



PRINCE MAHIDOL
AWARD CONFERENCE

2017



ADDRESSING THE HEALTH OF
VULNERABLE POPULATIONS
FOR AN INCLUSIVE SOCIETY

PS2.2

PARALLEL SESSION 2.2

Can the Right to Health be Used
to Overcome Exclusion from Health Services

BACKGROUND

The path to UHC is challenging. Quality and quantity of health services need being increased, people presently being excluded need being included, and reliance on user fees needs being decreased. Many proponents of UHC consider anchoring UHC in the human right to health as a way to hold governments accountable. Others are sceptic, and argue that the right to health is not enforceable, not enough specific enough to address the exclusion of particular groups, or can even produce undesirable side-effects, such as excessive claims by individuals, sapping inevitably constrained resources.

OBJECTIVES

In this session, we will explore arguments in favour and against the usefulness of anchoring UHC in the right to health, and different ways how the right to health can be used (and abused) to improve equity in UHC.



MODERATOR

Gorik OOMS

Senior researcher
Heidelberg University

Germany

Gorik Ooms is a human rights lawyer and a global health scholar, Professor of Global Health Law & Governance at the London School of Hygiene & Tropical Medicine. During most of his professional career he worked with Médecins Sans Frontières Belgium, of which he was the executive director from August 2004 until June 2008. He was a member of the Lancet-University of Oslo Commission on Global Governance for Health and is a member of the Lancet-O'Neill Institute, Georgetown University Commission on Global Health and the Law.



MODERATOR

Peter HILL

Associate Professor
School of Public Health
University of Queensland

Australia

Peter Hill is a Public Health Physician and academic with research and teaching interests in global health governance, health in the Sustainable Development Goals, health systems strengthening and Indigenous health in Australia. He is a medical practitioner by training and holds the Fellowship of the Royal Australasian Faculty of Public Health Medicine. He completed his PhD at the Vrije Universiteit Brussel, examining the emergence of global health policy and its translation into country level policies and programs, with a particular focus on the Cambodian Health Coverage Plan. In his recent research he is principal investigator in a series of projects that have examined the development of the health goal in the Sustainable Development Goals, the uptake of the Indigenous Burden of Disease Research findings into policy in Australia, and health services provision in six fragile and conflict-affected states. He has coordinated a multi-stakeholder research project developing Vietnam's mortality data, undertaking its first national Burden of Disease study and cost-effectiveness analyses of the key interventions identified, and tracked the changes in recent policy, in particular in the areas of mandatory motorcycle helmets and tobacco control. He has extensive research and professional experience across West Africa, South East Asia and the Pacific – with particular focus on Nigeria, Cambodia, Vietnam, Papua New Guinea and Aboriginal Australia. He has undertaken consultancies for AusAID, GIZ, Australian Red Cross, the GAVI Alliance, the Global Fund to Fight AIDS, TB and Malaria and the World Health Organization. His research collaborations include the Health Strategy and Policy Institute, the Hanoi School of Public Health and the Hue Medical University in Vietnam, the Institute for Tropical Medicine in Antwerp, Belgium, and the Swiss Tropical and Public Health Institute in Basel, Switzerland.



SPEAKERS

Walter FLORES

Director
Center for the Study of Equity and Governance
in Health Systems

Guatemala

Walter Flores (Guatemala) is the director of the Center for the Study of Equity and Governance in Health Systems (CEGSS), a Guatemalan civil society organization specializing in applied research, capacity building and advocacy around issues affecting indigenous population health rights and other marginalized populations. He is also a steering committee member of the Community of Practitioners on Accountability and Social Action in Health (COPASAH), a global network of CSOs working towards improving healthcare services for marginalized populations through human rights, accountability and social mobilization. He is also a member of the People's Health Movement. He holds a PhD and a MCommH from the Liverpool School of Tropical Medicine, UK. Walter has carried-out research, teaching and consultancy work in more than 30 countries of Latin America, Africa, Asia and Europe.



SPEAKERS

Ines KEYGNAERT

Senior Researcher & Team Leader
Ghent University-International Centre for Reproductive Health
Belgium

Ines Keygnaert is a postdoctoral researcher and the team leader of the “Priority Team” which heads the research line on sexual and gender-based violence (SGBV), harmful cultural practices and gender in adolescent and migrant health at ICRH-Ghent University (Faculty of Medicine–Dpt Uro-Gynaecology).

Dr. Keygnaert is holding a PhD in Medicine on the topic of sexual violence and health in refugees, asylum seekers and undocumented migrants from the Ghent University. In addition she holds a Masters in Eastern Languages & Cultures (UGENT), a Third Cycle Degree in Social and Political Development (UCL) and a postgraduate in Middle Eastern Studies (NVIC).

Since 2006, Dr Keygnaert has been coordinating different European (multi-country) intervention research projects on sexual and reproductive health promotion and on prevention of and response to SGBV in the European reception and asylum sector (CHAFEA-DG Justice & Internal Affairs-Daphne, ERF) and the European Neighbourhood (EU-Morocco). In addition she coordinated several national projects on holistic management of victims of sexual and domestic violence (Public Health service) and has now been requested by the Belgian federal government to develop and pilot Belgian sexual assault referral centres.

