Universal Health Coverage and the Right to Health: From Legal Principle to Post-2015 Indicators

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Abstract
Universal Health Coverage (UHC) is widely considered one of the key components for the post-2015 health goal. The idea of UHC is rooted in the right to health, set out in the International Covenant on Economic, Social, and Cultural Rights. Based on the Covenant and the General Comment of the Committee on Economic, Social, and Cultural Rights, which is responsible for interpreting and monitoring the Covenant, we identify 6 key legal principles that should underpin UHC based on the right to health: minimum core obligation, progressive realization, cost-effectiveness, shared responsibility, participatory decision making, and prioritizing vulnerable or marginalized groups. Yet, although these principles are widely accepted, they are criticized for not being specific enough to operationalize as post-2015 indicators for reaching the target of UHC. In this article, we propose measurable and achievable indicators for UHC based on the right to health that can be used to inform the ongoing negotiations on Sustainable Development Goals. However, we identify 3 major challenges that face

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any exercise in setting indicators post-2015: data availability as an essential criterion, the universality of targets, and the adaptation of global goals to local populations.

Keywords
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Universal Health Coverage (UHC) rooted in the right to health is widely considered one of the frontrunners to represent the health element of the post-2015 development agenda. On December 12, 2012, UHC received unequivocal endorsement from the United Nations General Assembly (including the United States) with the approval of a resolution on UHC that confirmed the “intrinsic role of health in achieving international sustainable development goals.”

Yet despite UHC’s growing prominence in the post-2015 agenda, there is not yet any single, agreed-upon definition of what it is, and there is ongoing discussion about what indicators might measure progress toward it. Although the 2005 World Health Assembly’s definition of its achievement as “access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access” captures key elements, and the World Health Report 2010 identified the 3 dimensions of who, what, and which proportion of the costs are covered, neither are easily operationalized for routine use. A notable exception is the 2014 World Health Organization (WHO)/World Bank report, which attempts to fill this gap by discussing possible targets and indicators from the 3 dimensions related to service delivery and financial protection.

In this article, we complement the WHO/World Bank approach by grounding UHC in the right to health. The right-to-health framework is a valuable starting point to develop measurable and achievable indicators of both process and outcome that can inform the ongoing post-2015 global negotiations and implementation, as well as national debates on how to integrate UHC into domestic policies.

Six Principles Derived from the Right to Health

Our indicators of UHC are based on 6 principles pertaining to the right to health, as specified in General Comment 14 of the Committee on Economic, Social, and Cultural Rights, which is tasked with monitoring compliance with the International Covenant on Economic, Social, and Cultural Rights. This approach means that we can draw on a body of jurisprudence and authoritative interpretation of international human rights law that identifies the rights of individuals and the obligations of those who should secure their rights.

The first principle is that all states, no matter how poor, should offer a minimum core level of provision that should include “at least the following obligations: (a) To ensure the right of access to health facilities, goods, and
services on a non-discriminatory basis, especially for vulnerable or marginalized
groups; ... (d) To provide essential drugs, as from time to time defined under the
[World Health Organization] Action Programme on Essential Drugs; (e)
To ensure equitable distribution of all health facilities, goods, and services;
(f) To 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; ...”7(pp13,16)

The second principle is progressive realization of the right to health. This requires
countries to move forward toward the right to health and, by implication, not to adopt
measures that are regressive. In addition, each state
should make progress “to the maximum of its available resources.”7(p17)
This implies an explicit comparison of what is being provided and what
resources are available. If states claim they cannot provide healthcare to a
level seen elsewhere, they are obliged to demonstrate why. And if states are
able to move beyond their core obligations, they have a legal obligation to do
so: core obligations constitute a universal floor, not a ceiling.

The third principle is that interventions should be cost-effective to maximize
the benefit from available resources, derived from nondiscrimination.
“Expensive curative health services which are often accessible only to a small,
privileged fraction of the population, rather than primary and preventive health-
care benefiting a far larger part of the population,” have been qualified as
“[i]nappropriate health resource allocation [that] can lead to discrimination
that may not be overt,” by the Committee on Economic, Social, and Cultural
Rights in its General Comment on the right to health.7(pp7,8)

The fourth principle is that of shared responsibility among states. Article 2(1)
of the International Covenant on Economic, Social, and Cultural Rights
prescribes that states “take steps, individually and through international assist-
ance and co-operation, especially economic and technical, to the maximum of its
available resources...”(emphasis added), and when the Committee elaborated
states’ core obligations arising from the right to health, it explicitly referred to
international assistance: “For the avoidance of any doubt, the Committee wishes
to emphasize that it is particularly incumbent on States’ parties and other actors
in a position to assist, to provide ‘international assistance and cooperation,
especially economic and technical’ which enable developing countries to fulfil
their core and other obligations...”7(p16) Thus, there is an obligation on rich
states to prioritize healthcare in their international assistance programs.

