in the eating, then the most informative way of comparing UHC anchored in the right to health with UHC not explicitly anchored in the right to health would be to compare how public health practitioners monitor progress towards UHC with the way human rights practitioners monitor the realization of the right to health.

As important as the scholarly debate, is the implementation in real life of UHC, and how public health practitioners engage with UHC. When these practitioners monitor UHC, are they measuring the progress human rights lawyers would measure when monitoring the realization of the right to health? Are they identifying the same shortcomings? Are they making the same recommendations?

In 2014, PLoS Medicine published a collection of country studies on “Monitoring universal health coverage” (9). The collection includes 13 relatively short country studies, but each of them comes with a longer and more comprehensive full case study. The countries are: Bangladesh (34, 35), Brazil (36, 37), Chile (38, 39), China (40, 41), Estonia (42, 43), Ethiopia (44, 45), Ghana (46, 47), India (48, 49), Singapore (50, 51), South Africa (52, 53), Thailand (54, 55), Tunisia (56, 57) and the United Republic of Tanzania (58, 59).

To assess whether the authors of these country studies look for the same advances and gaps human rights practitioners would look for, and whether they make the same recommendations human rights practitioners would, we used the so-called OPERA framework, developed by the Center for Economic and Social Rights (8). Because the OPERA framework was developed for all economic, social and cultural rights, not for the right to health in particular, we adapted questions using the framework developed by Backman et al. for a “health systems and the right to health” assessment of 194 countries (60). The complete results appear in Annex 1; here we summarize the main points.

1. Outcomes: Assessing the health services included in the UHC package

To measure the aggregate levels of rights enjoyed (and progress over time) the OPERA framework guides us to assess whether the health services included in the UHC package respond to the priority health needs of the population, which overlap with the core obligations identified by the right to health. Most country studies measure access in terms of access to a predefined package. However, the predefined package may not be the appropriate one – it may not live up to the minimum level of health services to which all people should have access, regardless of the economic conditions of the country they live in – and it may not meet the requirements of progressive realization – it may not include all

the services that the state could provide, if it mobilized and allocated maximum available resources. At present there is no WHO directive as to what these services include.

UHC “is *not* about a fixed minimum package” (1), and the right to health does not require a *fixed* minimum package that is the same for all countries. But the right to health does require that people have access to *essential* medicines, and “[e]ssential medicines are those that satisfy the priority health care needs of the population” (61). Therefore, for UHC to be (or become) anchored in the right to health, any effort to measure UHC should start from an assessment of the priority health needs of the population, and not from an agreed package. None of the country studies includes a systematic assessment of the health services covered or whether they respond to the priority health needs of the population. However, the Chile country study provides a comprehensive list of health issues covered by its Explicit Health Guarantees, noting that they had expanded from 25 in 2005 to 80 in 2013, but nevertheless do not adequately respond to the changing pattern of burden of disease (e.g. towards noncommunicable diseases) and injury.

2. Outcomes: Vulnerable and marginalized populations

The right to health requires that health services be provided “without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (17). The OPERA framework captures this aspect by asking us to assess outcomes in terms of disparities in access to rights for vulnerable and marginalized populations in a broad sense. Most studies of UHC focus on exclusion or discrimination for financial reasons. Indirectly this may capture other forms of discrimination that occur in societies, as these other forms of discrimination will often lead to lower socioeconomic statuses as well. But it should not be taken as a given that solving socioeconomic exclusion will solve all exclusion.

Therefore, for UHC to be(come) the practical expression of the right to health, any effort to measure UHC should start from an assessment of all the excluded people, and be mindful of possible exclusion based on “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (17). According to the Committee, “[r]ight to health indicators require disaggregation on the prohibited grounds of discrimination” (10). Most country studies include data about access to maternal health services. However, disaggregated data about access to general health services are less common. Several studies, including those on Bangladesh, Brazil, China, Chile and Thailand, disaggregate data related to noncommunicable diseases (e.g. diabetes and hypertension) by gender and the Singapore study notes that women in lower social classes access cancer screening less often.

