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## **Universal Health Coverage, Priority Setting and the Human Right to Health.**

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## **Abstract:**

As health policy-makers around the world seek to make progress towards universal health coverage they must navigate between two important ethical imperatives: to set national spending priorities fairly and efficiently; and to safeguard the right to health. These imperatives can conflict, leading some to conclude that rights-based approaches present a disruptive influence on health policy, hindering states' efforts to set priorities fairly and efficiently. Here, we challenge this perception. We argue first that these points of tension stem largely from inadequate interpretations of the aims of priority setting as well as the right to health. We then discuss various ways in which the right to health complements traditional concerns of priority setting and vice versa. Finally, we set out a three-step process by which policy-makers may navigate the ethical and legal considerations at play.

## **Introduction**

Following endorsement by the World Health Organisation (WHO),<sup>1,2</sup> the World Bank,<sup>3</sup> and, most recently, 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 an extensive philosophical literature on the ethics of priority setting in healthcare, a recent WHO report provides guidance on how states may resolve these issues.<sup>5,6</sup> However, policy-makers also face a further question largely left open by the report: where do states' moral and legal obligations regarding the right to health fit in?

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 NHS, including NICE's evaluation of healthcare 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 might be seen in recent judicial decisions in some Latin American countries, where some courts' defence of what they take to be individuals' rights to expensive new drugs and services have clashed with on-going efforts by national health planners to prioritise expenditures that improve population health.<sup>9</sup> For

example, in a systematic analysis, Norheim and Wilson found that in Costa Rica less than 3% of the successful cases for medications outside the agreed-upon benefits package would be considered high priority in accordance with 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 may 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 article we reject this view. When properly interpreted, 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.

### **The limited justification for the sceptic's worries**

It is important to acknowledge that there are ways in which one could interpret both what constitutes a just distribution of health care resources and what constitutes the human right to health which 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 maximize health benefits across a given population, and the 'right to health' as simply the claim that all individuals ought to have access to any medical treatment they might 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 respect to some of the cases in Latin America – it has been as a result of precisely these kinds of inadequate interpretations.

However, there is little in the philosophical and legal literature or international law to justify such readings, and they are increasingly out of step with judicial practice.<sup>11,12</sup> First, philosophers have long argued that achieving justice in healthcare priority setting involves applying a range of substantive ethical principles beyond utilitarian calculations of which policies maximize health.<sup>5,13,14,15,16,17</sup> In addition, both philosophical discussion and legal theory are moving away from seeking to determine health policy priorities through an appeal to particular substantive principles alone, instead looking to ensure just distribution through a fair and accountable process.<sup>11,18,19,20</sup>

The notion that the right to health means that an individual has a claim against the state to any medical treatment they need, regardless of cost, also fails to reflect current philosophical thinking,<sup>21</sup> not to mention being plainly 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, goes further, 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:

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>

### **How rights concepts can aid priority setting**

Far from being disruptive, there are various ways in which the right to health, 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: actors must decide how to allocate resources across different populations under conditions of scarcity.<sup>26</sup> The right to health, though, helps to explain how we got to the committee room in the first place: that is, each individual, by virtue of being human, has a right to health. The committee is brought together to respond to those moral (and legal) claims, showing equal concern for each individual.

Second, rights can provide a powerful 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, ‘rights talk’ forces attention on issues of equity. Thus, if priority setters were, misguidedly, to seek only a utilitarian maximization 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 emphasizes citizens' role as agents, who are entitled to influence priority setting and to hold decision-makers to account.<sup>19</sup>

### **Ways in which the realisation of the right to health relies on good priority setting**

Interpreted correctly, priority setting is also integral to realisation of the right to health. First, as noted above, aspects of international law regarding the right to health *require* policy-makers to prioritise between different services and treatments.

While not a feature of all conceptions of the right to health, international human rights law also demands the fulfilment of certain '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.

### **Recommendations for policy makers**

In sum, 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 (e.g. priority setters, local and national health planners) as well as those charged with upholding the right to health (e.g. legislators, judges), need to recognize broader and more recent interpretations of each imperative. Priority setting is not only about a utilitarian drive to maximize health benefits across the population nor is the right to health about securing every individual's access to health care regardless of cost.

Second, once substantive and procedural principles for ensuring fair allocation of resources devoted to health have been decided through a transparent and participatory process, states need to institutionalize priority setting. This could include an organization for systematic assessment of new and existing health technologies as well as 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, 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, once 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 in light of the state's obligations under that right. The right to health, just as civil and political rights, requires resources of various kinds, whether through taxation or other means. As with civil and political rights, the right to health is supposed to have teeth. When the *status quo* fails to uphold people's rights, changes, including judicial remedies, are needed.

## **Conclusion**

As they progress towards the achievement of UHC, policy-makers around the world 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, understood properly, there are a number of ways in which priority setting and the right to health are mutually supportive. As well as highlighting these points of convergence, in this article we have set out a three-step process for establishing policies and procedures that progressively realize people's right to health and set fair priorities.

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### **Author Contributions**

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. Benedict Rumbold was responsible for drawing up a first draft of the article and handling subsequent edits. Paul Hunt 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 A-Z order. 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, or the Department of Health and Human Services.

