



## Universal health coverage, priority setting, and the human right to health

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*Lancet* 2017; 390: 712–14

Published Online

April 26, 2017

[http://dx.doi.org/10.1016/S0140-6736\(17\)30931-5](http://dx.doi.org/10.1016/S0140-6736(17)30931-5)

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Following endorsement by WHO,<sup>1,2</sup> the World Bank,<sup>3</sup> and the UN's Sustainable Development Goals,<sup>4</sup> the drive towards universal health coverage (UHC) is now one of the most prominent global health policies. As countries progress towards UHC, they are forced to make difficult choices about how to prioritise health issues and expenditure: which services to expand first, whom to include first, and how to shift from out-of-pocket payment towards prepayment. Building on extensive philosophical literature on the ethics of priority setting in health care, a 2014 WHO report provided guidance about how states can resolve these issues.<sup>5,6</sup> This report argues that three principles should inform choices on the path to UHC: (1) coverage should be on the basis of need, with extra weight given to the needs of the underprivileged; (2) one aim should be to generate the greatest total improvement in health; (3) contributions should be based on ability to pay, and not need. The report also explains how these principles determine which trade-offs are generally unacceptable: for example, choosing to expand coverage for low-priority or medium-priority services before there is near-universal coverage for high-priority services. However, policy makers also face a further question largely left unanswered by the report: how do states' moral and legal obligations regarding the right to health fit with their obligations to set health priorities fairly?

This question is pertinent even for countries who have largely achieved UHC.<sup>7</sup> For example, British policy makers considering whether to make the UK's commitment to the right to health more explicit in national law would need to consider what effect this would have on existing priority-setting processes in the National Health Service, including within the National Institute for Health and Care Excellence evaluation of health-care technologies.

The sceptical position is that these two sets of demands—priority setting and the right to health—are irreconcilable.<sup>8</sup> Evidence of such tensions has been seen in a number of judicial decisions in Latin American countries, where courts' defence of what they take to be individuals' rights to expensive new drugs and services have clashed with ongoing efforts by national health planners to prioritise expenditures that improve population health.<sup>9</sup> For example, in a systematic analysis, Norheim and Wilson<sup>10</sup> found that in Costa Rica less than 3% of the successful legal cases for medications outside the agreed benefits package would be considered high priority in accordance with the standard criteria of clinical effectiveness, cost-effectiveness, severity of

disease, and strength of evidence. By contrast, more than 70% of the court-mandated provisions concerned medications judged to be of low priority.<sup>10</sup>

Such cases might lead to the perception that a rights-based approach to health policy necessarily presents a disruptive influence on states' efforts to set priorities fairly and efficiently. In this Viewpoint, we reject this view; we believe that there are ways in which the right to health can aid priority setting and, conversely, in which fair priority setting is essential to the realisation of the right to health.

It is important to acknowledge that there are ways in which one could interpret what constitutes a just distribution of health-care resources and what constitutes the human right to health that could lead the two imperatives to pull in separate directions. That is, if one were to equate priority setting simply with a utilitarian drive to maximise health benefits across a population, and the right to health as simply the claim that all individuals ought to have access to any medical treatment they need regardless of cost, then the two imperatives would clearly conflict. Indeed, where we find that there has been a conflict between these imperatives, such as in several Latin American cases, it has been as a result of these kinds of inadequate interpretations.

However, there is little in the philosophical and legal literature or international law to justify such interpretations, and they are increasingly in contrast with judicial practice.<sup>11,12</sup> Philosophers have argued for a number of years that achieving justice in health-care priority setting involves applying a range of substantive ethical principles that extend beyond utilitarian calculations of which policies maximise health.<sup>5,13–17</sup> In addition, both philosophical discussion and legal theory are moving away from seeking to determine health policy priorities through an appeal to specific substantive principles alone, but are instead looking to ensure just distribution through a fair and accountable process.<sup>11,18–20</sup>

The notion that the right to health means that an individual has a claim against the state to any medical treatment that they need, regardless of cost, also fails to reflect current philosophical thinking,<sup>21</sup> in addition to being inconsistent with the ordinary and natural reading of international human rights law. For example, according to article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the rights in the covenant, including the right to health, are subject to both progressive realisation and resource availability.<sup>22</sup> General comment 14, arguably an authoritative interpretation of the ICESCR, extends this

concept, requiring that, under resource constraints, trade-offs between ensuring effective interventions—including between health care, public health policies, and tackling the social determinants of health—are made fairly. This states that: “With respect to the right to health, equality of access to health care and health services has to be emphasized... Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour 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.”<sup>23</sup>

Far from being disruptive, there are various ways in which the right to health, when properly understood, can help priority setting. First, the notion that all human beings have a right to health by virtue of being human can establish a moral foundation for why prioritisation needs to occur.<sup>24,25</sup> In articulating the problem of priority setting, academic writers, especially health economists, often describe the dilemma as one that manifests in the committee room: policy makers must decide how to allocate resources across different populations under conditions of scarcity.<sup>26</sup> The right to health, however, helps to explain how we got to the committee room in the first place—namely, that by virtue of being human, everyone has a right to health. The committee is brought together to respond to such moral (and legal) claims, with equal concern for all individuals.