Aside from limited data disaggregated by gender, data related to marginalized and vulnerable groups, the key focus of the right to health, are mentioned in only a few studies; including a reference to so-called Tribals in the India study, the urban–rural divide in Chile and the coastal–rural (inland) divide in Tunisia. The study on Tunisia specifically mentions that certain vulnerable groups (mainly comprising unemployed, seasonal and occasional workers) do not enjoy the right to health.

3. Outcomes: Mixed systems require disaggregated monitoring

The country studies highlight the diversity of approaches taken in pursuing UHC including with respect to public, private and mixed health-care systems. As the Committee noted in General Comment 3, “in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or *laissez-faire* economy, or upon any other particular approach” (30). In General Comment 14, the Committee explicitly allows “the provision of a public, private or mixed health insurance system” so long as it “is affordable for all”, and asserts that states must “ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services” (10). The country studies suggest that efforts to advance towards UHC in most of the countries rely upon the integration of private health-service providers and private health insurance schemes into the health system, which is organized and subsidized by the government. This is not, in itself, problematic from a right to health perspective. However, one can presume that at least private *for-profit* providers and insurers will tend towards selecting the more profitable health-care seekers, and this may result in discrimination based on socioeconomic status (62). None of the country studies provides these disaggregated data. The study on Chile mentions problems associated with the current dual system at pooling and providers’ level, resulting in unequal availability of funds and risk selection issues. The WHO Health Inequalities Monitor can assist governments with disaggregated monitoring (63).

4. Outcomes: Access ≠ AAAQ

The OPERA framework invites us to look at policy content and implementation with respect to AAAQ (or triple A–Q), which stands for availability, accessibility, acceptability and quality. Most country studies focus on utilization, which presupposes availability, accessibility and – most often – acceptability, but not quality. The Singapore country study notes the efforts made to track access to care by waiting time.

Several country studies (including that of India) highlight that the quality of health services is not captured adequately by the indicators they use. The Estonia study notes that the methods for measuring quality are under development and at present include re-hospitalization rates, patient satisfaction surveys (also in the United Republic of Tanzania) and efforts to develop quality surveys. However, the South Africa study suggests that patient satisfaction surveys are a poor indicator of quality. For UHC to be(come) the practical expression of the right to health, further efforts to develop quality indicators are needed so that monitoring efforts can include vital indicators on quality.

5. Policy: Participation matters

Analysing policy processes to identify avenues for genuine participation is key to the OPERA framework assessment of policy efforts. This priority flows directly from General Comment 14, which notes that it is a core obligation “[t]o adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy *and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process*” (emphasis added) (10). Only the Brazil country study mentions the role of community participation and “social participation” in the social control of the health system (37). However the Tunisia study suggests that, in the future, civil society may be able to push for political commitments to UHC and provide input into the package of services and mechanisms for monitoring progress.

6. Policy: Legal commitments

The OPERA framework includes monitoring of legal and policy commitments as an element for assessing policy commitments. Although the majority of the countries in the PLoS Collection have ratified the Covenant, none of the country studies refers to the Covenant or to its ratification. It appears as if ratification of the Covenant is not relevant for scholars who monitor UHC. To be fair, some country studies do refer to the place of health in the national constitutional (including Brazil and Chile) or national legislation (including Brazil, Chile, Estonia, Ghana, India, South Africa, Thailand and the United Republic of Tanzania) but the international context is largely absent; although several country studies mention the Abuja Declaration (Ghana, Tunisia and the United Republic of Tanzania), Alma Ata (Ghana and India) and the Ouagadougou Declaration (Ghana).