### **Declaration of Interests**

There are no conflicts of interest

### **References**

- 1 World Health Assembly. *Resolution on sustainable health financing and universal coverage and social health insurance*. Available from: [http://www.who.int/mediacentre/news/releases/2005/pr\\_wha06/en/](http://www.who.int/mediacentre/news/releases/2005/pr_wha06/en/) [Accessed 20<sup>th</sup> October 2015]
- 2 World Health Organisation. *World health report 2010: Health systems financing: the path to universal coverage*. Available from: <http://www.who.int/whr/2010/en/> [Accessed 20<sup>th</sup> October 2015]
- 3 World Bank Website. Available from: <http://www.worldbank.org/en/topic/universalhealthcoverage> [Accessed 20<sup>th</sup> October 2015]
- 4 United Nations Website. *Sustainable development goals: goal 3.8*. Available from: <https://sustainabledevelopment.un.org/sdgsproposal> [Accessed 20<sup>th</sup> October 2015]

- 5 World Health Organisation. *Making fair choices on the path to universal health coverage*. Geneva: World Health Organisation, 2014. Available from: [http://apps.who.int/iris/bitstream/10665/112671/1/9789241507158\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112671/1/9789241507158_eng.pdf?ua=1) [Accessed 20<sup>th</sup> October 2015]
- 6 Chan M. Making fair choices on the path to universal health coverage. *Health Systems & Reform* 2016; **2**: 5-7
- 7 Ottersen T, Førde R, Kakad M, Kjellevoid A, Melberg HO, Moen A, Ringard Å, Norheim OF. A new proposal for priority setting in Norway: Open and fair. *Health Policy* 2016; **120**(3): 246-51.
- 8 Easterly W. Human rights are the wrong basis for health care, *Financial Times*. 2009. Available from: <http://www.ft.com/cms/s/0/89bbda2-b763-11de-9812-00144feab49a.html> - last accessed 11/11/13 [Accessed 20<sup>th</sup> October 2015]
- 9 Maestad O, Rakner L, Ferraz O. Assessing the impact of health rights litigation: a comparative analysis of Argentina, Brazil, Colombia, Costa Rica, India and South Africa. In Yamin AE and Gloppen S (eds.), *Litigating the Right to Health: Can courts bring more justice to health systems?* Harvard University Press, 2011. 273-303.
- 10 Norheim OF, Wilson BM. Health rights litigation and access to medicines: priority classification of successful cases from Costa Rica's Constitutional Chamber of the Supreme Court. *Health and Human Rights* 2014; **16**(2): 47-61.
- 11 Yamin AE, Lander F. Implementing a circle of accountability: a framework for judiciaries in enforcing health-related rights. *Journal of Human Rights* 2015; **14**(3): 312-331.
- 12 Yamin AE, Norheim OF. Taking equality seriously: applying human rights frameworks to priority setting in health. *Human Rights Quarterly* 2014; **36**: 296-324.
- 13 Anand S, Peter F, Sen AK. *Public health, ethics and equity*. Oxford: Oxford University Press; 2004.
- 14 Sen A. Why health equity? *Health Economics* 2002; **11**(8): 659-66.
- 15 Brock D. Ethical issues in the use of cost effectiveness analysis for the prioritization of health resources. In: Khushf G, (ed.) *Handbook of bioethics: taking stock of the field from a philosophical perspective*. Dordrecht: Kluwer Academic, 2004. 353-380.
- 16 Daniels N. *Just health care*. New York: Cambridge University Press, 1985.
- 17 Norheim OF, Baltussen R, Johri M, et al. Guidance on priority setting in health care (GPS Health): the inclusion of equity criteria not captured by cost-effectiveness analysis. *Cost Effectiveness and Resource Allocation* 2014; **12**:18
- 18 Holm S. Goodbye to the simple solutions: the second phase of priority setting in health care. *BMJ* 1998; **317**(7164): 1000-2.
- 19 Daniels N, Sabin JE. *Setting limits fairly: learning to share resources for health*. 2nd Edition. Oxford: Oxford University Press, 2008.

- 20 Yamin, AE. *Power, suffering and the struggle for dignity: human rights frameworks for health and why they matter*. Philadelphia: University of Pennsylvania Press, 2016.
- 21 Rumbold BE. The moral right to health: a survey of available conceptions', *Critical Review of International Social and Political Philosophy* 2015; online first: doi:10.1080/13698230.2014.995505.
- 22 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966. Available from: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx> [accessed 9 November 2016].
- 23 UN Committee on Economic, Social and Cultural Rights. *General comment no. 14: the right to the highest attainable standard of health (Art. 12 of the Covenant)*. 11 August 2000, E/C.12/2000/4, para 19. Available from: <http://www.refworld.org/docid/4538838d0.html> [accessed 7 January 2016].
- 24 Sen A. Why and how is health a human right? *The Lancet* 2008; **372**(9655): 2010.
- 25 Venkatapuram S. *Health justice: an argument from the capabilities approach*. Cambridge: Polity Press, 2011.
- 26 Culyer AC, McCabe C, Briggs A, Claxton K, Buxton M, Akehurst R, Sculpher M, Brazier J. Searching for a threshold, not setting one: the role of the National Institute for Health and Clinical excellence. *Journal of Health Services Research and Policy* 2007; **12**: 56–58.
- 27 Dittrich R, Cubillos L, Gostin L, Chalkidou K, Li R. The international right to health: what does it mean in legal practice and how can it affect priority setting for universal health coverage? *Health Systems & Reform*. 2016; **2**(1): 23-31.