Furthermore, Dr Keygnaert is an acknowledged expert on sexual violence and migrant health, having provided several international consultancies for leading global health organisations, as for

example: the writing of a Health Evidence Network-report on migrant maternal health for the WHO European region (WHO), migrant sexual health (WHO) and a national strategy on SGBV in Kosovo (UNFPA). Dr Keygnaert has published over 50 publications dealing with prevalence, policies, clinical management, prevention of and response to SGBV in different groups in Europe and the European Neighbourhood.

Dr Keygnaert teaches on migrant mother & child health, on sexual health in migrants and on holistic management of victims. She has proven robust knowledge of researching, education and service delivery (tailored consultancies) on prevalence and a holistic approach to SGBV, human rights, gender-sensitive research, participatory and mixed methods research approaches, migrant health and migrant education. She is the founder of EN-HERA! (The European Network for Sexual Health Promotion of Refugees, Asylum Seekers and Undocumented Migrants in Europe and beyond), co-founder of CESSMIR (the Centre for Social Studies on Migration and Refugees at the Ghent University) as well as the coordinator of the “Gender, rights and Interpersonal Violence” Subgroup of the International Academic Network on Sexual and Reproductive Health Rights & Policies.



SPEAKERS

Rachel HAMMONDS

Researcher
University of Antwerp

Belgium

Rachel Hammonds is a researcher in the Law and Development Research Group at the Law Faculty of the University of Antwerp, Belgium. She also leads a team of researchers examining the challenges of localizing human rights. Her work focuses on the intersection of development policy, health and human rights. Rachel received her PhD in Medical Sciences from the VUB University in Brussels in 2014 for her dissertation entitled, Challenging National Borders – What role for the norm of shared responsibility for realizing the right to health for all? Rachel Hammonds studied political science at McGill University, Canada, and law at the University of Ottawa, Canada and Edinburgh University, UK. She is a NY State licensed attorney.



SPEAKERS

Everaldo Lamprea
MONTEALEGRE

Professor
Universidad de los Andes
Colombia

Everaldo Lamprea is a Colombian scholar, currently based at Los Andes Law School in Bogotá, where he is an associate professor and directs the legal clinic on Public Health and the Environment (MASP). He has published widely in areas such as the right to health from a comparative and global perspective, health rights litigation in the global south, health systems reform, and the environmental determinants of health care. He holds a PhD from Stanford Law School and has been a visiting fellow at Harvard Law School's program on Human Rights. He is member of the Global Health Law Committee of the International Law Association (ILA). Some of his recent publications include Lamprea, "Closing the Gap Between Formal and Material Health Care Coverage in Colombia", *Health and Human Rights*, Volume 18, Issue 2, December, 2016, "The Judicialization of Health Care: a Global and comparative Perspective", *Annual Review of Law and Social Sciences*, 2017, and *Structural Reform Litigation and Regulation in Colombia*, in *Comparative Law and Regulation-Understanding the Global Regulatory Process*, Edward Elgar Publishers, 2016.



SPEAKERS

Clare DANBY

Regional Program Manager
HelpAge International Asia/Pacific

Thailand

Clare Danby is a Regional Programme Manager at HelpAge International's East Asia Pacific Regional Office in Chiang Mai, Thailand. Clare is a development professional with over twenty years of experience, mostly in the South-East Asia region. She has managed rights-based country and regional programmes in health systems strengthening, community health, livelihoods and network strengthening with civil society, government and private sector partners regionally and in Cambodia, Timor-Leste, Indonesia, Vietnam, Philippines, Thailand and Myanmar. Technically, her focus is on health and care systems. She is currently working with partners to reorient national health and care systems to meet the needs of older people and to promote a life-course approach to health and ageing. She is committed to ensuring that the views of older people is heard as policies and plans are developed. Clare recently conducted an analysis to strengthen the links between community based associations of older people in Vietnam and the Vietnamese health system.

The HelpAge network has been working for 35 years to ensure that every older person can enjoy their right to lead a dignified, healthy and secure life. HelpAge recognizes that existing rights instruments and the SDGs apply to all people. However, the HelpAge network believe that these instruments are inadequate because they are not directed specifically at older people and do not address the ageism and age discrimination that underpins the violation of human rights in older age.

Clare has a MSC in Public Health in Developing Countries from the London School of Hygiene and Tropical Medicine.