7. Resources: Maximum available resources?

When it comes to domestic financing, UHC provides very little guidance, while the right to health entails that countries should allocate “maximum available resources”: “A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above” (10). Several country studies indicate that domestic public health financing is actually going backwards (including Bangladesh, Ghana and Tunisia), while the South Africa study mentions the absence of benchmarks and highlights the problems this causes in monitoring progress: “It is challenging to interpret the indicators proposed by the WHO, in terms of a country’s status relative to the goal of UHC, at a single point in time unless there are ‘benchmarks’ to which they can be compared. There are currently no widely agreed UHC ‘benchmarks’, although some have recently been suggested by different groups on which

we draw here” (52). The “recently suggested benchmarks” mentioned in the South Africa study draw upon the right to health:

- The Sustainable Development Solutions Network was inspired by “Universal Health Care as being built on the foundation of human rights and equity”, and argues for all countries to “make progress to allocating at least 5% of national GDP as public financing for health” (64).
- The Chatham House Centre on Global Health Security Working Group on Health Financing argues that, “to promote sustained progress, agreement on clear targets and shared responsibilities should be sought on the basis of justice, solidarity and human rights”, and recommends “that the [Government Health Expenditure]/GDP target should be at least 5 per cent for all countries” (27).

8. Resources: Pooled financing does not always mean equitable financing

The World health report of 2000 offers a simple and straightforward description of fairness in health financing: “Achieving greater fairness in financing is only achievable through risk pooling – that is, those who are healthy subsidize those who are sick, and those who are rich subsidize those who are poor” (65). According to the Committee, “equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households” (10).

The OPERA framework guides us to look at resource generation, expenditure and allocation when assessing progress towards the right to health and to understand their impact on equitable and non-discriminatory access to health-care services. It is widely acknowledged that out-of-pocket expenditure for health services frequently results in a disproportionate financial burden for poorer households or people, and the focus of UHC efforts on moving away from out-of-pocket expenditure for health services will therefore most often result in steps in the right direction. However, it should not be taken for granted that all forms of pooling of financial resources contribute to “rich subsidizing poor” or “healthy subsidizing sick”. The Chile country study notes the problem of fragmented pooling. Mixed systems often come with ring-fenced pools that separate the rich from the poor and the healthy from the sick. Only two country studies examined the equity of financing explicitly, South Africa and the United Republic of Tanzania, which used the so-called Kakwani index.¹

9. Resources: Future resources

WHO asserts that UHC is a dynamic process, it “is *not* about a fixed minimum package, it is about making progress on several fronts” (emphasis in original) (1), and as such it aligns well with the notion of progressive realization which is an essential principle of the right to health. Just as the right to health can never be fully achieved, UHC can never be

¹ The Kakwani index is a widely used summary index of progressivity. It measures tax progression by focusing on whether the tax system is progressive, proportional or regressive, to help measure “income-related” health inequality. It is based upon a comparison of the inequalities of expenditures for health care and income (66, 67).

fully achieved. Most country studies document progress made in recent years (or absence thereof), but very few look forward. The OPERA framework pushes us to examine the policy processes around resource generation – looking both forward and back. According to the World Bank, “[i]n the past twenty years more than 130 countries have adopted a Medium-Term Expenditure Framework (MTEF) as a tool for improving fiscal performance. The rationale behind these reforms is that MTEFs allow governments to more adequately incorporate future fiscal challenges in the budget process, thereby reducing an undue emphasis on short-term goals” (68). None of the PLoS country studies mentions the MTEF.

10. Resources: International resources

The notion of shared – i.e. national and international – responsibility seems to be excluded from normative definitions of UHC, thus casting doubt on the universal nature of UHC. The country studies from Bangladesh, Ethiopia, Ghana, South Africa, Tunisia and the United Republic of Tanzania mention aid but do not consider whether or how aid advances UHC or whether or not these countries receive enough aid: international financing seems to be regarded as windfall. The OPERA framework suggests that all countries should examine the role of development assistance in realizing the right to health to ensure that sufficient resources are allocated and received.

The “recently suggested benchmarks” mentioned in the South Africa study include benchmarks for international financing as well:

- The Sustainable Development Solutions Network suggests that high-income countries ought to “allocate at least 0.1% of gross national income as international assistance for health, for supporting the efforts of low- and middle-income countries for implementing UHC” (63).
- The Chatham House Centre on Global Health Security Working Group on Health Financing recommends that high-income countries “should commit to provide external financing for health equivalent to at least 0.15 per cent of GDP” and most upper middle-income countries “should commit to progress towards the same contribution rate” (27).

