



Solidarity, equity and rights-based to health provision

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Solidarity, Equity and Rights-Based Approaches to Universal Health Coverage – considerations for a post-2015 global health agenda

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1. Introduction: From UHC to the 'triple bottom line'

The goal of 'universal health coverage' (UHC) has risen to prominence in global debates, comprising the core of the World Health Organization's (WHO) key proposals for a post-Millennium Development Goals agenda after 2015 (WHO 2012). There are two main elements to 'universal health coverage' – provision of necessary health services and expansion of insurance coverage. UHC proposals are gaining traction as countries at varying levels of economic development, including Rwanda, Thailand, China and the United States, have undertaken significant coverage reforms.

While there is currently a significant consensus and momentum pushing UHC to the forefront of global health policy, its meanings and implications have not always been clear (Bump 2010, 3). UHC may be taken to mean that all medical services should be available at no cost, or low cost. It may refer to comprehensive, unified health services such as the UK National Health Service, or it may simply mean that every individual should have health insurance (IoM 2004), without specifying particular principles or entitlements. How the term 'UHC' is used is highly dependent on the specific policy context surrounding the particular policies being advanced under its banner. On her appointment to a second term as Director-General of the WHO in 2012, Margaret Chan declared UHC to be '**the most powerful concept that public health has to offer**', due to its ability to function as an 'inclusive umbrella' for different programmatic interests in global health reform. According to the WHO (2014), UHC reforms entail four priorities:

1. The development of strong, efficient and well-run health systems able to meet priority health needs, practising people-centred, integrated care, including health promotion, prevention and early detection, capacity to treat and rehabilitate. Non-health sectors, such as transport, education and urban planning also make important contributions to this goal.
2. Affordability: the development of financing systems that help people to avoid financial hardship if they incur health costs.
3. Access to essential medicines and technologies to treat and diagnose conditions.

4. A sufficient capacity of well-trained and motivated health workers to provide the needed services, based on the best available evidence.

Reichlin (2011) sets out three relevant bioethical principles of equity, rights and solidarity. This discussion asks if these fundamental ethical principles are in place, and re-visits the UHC concept in the light of them for two reasons. Global health reforms can be strengthened using human rights, but human rights, especially right to health may also gain greater depth through a fuller engagement with UHC's twin concerns of collective health and health financing. Both should consider the role of underlying social and political arrangements influencing health provision and risk sharing. This discussion will focus particularly on dimensions of solidarity in health and human rights, arguing that health solidarities need to be better understood in both global health reform and human rights advocacy. The theme of solidarity also enables essential links to be made between health and other global sustainable development goals (UNGA 2012). Solidarity takes us beyond narrow concepts of financial sustainability, to reconnect the current goals of human health and well-being to those of future generations. This is important because the current generation imposes significant risks and costs on future generations, and because public health involves collective goods that must be maintained. Solidarity is thus an important consideration underpinning the centrality of health in the pursuit of the 'triple bottom line' of social, ecological and financial sustainability.

2. Primary Health Care - a transformative agenda for global health equity

In 2005, the World Health Assembly resolved to develop health financing systems enabling UHC and the 2010 World Health Report subsequently highlighted health systems financing as 'the path to Universal Coverage'. In 2011, the World Health Assembly called upon the WHO Director-General, Margaret Chan to bring the UHC issue to the UN General Assembly, which she duly did on her appointment to a second term as WHO Director-General in 2012. However, it must not be forgotten that Chan had championed Primary Health Care (PHC) as the global health priority several years earlier (WHO 2008). The 2008 World Health Report represented an important moment, returning the focus of global health governance to the **transformative agenda for health equity** advanced three decades earlier at the International Conference on Primary Health Care, Alma-Ata, with the popular slogan: 'Health for All' (International Conference and WHO, 1978). The language of rights and equity connected the WHO leadership to a broad social movement of professionals, researchers, institutional and government reformers, progressive civil society and grassroots organizations, collectively aiming to tackle the '*politically, socially and economically unacceptable*' health inequalities in all countries, and to effect a value change towards people-centred healthcare based on 'social justice and the right to better health for all, participation and solidarity' (WHO 2008, 1, original emphasis).