Second, rights to health can also provide a framework for dealing with issues of discrimination, exclusion, and power asymmetries, establishing the normative significance of many of the moral principles appealed to in priority setting. Importantly, debate about rights forces attention on issues of equity. Thus, if priority setters were, misguidedly, to seek only a utilitarian maximisation of population health, then rights would provide normative and legal resources for a critique.

Third, rights offer an important mechanism for citizens and health planners to petition for additional resources and for the health service to actually deliver on services already established as high priority. In this way, litigation under the right to health can be a mechanism by which health systems are prompted to deliver the services they should be providing,<sup>27</sup> rather than services they should not (such as in some of the cases from Latin America cited earlier).<sup>9,10</sup>

Following this last point, it should also be noted that the language and strictures of rights emphasises citizens' role as agents, who are entitled to influence priority setting and to hold decision makers to account.<sup>19</sup>

Interpreted correctly, priority setting is also integral to realisation of the right to health. As noted above, aspects of international law regarding the right to health require policy makers to prioritise certain services and treatments.

While not a feature of all conceptions of the right to health, international human rights law also demands the fulfilment of specified core obligations with respect to the right to health, one of which is a requirement that states devise national strategies and plans of action based upon the burden of disease across the entire population through a legitimate and participatory process.<sup>23</sup> In other words, it requires a fair and accountable priority setting process.

In summary, efforts to uphold individuals' right to health and to set priorities in the health-care system have a common grounding and can be mutually dependent and mutually reinforcing. For states with the necessary civil institutions in place, we offer the following three-step process by which decision makers can reconcile these imperatives on the path towards UHC.

First, those responsible for advising on or ensuring a fair allocation of health-care resources (eg, priority setters and local and national health planners), and those charged with upholding the right to health (eg, legislators and judges), need to recognise broader and more recent interpretations of each imperative.<sup>28</sup> Priority setting is not only about a utilitarian drive to maximise health benefits across the population, nor is the right to health about securing every individual's access to health care regardless of cost.

Second, when substantive and procedural principles for ensuring fair allocation of resources devoted to health have been decided through a transparent and participatory process, states should institutionalise priority setting. This could include an organisation for systematic assessment of new and existing health technologies, an advisory panel for wider questions of allocative efficiency and fairness, and action on the social, economic, and political determinants of health. Such bodies must be accountable to their populations, the government, and the judiciary. Ensuring the proper functioning of these bodies should be recognised as one way in which states contribute to the implementation of the right to health.

Third, when an acceptable interpretation of the content of the right to health under national law has been clarified, respecting the principles discussed above, finance ministers should reappraise their budgets, considering the state's obligations under that right. The right to health, just as civil and political rights, requires resources, whether through taxation or other means. As with civil and political rights, the right to health is supposed to be binding. When the status quo fails to uphold rights, changes, including judicial remedies, are needed.

As they progress towards the achievement of UHC, policy makers face two ethical imperatives: to set national spending priorities fairly and efficiently, and to safeguard the right to health. Under certain, inadequate interpretations, these aims can appear to conflict. However, when understood properly, there are several ways in which priority setting and the right to health are mutually supportive. In addition to highlighting these points of convergence, in this Viewpoint we have set

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out a three-step process for establishing policies and procedures that progressively realise the right to health and set fair priorities.

#### Contributors

The argument presented in this paper represents the collective and equal effort of all the named authors, the paper itself being the result of a workshop on the issue attended by all parties. BR was responsible for drawing up a first draft of the Viewpoint and handling subsequent edits. PH worked closely in an advisory capacity, reflected in his position as last author. All other authors provided comments and suggested edits throughout the drafting process, their equal contributions reflected in the listing of their names in alphabetical order.

#### Declaration of interests

We declare no competing interests.

#### Acknowledgments

This Viewpoint is the result of a related workshop, drawing together researchers from a wide variety of disciplines including philosophy, law, health economics, political science, and global health. The roundtable was funded by the Wellcome Trust Ethics and Society Panel (grant number 106704/z/14/z) and held at University College London on June 25–26, 2015. OFN received funding to participate from NORAD through a Priorities in Global Health 2020 grant (grant number 218694/H10). The opinions expressed are the view of the authors only. They do not represent any position or policy of the U.S. National Institutes of Health, the Public Health Service, the U.S. Department of Health and Human Services, the National Health Service, the National Institute for Health Research, or the UK Department of Health.

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