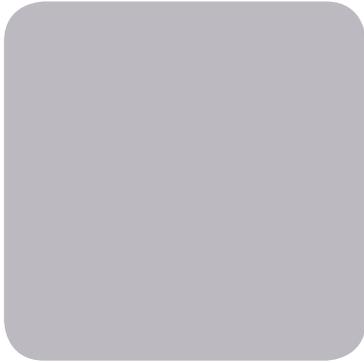
SPEAKERS

Khairunissa DHALA

Refugee Researcher/Advisor
Amnesty International
United Kingdom

Khairunissa Dhala is a Researcher and Advisor on the Refugee and Migrants' Right team at Amnesty International's International Secretariat. She has carried out research on a number of issues affecting refugees in host countries around the world. This includes access to health care for Syrian refugees in Lebanon and Jordan, and human rights abuses faced by refugees from Syria as a result of lack of regular status; and on the forced return of Somali refugees in Kenya following the announcement of the closure of Dadaab refugee camp. In addition she carried out advocacy and campaigning on the implications of failure by the international community to share responsibility with countries hosting large numbers of refugees. Khairunissa was previously researcher on South Sudan and Sudan at Amnesty International and documented human rights abuses as a result of conflicts in the region.

Khairunissa has an MSc in Development Studies from the School of Oriental and African Studies and a BA from the London School of Economics and Political Science.



SPEAKERS

Moses MULUMBA

Director

Centre for Health, Human Rights & Development (CEHURD)

Uganda



SHORT PAPER

THE LITIGATION EPIDEMIC OF HEALTH RIGHTS

Everaldo Lamprea¹

INTRODUCTION

The judicialization of health care has been an important subject in the literature that explores the enforceability of socioeconomic rights from a comparative and global perspective. This is due, in great part, to the strong presence of the right to health in most national constitutions and in the jurisprudence of a vast number of higher courts and regional bodies (Langford 2008). For instance, a comparative study found that approximately 70% of constitutions worldwide entrench health-related guarantees, and that 40% of constitutions include a justiciable right to health (Jung & Rosevear 2014).

In highly litigious countries like Colombia, Brazil and Costa Rica, the judicialization of health care has been spearheaded by plaintiffs who, in large numbers, utilize the courts to demand access to drugs and treatments (Gloppen 2008). In contrast, the judicialization of health care in South Africa is not the result of the accumulation of thousands of lawsuits clustering around demands for medications and treatments, a phenomenon that has been described as the *routinization* of litigation (Abramovich & Pautassi 2009, Bergallo 2011). On the contrary, in South Africa health rights litigation has been conducted by support structures of well-financed rights-advocacy lawyers and civil society organizations similar to those that prompted a rights-based legal mobilization in the United States during the 1970s (Epp 1998). The ultimate goal of health rights litigation in South Africa has been to obtain structural judicial remedies, such as policy reform, in favor of a large class of individuals (Forman 2008a). Furthermore, the threshold for standing and bringing rights-based claims in South Africa is much higher than in Latin America. As a result of this, health rights litigation in South Africa is far less widespread than in Latin American countries like Brazil, Colombia and Costa Rica. For instance, a comparative study found that the number of health rights lawsuits per one million individuals was 3,289 in Colombia, 206 in Brazil, 109 in Costa Rica, 29 in Argentina, and only 0.3 in South Africa (Moestad et al. 2011).

The benefits and costs of the two approaches have been weighed by a growing interdisciplinary literature. On the one hand, during the past two decades several Latin American countries have experienced a *litigation epidemic* of health rights (Yamin & Gloppen 2011, p. 3) with negative effects on public health care budgets and on the government's capability to allocate scarce health resources. In Colombia and Brazil, increasing numbers of litigants demand high-cost medications for the treatment of rare diseases and conditions like cancer, diabetes and renal failure, among many others. According to some authors this type of litigation both negatively impacts the financial

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stability of health systems and is regressive, since it skews resources from the public health system in favor of privileged litigants (Ferraz 2011a).

The unintended effects of the judicialization of health care

Among the overwhelming number and diversity of rights-based lawsuits in Colombia, health rights cases stand out. A set of studies published by *Defensoría del Pueblo*, Colombia's Human Rights Ombudsperson Office, indicate the right to health was the most litigated right in Colombia between 1999 and 2014, with an aggregate of 1.323.292 cases out of a total of 4.507.850 basic and social rights lawsuits. According to the Ombudsman's studies, rates of success in favor of plaintiffs have been extremely high (close to 80%) since 1999.

Although less marked than in Colombia, the explosion of litigiousness in Brazil during the past two decades has been remarkable. While there was only a single case of health litigation in the State of Rio de Janeiro in 1991, there were 1,144 lawsuits in 2002 (Messeder et al. 2005). Another study found there were 2,245 cases in 2005 in the State of Rio de Janeiro, representing a growth of more than 100% from 2002 levels (Borges 2007). This trend has been consistent in most Brazilian States, which also have a high success rate for claimants, ranging from 82% at lower courts and nearing 100% at Brazil's Federal Supreme Court (Ferraz 2009).

As right-to-health litigation spiraled out of control in Brazil and Colombia, the two South American countries became the most notorious examples of the unintended effects of the judicialization of health care. According to an empirically-oriented literature, litigation in Colombia and Brazil promotes a regressive allocation of health resources that privileges high-income patients living with cost-intensive, chronic medical conditions, and disempowers vast portions of the population whose needs can be better served by public health investments in basic care, sanitation, vaccination, prevention and medical infrastructure (Mota- Prado 2013).