(Reference in endnote: Tracking Universal Health Coverage, First Global Monitoring Report, Geneva, 2015, (http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1, accessed 12 August 1 2015) (1). WHO defined UHC as “coverage with needed health services (prevention, promotion, treatment and rehabilitation) and coverage with financial risk protection, for everyone” (1).

Conclusions from this approach

We will not try to summarize the 10 points above which clearly highlight the difference between what public health practitioners are looking for when they assess progress in UHC and what human rights lawyers would be looking for if they were to assess the realization of the right to health in the same countries. These gaps highlight two key points.

1) First, if UHC is not anchored in the right to health it risks not being universal with respect to providing coverage to all people. Focusing on coverage percentages and not disaggregating data can mask exclusion. The complex interplay between social marginalization or exclusion and economic exclusion can render vulnerable and marginalized individuals, (e.g. the child of an unmarried, undocumented migrant) and groups invisible to the authorities. Addressing this added dimension of exclusion would be a priority if UHC is anchored in the right to health.

2) Second, like the right to health, progress towards UHC is about the journey, not the destination. UHC monitoring is often backward looking, analysing a snapshot. While this snapshot is vital it is equally important to focus on the journey ahead, and how the country will progress towards UHC. This requires examining the policy processes, including resource generation and allocation, as well as opportunities for genuine participation and input. UHC anchored in the right to health requires that authorities engage with those who are excluded and devise policies to include them in the health system, and the social system more broadly, thus making progress towards UHC truly universal.

Key guiding questions

These questions, tailored for national health sector policy-makers, aim at ensuring that the actions the health sector takes to advance towards UHC can also contribute to realizing the right to health in a given country. Health sector policy-makers are reminded that the realization of the right to health depends on other sectors as well. They are encouraged to contribute to advancing the right to health beyond the health-care system, by, at a minimum, assuming responsibility for advocacy aimed at other sectors that have an impact on health, including education, sanitation, water and nutrition.

1. Do the health services included in the UHC package respond to the priority health-care needs of the whole population?

The existence of a UHC package or package of basic services is not sufficient in itself because the package on offer may not be the appropriate package to respond to the priority health-care needs of the whole population. Additionally, the package on offer must be flexible and responsive to changes in priority health-care needs of the whole population.

2. Do the UHC plans identify marginalized and vulnerable groups in the country and the different regions?

Identifying and removing the multiple barriers stemming from socioeconomic exclusion and/or discrimination is certainly vital to advancing UHC but it is not sufficient in itself. Efforts are required to identify the specific groups that are vulnerable or marginalized in a given country and region(s) and include them in UHC plans to ensure that health coverage is truly universal.

3. If you have a mixed (public and private system) does your monitoring system disaggregate findings pertaining to private providers or insurers from findings pertaining to public providers or insurers?

Efforts to monitor UHC should ensure that a mixed system does not lead to discrimination or exclusion on the basis of socioeconomic status. Disaggregating findings can help determine whether or not private for-profit providers and insurers cover all health-care seekers.

4. Do you measure the progressivity of each of the funding streams of your pooled financing system to ensure that poorer households or people do not bear a disproportionate financial burden?

Using pooled financing as a means of moving away from out-of-pocket payments for health services should assist poorer households or people, but it does not necessarily result in equitable financing. Applying the Kakwani index can assist in measuring the progressivity of funding streams or pools.

5. *Do your UHC monitoring efforts include quality of care indicators?*

Agreeing on indicators of quality of care is a difficult process, but agreeing on and monitoring such indicators is key to advancing UHC.

6. *Is your national public health strategy and plan of action designed and periodically reviewed on the basis of a participatory and transparent process?*

The development of the national public health strategy and plan of action needs to consider input gathered through a participatory and transparent process. The periodic review of the strategy and plan of action should also be a participatory and transparent process which feeds into strengthening accountability.

7. *Do your UHC monitoring efforts look at the medium term expenditure framework (MTEF) and the budget for UHC for the years to come?*

UHC is not a goal that can be fully achieved but a dynamic process that requires constant attention. Therefore efforts to advance UHC need to look forward not just back; thus, including MTEF and budget projections in monitoring efforts helps in assessing the sustainability of progress.