Surveying the challenges for global health three decades later, the 2008 World Health Report revived the PHC agenda to address the major deleterious global trends of growing inequalities; 'inverse care' (disproportionately focused on high-cost, specialist, tertiary interventions); fragmented care (due to the multiplication of vertical health programmes and projects); and the problems posed by the commercialization of health care. It noted the trends of urbanization and ageing, and the policy realities of globalization, cost-containment and deregulation (WHO 2008, 11). Four main types of reforms were proposed: universal health coverage to improve health equity; service delivery reforms to make health services more people-centred; public policy reforms to prioritise community-based health protection and promotion; and leadership reforms to make health authorities more answerable and reliable (WHO 2008, xvi). The fundamental rationale for

reviving PHC was a democratic one – that '[p]eople expect their health systems to be equitable', obliging governments to reform systems to achieve '**universal access to health services with social health protection**' (WHO 2008, 23)

3. 'Swimming upstream' – inequality, policy drift and the fate of health solidarity

Amidst growing acknowledgement of the economic and human costs of inequality, Göran Therborn powerfully argues that inequality is a 'killing field', reproducing vital inequalities of life and health via mechanisms of '**distanciation**' that polarize 'winners' and 'losers' in the social system (2013). Whitehead and Popay (2010) suggest that efforts to address inequalities are 'swimming upstream' against powerful countervailing currents of power and vested interest. In comparison to the earlier proposals for transformative Primary Health Care, the current 'umbrella' concept of UHC may be obscuring a significant drift in arguments and rationales. There is tension between the original PHC aim of universally accessible, people-centred health services and the newer aim of 'financial risk protection' that is contingent on socialized forms of risk-sharing. Questions about the social nature of health risk protection have become more complex, couched within increasingly individualized, financialized and globalized insurance mechanisms. The results may complicate and confound the requirements of public health, leading to the persistent under-provision of public health goods as the very understanding of collective health becomes more commodified and conflicted.

Houtepen and ter Meulen analyse the challenges of health solidarities, writing from the perspective of a relatively strong, equitable and efficient health system with UHC, the Netherlands (2000). Defining solidarity as a mixture of social justice and a set of cultural values and ascriptions, they show how health solidarities evolved from limited forms of mutual aid towards a comprehensive welfare state offering collectively financed universal health services. Mutual solidarities gradually transformed into national citizenship rights, with government coordinating the collective responsibility for health, and guaranteeing universal coverage and accessibility. However, since the 1990s, financial pressure has led to changing conceptions of justice and more restricted notions of solidarity within the welfare state. Individual responsibility for health is more emphasised, focusing on healthy behaviours and lifestyles. As health insurance was privatized, solidarity declined. Given the health-care gap caused by rising service demands and strict cost controls, longer waiting lists and waiting times have resulted. As government and citizens have turned to private solutions, public attitudes towards solidarity have changed. Lower solidarity is correlated with lower public trust in the health care system as a whole, and there are worries that the effectiveness and quality of the overall health system may be affected. In European social democracies like the Netherlands, market-based health reforms have been limited, while social solidarity has been quite strictly reinforced by the government (for example by compelling universal social insurance, prohibiting risk selection and strictly controlling the quality of services). There is a strong awareness that public measures must maintain solidarity in order to effect increasing '**solidarity transfers**' ensuring that higher income groups contribute to healthcare services for lower income groups. Potentially more important than income solidarity, however, is risk solidarity as the 'inverse care' trend means that the most expensive 10% of patients in the curatively-concentrated health system consumed some 70% of the total health costs in 2001 (ter Meulen and Maarse 2008, 271). Ageing societies mean that inter-generational solidarity must necessarily increase, as more costs attach to curing and caring for the diseases of ageing. Individual responsibility is insufficient in cases of vulnerable persons with intellectual disability, dementia or psychiatric problems, so collective solidarity must protect these individuals, while maintaining the overall quality of public services and a public health ethos which might otherwise be eroded as individual responsibility increases.