The assumption that health rights litigation is regressive has led researchers to investigate the socioeconomic composition of litigants in Brazil and Colombia. According to some results, middle or upper-middle class patients with easy access to litigation and Courts, have "captured" health rights litigation. In Brazil, findings suggest that the higher the region's level of Human Development Index, the more likely it is to have a high volume of right-to-health litigation (Ferraz 2009). Similarly, a study carried out in São Paulo surveyed the socioeconomic profiles of a large group of health rights litigants, finding that most of them were middle and upper-middle income individuals (Da Silva & Terrazas 2011).

In Colombia, a study conducted by *Procuraduría*, the Public Defender's Office, found that most right-to-health litigants belong to the *contributive regime*, the sector of the population with a formal job that contributes to the social security system. Based on that

finding, this study suggests that most right-to-health litigants in Colombia are middle or high-income individuals (Procuraduría 2008).

The assessment of the fiscal impact of the growth of health rights litigation in Colombia and Brazil is another common subject in the extant literature (Andia 2011; Ferraz 2011b; Ferraz 2009; Méndez et al. 2012). In Brazil, due in large part to the shortcomings of the data on health rights litigation at the state and municipal levels, establishing the real dimensions of its fiscal costs has been problematic for scholars (Biehl 2009; Biehl et al. 2012). Nonetheless, the fragmented picture offered by the available data suggests a critical situation. During 2008, around US\$24 million (approximately 1% of the federal total health budget) was spent by the Brazilian Federal government in pharmaceuticals ordered by judges. The data becomes more critical if the state-level is also considered. In 2004, São Paulo, Brazil's largest and most populous state spent 10% of its US\$261 million health budget on pharmaceuticals ordered by judges. Moreover, the cost-escalation trend seems to be growing at alarming rates. In 2008, the money spent at the federal level on pharmaceuticals ordered by courts was three times higher than the 2007 expenditure (Ferraz 2009). Even more strikingly, the Brazilian Federal Government's total drug expenditure increased approximately 222% from 2003 to 2007 (Vieira 2009). As Vieira's study shows, while governmental expenditure on biotech drugs increased 252%, spending on essential or basic drugs only increased 75% during the same period.

Notwithstanding the significance of Brazil's case, the public expenditure associated with health rights litigation in Colombia, a country approximately four times smaller than Brazil's, dwarfs even the most pessimistic assessment of Brazil's situation. According to a study, in 2003 Colombia's Ministry of Health used taxpayer money to pay US\$56 million for pharmaceuticals and other healthcare services not covered by the health system but successfully claimed by *tutela* plaintiffs against health insurance companies. By 2010 the yearly repayments reached approximately US\$1.3 billion. This study estimates that the annual public expenditure used to cover the costs of right-to-health litigation has oscillated around 1% of Colombia's GDP since 2008 (Méndez et al. 2012). A different study conducted by Colombia's Department for Economic Planning (DNP) found that in 2009 87% of the US\$963 million spent by the Ministry of Health in reimbursing health insurance companies was used for covering the costs of pharmaceuticals not included into the mandatory basket of healthcare services widely known as POS. (Departamento Nacional de Planeación 2010).

The “pharmaceuticalization” of health rights litigation

The fact that most of the public expenditure associated with the judicialization of health care in Colombia, Brazil and Costa Rica is invested in paying for costly, but not necessarily cost-efficient, drugs has led some authors to explore the increasing “pharmaceuticalization” of health rights litigation in those countries. According to the work of several health anthropologists the term *pharmaceuticalization* implies an

“overfetichization” of medications inimical to a more robust public health approach (Petryna 2009, Petryna & Kleinman 2006).

There is abundant evidence about the growing “pharmaceuticalization” of health rights litigation in Brazil, Colombia and Costa Rica. For instance, a set of studies shows that most of the federal government’s expenditure on health services demanded by Brazilian litigants is focused on expensive biotech drugs for chronic medical conditions like cancer, arthritis and rare diseases, which are not included in the health benefit plan (Vieira & Zucchi 2007). A study concluded that the State of São Paulo, attending the orders handed down by judges, spent 65 million Brazilian Reais to provide drugs for approximately 3,600 claimants in 2006. Contrastingly, during the same year, the federal government’s Special Medication Program spent 838 million Reais to provide drugs for 380.000 patients. That means that while a litigant was awarded, on average 18,000 Reais (US\$5.400) in medications, a patient that obtained drugs from the Special Medication Program received only 2,200 Reais (US\$660) worth of drugs (Chieffi & Barata 2009), or eight times less than the litigant.