8. *Does your level of domestic public health financing meet international or regional targets?*

Monitoring efforts to comply with international or regional commitments on domestic public health financing requires identifying the domestic public health financing targets your country has committed to at the international or regional level (e.g. the Abuja Declaration). Tracking compliance with these targets over time will help to identify progress.

9. *Does your level of development assistance for health meet international or regional targets?*

Monitoring efforts to comply with international or regional commitments on financing development assistance for health requires identifying the international or regional targets your country has committed to (e.g. the 0.7% of GDP target). Tracking compliance with these targets over time will help to identify progress.

10. *If you have ratified the Covenant do you comply with its periodic reporting obligations regarding the right to health?*

Efforts to make progress towards UHC can be viewed as practical efforts to realize the right to health. Those states that have ratified the Covenant should highlight their efforts to progress towards UHC as a fundamental element of their commitment to realizing the right to health.

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Annex 1

The OPERA framework¹

| OPERA | | | PROJECT | PLOS Medicine papers | | | | | | | | | | | | | | |
|--|---|--|---|----------------------|--------|-------|-------|---------|----------|-------|-------|-----------|-----------|-----------------------------|----------|---------|---|---|
| | WHAT CONCEPTS ARE WE MEASURING? | HOW CAN WE MEASURE THEM? | ELEMENTS | Bangladesh | Brazil | Chile | China | Estonia | Ethiopia | Ghana | India | Singapore | S. Africa | United Republic of Tanzania | Thailand | Tunisia | | |
| Measure aggregate levels of rights enjoyment | Minimum core obligations: Widespread deprivation suggests obligations (e.g. to reach minimum essential levels of a right) are not being met. | Compare socio-economic outcome indicators to relevant benchmarks and/or comparable countries. Deviations can point to whether or not a country's performance is reasonable. | Package of services | | | X | | | | | X | | X | | | X | | |
| | | | Essential medicines | | | | | | | | | | | | X | | | |
| | | | Geographical access | | X | X | X | | X | X | X | X | X | | X | | X | |
| | | | Millennium Development Goals (MDGs) | X | | X | | | X | X | | | | | X | X | X | |
| Measure disparities in rights enjoyment | Non-discrimination and equality: rights raise concerns about possible discrimination or failure to address disadvantage. | Disaggregate socio-economic indicators by relevant social groups (e.g. ethnicity, religion, gender, region, income, etc.) to uncover any particular or intersecting disparities. | Gender | | X | X | X | | | | | | | | X | | | |
| | | | Marginalized groups | | | X | | | | | X | | | | | | | |
| | | | Income quintiles/deciles | X | X | X | X | X | X | X | X | X | X | | | | | X |
| | | | Different tiers (public-private) | X | X | | | | | | | | | | | | | |
| | | | Level of education | | X | X | | X | | | | | X | X | | | | |
| Measure progress over time | Progressive realization and non-retrogression: Identifying trends in the enjoyment of a right over time indicates whether there is progress or backsliding and whether disparities are growing or reducing. | Compare the same socio-economic indicators over time (aggregate or disaggregated). | Package of services/essential medicines/geographical access | | | X | X | | X | X | | | | | | | | |
| | | | MDGs | X | | | | | X | X | | | | X | | X | | |
| | | | Gender | | X | | X | | | | | | | | | X | | |
| | | | Marginalized groups | | | | | | | | | | | | | | | |
| | | | Income quintiles/deciles | X | X | X | X | | | | | | X | X | X | X | | |
| | | | Different tiers (public-private) | | X | | | | | | | | | | | | | |

¹ The Centre for Economic, Social and Cultural Rights is gratefully acknowledged for the reproduction of its OPERA framework.