The fifth principle is the imperative for participatory decision making, the
second derived from nondiscrimination. National public health strategies and
plans of action that states are required to adopt and implement “shall be devised,
and periodically reviewed, on the basis of a participatory and transparent process,”
according to the Committee on Economic, Social, and Cultural Rights.7(p16) Thus,
“the health concerns of the whole population” should not simply be assessed from
epidemiological data but should incorporate people’s expressed priorities.
The sixth is that the needs of vulnerable or marginalized groups should be addressed explicitly, the last derived from nondiscrimination. This derives from the statement by the Committee on Economic, Social, and Cultural Rights that “the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.” Participation in the process of developing and monitoring national plans must specifically include marginalized populations in a meaningful way. Where particular health concerns disproportionately affect vulnerable or marginalized populations, it may be incumbent on the state to include interventions within its benefit package, even where the interventions needed are not considered cost-effective overall.

**Universal Healthcare Indicators Rooted in the Right to Health**

The European Commission has set out criteria for any proposed post-2015 goals. They should be measurable, achievable, and sustainable, and they should consider the constraints of developing countries for improving health outcomes themselves. Bill Gates has also argued that the goals should be measurable, demonstrating tangible change in health status, but also operational, focused on extreme poverty, and based in global consensus. There is a consensus on the right to health, as shown by the accession of all countries except South Sudan joining at least one treaty recognizing it. We now propose 10 indicators that capture the achievement of the principles that flow from the right to health but that can also be operationalized to generate measureable, achievable, sustainable indicators.

The first is the existence of a legal mandate for UHC in each country. This may take different forms, depending on the country’s legal system, but its presence is easily determined. Thus, it may be incorporated in the constitution (as in South Africa), it may be established in national legislation, or it may exist because the country is one where the ratification of an international convention has direct effect in domestic law. These instruments could be recorded in a proposed global health law repository. The existence of a legal basis is an important requirement for UHC, with empirical evidence illustrating that countries with such a mandate spend more on public health services.

The next 3 are the extent of coverage measured on 3 dimensions of depth (which services are covered), breadth (who is covered), and height (what proportion of the costs are covered). The challenge then becomes how to operationalize these 3 dimensions. Currently available data on coverage of specific services refer largely to maternal and child health, such as antenatal care, delivery care, and immunization. This provides a starting point, but needs to be extended to other key areas of healthcare, such as noncommunicable diseases, so as to include the main contributors to the burden of disease in a particular
## Table 1. Ten Indicators for UHC Based on the Right to Health.

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<th>Underlying legal principle</th>
<th>Data source</th>
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<td>1 The existence of a legal mandate for UHC in the country</td>
<td>Minimum core obligation/progressive realization</td>
<td>Global health law repository</td>
</tr>
<tr>
<td>2 The extent of coverage in terms of depth (which services are covered)</td>
<td>Minimum core obligation/progressive realization</td>
<td>Household Survey Data</td>
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<td>3 The extent of coverage in terms of breadth (who is insured) with attention to equity</td>
<td>Minimum core obligation/progressive realization</td>
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<td>4 The extent of coverage in terms of height (what proportion of costs are covered) with focus on reduction in share of out-of-pocket payments for health care</td>
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<td>5 The commitment of adequate resources to deliver UHC with focus on percentage of gross national product for healthcare</td>
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<td>9 SARA assessment on participatory decision making</td>
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<td>10 SARA assessment on prioritization of marginalized groups</td>
<td>Attention to vulnerable and marginalized groups/nondiscrimination</td>
<td>Extended SARA</td>
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Abbreviations: GDP, gross domestic product; SARA, Service Availability and Readiness Assessments; UHC, Universal Health Coverage; OECD-DAC, Organisation for Economic Co-operation and Development’s (OECD) Development Assistance Committee.
country. Breadth is arguably the simplest to measure, e.g., by asking in household surveys whether respondents consider that they are included in some insurance scheme or equivalent (with the caveat, however, that those least likely to be covered are least likely to be included in surveys, such as illegal migrants). This should also take account of equity, e.g., by capturing differences in coverage by wealth, gender, or income quintile. This should also consider other markers of marginalization such as having a disability or being a member of an indigenous population. Height is also relatively straightforward and can be measured as a reduction in the share of out-of-pocket payments for healthcare below a fixed percentage, using data from the World Bank’s Living Standards Measurement Surveys and similar household surveys.