In Colombia, the “pharmaceuticalization” of health care is as acute as in Brazil. According to a study published by Observamed, a Colombian think-tank, in 2008 the government reimbursed health insurance companies with approximately US\$156 million for seven high-end biotech pharmaceuticals demanded by litigants. That figure represents approximately 22% of the total public pharmaceutical expenditure. Even more striking is the fact that five out of the seven pharmaceuticals are oncologic. These five oncologic medications alone represented approximately 15% (close to US\$101 million) of Colombia’s public pharmaceutical expenditure in 2008.²

In Costa Rica, according to a recent empirical study, the health rights opinions handed down by the Supreme Court’s Sala IV failed to foster a fair access to medications (Norheim & Wilson 2014). In their study, the authors randomly selected cases on access to medicines handed down by the Supreme Court, and found that approximately 70% of the judicial opinions ordered the government to provide “experimental” or “low-priority” pharmaceuticals with only marginal benefits for patients.

Based on the findings that indicate that health rights litigation in Latin America is strongly related with a growing *pharmaceuticalization* of health care, an emerging literature has investigated how transnational pharmaceutical companies are deploying pro bono litigation counseling conducted by patients’ organizations as a mechanism to boost the sales of their products at the expense Colombia’s, Brazil’s and Costa Rica’s health systems. A study of Brazil’s health rights litigation argues that pharmaceutical companies might have, indirectly, incentivized right-to-health litigation through NGOs and patients’

² Observamed, “Análisis de recobros con Factor VIIaR muestra sobrecostos importantes y dominancia de pocas EPS en el beneficio”, available at: http://www.med-informatica.net/BIS/BisBcm43de2010_18a24oct10.htm

organizations (Hoffman & Bentes 2008). A different study found evidence that in Brazil, Costa Rica and Colombia, national and transnational pharmaceutical companies have stimulated health rights litigation through their ties with patients' organizations. Yet, the authors of this study concluded that the linkages between pharmaceutical companies and civil society organizations like patients' groups "are difficult to uncover and credibly establish." They also concede that the comparative literature's data about such links "are still rudimentary, and more research is needed to reach a firm conclusion on the nature and extent of this influence" (Gloppen & Roseman 2011, p. 264).

A empirical study conducted in Colombia offered an account of the multifaceted linkages between patients' organizations that provide pro bono litigation support and transnational pharmaceutical companies (Lamprea 2015). The findings of this study suggest patients' organizations and advocacy groups that provide a support structure for litigation in Colombia advance a political or moral cause in which they "believe in" (Scheingold & Sarat 2004), namely helping "high-cost" patients to obtain life-saving medical treatment refused by health insurance companies and not covered by the health system, despite the economic linkages tying them to sponsoring pharmaceutical companies. But at the same time, due to their underpinning linkages with the pharmaceutical industry, the patients' organizations and advocacy groups have ambiguous and puzzling features of what the sociolegal literature calls *cause-lawyering* (Scheingold 2004).

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When the right to health does not work: the case of migrants' sexual and reproductive health in the European Union- Background paper to the Prince Mahidol Award Conference 2017-Session 2.2

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Migrants in the European Union

The European Union (EU) lays at the heart of an expanding range of increased migration streams. This influx generates the presence of newly arrived migrants, migrants in transit not claiming asylum, asylum seekers, migrants having been granted refugee or protected status, migrants who strand on their journey and migrants who become and remain undocumented. Many arriving have to survive an arduous journey involving smuggling, exploitation, crossing deserts, mountains, seas and unfriendly European nations. The legal status of these migrants is usually precarious. As unauthorised entrants they are considered 'irregular/undocumented migrants'. In some European countries unauthorised entry is a criminal offence, in others only an administrative one. However, article 31 of the 1951 Geneva Convention prohibits imposing penalties on such migrants *"provided they present themselves without delay to the authorities and show good cause for their illegal entry or presence"*. Countries vary greatly in the way this article is implemented (1).

The number of undocumented migrants present in EU was estimated to be around 2,1 million in 2015. Up to 2012 a gradual increase in the number of asylum applicants could be noted, after which it rose to 431.000 in 2013, 627.000 in 2014 and close to 1.3 million in 2015. These migrant groups add up to the 51 million other 'regular' migrants already residing in the EU (17 million EU migrants and 34 million third country nationals according to Eurostat).

The health and health needs of extra-EU migrants may differ greatly from those of the general European population and or to be considered an issue of public health importance (2-4). Gaps exist in the national health information and disease surveillance systems which increases the risk of vaccine preventable diseases and epidemic outbreaks. The profile of the displaced population indicates an increased need for sexual, reproductive and child health services. Compared to the general EU population, migrant women face poorer maternal health including higher rates of maternal complications and mortality, worse perinatal health outcomes, as increased rates of obstetric interventions, perinatal mortality, low birth weight and preterm birth (5). Identified risk factors are often linked to factors that already precede and contextualize migrant maternal health as for example family planning, health seeking behavior, sexual and gender-based violence and asylum procedures. Conditions during migration, low socioeconomic position and irregular status may all have a negative impact on maternal health (5). Both migrant women and men are more at risk of

sexually transmitted infections (STIs), including HIV and hepatitis B (6, 7) and of sexual violence (7). Sexual violence is also a specific reason for claiming asylum and a priority health concern, which requires specific interventions (8). Many of these migrants are survivors of physical violence or torture and have serious medical conditions. Some are amputees needing prostheses, victims of trauma needing specialized treatment or cancer patients. Hence the compounded effect of acute critical health needs that warrant humanitarian interventions as well as health needs that require access to regular comprehensive health care and public health interventions (1).