While the right to health highlights what people are entitled to and explains what duty bearers must respect, protect and fulfil, public health perspectives point to important examples of collective goods requiring protection. The public health ethos itself requires forms of solidarity that cannot be secured by individual responsibility, while necessary levels of trust and quality depend on collective attributes of the health system and its staff. Blood and organ donation and herd immunity arising from mass vaccination are examples of health solidarities where the larger population takes responsibility for an overall, systemic outcome that cannot be reduced to individual responsibility.

4. UHC and the Right to Health

The Right to Health appears indirectly as a 'development' issue within Article 25 of the Universal Declaration of Human Rights (UDHR). The 'social determinants' of health are broadly captured in the phrase 'adequate standard of living' in Article 25 of the UDHR. This leads on to Article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), defining the Right to an Adequate Standard of Living, as 'adequate food, clothing and housing, and to the continuous improvement of living conditions'. As Craven notes, the right to an adequate standard of living is wide-ranging and general, but it is paramount, 'not least because at minimum levels it presents a question of survival', even if '...it is also true to say that the right to an adequate standard of living has been violated more comprehensively and systematically than probably any other right' (1995, 287-8).

The 1946 WHO Constitution, which pre-dated the UDHR (1948) and ICESCR (1966, Art.12) address the right to health specifically, yet expansively, as the right to 'the highest attainable standard of health as a fundamental right of every human being'. The right to health is included in a number of regional rights conventions, including the American Declaration of the Rights and Duties of Man (Art. 11), the 1981 African Charter on Human and Peoples' Rights (Art. 16), and the 2000 European Union Charter of Fundamental Rights (Art. 35).

The basic feature of a rights-based approach is that it defines duties, criteria and standards that states and non-state actors (such as international organizations and private corporations) have duties to respect, protect and fulfil as a matter of international laws and norms. The right to health obliges governments to act positively to create conditions for 'the highest attainable standard of health' and to refrain from harming people's right to health. While this does not mean that everyone automatically has the right to be healthy, the Right to Health obliges governments to ensure that timely, acceptable, and affordable health care is available to all, without discrimination, that care is aligned with medical ethics, is culturally appropriate and is of appropriate quality (i.e. safe and medically appropriate). The non-discrimination aspect is active and positive in the sense that special provisions exist to ensure that the vulnerable, needy and disadvantaged are accorded priority. Pregnant women and children are afforded special protection, while occupational health and disease control are also prioritised (UN Economic and Social Council 2000).

The Right to Health specifies criteria of 'availability, accessibility, acceptability and quality', and these criteria are reflected in the articulation of the first UHC goal regarding the provision of health care services. However, the approach taken to affordability as risk protection in the second goal tends to individualize costs, neglecting the key issue of how risk is socialized, as well as the concerns surrounding commercialization, cost-containment, prioritization and the public health dimension. The balance of costs and risks impact on the other stated UHC priorities regarding access to essential medicines and treatment and also affect the issue of health worker capacity.

Conclusion

The current push for Universal Health Coverage as a global goal represents a partial return to an earlier transformative agenda for health equity and social justice under the banner of Primary Health Care. However, European countries that achieved equitable, rights-based Universal Health Coverage in earlier decades have experienced over two decades of reforms in the opposite direction, changing the distribution of responsibility between the welfare state and the individual citizen. Ter Meulen and Maarse's analysis (2008, 262) suggests that this redistribution points to 'distanciation' as one tier universal systems have given way to two-tier systems, with increasing public ambivalence towards the principles of universality and solidarity in health care. The increasing currency of the human right to health appears to guarantee available, accessible, acceptable quality health care services to all, equitably, without discrimination and with special care towards the most vulnerable and disadvantaged. Nevertheless, several aspects of health solidarity come to light as important concerns. The health care gap, driven by increasing needs and retreating welfare state, has translated into widening gaps between the well-off who can afford private insurance and care solutions and lower income groups who require income and risk solidarity in order to access care on an equitable basis. The global trend towards ageing societies makes strong demands on intergenerational solidarity, which cannot be taken as a given. Financial sustainability is impossible without social solidarity, but even these two together will not suffice. Health system reforms must look to environmental and ecological health and a genuinely multi-sectoral global agenda in order to sustain improvements in wellbeing. Individual responsibility must be complemented government action to preserve solidarity, in order for health rights to be equitably vindicated.

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