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|--|---|---|---|---|--|---|---|---|---|---|---|---|---|---|---|---|---|---|--|
| Identify legal and policy commitments | Obligation to take steps: Whether the government is taking adequate legislative, judicial, administrative, social and other measures towards the full realization of rights. | Identify indicators that demonstrate commitments made and analyse the provisions of relevant laws and policies against international standards, guidelines, etc. | ICESCR | | | | | | | | | | | | | | | | | | | |
| | | | International declaration | | | | × | | × | | × | × | | | | | × | | × | | × | |
| | | | Constitution | | | × | × | | | | | | | | | | | | | | | |
| | | | National law | × | × | × | | | × | | × | × | × | × | | | × | | × | | × | |
| | | | Administrative directive | × | × | × | × | | | × | | × | × | × | × | | × | | × | | × | |
| Examine policy content and implementation | Available, accessible, acceptable, appropriate and of good quality (AAAAQ): Whether the goods and services needed to fulfil a right are increasingly available, accessible, acceptable and of adequate quality, without discrimination. | A range of techniques can be used to gather primary or secondary data that measure these criteria. Cross-country comparisons, disaggregated and temporal data all help in judging the reasonableness of the state's performance. | Satisfaction surveys | | | | × | | | | | | | × | | × | | × | × | | | |
| | | | Quality of monitoring and evaluation tools | | | | × | | × | | × | | × | | × | | × | | × | | × | |
| Analyse policy processes | Participation, transparency, right to a remedy: Whether rights holders can actively participate in the design, implementation and oversight of policies and have avenues to hold government to account or seek redress when they are negatively affected by them. | Qualitative techniques (e.g. focus groups, interviews) can gather feedback from particular rights holders. Quantifiable studies (e.g. perception surveys and governance indicators) may provide a general overview. | Parliamentary debate | | | | | | | | | | | | | | | | | | | |
| | | | Participatory decision-making at national level | | | | | | | | | | | | | | | | | | | |
| | | | Participatory decision-making at local level | | | | | | | | | | | | | | | | | | | |
| | | | Litigation | | | | | | | | | | | | | | | | | | | |
| Analyse resource allocation and expenditure | Progressive realization according to maximum available resources: Whether expenditures (planned and actual) in relevant sectors are a transparent, equitable and effective use of available resources. | Allocation ratios, judged against relevant reference points and over time, show reasonableness of amounts earmarked for key sectors and population groups. Various governance tools (e.g. social audits) review the disbursement of funds. | Government health expenditure as percentage of THE | × | × | × | | | | | × | | | | × | | × | | × | × | | |
| | | | Government health expenditure as percentage of government budget | × | | | | | | × | | | | | | × | | × | | | × | |
| | | | Medium-Term Expenditure Framework (MTEF) | | | | | | | | | | | | | | | | | | | |
| | | | Allocation primary/ secondary/ tertiary | | | × | | | | | | | | | | | | | | | | |
| | | | Allocation urban/ rural | | | × | | | | | | × | | | | | | | | | | |
| | | | Ring-fenced allocation vulnerable groups | | | | | | | | | | | | | | | | | | | |
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| Analyze resource generation | Progressive realization according to maximum available resources: Whether sufficient revenue is being mobilized transparently, equitably and effectively from different sources. | Identify the state's main revenue sources (e.g. taxation, borrowing, international assistance). Evaluate relevant fiscal, monetary, and macro-economic policies against human rights principles. | Government budget as percentage of GDP | × | × | × | | | | × | × | × | × | × | | | |
| | | | Progressivity of tax income | | | | | | | | | | | | × | | |
| | | | Progressivity of insurance fees | | | × | | | | | | | × | | × | × | |
| | | | Out of pocket | × | × | × | × | × | × | × | × | × | × | × | × | × | × |
| | | | Aid | × | | | | | | × | | | | | × | | × |
| Analyze policy processes | Participation, accountability and transparency: Whether the budget process is open and accessible to citizens and whether they have avenues for review of budget decisions or redress. | Evaluate channels for participation in budgeting. Assess to what degree people have access to budgetary information. Evaluate administrative, judicial or other avenues for review of budget decisions and redress the state's performance. | Government budget | | | | | | | | | | | | | | |
| | | | Government health expenditure | | | | | | | | | | | | | | |
| | | | MTEF | | | | | | | | | | | | | | |