Health needs change and accumulate during the trajectory of flight/migration. This means, first of all, that it is important to address health needs according to their context 1) across the countries (countries of first arrival/transit and destination) and 2) within each country according to which step of the trajectory of flight the assessment concerns (arrival, asylum process, settlement). Secondly, it means that awareness of the cumulative effect of health needs during this trajectory calls for early and coordinated specialized action: vulnerable groups may become increasingly vulnerable during flight. Thirdly, it means that health protection during the final stages of a flight/migration trajectory must be targeted based on the complexity of (physical, psychological and social) unmet health needs that have arisen (and potentially keep rising) during the trajectory (1).

The right to health for migrants in the EU in theory

With the Universal Declaration of Human Rights (UDHR, 1948), the *enjoyment of the highest attainable standard of health* was put forward as a fundamental right of every human being. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. In 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued “General Comment 14”, an authoritative explanation of the Article 12.1 on the right to health of the ICESCR. It states in paragraph 12 (b) that governments have legal obligations to ensure that *“health facilities, goods and services are accessible to all, especially the most vulnerable of marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds”*, defined as *“race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status”* (§18). In addition, the CESCR specified that States have an obligation to respect the right to health *“by refraining from denying or limiting equal access (...) for all persons, including (...) asylum seekers and illegal immigrants, to preventive, curative and rehabilitative health services”*. All 27 EU Member States ratified this “International Bill of Human Rights” which integrates the human right to health defined in UDHR, ICESCR and ICCPR.

The EU prides itself as a promoter of human rights and adopted its Charter of Fundamental Rights in 2000. Yet, the Charter stipulates that: (Art 35) *“the right to health care includes the right of every person to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws”* (9). Every Member State can thus decide to what access of health care migrants are entitled in their country.

As for asylum seekers however, the European Directive on Minimum Standards for Reception of Asylum Seekers (2013/33/EU) contains several stipulations on ensuring health care access for asylum

seekers and more specifically emergency care and essential treatment of illnesses and of serious mental disorders (Art 19.1), necessary medical and other assistance to applicants with special needs, including mental health care (Art 19.2), assessment of vulnerable persons such as minors who have been victim of torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation (Art. 21) and applicants with special needs (Art 22), treatment for victims of sexual and gender-based violence and torture (Art 25.1), minors who have been victim (Art. 23.4) and prevention of sexual and gender-based violence in the reception facilities (Art 18.4). Besides, EU Member States need to guarantee applicants' subsistence and protection of their physical and mental health (Art. 17.2), ensure adequately trained staff, bound by confidentiality rules (Art 18.7), ensure necessary basic training of staff with respect to both male and female applicants (Art 29.1), and provide free legal assistance (Art. 26.2) (10).

The first comprehensive framework on sexual and reproductive health (SRH) was drawn at the 1994 International Conference on Population and Development (ICPD), which put SRH forward as a human right. The ICPD declaration stated that *"for sexual health to be attained and maintained, sexual rights of all persons must be respected, protected and fulfilled"* (11), which was re-emphasized in the General Comment no.14 (12). Furthermore, the ICPD Action Plan fostered specific actions to overcome migrants' vulnerability and was endorsed by the EU MS. Hence, SH was defined as *"a state of physical, emotional, mental and social well-being related to sexuality [and] not merely the absence of disease, dysfunction or infirmity"* (11).

The right to health for migrants in the EU in practice

Understanding health as a holistic state has irrigated research on SRH. Yet, our research demonstrated that at EU level, this holistic perspective in the context of migrants' access to SRH has been little developed and that legal frameworks are often an obstacle to care in itself.

First of all, a review of SRH policies and migration in the EU highlighted the discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH (6). Uncertainties on entitlements of diverse migrant groups are fuelled by unclear legal provisions, creating significant barriers to access health systems in general and SRH services in particular. While the rights-based approach of health seems to gain some momentum in international and regional frameworks, the European Charter leaves room to different and potentially more restrictive national or subnational provisions to health care which are often influenced by national migration policies. This clearly conflicts with a rights-based approach, as the prioritization of migration controls creates obstacles preventing migrants from realizing their right to health, particularly by restricting access to care. Allowing (ir)regular migrants to access health care is now often considered a State charity or generosity [31] while General Comment no.14 specifies that accessibility is core in the right to health [32] and thus a *"legal obligation and not a matter of charity or political choice"* [59]. Yet, the EU does not condone national conditioning of all human rights. Does the EU then care less for health as a human right than for another? As noted by Dean H. (13), the application of a rights-based approach is currently overlooked by European welfare regimes traditionally based on citizenship rather than on universality. This may be linked to the European democracies' conception of state sovereignty based on citizenship and subsequent perceptions of migration as a potential threat to this sovereignty [4].