The fifth indicator is the commitment of adequate resources to deliver UHC. There is emerging evidence that the ability to deliver UHC is associated with the ability to raise direct taxation. Accordingly, we propose the achievement of a fixed percentage of gross national product on healthcare and not, as in the Abuja Declaration, a percentage of government spending. We have considered, but rejected, the idea that the percentage should vary, from a low figure in the poorest countries to a higher one in the richest, as this would accentuate inequalities.

The sixth indicator relates to cost-effectiveness. Policymakers at national and subnational levels have limited resources and must choose among many interventions that target different diseases and vulnerable populations. A possible indicator could be the use of expensive branded drugs when cheaper alternatives are available or the ratio of complex items to basic items of equipment. However, cost-effectiveness of mortality reduction for the entire population does not necessarily mean that it will also be “equitable,” as these are 2 separate dimensions. Deaths can be reduced in a highly cost-effective way when investments are targeting the wealthiest quintiles, just as when they are targeting the poorest. An appropriate indicator might be the number of deaths or disability-adjusted life years averted per cost of intervention scale-up in the poorest quintile of the population.

The next 2 indicators relate to financial and nonfinancial dimensions of shared responsibility. The first is international assistance as a percentage of gross domestic product (GDP), using the widely accepted target of 0.7% of GDP. The second is the existence of an international development policy explicitly including specific provisions to promote and protect the right to health.

We finally consider the challenging issue of developing indicators for participatory decision making, nondiscrimination, and prioritization of marginalized groups. Rifkin, e.g., notes that trying to capture these dimensions by indicators approved at the United Nations level may be meaningless or even counterproductive. Her main argument is that as soon as indicators are accepted, we are likely to see some tokenistic application of principles, which is likely to distract
from the real issue, which is political willingness. The most feasible proposal is by O’Neill and colleagues to conduct Service Availability and Readiness Assessments as a baseline for UHC,\textsuperscript{16} updating these regularly as a way of monitoring progress. These underpin the ninth indicator, on participatory decision making, and the 10th, on nondiscrimination and prioritization of marginalized groups, adapted to the reality of each country.

**Challenges in Indicator Development**

Three major challenges face any exercise to set indicators post-2015: data availability as an essential criterion, the universality of targets, and the adaptation of global goals to local populations.

Few developing countries have adequate data, and there is growing recognition of the need for serious investment in data and sustainable information systems. These challenges should not be underestimated, and they pose a question about the extent to which measuring progress toward transformative goals can be achieved. Measurability will inevitably influence which targets and goals can be considered, thus potentially limiting the ambitious and transformative nature of the goals.

Second, universal goals may not capture the priorities of all countries. Spending time and money to collect data for indicators that are not relevant in specific contexts could lead to neglect of problems associated with specific marginalized groups. In addition, developed countries have resisted universal goals, given the political implications they present for their own domestic policies, in contrast to the Millennium Development Goals, which were applied to low- and middle-income countries.\textsuperscript{17}

Third, while some indicators might be universally relevant, such as maternal or child mortality, or life expectancy, others, such as mortality from malaria, are highly contingent. The choice of indicators may, therefore, directly affect people’s health, meaning that people have the right to participate in deciding what the indicators are. Although this should include decisions at the United Nations level, as a practical and normative matter, to enable the most meaningful participation, it should also occur nationally (or even locally). And if participation is to be meaningful nationally (or locally), then the results of participation must have the possibility of having an impact, in this case, of affecting the nature of the indicator.

In this article, we have explicitly avoided setting specific targets to be achieved in terms of individual indicators. Instead, we note the principles that underpin any target-setting exercise. Targets should be specific, measurable, accurate, realistic, and time-bound.\textsuperscript{18} The process of determining targets will inevitably involve political considerations, but it is also important that it be informed by technical considerations. In some cases, the process is straightforward. Thus, we note that the target for the percentage of GDP spent on health proposed by the
Sustainable Development Solutions Network is 5%. However, we also recognize that in the poorest countries, this sum will be inadequate to provide universal coverage and will need to be supplemented by additional funds from development assistance. Crucially, we emphasize that whatever figure is chosen should be a minimum, not a maximum. A mid-term target might reasonably be to halve the gap between the existing level of expenditure and the target. In other areas, there is a need for modeling to determine feasible but challenging targets based on starting conditions, effectiveness of policies to achieve the targets, and the time lags that apply.

Despite these challenges, for UHC to continue to gain momentum in the mainstream post-2015 agenda, attention must be given to the development of indicators that are universally accepted, implementable, and based on an agreed-upon legal framework. It is only through law, and the right to health, that individuals and populations can claim entitlements to health services and that corresponding governmental obligations can be established and enforced. A crucial next step is to build on the WHO/World Bank report to measure UHC by complementing it with the right to health and the values that such a basis brings with it.

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References


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