Also for maternal health, we demonstrated that access to maternal health is not yet universal. At national level, several EU countries tend to restrict access to “emergency care”, often without clearly defining “emergency”, creating uncertainty within countries and over time. In several countries as for example Greece, Italy and Croatia this “emergency care” might cover delivery but not comprehensive access to ante and post-natal care (5). Inclusion does not however preclude appropriate care for pregnant women, with the example of Croatia where pregnant women are recognized as vulnerable but legal provisions do not yet address their specific needs (5). The UK removed HIV treatment from its emergency care list in 2009, hence abandoning free of charge treatment for all patients including pregnant and newborn ones (5). In Sweden, for example, asylum seekers can access care that “cannot wait” without co-pay, including maternal, abortion and family planning care, but undocumented migrants do have to pay to access such services (5). In Belgium, as an undocumented HIV-positive mother you can get ART but the baby cannot get powder milk (14).

Apart from maternal health, the rare strategies addressing migrants’ health fail to address sexual health rights and are generally limited HIV screening, applying a disease-oriented rather than a right to the best standard of health-approach (6). Moreover, legal and policy documents dealing with sexual violence and migrants, apply ‘tunnel vision’ (15). They ignore: a) frequently occurring types of sexual violence, b) victimisation rates across genders and c) specific risk factors within the EU such as migrants’ legal status, gender orientation and living conditions (15). The current EU policy-making paradigm relegates sexual violence in vulnerable migrants as an ‘outsider’ and ‘female only’ issue while EU migration and asylum policies reinforce its invisibility (15).

Conclusion

The question of migrants’ access to SRH services is key to understand the extent to which a positive approach of SRH is applied throughout EU MS. The assessment of the current situation clearly unveils both blurred legal and policy frameworks and patchy practices, which are major breaches to the realization of a rights-based approach to (SR)health. The interaction between migrants’ status, living conditions and sexual violence is complex; however it is striking that while sexual victimisation should open grounds for international protection, the legal and social status of migrants still largely prevents their access to specialised support and care in Europe. Effective response must be guided by participatory rights- and evidence-based policies and a public health approach, acknowledging the occurrence and multiplicity of sexual victimisation of vulnerable migrants of all genders within EU borders (15).

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Session: Using the Right to Health to Tackle Exclusion from Health Services

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Using the Right to Health for Budget Monitoring – the OPERA Framework

Great strides have been made in the past two decades in realizing the right to health for all, including a drop in the number of women dying from maternal causes from over 500 000 annually in 1990 to approximately 300 000 annually in 2015.¹ From a global health justice perspective, the facts that most of these deaths are preventable and that over 99% of these deaths occur in developing regions are indicators of how far we still need to go as a global community to realize the right to health for all. Much of my work as an academic lawyer working on health and human rights has focused on understanding how and why some health issues capture global attention (e.g. HIV/AIDS, child health) and others fail to (e.g. non-communicable diseases), and seeking to better understand the role of the right to health in helping people to claim their legal entitlements. The right to health has many detractors who critique its lack of precision, unenforceability and other failings. I prefer to view it as a work in progress with diverse, useful attributes that make it adaptable for the many challenges that must be confronted in advancing global health justice. I am also wary of viewing rights as a solution to all problems. I prefer to view the right to health as a (not *the*) tool and a spice – one of many spices needed to make a good curry. In this brief discussion, I will focus on a practical application of the right to health: budget monitoring.

Before looking at budget monitoring, it is worth noting how the right to health has progressed as a normative concept and as a practical tool since 2000. This progress can be attributed to a diversity of sources including the normative contribution of General Comment 14 on the right to health, the political will harnessed by the prominent role of health in the Millennium Development Goals, and the crossing of disciplinary bridges evidenced by the increased attention paid to global health financing and taxation by right to health scholars. The holistic global agenda outlined in the Sustainable Development Goals is welcome as it embraces the complexity of advancing human rights; recognizing interlinkages and complementarities. However, one problem with such complexity is that it is hard to translate into practical policy objectives that can contribute to advancing rights. In addition, the issue of accountability, fundamental to realizing the potential of human rights enshrined in international law, falters if governments are not held accountable for their failure to achieve policy objectives and outcomes aimed at realizing rights, or lauded for accomplishments in realizing rights.

The right to health as an accountability tool

Human rights activists and scholars have often focused on ex post facto accountability, which is a traditional legal approach. The naming, shaming and litigation associated with such an approach can help to deliver a sliver of justice, for example, for those that suffer loss due to discrimination in accessing health care services. A prominent international example in this area is the tragic case of *Alyne da Silva Pimental v. Brazil*. This was the first time an international human rights treaty body, the

¹ http://www.unfpa.org/sites/default/files/pub-pdf/9789241565141_eng.pdf

Committee on the Elimination of Discrimination Against Women, held a state liable for a preventable maternal death.² The mother of Alyne da Silva Pimental, a 28-year-old Brazilian woman who died due to denial of access to health services to address a pregnancy-related complication, fought five years for this decision, which does not reverse the injustice done to her daughter. Alyne herself died and the ground-breaking changes her suffering and death brought to the international legal sphere do not help her or her family, but they have contributed to setting standards regarding discrimination and access to health services. Using the law to advance human rights has both positives and negatives, as my colleagues on this panel, Everaldo Lamprea³ and Moses Mulumba⁴, have documented.

Human rights scholars and activists also use rights analysis to contribute to shaping policy and policy dialogue. For these purposes, human rights impact assessments are useful tools for structuring and analyzing the merits and deficits of a given policy. The use of such tools has been trumpeted by the former UN Special Rapporteur on the right to food, Olivier De Schutter.

Increasingly, human rights scholars have turned to looking at government budgets to assess whether and how they do or do not advance rights. In countries that are party to the covenants and conventions that comprise the international human rights treaty web, such an assessment provides a strong legal basis for a particular course of action or policy. Many governments may choose to ignore their commitments, as accountability mechanisms are weak. But this does not render the commitment invalid; it means they are unrealized, and it is our job to point this out and show how such commitments can be realized.

The rest of this brief discussion focuses on budget monitoring, which I consider an important tool for public health advocates, economists and human rights activists, and which scholars can employ to advance the right to health. Before doing this, it is worth highlighting that for lawyers working in the health field, engagement with public health experts and economists is vital. To put it simply, understanding the cost effectiveness of a preventive measure or treatment – and the public health contribution of such a measure – are vital components in assessing whether a funding measure has the potential to increase discrimination in accessing health services for particular vulnerable groups, which is a key human rights consideration.

Budgets and health care financing

To engage in budget analysis, it is important to understand the basics of budgeting and health care financing. It is worth noting that it can also be important to look outside the health sector – as non-

² Cook RJ. Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision. 41 J.L. Med. & Ethics 103 (2013).

³ Lamprea E. (2014) Colombia's right to health litigation in a context of health Care Reform in "The Right to Health at the Public/Private Divide: A Global Comparative Study" Cambridge University Press Editors Flood C and Gross A.

⁴ Mulumba M. <https://theconversation.com/profiles/moses-mulumba-229377/articles>

health spending for example on education or public works (e.g. sanitation, roads and bridges) also impacts on health. A hospital that has no access road or is cut off from most a region's population due to the absence of a bridge is not very useful. Most importantly for health, if we want to assess a given country's efforts to achieve the right to health for all, we need to examine the volume of health care expenditure (the health budget), what the budget is spent on, and how the state finances the health care budget (e.g. different forms of taxation, external sources including loans and grants). There is no "correct" answer to these questions, but there are "wrong" answers and identifying these wrong answers can be made easier through using the OPERA framework, which examines the Outcomes, Policy Efforts and Resources to make an overall Assessment of the compliance of government policy, or proposed policy, with human rights standards.⁵

The OPERA framework was developed by the New York based international NGO, the Center for Economic and Social Rights to assist human right scholars in tackling accountability for violations of economic and social rights stemming from misguided public policy. When adapted for health, it is useful for public health scholars. Engaging in an OPERA analysis helps to make explicit the "crucial link between the various human rights standards and principles that underpin the obligation to fulfill and the different assessment methods available to monitor them, the framework enables a systematic approach to building evidence of failures to fulfill ESc rights."⁶ So, it is not a health-specific tool, which adds to its richness. It can help identify issues that cross or transcend the health sector that impact on health systems and health outcomes, including issues like infrastructure spending. For example, does the public works budget disadvantage a certain region of the country? Does it focus spending on the urban areas?

In 2014, my colleague Gorik Ooms and I worked with the WHO to develop a practical tool integrating right to health concerns with progress on universal health care coverage (UHC), a key SDG commitment.⁷ The attraction of using the OPERA framework is that it enables a systemic approach to identifying failures to fulfill economic and social rights like the right to health. It aims to assist governments on the path to UHC and we are hoping that national governments, public health practitioners, and human rights scholars will use it and refine it so that it contributes to advancing the right to health for all. I encourage you to read the whole report, but the 'take away' I want you to have from this discussion can be best summarized in the ten guiding questions we developed. They are not perfect, but they start the dialogue on the transformational change that is needed to make the right to health a reality for all.

⁵ <http://cesr.org/downloads/the.opera.framework.pdf>

⁶ <http://cesr.org/downloads/the.opera.framework.pdf> (page IV)

⁷ <http://www.who.int/gender-equity-rights/knowledge/anchoring-uhc.pdf>

Key guiding questions

These questions, tailored for national health sector policy makers, aim at ensuring that 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 towards other sectors that 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 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 of the country and different regions?

Identifying and remedying the multiple barriers stemming from socio-economic exclusion and/or discrimination is certainly vital to advancing UHC but it is not sufficient. It is necessary to make efforts 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?

UHC policies monitoring efforts should ensure that a mixed system does not lead to discrimination or exclusion on the basis of socio-economic status. Disaggregating findings can help identify whether or not private for profit providers and insurers include 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 indicators on quality of care is a difficult process, but agreeing and monitoring indicators on quality 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 backwards, thus, including MTEF and budget projections in monitoring efforts helps assess 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.